

Checklists for Self-Assessment: Steps Toward Family-Centered Adolescent Treatment

Theodora Ooms and Wendy Snyder

Introduction

While no adolescent treatment program completely ignores parents, few programs are totally organized around working with families—most programs function somewhere between the two extremes. Many program professionals would like their programs to work more closely with families than they do.

The contributors to this monograph have emphasized that family-centered treatment is not simply a new technique that can be learned by frontline clinicians. Family-centered treatment involves the program's philosophy, organization, financing, staffing, and many other policies and procedures. This checklist addresses all of these program factors. It serves as a summary review of much of the information presented in the monograph. We have designed it to be used as a diagnostic tool to help review and assess various program elements, staff attitudes, and practices. By using the checklist to assess your own program, you can determine:

- the profile of the teens and families being served — an indication of service needs;
- which aspects of the program are already family-centered;
- which could be more so;
- what policies and procedures constitute barriers to working with families;
- what can be improved and strengthened;
- and what needs to be radically changed.

This checklist is not an instrument for teaching or instituting family therapy. It focuses on identifying program practices and procedures involved in a family-centered approach. This approach may mean that members of the clinical staff need to develop some specific skills in interviewing families and/or that more family therapists need to be hired on staff or as trainers and consultants. Alcohol and drug abuse counselors and mental health professionals can learn to work more effectively with families without becoming family therapists themselves (which requires formal training). However, in order for them to do so, many of the program supports and components identified in this checklist need to be in place.

We have designed this checklist to help those working in inpatient, residential, outpatient, and day treatment settings and in the public and private sectors.

Self-Study Process

Why do we suggest a process of self-study? We hope that you as an alcohol, drug abuse, and mental health (ADM) professional or administrator will find that the checklist raises your awareness and stimulates ideas for changing some of your own clinical or program practices, policies, and procedures when providing treatment to troubled teens and their families. If you are a program administrator, you may then wish to initiate the desired changes throughout the program. However, as those who understand systems and organizations well know, organizational change is much more likely to be effective and long lasting if the people who have to implement change are involved in planning it. Thus we recommend that you undertake the following steps in moving towards a more family-centered approach in your treatment program:

1. Develop a staffwide consensus that such change is desirable. Schedule staff discussions and set up presentations from, or site visits to, other programs that are working successfully with families. It is very important that all the key administrators and board members are involved at this stage and are themselves convinced of, or at least open to, the goal of becoming more family-centered. Suggest they read relevant sections of this monograph.

2. Institute a self-study process. Set up a study group or ad hoc committee that can plan a process of self-study using this checklist as a guide. All the key program units or departments that are involved should be represented (including, for example, intake, records, billing departments).
3. Decide on the scope, timetable, and audience of the self-study. Clarify at the outset the boundaries of the study. Are you looking at one department within a large program or at the whole program? How long should the study take? By when do you need the report and recommendations? The study may be conducted formally or informally. It may be accomplished in a matter of a few weeks or be more detailed and take a longer time. The information may be collected from staff discussions at meetings, conducting interviews, or distributing written questionnaires to staff, patients, and their families. Such studies can be done entirely in-house or may involve outside consultants.
4. Make balanced and realistic recommendations for change. The study should be careful to identify and report on the program's strengths as well as weaknesses in working with families. Recommendations for change should be realistic and take into account practical feasibility and available resources. One way of doing this is to identify under each heading a set of long run goals and then suggest a series of immediate changes that will quickly and noticeably move the program in the desired direction.
5. Outline plans for implementing the recommended changes. Specify which person and/or department has responsibility for carrying out the changes and what the timetable is. Identify what financial resources are available. Changes and program improvement nearly always cost additional money initially, though farther down the road family-centered treatment may save costs by avoiding institutional placements and by sustaining the improvement gained through treatment. Identify needed expertise within and outside the program.

Self-Assessment Checklist

This checklist is organized under various headings representing key program components and features. While they are artificially separated here, the exercise of working through the checklist should show how each is closely interrelated with the others. Changes should be consistent across all areas.

The questions listed under the major headings are only a beginning. We suggest that you review them all and decide which ones are relevant to your program. You will probably want to rephrase some and add others to meet your specific situation. At the end of each list of questions we suggest some overall assessment questions and issues that you may want to return to after you have gathered all the basic information. (For example, the question about how well the program relates to minority families is easier to answer when you have reviewed the questions under the staffing section about how many staff are members of the same minority group or about what special inservice training has focused on the special issues of that minority group.)

