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Leah Jackson
Clinician perceived barriers to
effective discharge planning for
youth coming out of residential and
inpatient treatment: A Qualitative
Study

ABSTRACT

This qualitative study examines clinician perceived barriers to successful discharge planning from inpatient and residential treatment settings, as well as factors that may contribute to recidivism. Eight clinicians participated in semi-structured interviews in an attempt to elicit their views and best practices when discharging clients from treatment. Participants worked in a multitude of settings at different levels of care and were asked to evaluate both their individual approaches to discharge planning as well as practices within their agencies.

Findings suggest multiple factors contributing to successful discharge plans, though clinicians reported having control over only a fraction of these factors. For example, patient 'buy in' regarding the treatment plan and keeping the client and family actively engaged is shown to have an effect on successful discharge. Furthermore, how families are presented with information and how it is perceived was shown to contribute to success following discharge. Additionally, plans that cater to the client, as opposed to generic plans, are needed to meet individual needs. Factors identified as out of the clinician's hands include managed care restrictions, which greatly influence the types of referrals made following discharge, as well as management of long-term mental health

issues that often increase the odds of future re-placement. Most noteworthy, lack of community resources to meet the demands of current youth mental health was identified. While participant responses were insightful as to how to address potential barriers to treatment planning, there remain factors that clinicians have little influence over.

CLINICIAN PERCEIVED BARRIERS TO EFFECTIVE DISCHARGE PLANNING
FOR YOUTH COMING OUT OF RESIDENTIAL AND INPATIENT TREATMENT:
A QUALITATIVE STUDY

A project based upon an independent investigation, submitted in partial fulfillment of the requirements for the degree of Master of Social Work.

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2009

ACKNOWLEDGEMENTS

I would like to thank a number of people for supporting me throughout this research endeavor. First and foremost, I would like to thank my participants for taking time out of their busy schedules to participate in my research. My research advisor, Luba Feigenberg who supported me through this process, encouraged me to do my best and motivated me to get it done. Luba, I appreciate you taking extra time out of your life to walk me through this tough, time consuming process; I cannot thank you enough.

Jamie, I don't know how I would have tolerated the stress, frustration and doubt without our thrice daily conversations; you kept me sane this year. Eugene, although separated by 11,000 miles, the ability to see your face and hear your voice via our skype messages inspired me throughout these past 8 months. George, you took time to review my writing, help me make changes and listen to me complain about last minute revisions, thank you. And finally, Mwaniki, for the constant reality statements throughout this year telling me that I am a smart and capable writer, your faith in me kept me going.

Lastly, I would like to thank my family who have always encouraged and supported me to continue in my education. Thanks for giving me a place to live, food to eat and love to sustain me; I would be nothing without you.

Mom and Dad, you're my inspiration to achieve, this is for you!

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CHAPTER I

INTRODUCTION

Understanding the mental health needs of children and adolescents, predicting frequency of treatment for outpatient services and predictors of successful discharge using needs-based assessments have been a focus of the literature thus far. Although previous literature discusses ways for youth to continue with outpatient treatment following discharge, it fails to highlight why recidivism may actually be an issue. Most studies address (and even emphasize) a need for families to be continuously engaged following discharge from inpatient or residential treatment but does not address what steps may potentially be taken during the inpatient process that could help the transition back into the community. It is my experience that discharge planning can, at times, be flawed, which leads to adolescents being treated in inpatient or residential settings, to return to those placements within a year of discharge for multiple reasons.

Some literature speaks to the fact that the onset of deinstitutionalization has almost guaranteed recidivism (Appleby et al., 1996). In addition, these authors highlight that the focus on short-term care is also a major factor in clients returning to inpatient care (Appleby et al., 1996). Harper (1989) discusses focal treatment planning as an integral part of successful discharge. It seems that many youth who return to treatment do so because of a lack of focus regarding their needs in the community as well as within their families. If clinicians are able to better identify the needs of clients during their inpatient or residential treatment, they will be able to better assess the needs of the client when planning for their discharge. An article by Brookman-Frazee, Haine, Gabayan,

Garland (2008) examines the involvement of youth in their treatment process. The study shows that the more severely youths perceive their socioemotional issues, the more likely they are to consistently attend outpatient treatment. In thinking about this concept, it seems important that mental health service providers should be including youth when making their plans for discharge to help ensure success once back in the community.

