
Overview of Best Practices in Family-driven Care

Overview of BBI
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Family Driven: What’s It All About
What is Family Driven?

Family Driven means families have a primary decision making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation.

This includes:
• Choosing culturally and linguistically competent supports, services, and providers;
• Setting goals;
• Designing, implementing and evaluating programs;
• Monitoring outcomes; and
• Partnering in funding decisions.

Source: Federation of Families for Children's Mental Health

Why Is It Important?

• Strongest predictor of post-transition success, after education, is support from family
• Fifty percent (50%) of youth who have aged out will live with some member of their family within a couple of years (about equally divided between parents and other relatives)

Source: Courtney, M., 2007; Courtney, M., et al, 2004

• “Work with family issues and on facilitating community involvement while adolescents are in residential treatment may have assisted these adolescents to maintain gains for as much as a year after discharge.”

The effectiveness of services, no matter what they are, may hinge less on the particular type of service than on how, when, and why families or caregivers are engaged in the delivery of care. While traditional forms of care approached mental health treatment in a hierarchical top down approach (with the clinician maintaining some distance from the recipients of treatment), this approach is not reflected in newer forms of service delivery. It is becoming increasingly clear that family engagement is a key component not only of participation in care, but also in the effective implementation of it.

Source: Burns, B. et al, 1999, p. 238
What Can Programs Do?

Hire Family Partners/Advocates

1st MOST IMPORTANT STEP:

- Hire multiple family partners/advocates

- Have senior family partner as part of executive team & provide supervision to all family partners

- Have family partners (AND FAMILY MEMBERS) as part of EVERY organizational work group/committee/task force

- Have family partners share offices with other staff – spread throughout the organization
Hire Family Partners/Advocates

- They serve as co-trainers in staff orientation and ongoing training programs
- They serve as part of hiring groups to hire staff
- They serve as part of evaluation teams to evaluate each individual staff
- “Nothing about us without us!”

2ND MOST IMPORTANT STEP:

- Develop A Strategic Plan to Successfully Engage Families and Operationalize Family-driven Care

Go to the BBI website download, review and plan to use the BBI Self-Assessment Tool as part of your strategic plan

www.buildingbridges4youth.org
As Part of Strategic Plan

Have all leadership team members read and read and read:

• **BBI Family Tip Sheets** (long and short versions) & **BBI Engage Us: A Guide Written by Families for Residential Providers**

• **Massachusetts Department of Mental Health Creating Positive Cultures of Care Guide Chapters:**
  - *Successfully Working with Family Partners*
  - *Embracing Family-driven Care*

• A variety of other materials to support increased understanding and improved knowledge-base (see references at end of this chapter and in the Positive Cultures of Care Guide Chapters referenced above)

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Pederson-Krag/Long Island, NY

Two 8-bed Community Residences strategic planning led to improvements:

- Two Family advocates/youth advocate
- Family support program keeps families connected to local family supports
- Clinical staff > 75% in homes/service plan reviews in homes – w/youth leading
- Recreation staff work in home communities: connecting & supporting youth to activities/friends/mentors during ‘residential’ (ideally those in place pre-residential & matching talents/interests) & will continue post-discharge
- Youth spending time at home multiple x weekly
- Staff calling families multiple times weekly; youth call home frequently
- Major push for travel to home community for health/MH appointments
- Youth engaged in state level leadership activities
- All staff interviewed re: overall goal of program: “successful reunification with family”
TO ENSURE WELCOMING OF & PARTNERING WITH FAMILIES YOU WOULD SEE:

Board/Executives Focusing on Specific Areas

If These Areas are Not Already in Place, Consider Including in a Strategic Plan.
Board/Executive Focus Areas

- **Leadership**
  Passionate focus on transformation towards FDC (ala Bill Anthony: walk the walk vs. just talk the talk)

- **Agency clear values**
  (e.g., strength-based, trauma-informed, individualized & flexible; family-driven; youth-guided; cultural and linguistic competence; community integrated)

- 100% staff competent in skills which = values (primarily: respect/compassion/empathy /listening/choice /kindness/patience)

- **Multiple program practices**
  clearly spelled out for each value

- **Sophisticated Supervision Systems**
  – especially Clinical

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Small Step Example

**Raquel Hatter**, CEO of large residential program, went back to her agency after the first BBI Summit and implemented multiple improvements, including:

- Primary focus on welcoming families as full partners
- Hired senior executive focused on family
- Rewrote job descriptions to include FDC
- Made supervisors accountable (some eventually asked to leave)
Board/Executive Focus Areas

Fully implementing:

- Family Search & Engage
- Wraparound/Child & Family Teams
- Best Practice Clinical Engagement Skills (i.e. variations of Functional Family Therapy/Multi-systemic Therapy)
- Clear expectations for all disciplines of staff to work interchangeably in residential, home & community

Board/Executive Focus Areas

Use Data to Inform Practice:

- Restraint/Seclusion
- Achieving Permanency for Every Child
- Putting into Place for Every Child a Broad Community Support Network
- Precipitous Discharges
- Hospitalizations
- Re-admissions into Out-of-home Care/Hospitals for all Youth at Least 1 to 2 Years Post Discharge
THE NEW BAR IS HOW CHILDREN AND FAMILIES ARE DOING 6 MONTHS TO 3 YEARS POST DISCHARGE

