‘Building Resilient Lives’

including families in residential intervention

Melanie Pearson *examines issues of family involvement in residential intervention such as Children’s Health Camps*

The popularity of residential interventions for children and youth has fluctuated, both around the world and over time. Such interventions, although relatively infrequently used in New Zealand, have the potential to significantly improve the quality of life of both the children they serve and their families, when the child returns home. In this article the literature on one factor, family involvement, is summarised. That is almost unanimously agreed to be of great importance in enhancing the probability of long-term change. The notion of families as treatment partners is then demonstrated by a description of Children’s Health Camps, a unique and innovative cluster of interventions attempting to ‘build resilient lives’.

Here, family is broadly defined as parents, caregivers, or significant individuals in the child’s life. It is acknowledged that the concept of family is culturally determined, and that the Māori notion of whānau and the concept of a nuclear family are far from synonymous.

A review of the literature

The great majority of residential outcome research has been conducted in the United States, involving long-term stays (typically six months to two years) and children or youth who were admitted to the residential programme as a ‘last resort’ with diagnoses as varied as conduct disorder and mental retardation. Very little outcome research has been conducted in New Zealand, with our relatively short-term residential programmes (usually between four weeks and three months in duration) and unique population and interventions.

Research indicates that children often display positive behavioural changes in the residential environment. However, follow-up studies of children placed in out-of-home care indicate that, generally, these changes are not maintained when the intervention has ended (Jenson and Whittaker, 1987, 1989). How they respond to treatment in residential centres does not necessarily indicate what the child’s adjustment will be like post-discharge (Burks, 1995). In fact, children and adolescents, on discharge into an environment that has often altered very little from the point of admission, commonly return to former behaviour patterns and fail to generalise changes by not incorporating the new behaviour on their return home (Finklestein, 1981; Jenson and Whittaker, 1989).

It is reasonable to expect that the level of positive behaviour change would tend to decrease over time. As the time since discharge lengthens, it is increasingly likely that the effects of the residential programme will exert less influence over the child's life (Hooper et al, 2000). However, the decomposition of treatment effects tends to be sufficiently rapid so that the process usually cannot be attributed solely to the effect of the passage of time.

When focus is on the isolation of those factors that encourage the maintenance of positive changes, a consistent observation has been that family involvement in the residential intervention improves generalisation post-discharge. In fact, Chamberlain (1999) goes so far as to assert that 'failure to include parents in youngsters' treatment may be the single largest barrier to generalisation of treatment effects from residential care to living at home' (p502). Thus, if parents and/or family members are involved with the child during their residential stay, the propensity for maintenance of positive changes will be increased. Emphasising this, Whittaker (1981) notes that any approach to treatment for children in need, including residential treatment, 'will succeed according to its ability to influence the total ecology of the child's world: most notably the family' (p68).

Jenson and Whittaker (1989) confirm the importance of family involvement with their statement that 'parental involvement and family support in the treatment process for children and youth removed from their homes are among the strongest predictors of a child's ability to adapt to the community successfully following placement' (p210). The authors argue that although parents are perceived, on occasion, by professionals as unable to care for their child, several powerful reasons exist for pursuing their involvement in the child's residential placement, including the strong empirical evidence establishing the importance of this involvement.

Few evaluations of interventions with a focus on family involvement in the residential setting have been attempted, but specific factors such as the frequency of visits from parents have been examined (Borgman, 1985). Jenson and Whittaker (1987) reviewed such studies and concluded that the frequency of parental visits during placement is 'positively associated with a child's successful return to his or her biological family' (p155). This conclusion is also supported by a study of 608 boys in a North American residential centre, for whom a successful outcome was associated with, among other factors, the number of face-to-face contacts between family workers and family members (Savas, Epstein and Grasso, 1993). Day, Pal, and Goldberg (1994) found significant improvements in behaviour were maintained at six-month follow-ups with children and youth with conduct disorder following discharge from a residential setting that emphasised family involvement. At this centre, parents participated in mealtime and bedtime activities, attended parent training groups and weekly family therapy sessions.

> The success of treatment is contingent on parental involvement

Krona (1980) agrees that, to a large extent, the success of treatment is contingent on parental involvement, but goes further, suggesting that it ought to be an ethical premise to involve parents. He then suggests three reasons why

programmes without parental involvement are unlikely to effect lasting change:

1. The behaviour of the child is maintained by its effect on, and interaction with, the environment, most notably the family. The new behaviour patterns of the child, established in the residential environment, can be maintained most effectively by the actions and support of individuals in the child's usual environment.