While many of the specific ideas in this checklist are drawn from the chapters in the monograph, it also builds on the Family Impact Seminar's and others' work in developing checklists in other program areas that are moving towards increased family involvement for — example, in teen-parent programs, schools and hospitals, etc. (See Henderson, Marburger, & Ooms, 1984; Ooms, et al., in press. Also see Association for the Care of Children's Health, in press.)

Profile of the Teenage Clients' Family Backgrounds

The place to begin a program self-study is to review what is known about the family characteristics, circumstances, and living environment of the population currently served by your program. Program data may be available to answer some or all of these questions. If not, rely on knowledgeable guesstimates based on clinical experience.

What is the family structure breakdown of your current client population (percentage divorced, separated, remarried, never married)?

What percentage is living with parents? Other relatives? In foster care or other nonfamilial care?

What is the racial/ethnic composition of the families?

If there is a significant number of any minority, what does the staff know about adolescence in this minority culture and the attitudes of this culture toward getting ADM treatment?

What is the socioeconomic profile of the families? What are some of the mechanisms and barriers for families in gaining access to and paying for treatment?

What ages/life-cycle stages are the teens' parents? (Are these young families or middle-aged families?)

What stresses are the families likely to be dealing with in addition to their teenager? (For example, unemployment, neighborhood crime and violence, or rural isolation.)

Have there been any recent changes in the types of families that are served by the program? (An influx of immigrants?)

Are there any other special characteristics? (For example, high proportion of highly mobile families, military families, etc.)

Overall Assessment Issues and Questions

Once you have collected the answers to these questions, ask yourselves, especially if yours is a publicly funded program: Given what is known, does the client families' profile mirror the composition of the population the program is designed to serve? If not, why not? Is the program serving the type of family most in need? How well is the program meeting the special needs of this population? How well does it meet the needs of ethnic/racial minorities? What additional information is needed? What could the program do better?

Develop recommendations for change; identify long-term goals and short-run steps toward them.

Program Philosophy and Attitudes

The program philosophy—that is, its underlying assumptions about the role of families in mental health and alcoholism and drug treatment—permeates almost every area of the program's operations. This philosophy, which is often not made explicit, is usually an amalgam of the assumptions underlying the Federal or State programs and the beliefs of the program administrator and of influential staff. The philosophy may vary somewhat among units and staff members. However, any attempts at organizational change will need to confront these inexplicit assumptions and will reveal many of the inconsistencies among them.

Ask some of these questions to elicit how the philosophy is expressed:

Overall, on average, how are parents and other family members viewed in relation to the adolescent's problems? (They may be viewed in different ways by different staff or units.) As victims of the teenager's problem or as contributors to it? As a resource to help the teen or as a hindrance? As a resource to the program staff or as a hindrance? As consultants/partners in treatment? As having their own treatment needs?

How is this philosophy expressed? What is written about the family's participation in any program descriptions or advertising? What is told to the adolescent and family at intake? What is told to referral sources or expressed in any community outreach programs? What is told to new employees?

Overall Assessment Questions and Issues

How is the current philosophy about the family's role carried out in the program operations? Is it explicit or implicit? Consistent or inconsistent? What needs to be done, if anything, to reflect a more family-centered philosophy? If the stated philosophy is family-centered, how well does the program carry out this philosophy in its operations?

Develop recommendations for change; identify long-term and short-run goals.

Confidentiality and Consent

Family-centered treatment of adolescents raises troublesome issues concerning professional confidentiality and consent to treatment. Some of the questions to ask about this issue are:

What are the State's laws regarding parent consent for a minor's ADM treatment (and for related issues that may arise such as reproductive health care, venereal disease treatment, HIV testing, etc.). Are the laws made known to all relevant program staff?

What is program policy about parent consent for a minor's outpatient or inpatient treatment? (This may differ from State law.) About an adolescent's right to consent to treatment? What is said about these policies in program literature?

How are conflicts between parents and adolescents about consent/confidentiality handled?

What are the teens and parents told about protecting their confidentiality and about when and if information about each other will be divulged by the program professional?

What are the program's policies about the confidentiality of records? What access does the teen have to these records? The parent? Who signs for release of information to other agencies or professionals?

Does the program differentiate in practice on these issues between teenage clients who are minors and those who are adults?

If audiotaping, videotaping, or a one-way mirror is used, when and how are families informed and asked for permission to use these procedures? How is their confidentiality protected with respect to their use? What kinds of forms are used?

Overall Assessment Issues and Questions

Are the program's policies on these issues known and understood by staff? How are they carried out in practice? Are they consistent with a family-centered approach, or do they make it difficult to implement such an approach?