Similarly, Nickerson et al. (2007) assess the level of discharge planning that is conducted for youth in the residential environment. Results showed that the particular residential treatment center used in the study did provide residents and families with some strength-based skills, which families reported were very helpful. The study also shows that certain areas of discharge planning are still needed, especially information about and/or referrals to community resources.

Although there is a focus on mental health policy as a deterrent to successful discharge planning; contrarily, the involvement of families in the treatment process is also discussed as an effective way to maintain success in the community following discharge. What seems to be missing from the literature, however, is a discussion on the importance of thorough communication across the adolescent environment to help to maintain them once they have been placed back in the home. In addition, the clinician voice also seems to be missing from current studies on recidivism and supporting clients following discharge. It appears that effective changes to discharge approaches cannot be made if clinician perspectives are not being addressed. This research is an attempt to bridge the gap between successes and failures and identify what steps need to be taken by clinicians to ensure this feat.

This study is a qualitative exploration of clinicians' perspectives on discharge planning and the factors they believe prevent recidivism. The specific research question that guides this study is: What factors do clinicians take into consideration when planning for discharge from inpatient or residential programs? In addition, the study attempts to identify what factors clinicians understand to be imperative to successful discharge from inpatient or residential programs in an effort to prevent recidivism.

By interviewing clinicians, I looked at what types of preparation goes into discharge planning for youth from residential treatment centers or inpatient hospital programs. Clinicians were asked to reflect on what they believe constitutes effective planning as well as they feel needs to be done to prevent recidivism. The questions for this study were asked in an effort to look at what steps clinician may be missing when planning for discharge from inpatient or residential treatment. In addition, questions compelled clinicians to think about what external factors may be creating barriers to successful discharge planning and give them the opportunity to explore alternative approaches to the treatment models within those that they are currently working.

This topic is relevant to the field as many social workers do discharge planning and create and/or maintain community connections for youth and their families. This type of research is also needed to make sure that adolescents are obtaining quality, coordinated mental health care. Regardless of what field social workers are in, they are often involved in discharge planning and/or are often important factors in the prevention of recidivism as they often work in community mental health settings. If social workers are more aware of this issue, they will be able to better serve their clients in an effort to prevent client return to inpatient or residential placement. It is my hope that this research can shed a

beginning light on the barriers to effective discharge planning and encourage clinicians in the field to constantly challenge themselves to further engage families and work collaboratively with outpatient agencies to ensure adequate treatment for clients and families.

CHAPTER II

LITERATURE REVIEW

It has been my experience working in both inpatient hospital and residential treatment settings that youth often return to a similar level of treatment setting quickly following discharge. The goal of this literature review is to highlight the work that has already been done in regards to youth success in the community following discharge. Previous research in the field focuses on preliminary investigations of transitioning youth back into their communities without a focus on community resources. In addition, research has focused on understanding the mental health needs of children and adolescents, predicting frequency of treatment visits if the client has been referred for outpatient services and predictors of successful discharge using needs-based assessments.

The purpose of this section is to review the literature on assessing youth and their rate of success upon discharge but it will also attempt to bring to light what factors are still missing from the discharge process as youth are still returning to inpatient and residential treatment at alarming rates.

A definition of terms will be provided in an effort to use consistent language throughout this review. Furthermore a thorough review of what research has already be conducted will be used to highlight an ever growing area of need in the discharge process of youth transitioning out of inpatient or residential treatment settings.