2. Before the residential intervention, parents may have felt overwhelmed and unable to cope with their child's behaviour. These feelings, along with possible guilt, anger and resentment, may cause further family dysfunction if not addressed during the residential intervention.

3. Where family dysfunction is related to the child's difficulties, feelings of guilt and self-blame may place additional stress on an already unsteady family situation if these are not addressed during the period of the residential intervention.

Wells et al (1991) support this last point and, importantly, note that among the sources of social support available to youth following discharge, family support is related most strongly to post-discharge adaptation. Specifically, they found that family support was significantly correlated to three indices of adaptation: self-esteem, mastery and psychopathology.

Although the literature evaluating family-centred residential treatment programmes is scarce due to the relative rarity of such facilities, the empirical evidence strongly suggests that such programmes are desirable. In fact, studies are distinctive in their almost unanimous agreement on the significance of this factor. In the words of Baker, Blacher and Pfeiffer (1993), a lack of family contact 'leaves a void that even the highest quality treatment program cannot presume to fill' (p565). Let us now examine a service that is attempting to prevent that void from occurring in its residential programme.

Te Puna Whaiora – Children's Health Camps

Children's Health Camps are a group of seven facilities located throughout New Zealand. The history of this movement is interesting, unique to New Zealand and can be found in the enjoyable publication *Children's Health, the Nation's Wealth: A History of Children's Health Camps* (Tennant, 1994). The structure and function of the camps has altered dramatically from the early days of underweight, malnourished children confronted with lashings of milk, matrons and fingernail inspections. The modern Health Camps are more likely to serve children and families who have been referred by Public Health Nurses, social workers, school staff, counsellors and medical and/or cultural professionals for a variety of reasons. These include psychological aspects of functioning (such as emotional and behavioural needs), social aspects (including poor peer relationships), physical aspects (for example, poor management of asthma, diabetes, obesity or skin conditions), and environmental aspects (these can be poor self-care skills or lack of hygiene). Most commonly, referrals to the Health Camp service are to address a combination of these needs. Referrals are accepted for children aged 5–12, and represent a wide range of cultures, socio-economic levels and living situations, although the most common referrals relate to children living in solo-parent households.

Following referral, a trained and experienced multicultural team of fieldworkers carry out a thorough assessment. An appropriate

intervention is devised, with collaboration between the family, referral agent and Health Camp staff members. Historically, this intervention has involved a five-week residential stay at one of the purpose-built facilities, but several other interventions are now available. These include an individualised and specific mentoring programme. However, for the purposes of this article, the focus will be on the residential intervention.

Family involvement in practice

The Children's Health Camps encourage families to be involved with their child during the residential intervention in a number of ways. At least two three-day parent workshops are offered during each five-week residential intake and family/whānau members are encouraged to participate. They can even stay on-site, if they reside some distance from the facility, in comfortable, private bedrooms. Meals, childcare and laundry services are provided to encourage parents to relax, build social networks with other parents and spend considerable time with their children. Trained and experienced facilitators work with groups of parents, covering topics such as self-esteem and behaviour management, and the parents are invited to presentations on the types of programmes their child may be undertaking, in order to further aid generalisation of concepts to the home environment.

Each of the seven facilities has a strong team of experienced and multicultural fieldworkers. These staff members work extensively with the families of children before, during and after the residential intervention. They assist parents to strengthen networks with other professionals, coach them on the child's likely reaction to returning home and provide specific parenting advice in the home setting. This approach is supported in the literature, as evidenced by Small, Kennedy and Bender's (1991) assertion that 'perhaps more useful than family therapy would be a clinical case management approach that can help families to connect with outside supportive services which they would not otherwise pursue' (p336).

Several practical strategies are employed by residential staff members to encourage family members to be involved with their child while he or she is in residence. These include meeting with the child and family before the intervention, a pōwhiri to welcome the child and family into the 'Health Camp family' and weekly phone calls outlining the child's progress during their stay. Families are encouraged to visit their child, and are often provided with a meal if they happen to visit at dinnertime. Families have been observed going on outings with the dormitory group (these can include accompanying the child, staff and peers for a swim) and are encouraged to attend special occasions such as birthday parties and regular talent quests and award ceremonies.

Families have been observed going on outings with the dormitory group

An ongoing study at the Pakuranga Children's Health Camp in Auckland is examining the influence that family involvement has on outcomes for children, utilising a brief behavioural screening measure, the Strengths and Difficulties Questionnaire (SDQ), as one of the measures. This questionnaire is increasingly used in New Zealand, Australia and the United Kingdom and incorporates five domains:

- Emotionality.
- Conduct Problems.
- Hyperactivity.
- Peer Problems.
- Pro-social Behaviour.

