Parental involvement in residential child care: Helping parents to provide a secure base

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Introduction

In the Netherlands, about five percent children receive some type of youth care. This is governed by the Youth Care Act, whereby children and parents get support for problems which may arise in the process of child development or parenting. Inadequate parenting is the reason given for admission to residential care in approximately 70 percent of cases (Knorth & Van der Ploeg, 1994). Research demonstrates that it is helpful for a child if parents are actively involved in the youth care process. The Netherlands has facilities called 'multifunctional youth care organisations'. These are organisations which offer a range of services such as non residential care, day-care, and residential care. One such organisation called STEK developed a method called 'Child and Youth Care in Context' (CYC). This method builds on the idea of secure base and ensures that parents maintain the responsibility for the upbringing of their child and that they have a say in arrangements in the youth care process. This paper will present an overview of evidence encouraging family centred approaches, describe the CYC method and outline findings of a study carried out on its effectiveness.

Some studies have shown that programmes in residential youth care that adopt models based on family centeredness are associated with more positive results than treatment where family involvement is not a central feature. Sunseri (2001) investigated potential predictor variables that distinguish residents who are likely to complete a residential treatment programme compared to those who are not likely to complete treatment. Sunseri (2001) showed that children aged 9 to 17 years who had more visits from their family during residential treatment were more likely to meet their goals and graduate. Gorske, Srebalus and Walls (2003) provided evidence for the positive relationship between family support and involvement with goal attainment and programme

completion, which are critical for discharge to a less restrictive setting. Research in the Netherlands shows that fifty-eight percent of children whose parents are involved in care improve their problem behavior, while only thirty-two percent of the children whose parents are not involved show improvement (Scholte and Van der Ploeg, 2000)

Family centeredness

Studies that compared residential treatment where families are not highly involved, with family-centered approaches have resulted in mixed findings. Jansen and Feltzer (2002) found no significant differences between a residential behavior modification programme, child-centered residential treatment and family-centered residential treatment. However, a study of the REPARE programme by Landsman et al. (2001) found positive outcomes of a family-centered approach as compared to those receiving more usual treatment. The researchers concluded that the particular qualities of the REPARE model significantly increase the stability of the youngsters. These qualities were (a) ongoing parental contact and involvement, (b) shorter stay in residence, and (c) the availability of supportive aftercare services. Fraser et al. (1996) found that family-centeredness appears to be of paramount importance in the prospect of returning home from a residential treatment. Child contacts, parental involvement and maternal visiting were the strongest predictors of reunification (Davis et al., 1996; Lewandowski & Pierce, 2004). Davis et al (1996) found that when the child was visited by the mother there was approximately 10 times more chance of reunification. Lewandowski and Pierce (2004) found nearly the same; the ratio variable of child contacts increased the possibility of reunification about seventy percent. Regular parent-child visits and parent's contact with children in foster care facilitate continuity of care and parent-child attachments and help children cope with stress of separation and placement (Davis et al., 1996).

Building blocks for family centeredness

Family-centered service (FCS) is a philosophy and method of service delivery for children and parents which emphasizes a partnership between parents and service providers, focuses on the family's role in decision-making about their child, and recognizes parents as experts on their child's status and needs (Law et al., 2003, p.357).

Family-centered practices place families in central and pivotal roles in decision-making regarding support and resources needed by them (for example, information, advice, material assistance or parenting guidance). Their active involvement in procuring and obtaining resources and support has positive benefits and consequences (Dunst & Trivette, 2005). Family-centered group

care is designed to preserve and, whenever possible, to strengthen connections between children in placement and their parents and family members.

As the ultimate goal is to reintegrate young people back to their homes, communities, or both, family involvement is a strong component of treatment (Underwood et al., 2004). Studies throughout the years have shown that parental or family involvement and support in the residential treatment process is one of the successful treatment indicators for residential care (General Accounting Office, 1994).