WHATS HAPPENING IN THE COMMUNITY IS WHAT COUNTS

<table>
<thead>
<tr>
<th>Board/Executive Focus Areas</th>
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<tr>
<td>Quality Improvement:</td>
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<tr>
<td>▫ % of Youth Spending Time Every Day with Family Members and/or in Community Engaging in Pro-social Activities w/ Pro-social Peers</td>
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<tr>
<td>▫ % of Family Members Met with Every Week</td>
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<tr>
<td>▫ % of Families Connected to and Part of Family Support Groups in Community</td>
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Board/Executive Focus Areas

- Ensure Fiscal Strategies that Support Working with Families in their Homes and Communities during and post residential stays (i.e. 6 months to 2 years post)
- Offer Long Term: Respite/In-home Support
- Set Expectations in Staff Job Descriptions/Contracts for Minimum % of Time Staff Spend in Communities w/ Families
- Rename Positions (i.e. ‘Clinical Staff” Become ‘Reunification Specialists”) to Emphasize Focus on Permanency/Reunification

Board/Executive Focus Areas

Ensure Executive Team Members:

- Have Open Door Policy for Family Members

At Least One Team Member Meets/Greets Every New Family

At Least One Team Member Interviews Every Family Individually at Discharge and Again – 6 Months Post Discharge

And All Agency Staff Represent the Cultures/Ethnicities/Races & Speak the Languages of the Youth and Families Served
TO ENSURE WELCOMING OF & PARTNERING WITH FAMILIES YOU WOULD SEE:

Staff of All Disciplines Implementing a Variety of Family-Driven Practices
Examples of Practices You Would See:

- Every Staff is ‘Director of First Impressions’
  (Title Used In New Zealand Agency)
- Families Can Come to Program 24/7
- Warm and Comfortable Physical Environments
- Families Can go to Every Part of the Program – Spending Time in Their Child’s Room and Classroom and Activities

Small Step Example

A Staff Member from American Training in Boston Was Recently Describing Their Program to Dr. Gary Blau and Referred to Their Guests”....

Dr. Blau Discovered Upon Further Exploration That They Were Talking About the Young People They Served in Their Residential Program!

Not Clients, Not Consumers, Not Residents, But “GUESTS”!
Examples of Practices You Would See:

- Lose The Words ‘Home-Visits’
- Family Focus Groups Decide Education Offerings for Families
- Families Called Everyday to Share Child Strengths – Not Just About Issues & Encouraged to Call Multiple Times Daily
- Youth Call Different Family Members Multiple Times Daily
Examples of Practices You Would See:

• Ensure Families Have Dedicated Time to Talk with Front Line Staff

• Make it a Practice to Consult with Families to Seek Counsel and Engage Them in Decision-making

• Create Opportunities (i.e. Weekend Camping) for Families to be Proud of their Children/to Create Positive Memories

• Support Siblings

Examples of Practices You Would See:

• **NO MORE GROUP REC** – All Recreation Focused on Youth Individual Interests/Talents and any ‘Group’ Activity Involves Siblings/Families/Extended Families- i.e. Cousins

• **Gather Tickets/Freebies** for Families to Use with Children (maybe with a staff for support)

• **Develop Close Collaborations with Clinical Expertise in Community** (e.g., Trauma; Substance Abuse; Domestic Violence) & Supports (e.g., Housing; Community Activities; Peer Mentors; Respite)
Strategies For Dealing with Families From Long Distances

Have Policies/Practices/Staff Training to ENCOURAGE:

- Youth Calling as Many Family Members as Possible AND Friends Whenever Want/Need To

- Have Many Phones/No Restrictions on When Can Use (Except Maybe School/After Certain Time of Night)

- Allow Cell Phones (w/ Security – i.e. Photos Taking/Video Turned Off)

- Skype/Google Chat DAILY
Have Policies/Practices/Staff Training to ENCOURAGE:

• Do ‘Whatever It Takes’ to Get Youth Home 2x Week Minimum (and When Crisis Comes Up; ALSO- DO NOT ALLOW YOUTH TO MISS ANY IMPORTANT FAMILY EVENTS) – Up to 3 Plus Hours Drive 1-way/Worked on Revising Budget Items i.e. Gas $

• Develop/License Community Programs in Communities Youth Come From AND/OR Develop Strong Partnerships (e.g., Joint Values; Joint Training; Formal Sign-offs)

• Have Staff Phone and Email Regularly – ESPECIALLY TO SHARE STRENGTHS; Communicate Often;

Have Policies/Practices/Staff Training to ENCOURAGE:

• Train clinical staff to do family systems work on the phone (just for some meetings – MOST SHOULD HAPPEN IN HOMES)

• Have a clinical staff and a family advocate work in the community most youth/families reside (ala SCO/NYC)

• Get a grant to buy i- Pads/lap tops and rent (i.e. $1) for families (or - if charge more - return $’s when returned)

• Create back and forth art project/binder for families and youth to work on 2 to 3 x weekly or daily and either take each weekend home and/or scan/email back and forth (ala SCO/NYC)
What To Be Cautious Of:

• Events on Residential Campuses (why?)

• Lack of Sophisticated/Committed Clinical Supervisors

• Group Residential Recreation (why?/who to invite? (Build Memories with Families)

• Residential Holiday Traditions (“Is it About the Program or About the Youth/Family?”)

What can providers do to improve family-driven care in residential programs?
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