Results indicate that the Health Camp residential intervention is rated as useful in the short-term, as evidenced by a decrease in the 'total difficulties' score on the SDQ at two-week follow-up. The influence that family involvement has on outcomes in this setting is currently being determined. This study is also attempting to examine staff attitudes towards family involvement, because the literature identifies this as a potential barrier (Baker, Heller, Blacher and Pfeiffer, 1995). Initial feedback suggests that some residential staff members see the benefits of family involvement when the child is still in residence. Comments exhibiting this awareness include 'staff/caregivers/child can create a system of working towards their objectives together' and 'if parents are involved (eg parent workshop), they will be able to help children maintain progress made at camp at home'. Verbal feedback sought, on a regular basis through a client satisfaction survey, also indicates that families have generally felt very welcome at the camp and make positive comments about their interactions with staff members.

It appears that the Children's Health Camps are responding well to the recognition of the importance of family involvement in the research literature. The camps are translating this into practice, with positive results. They continue to seek ways of achieving their motto of 'Building Resilient Lives' by moving forward with families.

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REFERENCES

Baker, B L, Blacher, J and Pfeiffer, S. (1993) "Family involvement in residential treatment of children with psychiatric disorder and mental retardation". In *Hospital & Community Psychiatry,* 44(6). Pp561–566.

Baker, B L, Heller, T L, Blacher, J and Pfeiffer, S. (1995) "Staff attitudes toward family involvement in residential treatment centres for children". In *Psychiatric Services,* 46(1). Pp60–65.

Borgman, R. (1985) "The influence of family visiting upon boys' behaviour in a juvenile correction institution". In *Child Welfare,* 64(6). Pp629–638.

Burks, J. (1995) "Edgewater Childrens' Centre outcome study 1991/1992". In *Residential Treatment for Children and Youth,* 13(2). Pp31–40.

Chamberlain, P. (1999) "Residential care for children and adolescents with oppositional defiant disorder and conduct disorder". In H C Quay and A E Hogan (eds) *Handbook of Disruptive Behaviour Disorders.* Kluwer Academic/Plenum Publishers. New York. Pp495–506.

Day, D M, Pal, A and Goldberg, K. (1994) "Assessing the post-residential functioning of latency-aged conduct disordered children". In *Residential Treatment for Children & Youth,* 11. Pp45–52.

Finklestein, N E. (1981) "Family-centred Group Care: The Children's Institution, from a Living Centre to a Centre for Change". In A N Maluccio and P A Sinanoglu (eds) *The Challenge of Partnership: Working with Parents of Children in Foster Care.* Child Welfare League of America. New York. Pp89–105.

Goodman, R. (2001) "Psychometric properties of the Strengths and Difficulties Questionnaire". In *Journal of the American Academy of Child and Adolescent Psychiatry,* 40(11).

Hooper, S R, Murphy, J, Devaney, A and Hultman, T. (2000) "Ecological outcomes of adolescents in a psychoeducational residential treatment facility". In *American Journal of Orthopsychiatry,* 70(4).

Jenson, J M and Whittaker, J K. (1987) "Parental involvement in children's residential treatment: From preplacement to aftercare". In *Children and Youth Services Review,* 9(2). Pp81–100.

id. (1989) "Partners in care: Involving parents in children's residential treatment". In R D Lyman, S Prentice-Dunn et al (eds) *Residential and Inpatient treatment of Children and Adolescents.* Kluwer Academic/Plenum Publishers. New York. Pp207–227.

Krona, D A. (1980) "Parents as treatment partners in residential care". In *Child Welfare,* 59(2). Pp91–96.

Savas, S A, Epstein, I and Grasso, A J. (1993) "Client characteristics, family contacts and treatment outcomes". In *Child and Youth Services,* 16(1). Pp125–137.

Small, R W, Kennedy, K and Bender, B. (1991) "Critical issues for practice in residential treatment: The view from within". In *American Journal of Orthopsychiatry,* 61(3). Pp327-338.

Tennant, M. (1994) *Children's Health, the Nation's Wealth: A History of Children's Health Camps.* Bridget Williams Books and Historical Branch, Department of Internal Affairs. Wellington.

Wells, K, Wyatt, E and Hobfoll, S. (1991) "Factors associated with adaptation of youth discharged from residential treatment". In *Children and Youth Services Review,* 13(3). Pp199–216.

Whittaker, J K. (1981) "Family involvement in residential treatment". In A N Maluccio and P A Sinanoglu (eds) *The Challenge of Partnership: Working with Parents of Children in Residential Care.* Child Welfare League of America. New York. Pp67–89.