Treatment Procedures and Processes

The different steps involved when a teenage client and family receive treatment are presented in sequential stages below, but in practice these stages may overlap. For example, in some programs "treatment" begins after the process of intake and diagnosis, while in other programs treatment is considered to begin with the first phone or in person contact. Diagnosis and treatment planning are often continuing processes. At each of these stages, it is important to review how the family is involved.

Referral

What information about the family is required from the referral sources?

What is the referral source asked to tell the teenager and parents about the involvement that will be required of the parent(s) in your program?

Intake

What information is asked for about the family in the first phone contact? On the intake/interview form?

What determines who is considered to belong in this family, and who is significant in the life of this teenager?

What are the teenager and his/her parents told about how the family will be involved, and what services and information they can expect, etc.?

Who is asked to come to the first interview? If the family is asked to come, is it specified who in the family should come? (One or both parents? Grandparent? Everyone living in the household?)

If the teenager is seen alone for the first interview, what is he/she told about contacts with his/her family?

How is an absent father/mother involved?

Assessment/Diagnosis

What kind of information is generally gathered about the family in the assessment/diagnosis phase of service? Does it take place over the course of several initial interviews or in the form of a questionnaire?

Does the person who conducts clinical intake/diagnosis also provide treatment?

How much of the following types of information is routinely gathered?

- The significant family members in the teenager's life — both immediate family and extended family
- Each family member's assessment of the teenager's problem
- The current physical health and emotional/social functioning of members of the family
- The role of the important family members in the teenager's life, identifying positive and negative influences
- The specific behavior of different family members with respect to the teenager's problem behavior
- The family's social network and degree of social support. Which organizations or individuals are important to them (including church)?
- Family's relationship to the teenager's school or other relevant agencies
- Recent family events or crises
- Family's relationship to older generation (family of origin) and its involvement with the teenager
- Sources of family stress (other illnesses, workplace, unemployment, divorce battles, etc.)
- Sources of family strength and areas of healthy functioning
- Family problems that need to be addressed or referred elsewhere
- Family members' willingness to participate in treatment
- Other relatives who might be involved of parents are unavailable at any time
- How past problems have been dealt with by the family

To which sources do clinical staff turn to get this information about the family? The teenager? Family members themselves? Referral sources? Schools and referring agencies?

Do staff ever conduct home visits in order to meet with certain family members who do not or cannot come to the program, or to assess more fully the family's functioning and living environment?

Do staff ever make school visits to meet with the teenager's teachers or other school personnel? Do they conduct interviews with family, teen, and school staff together?

What role do family members and the teenager play in the assessment of the problems and in the decision to involve the adolescent in treatment?

How do staff generally conceptualize the adolescent's problem? In terms of a DSM diagnosis? A developmental stage difficulty? A problem of dysfunctional family alliances? Or a broader systems intrusion (for example, conflict between school and teen/family)?

Treatment Planning and Implementation

What role do the parents play in deciding upon treatment goals, reviewing treatment options, and developing a treatment plan? What role does the teen play?

Does the treatment plan spell out specific treatment goals, tasks, and responsibilities for the teen and members of his/her family? Are the tasks and responsibilities of program staff also specified?

Are the goals and plans specifically outlined in a written contract?

How are the teen's parents informed about treatment progress? How are they involved in any changes in treatment (e.g., changes in medication, class assignment, etc.)?

How many program staff members are directly involved with the adolescent? Is one person assigned to coordinate the work of these different professionals and to be the key liaison with the family? Are there times when everyone who works with the teenager meets together, and are the parents and teen ever invited to these meetings?

If the program is inpatient/residential, what plans are made for the parents to remain involved? What is the visiting plan? What kind of telephone communication is encouraged? Are these plans worked out with the parent and teen?

In a crisis, how is the family involved? For example, when there is a suicide threat, is the family asked to help avoid hospitalization by maintaining a 24-hour watch until the danger is passed?

What special activities are the parents required, expected, or encouraged to attend? Are they ever invited in to observe any of the group/educational activities?

What ongoing efforts are made to help the family work collaboratively with other significant professionals in the teen's life—e.g., school staff, probation officers, etc.?

When the parents seem resistant or are otherwise unavailable, what efforts are made to involve other members of the teen's family or community support network in the treatment as a supplement or substitute for the parents?

Termination/Discharge and Referral

How are the parents involved in assessing treatment progress, deciding about whether to terminate treatment, or making referral to any other program? How is the teenager involved?

What are the parents and teenager told about any future contacts with the program? Are they offered the option of initiating follow-up contacts?

What are they told about information that may be passed on to other professionals about the results of the treatment?