Definition of terms/Levels of treatment as defined by the Surgeon General Department of Health and Human Services (1999)

Inpatient treatment is the most restrictive type of care in the continuum of mental health services for children and adolescents, meaning that youth live and receive treatment in a locked section of a hospital. Privileges usually begin at very low levels in inpatient care and patients are restricted to areas within the unit. Time off the unit comes after careful assessment of both behaviors as well as dynamics between the individual and others. Staff usually needs to be present to open bedroom and bathroom doors, assist with meal preparation and perform 15 minute safety checks.

Residential treatment centers, the second most restrictive form of care is a licensed 24-hour facility (although not licensed as a hospital), which offers mental health treatment. The types of treatment vary widely; the major categories are psychoanalytic, psychoeducational, behavioral management, group therapies, medication management, and peer-cultural (U.S Public Health Service).

Partial hospitalization or day treatment is defined as a growing treatment modality for youth with mental disorders. Partial usually consist of hospital or clinics that offer day treatment to youth during the school day and then they return home during the evening. Although some partial hospitals or certified by the Department of Education, most provide therapeutic treatment to youth in the form of small peer groups, individual therapy and therapeutic activities to help build and strengthen coping skills. Research on partial hospitalization as an alternative to inpatient treatment generally finds benefit from a structured daily environment that allows youth to return home at night to be with their family and peers (Surgeon General Department of Health and Human Services 1999).

Outpatient therapy is defined as the use of different psychotherapy and alternative clinical approaches conducted outside of a restrictive hospital setting. Outpatient therapy can be held in clinics, unlocked areas of hospitals, or anywhere in the community including private treatment at a clinician's home or office. Treatment varies from 6 to 12 weekly sessions to a year or longer.

Outcome research on residential treatment indicates that although adolescents often improve in residential treatment, those gains are frequently lost when they return to the community (Leichtman & Leichtman, 2001). A review of the literature suggests that there are multiple factors that influence an adolescent's success when returning to his/her community after discharge. Factors include lack of family participation in outpatient services, public policies shifting the focus of residential treatment to short-term in an effort to save costs and level of intensity within the residential setting. Additionally research suggests that parent-child expectations of treatment (inpatient and outpatient), the amount of case management offered after discharge to maintain stability and low-risk and overall levels of discharge planning by the residential treatment centers are also reported factors.

The following sections will include discussion on the previously mentioned factors which affect levels of successful discharge from residential treatment centers. A majority of the recent research suggests that clinicians at multiple levels are aware that discharge planning is lacking in effectiveness. Some research was also very dated (over 30 years old) which also suggests that although there is a recognizable problem when planning the discharge of adolescents from treatment, there have still been no gains made to effectively evaluate the needs of those adolescents upon their discharge.

Transitioning Youth Back into the Community

The [recidivism] rate has risen markedly since the onset of deinstitutionalization, paralleling the decline in mental hospital populations and beds (Appleby, Luchins, Desai, Gibbons, Janicak & Marks, 1996). These authors looked at the length of stay and recidivism back into treatment among patients with schizophrenia. Although focusing on the particular mental health diagnosis of schizophrenia, this article is important as it addresses some of the potential reasons that clients come back into treatment.

Authors Cafferty and Leichtman (2001) have written extensively about facilitating a successful transition from residential treatment centers back into the community. Their primary emphasis has been the role of the social worker in that transition. They suggest that due to social work ethics and practices such as self-determination of the family as well as family preservation and use of community resources, the authors suggest that the social worker is best qualified to support youth and family upon discharge from inpatient or residential treatment.

Similarly, authors Jenson & Whittaker 1989; Schnier & Cohen 1998 also speak to this issue and discuss that much empirical research shows the loss of gains made in residential treatment after the child has left. These authors suggest that due to social worker training coupled with federal and state cuts to programs, the role of the social worker is imperative to maintaining youth function once back in the community.

This article proposes the need for treatment providers to work as a team when planning discharge of adolescents and to reinforce the importance and investment in

community resources in an effort to maintain the child in his or her community (Cafferty & Leichtman, 2001).

