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Characteristics related to family involvement in youth residential mental health treatment

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ABSTRACT

This study examined family involvement among youth in residential mental health treatment facilities in Florida. Data were obtained from the provider reports from January 2005 through December 2007. Treatment episodes were divided into 30-day periods with family involvement measured by the number of contacts by all family members, the mother, and the father. In addition, we examined contacts by all family members for in-person treatment, treatment-related phone contacts, treatment planning, campus visits, and therapeutic home passes. Families averaged 3.4 contacts per 30 days for the 1333 treatment episodes. Sixty-seven percent of the contacts included mothers, while 22% of the contacts involved fathers. A majority of contacts were for family therapy, either by phone (29% of contacts) or in person (43%). Nearly twenty percent of residential stays had no family contact. After the first 30 days of treatment, contacts did not vary significantly over the course of the treatment episode, although there was some evidence that youth with longer treatment episodes had fewer contacts throughout the residential stay. Total contacts were lower for girls than boys, for blacks than whites, and for older youth, and were higher when the youth lived in the same county as the residential treatment provider. Outreach programs could target specific demographic groups with low involvement, and the alternative methods for involvement that use internet conferencing tools should be explored for parents that live far from the treatment provider.

1. Introduction

Family involvement has been recognized as an important component of the treatment of youth with mental health needs (Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001), and has been associated with improved outcomes for youth receiving treatment in residential facilities (Gorske, Srebalus, & Walls, 2003; Stage, 1999; Sunseri, 2001). Such findings led the Child Welfare League of America, Inc. (2004) to state that family-centered treatment "is at the heart of good residential services" (p. 21). Family-centered treatment includes family involvement in each phase of treatment including planning, implementation, and evaluation of services; minimization of family disruption; strengthening of the family with culturally-competent services; and working towards reunification when possible (Child Welfare League of America, Inc., 2004). Similarly, the American Association of Children's Residential Centers (2005) and the Building Bridges Initiative (Blau et al., 2010) also promote the importance of family-centered treatment in residential facilities.

Family involvement is important to the development of stronger attachment and bonds between parents and youth (McWey, 2000). Attachment theory proposes that strong, secure attachments lead to an ability to form intimate, trusting and emotionally secure relationships due to high self-worth and an ability to trust others (Bowlby, 1969/1982). Research has found that the development of such bonds is not limited to young children and remains important throughout all stages of development (McWey, 2000). Youth in residential mental health treatment may lack strong attachments with parents because of their mental illness, family instability, and association with delinquent peers. By including parents and other family members in the treatment process, family therapy can help to improve those attachments and bonds. Once the youth leaves residential treatment, the stronger parental bonds are expected to improve youth outcomes in the community. Indeed, family support was a stronger determinant of positive outcomes after discharge from residential treatment than support from peers or teachers (Wells, Wyatt, & Hobfoll, 1991).

In a survey of residential treatment facilities, Allen, Pires, and Brown (2010) found that residential facilities used numerous approaches to include families in the treatment process. Family members were included

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in treatment planning, although the degree of involvement varies with 8% of the facilities reporting limited involvement, 79% some involvement, and 12% primary involvement. A majority of facilities held social events for families, paid for meals during visits, and paid transportation costs associated with visitation. Approximately one quarter of the facilities provided family peer support. Family visitation was allowed by all but one of the 293 facilities responding to the survey. However, 27% reserved the right to limit visitation based on child behavior, and therapeutic home passes were not allowed by 16% of facilities. Almost all facilities provided services to aid parents and youth with the transition from residential treatment back to the community.

While facilities report taking steps to encourage parents to be more involved, parents identified numerous obstacles to being more involved in their children's residential treatment (Demmitt & Joanning, 1998). From the parents' perspective, facilities needed to implement a number of changes to encourage family involvement. For example, the residential facility needs to include parents when developing the child's goals, increase communication, provide frequent updates on the child's status, make meeting times more convenient, increase the focus on family issues in treatment, organize support groups for parents, and work to build relationships with parents (Demmitt & Joanning, 1998; Kruzich, Jivanjee, Robinson, & Friesen, 2003). The majority of parents (79.4%) in another study reported that the residential facility imposed restrictions on contacts with their children that included limiting telephone calls, facility visits by parents, and therapeutic home passes for youth (Robinson, Kruzich, Friesen, Jivanjee, & Pullmann, 2005). Surveys with family members also indicated that transportation issues, such as distance from providers, transportation costs, and lack of transportation, were an impediment to family involvement (Kruzich et al., 2003).

