



TRANSITIONING FROM RESIDENTIAL TREATMENT: FAMILY INVOLVEMENT & HELPFUL SUPPORTS

Residential care for children and adolescents with severe emotional and behavioral challenges is often a last resort for families who have exhausted community resources and exhausted themselves in efforts to care for their children at home. Young people are also placed in residential care “through a number of public avenues: through child protective agencies; through the public mental health agencies, frequently after state hospital stays; by juvenile justice authorities as an alternative to incarceration; and with increasing frequency, by school districts, when the school [was] unable to educate and maintain the student within the school community” (Hoagwood & Cunningham, 1992). In addition to struggling with serious emotional disturbance or mental illness, children and adolescents in residential treatment may be dealing with issues related to child abuse and neglect, substance and alcohol abuse/addiction, delinquent behaviors, family violence, learning disabilities, mental retardation, and handicaps (McNair & Rush 1991).

In most cases, the goal of residential treatment is to return the young person to family-centered community living. However, making a successful transition back to family and community is a process with many challenges, especially given that a young person’s relationships with family members are often further stressed and disrupted during the period of residential treatment. Common sense and research both suggest that supporting, enhancing and maintaining family relationships during the period of residential care will increase the probability of successful transition; however, many families find that contact with their children and participation in service and transition planning is limited and/ or discouraged by policies at residential treatment centers (*see the article by Friesen et al. in this issue, page 20*).



Residential treatment programs conceptualize and prioritize family involvement in treatment and in discharge and transition planning using very divergent theoretical foundations. The spectrum of involvement practices ranges from the exclusion of parental and family involvement, to limited family involvement as directed by the program staff, to the ongoing maintenance of

parent and family involvement in all aspects of the treatment milieu from start to discharge with extensive family follow-up services, or to the rare family residential program at the far end of the continuum where parents and children are placed in residential treatment together. Many residential programs vacillate across this continuum in time and across components of the treatment program. Societal values and priorities also influence the emphasis placed on families by residential and community-based treatment and service options.

Roles for parents have included everything from being a topic in the therapy of children, to being clients along with their children, or to being an equal expert partner in the treatment and planning processes. While parents generally value family therapy, parent skills training, and a variety of family support groups as part of both residential and community-based interventions, respectful consideration of parental priorities is the best guide to the selection of services and supports.

Residential staff have struggled with issues that infringe upon their ability to support parents’ desire to participate in treatment and/or the planning process. Concerns include a fear that involved parents who visit more will criticize the program, a lack of understanding by staff as to why parents placed children in residential care, and a fear that parents once supportive of residential treatment will prefer community-based services and denigrate residential programming (McDonald, Owen &

McDonald, 1993). "Parental guilt about any placement, professional notions of 'saving' children from 'bad' home environments, and milieu therapy approaches which emphasize regulation of outside (family) influences on the identified patient have conspired against active involvement of parents" (Mitchell, 1982). Residential treatment programs traditionally explained away parents as resistant or unworkable thus erecting further barriers to their participation.

In a break with then-prevailing attitudes, Finkelstein (1980) proposed, based upon the experience of Parsons Child and Family Center in Albany, NY, that residential treatment programs be structured from inception upon the plan for discharge with priority given to a return to the family. Focusing treatment on the needs of the family, not just on needs of the child, altered the approaches traditionally utilized in residential treatment. This past research may have led to a change in staff attitudes towards family and parental involvement in treatment and in discharge planning: a more recent study showed that residential staff members were very supportive of greater family involvement, although they showed more support for families in the role of service recipients than as decision makers (Baker, Heller, Blacher & Pfeiffer, 1995).

Involvement of family members as service recipients was further supported in research employing a records review of 130 adolescents served in residential treatment. Researchers looked for predictors of discharge status, examining variables related to demographics, victimization, family dysfunction, prior antisocial behaviors, and therapies (Stage, 1999). "The results showed that the odds were 8:1 that residents who received family therapy were discharged to less restrictive settings" (Stage, 1999). Findings such as these support early and continued involvement of family members in their child's services.

It remains important that the family and service community work together during planning for discharge and transitioning back into family care. "Aftercare is a distinct and necessary intervention for children leaving residential treatment...[a time] when child and family face critical tasks" (VanHagen, 1982). Family involvement and contact, and/or resolution of issues surrounding biological families' parenting, represent crucial issues demanding attention when returning children to less restrictive environments while supporting treatment gains post discharge. Parents "were unable to rear the children themselves because of a host of problems, and...these problems ...[need to be] confronted to enable the parents to resume care" (Tam & Ho 1996). Family therapy

appears to be an important component in attaining this goal (Stage, 1999).

Since the majority of children eventually return to family-centered community living, service values have shifted toward supporting the child and family. In fact, "the degree of environmental support following discharge tended to be a stronger predictor of success and improvement than [the] clinical treatments received during placement (Durkin & Durkin, 1975)" as cited in Hoagwood & Cunningham, 1992. Environmental supports include family, school, community, peer group, and professional helpers. These same supports make it more likely that positive treatment gains achieved will be maintained: "The gains of the treatment experience were not maintained if supports were not in place when the child returned home (Whitaker & Pecora, 1984)" as cited in Hoagwood & Cunningham, 1992. In addition, Hoagwood & Cunningham cite a study that found:

"[O]ver two thirds of the respondents stated that the availability of community-based services for the student and family would have prevented residential placement. The availability of community-based services with which to transition a student from residential placement back into the community was the single most likely reason...for positive discharge. Specifically mentioned were services that included day treatment, respite care, intensive in-home family support, and crisis stabilization."

Current research also questions the effectiveness of residential treatment as compared to community-based alternatives. The recent report by the Surgeon General (U.S. Department of Health and Human Services, 1999) summarized its discussion on residential treatment centers by noting that the proposed justifications for residential treatment (such community protection, child protection, and benefits of residential treatment per se) have not stood up to research scrutiny. Further, residential treatment is expensive: a study comparing adjudicated juvenile delinquents in residential treatment to those in intensive day treatment found that the "post treatment measures support an interpretation of the similar effectiveness of the two types of treatment ...[with intensive day treatment] approximately half the cost of residential treatment" (Velasquez & Lyle, 1985). Perhaps the best answer to the problems associated with transitioning out of residential care is, at least for some children, not to leave their homes and communities in the first place.

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Research shares the responsibility to provide reliable information upon which parents and children can make decisions. When and for whom will residential treatment be most appropriate? How can outcomes be adequately documented, families be supported, and quality program components be assured? What environmental elements do individuals, families, and communities need to maintain gains and support prevention efforts? Promising and exemplary interventions and support services require ongoing collaborative study by teams of consumers, family members, practitioners, researchers, and educators to strengthen families who take on the difficult task of raising healthy, competent, happy, and productive future citizens.

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