Nickerson, Colby, Brooks, Rickert & Salamone (2007) assessed the level of discharge planning conducted for youth in residential treatment centers. The study also conducted a needs assessment of families who participated in an effort to look at what other factors of discharge planning are needed to help youth transition successfully back into the community from placement. The authors found that the most requested service by parents of children leaving residential placement was psychoeducation on the child's emotional and behavioral issues as well as resources in the community that could be accessed once the child has returned home. Similarly, the authors found that prior to discharge, providers at the residential treatment program "rarely" or "never" spoke to providers in the child's community such as, teachers or psychologists (Nickerson et al, 2007) which was identified as a major barrier to success.

Gains made in treatment often fail to generalize after discharge, with many young people engaging in problematic behaviors once they return to their homes and communities (Nickerson, Colby, Brooks, Rickert & Salamone, 2007). Sixty-two participants were involved in the study including facility administrators as well as residents and their families. Families were given a structured interview to examine strengths, family involvement, and transition planning for adolescents in residential treatment (Nickerson et al., 2007). A 5 point Likert scale was used to assess what aspects of care may be helpful to both parents and adolescents upon discharge.

Results showed that learning strength-based skills were viewed as "very helpful" by families, which seems to suggest that this is an important factor to consider when

planning for discharge. It appears that providers should be considering this type of psychoeducation when working with families to prepare them for discharge back into the community.

Predictors of Successful Discharge

On an inpatient level, Harper (1989) discusses the importance of treatment planning in an effort to promote successful discharge. This article focuses on the importance of focal treatment planning in an inpatient setting. Focal treatment or identifying what issue should be the main focus of treatment, appears to be increasing in many treatment settings and seems to be effective in many different settings. The author discusses the use of language as well as the involvement of the family and comprehensive, attainable goals. This article focuses on the changes that need to be made on an inpatient level to promote successful discharge into the community. Many factors, including consensus among treatment providers and attempts to address too many issues are discussed as potential issues to failed discharges. A major focus of this article is the principle of parsimony which Dr. Harper describes as choosing the less ambitious option for treatment in an effort to ensure adequate short-term care. The principle of parsimony encourages the team to define the relationship between the inpatient treatment and outpatient treatment, to counter the tendency to see the inpatient treatment as the whole treatment (Harper, 1989).

It is imperative that clinicians at all levels are aware of the objectives at hand and can work effectively within a team and with the family to address the focal problem as

identified by the treatment team. Identifying and working towards a focal problem seems to be an additional factor that needs to be considered when preparing for discharge.

Yampolskaya, Kershaw, & Banks (2006) conducted a study on predictors of successful discharge and what barriers affect successful discharge among adolescents. Although this study focused on a specific population (younger white males from single-parent homes) it shows that individuals with less case management after discharge are more likely to return to placement at a later time.

The study shows that children with a stable home environment and decreased parental substance abuse were major factors in determining a successful discharge, these factors should also be considered when working towards a discharge plan. Not only are these findings consistent with other literature, they are also consistent with what providers in the field are identifying as imperative factors to successful reunification. This study only considers children who are placed back in the home or into a foster placement and does not consider whether or not families will participate in outpatient care following discharge. However, it will be helpful in identifying those children who are at greater risk upon discharge and help clinicians to plan for an effective exit from out-of-home placements.

It appears from the literature that there are many factors that can determine the success of a child or adolescent discharged from residential or inpatient treatment. It seems that without proper assessment by mental health care providers, inability or unwillingness to participate in outpatient services, appropriate intensity levels of care, family assumptions and expectations of treatment and available community resources can be seen as barriers when attempting to make a successful discharge. The literature shows

that there needs to be more involvement and thoughtful process when making discharge plans for children and adolescents as well as the need to include the family in all aspects of their treatment goals. Participation in these practices would result in less out-of-home placements, reduce costs of multiple placements and effectively prepare children, adolescents and their families for a successful discharge back into the community.