A number of factors have been found to be associated with family involvement which is typically measured based on the number of contacts between the youth and family members. Greater involvement was found among families that resided closer to the treatment provider, when children were younger, and when children were in residential treatment due to psychiatric problems other than mental retardation (Baker & Blacher, 2002; Baker, Blacher, & Pfeiffer, 1993). Family involvement was fairly stable during residential treatment as contacts were not associated with the time in placement (Baker, Blacher, & Pfeiffer, 1996). Youth had far more contacts with mothers than with other family members (Nickerson, Brooks, Colby, Rickert, & Salamone, 2006).

Reported family involvement has varied across research with several studies reporting between 3 and 6 in-person family contacts per year (e.g., Baker & Blacher, 2002; Baker et al., 1993), although Baker et al. (1993) found that one-third of the youth had no family contact. Kruzich et al. (2003) found more frequent contacts, with 63% of the youth having weekly family contacts. Phone contacts were frequent with weekly phone calls occurring in 45% (Baker et al., 1993) to 88% (Kruzich et al., 2003) of the cases. Lee (2011) differentiated between parental contacts and contacts by non-parental adults because many youth in residential treatment did not have parents who were able or willing to be involved. Sixty-two percent of the youth had parental contact, 42% had extended family (e.g., grandparents, aunts, uncles) contacts, and 42% had non-family adult contact.

Most of the studies discussed thus far collected data on family involvement through surveys of parents and staff and/or requests for staff to compile information from logs and medical charts. Nickerson et al. (2006) found a considerable variation in staff, parent, and youth reports of in-person contacts. Staff members most often reported monthly in-person contact between the parents and youth, but parents tended to report weekly contact. Given the disparate reports of staff and parents, and the potential problems with residential provider staff compiling data from logs and charts, additional research is needed to gain a better understanding of the extent of family involvement in residential treatment. In addition, contacts vary between mother and father, occur for different reasons (treatment, treatment planning, visits, and home passes), and can also be in-person or via the phone. Prior research has paid little attention to whether such differences in contacts vary with youth characteristics.

The current study used administrative data from residential mental health treatment programs in Florida to examine family involvement in treatment. While administrative data have shortcomings, the collection of data on family involvement is contractually required in Florida, and uses clear and standardized definitions. The study was designed to address four research questions using: (a) what was the extent of family involvement during treatment?; (b) how did involvement change over the course of the treatment episode?; (c) did patterns of family involvement differ for shorter versus longer treatment episodes?; and (d) how did involvement vary based on factors such as race/ethnicity, gender, and geographic proximity to the residential treatment provider? Better understanding of what youth and parental characteristics are associated with parental involvement in treatment could potentially contribute to the development of targeted interventions designed to increase involvement.

2. Methodology

2.1. Participants

Florida has three types of Medicaid-funded out-of-home mental health treatment programs: the Statewide Inpatient Psychiatric Program (SIPP), Therapeutic Group Care, and Therapeutic Foster Care. This study focused on youth in SIPP residential treatment centers. Florida's SIPP providers are residential mental health treatment programs that offer crisis intervention, biopsychological and/or psychiatric evaluation, close monitoring by staff, medication management, individual, family and group therapy and connections to community services after discharge. As such, due to the focus on short-term mental health treatment, SIPP providers are most comparable to the residential treatment centers studied by Kruzich et al. (2003) and Lee (2011). Unlike SIPP facilities, Baker et al. (1993), and Baker and Blacher (2002) included individuals with mental retardation who are often in residential custodial care. In 2009, there were 14 RTC facilities with 414 beds in Florida. The duration of the SIPP stay is expected to be six months or less. Youth entering a SIPP must have a primary DSM-IV diagnosis other than substance abuse, mental retardation, or autism. The most prevalent diagnoses are: mood and affective disorders, disruptive behavior disorders, attention deficit hyperactivity disorder, and anxiety and stress disorders (Armstrong et al., 2010). Before admission, qualified examiners must certify that youth referred for residential treatment are expected to benefit from residential treatment and that no other appropriate treatment is available in less restrictive settings.

Data for this study were obtained from the SIPP Provider Monthly Report Database (SPMRD) from January 2005 through December 2007. These data are provider reports for each child enrolled in Statewide and include demographic and diagnostic characteristics, service history, psychotropic medications, critical incidents, contacts with children while they are enrolled and the nature of these contacts. Treatment episodes were created for each child based on their admission and discharge dates. The data set is maintained by the Florida Mental Health Institute at the University of South Florida as part of a contractual relationship with the Agency for Health Care Administration (the Florida Medicaid authority).

2.2. Measures

The SPMRD data contain demographic information (age, gender, race) as well as the county in which the youth resided at the time of admission and the name of the SIPP in which the youth was treated. The data also contain information on each contact made with a family member including the relationship of each visitor to the child