Family centered practice can have the following characteristics (Allen & Petr, 1998; Institute for Family-centered Care, 2006; Law et al., 2003):

- The notion of the **family as the unit of attention;**
- **Parents should have ultimate responsibility** for the care of their children;
- **Family involvement / participation:** clients and families are encouraged and supported in participating in care and decision-making;
- **The family as decision maker:** involve families to reach consensus about service delivery;
- **Information-sharing:** youth care workers communicate and share complete and unbiased information with clients and families in ways that are affirming and useful;
- **A focus on strengths;**
- **Dignity and respect:** youth care workers listen to and honour clients and family perspectives and choices. Clients and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care;
- The **needs** of all family members **should be considered;**
- **Service availability:** family centered practice constitutes of tangible provision of opportunities for involvement and educational programs that teach parenting skills with a goal to reach the optimal feasible level of family reunification;
- **Collaboration:** clients, families, youth care workers collaborate in policy and programme development, implementation and evaluation, in the facility design as well as in the delivery of care.
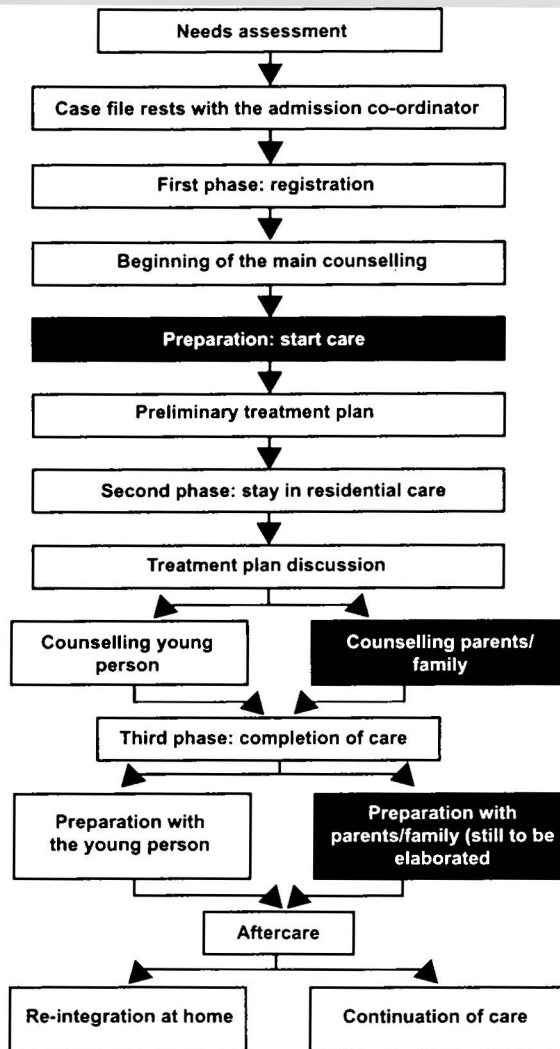
Child and Youth Care (CYC) in context

Studies show that programmes based on family centeredness are associated with more positive results, such as better goal attainment, shorter stay in residence, better programme completion and greater availability of supportive aftercare services. Based on this knowledge, STEK, a multifunctional organisation whose name stands for 'having your own place for security, growth and development' started a new approach in 2002 for building a family-centered residential programme called CYC. This because an imbalance was experienced between an individual, child-focused approach and a contextual, family-focused approach: there was a relatively strong emphasis on the counselling/treatment of the young person, while there was relatively little attention paid to the young person's social system (primarily parents and family). It was found that this one-sided focus on the child as opposed to the family led to longer stays in residential care. This study was conducted in twelve residential groups in Rotterdam and Mid-Holland that form part of STEK. The age of the young people in these residential units varies between 6 and 18 years old. Much attention was given to developing the concept, implementation of the method, and instructions and training for social workers. Since March 2005 the social workers have followed this method.

A basic principle of CYC is the *1-2-3 action plan*. The steps correspond with three different possibilities for the child:

1. Returning home;
2. Accepting the impossibility of returning home and optimizing the contact with the family;
3. Accepting the impossibility of the contact between child and parents and building and strengthening a substitute social network.

The primary goal is to realise the first aim. If that is not possible, the second aim becomes important. If the second aim is also not possible, then the care focuses on the third aim.

Every residential care process is subdivided into three stages: admission and preparation of the care, residential stay, and completion and aftercare. The figure overleaf shows the activities in residential care in STEK. The shaded boxes indicate the activities which are added through the implementation of CYC.