Follow-up

Who does the program contact for follow-up information — the teenager, the parents, or both?

Overall Assessment Issues and Questions

To what extent are these various treatment procedures and practices consistent with a family-centered treatment philosophy?

Administrative and Organizational Issues

Staffing

What kinds of professional background or experience do the program staff have in working directly with families?

To what extent does the staff's racial/ethnic background mirror that of the client population?

Which members of staff have the most contact with the teenager's parents? Do these people also have contact with the teenager?

When program staff account for their clinical hours, what credits can they claim for working with the family? Are there incentives or disincentives for the time spent with the family? For time spent on home visits, school visits, etc.?

Is the staff reimbursed for transportation to make home/school/agency visits?

What kinds of supervision do the clinical staff have for work with the family? What kinds of support are provided to deal with staff burnout? (Working with difficult family situations can be even more taxing than work with difficult adolescents.)

How is the staff's work with the families evaluated? What weight is given to work with family members in the staff's performance evaluations?

Staff Training and Consultation

What regular opportunities, if any, do you provide to the clinical staff for in-service training? How are the topics chosen? Have any ever focused on working with families? Have they ever focused on issues of working with cultural and racial minorities?

If there has been training or staff development in working with families, what was the nature of these sessions? Did you use clinical case material through videotapes or live supervision? Were the sessions helpful or not? What could have been improved?

How could more in-service training be financed?

What regular opportunities, if any, are provide for clinical consultation, especially with difficult family situations? Does the program ever employ family therapy consultants to work with the staff? How is consultation financed?

If the program serves racial/ethnic minorities, have consultants from their communities ever been used?

Has the program developed good contacts with other agencies or programs (for instance, adult ADM programs, social services, employment programs, etc.) in the community that program staff can use to refer families to for help with family problems not directly related to their adolescent?

Program Evaluation/Records and Data Collection (See Piercy, et al., 1989)

What kinds of program/management data are collected?

Do the format of client records and the filing system allow for the participation of family members to be recorded and followed?

Family-Friendly Facilities

Is the waiting room convenient, friendly, and attractive for family members, especially those with other young children?

Are there any toys or a separate playroom available for the younger children while the family waits for appointments?

Are the interview rooms/staff offices large enough to interview several members of a family at one time? Do they offer privacy from outsiders?

If the cost of transportation to the program is a major barrier in a family's participation are funds available to assist it with transportation?

For inpatient/residential programs, are inexpensive accommodations available in the community for the families who live at a distance?

Consumers in Program Advisory and Policy Roles

How, if at all, does the program tap into the experience, knowledge, and expertise of its clients as consumers to monitor and improve operations?

Does the program ever invite parents/family members who have been served by the program to join special committees, boards, or other structures set up to provide advice on program design, management, and policy?

Are former clients ever asked to be involved as volunteers in fundraising efforts?

Are ex-adolescent patients/clients ever used in these or other ways?

Are parent/consumers ever asked to participate in public education, media, and outreach programs? Are they ever asked to participate in governmental hearings or other events such as conferences?

Overall Assessment Issues and Questions

Which areas of administrative policy and procedures presently provide the strongest support for family-centered clinical treatment? Which areas most need to be changed? What are the expected rewards and benefits of working more with families? What are the anticipated problems and resistances?

How strong is the commitment of administrators and staff to a family-centered approach? Can it withstand the public pressures to change to a policy of institutionalization that often follows upon the suicide of a teenage client or other publicized violent behavior in a family?

Develop recommendations for change; identify long term goals and shortrun steps to implement them.

References

Association for the Care of Children's Health. (In press). *Caring for children and families: Guidelines for hospitals.*

A comprehensive guide to assist hospitals in providing family-centered, psychosocial, developmentally oriented pediatric care. Checklists follow each of the 15 chapters. Available from ACCH, 7910 Woodmont Avenue, Suite 300, Bethesda, MD 20814.

Henderson, A. T., Marburger, C. L., & Ooms, T. J. (1986). *Beyond the bake sale: An educator's guide to working with parents.* Columbia, MD: National Committee for Citizens in Education.

Ooms, T. J., Leitch, L., Hanson, S., & Smollar, J. (In press). *Guide to family involvement in adolescent parent programs.* Booklet prepared for the Adolescent Family Life Office, Office of Population Affairs, Department of Health and Human Services.

Piercy, F., Lasswell, M., & Brock, G. (Eds.). (1989). *AAMFT forms book.* Washington, DC: American Association for Marriage and Family Therapy. A collection of sample forms used throughout the treatment process by family therapists. Includes intake, assessment, consent, evaluation, and other forms.