Similarly, a study conducted by Teare, Larzelere, Smith, Becker, Castrianno, & Peterson (1999) evaluated whether or not youth discharged home from short-term placement experienced any disruption to their placement one year after discharge. The study was conducted at a short-term residential program that served as a shelter for adolescents whose families were in crisis (Teare et al., 1999). Subjects were youth admitted to the program over the course of one year and had been discharged after an average length of stay of 2 weeks back to their homes. Results of the study show that younger children, children with increased instability in the home, wards of state, those who had a negative incident once returning home and those less likely to externalize their problems were more likely to experience placement disruption (Teare et al., 1999). It seems that if these factors are identified early on, the treatment teams use this information to help determine placement and or resources following discharge. Results of this study show that youth who participated in services after their discharge were less likely to experience disruption in placement and that the higher risk of unsuccessful reunification for these [younger] youths appears to be mitigated by receiving additional services (Teare et al., 1999). This study overwhelmingly suggests the need for careful review of youth circumstances upon their admission to inpatient and residential and the importance of

discharge planning that includes the need for continuing care and the prevention of recidivism.

In another study, Segal (1987) examined discharge placement patterns of youth leaving emergency treatment. Using the origin of children as criteria to measure successes of placement following discharge, the authors that children do the best when returned to settings similar or equal to those in which they were before they were placed. Decision making out of desperation rather than a decision based on direct, identified goals, promotes the perception of the child welfare as a 'revolving door.' Within this concept, children may be returned to the same type of environment from which they were removed, with little attention devoted to which placement best serves the individual client.

510 children between the ages of 5-17 who were admitted to emergency services over the course of 6 years were used for the Segal (1999) study, half of which were admitted to emergency treatment with a diagnosis of abuse or neglect and the other half were admitted had emotional or behavioral diagnoses. Placement setting for these children following their discharge was to one of three places: natural family placement, foster family or residential settings. Admission-discharge patterns were chosen by comparing the child's original setting versus their discharge setting.

The authors discuss their findings by saying that, true to their hypothesis, children placed back into settings similar to those that they came from, were more successful than children who were not.

Although the article is over 20 years old and the authors were only examining children being placed in emergency treatment settings, specifically shelters, it suggests

that some potential barriers to effective discharge planning may include a lack of consideration for where the child originated and is ultimately more successful in his or her functioning.

An article looking at placement stability following residential placement by Teare, Larzelere, Smith, Becker, Castianno & Peterson (1999) examines youth discharged from short-term placement back home to their parents and looked whether or not there was any type of disruption in their placement due to their emotional and or behavioral needs. In addition, the authors discuss that specific treatment factors, such as specialized child and adolescent services, successful completion of treatment, and continuing psychotherapy after discharge predicted a favorable outcome (Teare, et al., 1999). The program used in the study provided treatment to youth ages 10-18 with the majority of clients staying no more than two weeks. Results show that about half of the youth discharged home remained in the home with minimal placement disruption after a year. Younger youth were shown to have greater risk of having unsuccessful reunification (Teare et al., 1999). In addition to looking at placement disruption, the authors also considered that intense treatment while still in placement had a great effect on potential placement disruption following discharge.

Although youth are often placed in short-term out of home care, it seems that if they receive and participate in intense services while still in placement, it will increase their chances of success upon their return home. It seems important for all service providers to consider these findings when working with children placed into inpatient and residential treatment in an effort to prevent a return to placement in the future.

Importance of Needs-Based Assessments

A study conducted by Lyons, Libman-Mintzer, Kisiel, & Shallcross (1998) discusses the importance of needs-based assessments when evaluating children and adolescents in an effort to determine whether or not residential placement is appropriate treatment. If residential is not deemed appropriate, then it appears that children can return to their communities. The authors suggest that many residential placements could be avoided and that youth could potentially receive equal and adequate care that is not only less costly but, keeps them in their homes. If it is determined that the child should be in residential treatment, a needs assessment can help to identify and secure resources upon discharge to ensure successful discharge. The study showed that conducting a needs-based assessment of children and adolescents placed in residential treatment is effective in determining if they were at a low enough risk to be treated by outpatient community mental health services. Results of the assessment would potentially help to free up federal funds that are used to put kids in placement and reinvest the money into community mental health services.