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┌─────────────────────────────────────┐
│          Needs assessment            │
└─────────────────────────────────────┘
                  ▼
┌─────────────────────────────────────┐
│ Case file rests with the admission co-ordinator │
└─────────────────────────────────────┘
                  ▼
┌─────────────────────────────────────┐
│        First phase: registration     │
└─────────────────────────────────────┘
                  ▼
┌─────────────────────────────────────┐
│    Beginning of the main counselling │
└─────────────────────────────────────┘
                  ▼
┌─────────────────────────────────────┐
│        Preparation: start care       │
└─────────────────────────────────────┘
                  ▼
┌─────────────────────────────────────┐
│       Preliminary treatment plan     │
└─────────────────────────────────────┘
                  ▼
┌─────────────────────────────────────┐
│   Second phase: stay in residential care │
└─────────────────────────────────────┘
                  ▼
┌─────────────────────────────────────┐
│      Treatment plan discussion       │
└─────────────────────────────────────┘
           ▼                  ▼
┌──────────────────┐  ┌──────────────────┐
│ Counselling young│  │ Counselling parents/│
│      person      │  │      family       │
└──────────────────┘  └──────────────────┘
           ▼                  ▼
┌─────────────────────────────────────┐
│   Third phase: completion of care    │
└─────────────────────────────────────┘
           ▼                  ▼
┌──────────────────┐  ┌──────────────────┐
│  Preparation with│  │  Preparation with │
│  the young person│  │ parents/family (still to be│
│                  │  │     elaborated    │
└──────────────────┘  └──────────────────┘
           ▼                  ▼
          ┌──────────────┐
          │   Aftercare  │
          └──────────────┘
           ▼                  ▼
┌──────────────────┐  ┌──────────────────┐
│ Re-integration at│  │ Continuation of care│
│       home       │  │                   │
└──────────────────┘  └──────────────────┘
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Preparation: start care

- Home visit before admission
- Talks with regional child care services
- Introduction to residential group
- Parent counselling
- Youth counselling
- Talks with school
- Comprehensive diagnostics
- Considering the perspective

Counselling parents/family

- Treatment plan discussion
- Evaluation of the weekend
- Parental responsibilities
- Parent counselling
- Home visits
- Telephone contact
- Parental visit to residential group
- Participation of parents in the group
- and it's activities
- Parenting support

Research in practice

Child and Youth care in Context (CYC) makes use of questionnaires and interviews, both as a source of information in the care process and for evaluation purposes. At the start and at the end of each treatment information is collected through various instruments used in the Netherlands. These include *Standard Evaluation of severity of Problems* (STEP), the *Child Behaviour Checklist* (CBCL), *the Youth Self Report* (YSR), the *Parenting Stress Index* (PSI) and the *Family Climate Scale* (GKS-II).

For those children who were placed in care at STEK from the period March 2005 until November 2007, we examined how the programme was outlined and which results were gained for the children and parents (Geurts, 2010). Data were collected from 173 children and parents.

A comparison was made with residential care that was considered to be the more usual type of care which has little family involvement. We called this 'care as usual' (CAU). This consisted of a youth care programme focusing on the same target group and applying the same basic methods of youth care as STEK, but paying no extra attention in its professional work to the family environment of admitted young people. The hypothesis was that the results gained with CYC would be better than the results gained with CAU for young people in a residential framework.

With regard to the target group, the following picture emerged from the results. The groups of young people who were referred to CYC and CAU had many features and characteristics in common. The young people were on average 16 years old. The group consisted of approximately equal numbers of boys and girls. Over one third of the young people were placed on a voluntary basis, while more than half of them were referred through a child protection measure. More than one third (CYC) to over half (CAU) of the youths had an immigrant background. Disharmonious family relations (divorced parents, siblings placed in care, only a few of the youths are in touch with both parents) were typical for the young people in this study. About half of the youths have received residential and/or non-residential youth care prior to placement and a quarter of them had lived in a foster family before.

To examine to which extent and in which way parents were involved, 163 social workers and 69 parents were interviewed. CYC was expected to have a higher level of family-centeredness than CAU. The results showed that this was indeed the case. The social workers and parents both indicated that parents were more involved during the admission phase and received more counselling by residential workers in the CYC programme as compared to CAU. Also the CYC parents themselves reported a higher level of counselling overall. Workers

added to this that, in comparison with parents in the CAU condition, CYC parents had more opportunities to have a say in care arrangements, felt more parental responsibility during the residential stay of their son or daughter, and overall had been approached more often in a family-centred way.

