



Changes at The Bridge: Promoting Family Voice in Residential Treatment Programs

At The Bridge of Central MA, Inc., we have 34 years of experience providing comprehensive human services. As part of our service array, we serve children and adolescents ages 8 to 20 in three residential programs. During the last several years, we have worked to restructure our residential treatment programs, with the goal of providing care that accurately reflects families' goals and concerns. Making these changes has required us to adopt a new perspective about our work, and to learn new practices and procedures.

In the past, our approach was very traditional. We had our set of rules and policies, and we would essentially tell the parents what we thought the treatment plan should be and how the goals should be accomplished. We would ask their opinions, but ultimately *we* would write the treatment plan. It was not really a collaborative effort. In general, we ran our programs based on our own ideas and perspectives, and developed program policies that reflected what we thought.

A New Philosophy

Starting approximately five years ago, we began to question that approach. We began to hear in trainings and at conferences about new ways of working with families. We also heard more about strengths-based approaches and about the importance of helping children develop and maintain connections to their communities, even if they needed out-of-home placement for a while.

It all sounded good, but at first it was just words to us. What really motivated us to start our own change process was when several of our staff members attended the System of Care Training Institutes in the summer of 2006. There, for a week, we were immersed in a new philosophy of care. What made the biggest impression was hearing from families—hearing their stories—and we began to truly see that there were better ways to do our work. During that week, we were surrounded by people who were

working in new ways, who were really living their words, and we were inspired. We came home committed to making changes of our own.

There was another piece of motivation as well. Recently, there has been external pressure from state funding agencies, who are encouraging wraparound and family-friendly services. The environment in Massachusetts and our training experiences were exposing us more and more to this philosophy. Through these experiences, we began to fully recognize how difficult it is for a family to place their child outside the home. We began to appreciate the family's perspective more.

New Practices and Policies

In the last year and a half, we have made significant changes within our residential programs. One area where this is particularly obvious is in treatment planning. Our whole approach is different. We work over the course of several meetings to develop a plan

of care with the families. We start with finding out about their vision and goals. The whole plan is built around what family members feel are the outcomes that are most important for them. We also ask about child and family strengths; we talk about what's worked (or not) in the past; and we find out about the family's support system and the people who are there to help them. We do all this with a laptop and a projector, so the family can see the record of this conversation as we're having it.

When we get to the point of creating the plan, we examine areas of concern. Families and staff contribute, and we all talk about what we feel the priorities are. We think about how

Some of the changes have been bigger from a program perspective. Previously, we had very specific ideas about what kinds of therapy a child would have while he or she was part of our program. We were somewhat rigid in our ideas about what therapy was like, who would be there, how often it would happen. Almost exclusively, therapy was provided by our own staff. Now, we think about it more on an individual level and what will meet a particular child and family's need. If a child and/or family has a therapist that they're working with, we support that, and they can continue to work with that therapist. Such relationships can be important for maintaining continuity of care

tive. We get better results when we are working collaboratively with families rather than just telling them what we think is best.

Some of the direct care staff struggle with working in a more collaborative way. Many of them are very young—just out of college—and often they don't have families of their own. Sometimes it is not easy for them to connect with families or be sympathetic to their perspective. We are persistent in reminding them that this is the way we work. We offer training and supervision, but if staff aren't willing to be open to this way of working, they are welcome to look for work elsewhere.

We are committed to this new philosophy of care, and we believe that it is working out better for everyone involved. Of course, there is plenty of room for improvement, and there are further

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each one might relate to the family's vision. Everyone explains their thinking, but ultimately we defer to the parents if there is a disagreement.

We've changed policies and procedures in a number of areas, based on feedback we've received from families. Much of this feedback has come through focus groups with families and with the young people themselves. Some of the things we've changed have been simple, but important. For example, families wanted to know the staff members who are involved with their children and staff roles and responsibilities. So now we are very intentional about making sure that families are able to meet the entire staff team. We've also created a calendar of events to keep families better informed and give advance notice of different activities. We invite family members to go along on field trips and to attend special activities, and we've started a family movie night once a month. As a result of these changes, all family members (including siblings) have opportunities to participate in fun activities rather than having all interactions focused on therapy.

and community-based support.

We've also made big changes in how we look at home visits. Passes for our young people to spend time at home with family used to be based on a points and level system. A child would have to earn a pass through good behavior. Now, families have much more say in that. We collaborate with them, and our focus is on "What can we do to be sure that the visit will be successful?" It is not about the points and level system anymore.

Changing Roles

The responsibility for putting these changes into practice has really fallen on our program managers and clinicians. It is a challenge to learn how to work with families in a positive and collaborative way. The whole focus of these roles has changed. Rather than just dictating, the role now centers on stimulating ideas and options. On the whole, our clinical staff has adjusted well. There are definitely more demands and more meetings, but there is also a strong feeling that this approach makes their jobs more produc-

changes we would like to implement, but for which we haven't been able to obtain funding. For example, we would like to hire family partners, but we don't currently have the resources. Despite the challenges, we are excited about what we have accomplished and are eager to continue. Though we don't yet have a lot of solid data, we have experienced reductions in restraints and length of stay. But what makes us most certain that we are moving in the right direction is the affirmation that we have received from our young people and families.

Based on an interview with Margaret Crowley and Nancy Bishop of The Bridge.

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