Effectiveness and satisfaction experienced

The effectiveness of and satisfaction with the method was also explored during interviews. The effectiveness experienced is the impression of parents and care workers that the care was successful. The effectiveness of and satisfaction with the method were greater in the CYC group than in the CAU group. Social workers in CYC indicated more often that there was progress in education and in family functioning and that the parents understood their child better at the end of treatment. Social workers in CYC were also more often satisfied about the choice of residential care. In comparison with parents in CAU, parents in CYC indicated more often that they experienced progress in their child's behaviour. They were also more often satisfied about the number of times they had contact with social workers.

We examined which factors turned out to be important for the effectiveness and satisfaction experienced. Firstly, there is a positive association between the experienced effectiveness and the level of parent counselling through the residential team. The level of parent counselling is higher if parents experienced more difficulties with their child. This could mean that parents with poor parenting skills received more counselling than competent parents.

Secondly, improvement of family functioning improved if parental responsibility was encouraged during treatment. Emphasising parental responsibility was a good example of taking people seriously. Furthermore, the parents' self-confidence increased (Dekker and Van den Bergh, 2002). Self-confidence contributed to experienced parental competence. This confidence may increase further as family functioning improves and this association should be examined in further research.

Thirdly, satisfaction with the contact between social workers and parents is related to the involvement of parents in youth care. This upheld the findings of previous research, where it has been found that participation, defined as sharing ideas and having a right to make decisions, is one of the predictors of satisfaction regarding the contact between social workers and parents (Kruzich et al., 2003; Schmidt et al. , 2003; Van Erve et al., 2005).

A case illustration of CYC in action

Jona was a 15 year old and regarding his parents he was rebellious and obstinate. There were also problems at school. He had learning difficulties and conflicts with the teacher. Also at home the problems were increasing. His father and mother were both unemployed. They were over-concerned and did not know how to get through to Jona. After several attempts at non-residential care, the parents decided to place Jona in residential care. Jona's parents visited the residential group two months before admission to get acquainted with the residential group. The parent counsellor visited the parents at home and together they discussed to which extent and in which way parents would be involved. When he was in care, Jona visited his parents once every two weeks. Once a week they had the opportunity to have contact by telephone. His parents wanted to buy his clothes and wanted to be informed about his progress in school. Furthermore, they wanted to be involved in important decisions. Jona's parents had three care needs: (1) they wanted help in organising what to do at the weekend; (2) they wanted help in how to assist Jona in his ability to cope independently; and (3) they wanted help in providing a clear structure for Jona.

Jona's keyworker was counselling him to help him get up on time in the morning and to take a shower, to have a chat with peers and adults, to deal with remarks and conflicts, to improve his self-esteem, to learn to express his needs, to have contacts with friends and parents, and to achieve his school certificate. The parents were getting support from the parent counsellor, who was visiting their home every month. The parents asked for advice and tips. They talked about their contact with Jona. They stated that Jona was always playing with the computer in the weekends and that he became very angry when his parents said something about it. His parents wanted to drink tea with Jona. The parents' counsellor worked with the parents on how to achieve this. In the residential group there were conversations between Jona, his parents, his keyworker and the parent counsellor, to find ways to communicate with each other in helpful ways.

After one year of residential care, Jona, his parents and his supervisor agreed that the treatment was completed and that Jona could return home. In subsequent conversations with Jona, his parents, and the parent counsellor, they made agreements about rules at home and how to create a pleasant atmosphere. Jona discussed with his keyworker about who to contact when he was angry, with whom he could talk when he was feeling upset, or with whom he could have enjoyable activities. His parents were allowed to have three contacts with the parent counsellor and Jona was also allowed to have three appointments with his keyworker for advice as a to provide aftercare.

Conclusion

The research carried out at STEK shows that having a say in arrangements, having a good level of parental responsibility, and taking part in frequent parent counselling are care elements for parents that contribute insight into the behaviour of their child. In this way, they acquire more skills in dealing with the child's behaviour and are more able to provide a much needed secure base. The CYC method gives a clear role for residential child care practitioners in maintaining or re-establishing relationships between parents and their children in care..

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