A study conducted by Burns, Phillips, Wagner, Barth, Kolkhoz & Campbell (2004) addresses the mental health needs and subsequent access to services of youth involved in the child welfare system. The purpose of this study was to identify factors related to the need for and use of mental health services among youths early in an episode with the child welfare system (Burns, et al., 2004). The authors used previous research to determine that a majority of youth involved with child welfare, but remaining in their homes, still suffer from multiple mental health issues and are less likely to be referred to and utilize services in the community. Based on this, it seems that being in contact with a

social worker or other outpatient providers as a way to stay connected to the community are imperative for youth once they have been discharged back into the community.

Using 5,504 youths involved in the child welfare system over the course of one year, a needs assessment was conducted and compared to the amount of youths referred for services during that time. Youth were between the ages of 2-14 with a majority of them living at home with a permanent primary care giver and the remainder split between kinship and non-kinship foster placement with a very small percentage living in group homes. The aim of the survey was to address (1) the clinical need and related characteristics, (2) the correlates of mental health service utilization and (3) the rates and types of mental health service use (Burns et al., 2004). Each of these factors are important in thinking about discharge planning as they look at the individual needs of the client as well as the types of services that they may use following their discharge back into their communities. If clinicians have this information ahead of time, it will assist them in creating a comprehensive discharge plan.

The authors found that school-aged children who remained in their homes were less likely to have received services even when the clinical need was controlled for (Burns et al., 2004). The likelihood of referral to services increased when the child had a parent or guardian who also suffered from a mental health illness. This suggests that children are more likely to be seen on an outpatient basis if they also have a family member, mainly a parent or guardian who is also utilizing outpatient services. It appears that it is still unclear as to how to best engage families in the outpatient process so that they can maintain functionality in their communities upon discharge. The authors argue that there is a gap in multisystem intervention for youth involved with child welfare

services and in addition, mental health service workers are inadequately trained to assess multisystemic needs of youth involved in the system. If there is a gap in mutisytemic intervention and clinicians are improperly trained, these factors suggest that clinicians at all levels may be included as potential barriers to effective discharge planning.

Importance of Interagency Collaboration

Epstein, Nelson, Polsgrove & Coutinho (1993) discuss a community-based approach to implementing services. This article begins by discussing the need for community based services by highlighting the costs of placing children in out of home (and often out of state) settings; approximately \$50000/child or \$200/day per child. The authors discuss the prevalence of youth who need mental health services by referencing a study done in 1986 by the Office of Technology Assessment, which concluded that while 7.5 million youth were in need of services, very few are actually receiving any. The authors summarize this data and proceed to discuss a community-based model for services which consists of a “best practices” approach to providing a comprehensive system of care for children and youth and their families (Epstein, Nelson, Polsgrove & Coutinho 1993).

The authors present a model based in two levels of care. The first level, an Interagency Coordinating Council (ICC) consisting of primary service providers who write up agreements, determine target population definition, agree on community’s principles of care and secure financial alternatives (Epstein et al). The second level, Interagency Intensive Case Management (IICMT), is made up of direct care providers

who coordinate the intensive case management plans, implement treatment and monitor individual case plans along with family members (Epstein et al., 1993).

This article also discusses the interagency care model developed by Stroul and Freidman (1986) which focuses on function-specific sources of service, such as development of a system of care. It seems to show across the literature that a community-based spectrum of care is needed to help prevent recidivism among youth. In addition, Stroul and Freidman (1986) highlight the need to define the population and establish principles of care to determine the direction and purpose of the program. As described by Harper (1989), if the focal problem is identified, it will provide direction and purpose of care both during out of home care as well as back in the community. Similarly, conducting needs assessments for children and families to determine appropriate services to families with multiple complex needs and is similar to the concept outlined by Lyons et al (1998).

The information presented demonstrates that many issues can also be addressed in communities and effectively serve emotional and behaviorally disturbed youth. The authors conclude that the issues discussed present a challenge to service providers but that through advocacy and interagency collaboration, effective treatment plans can be produced and implemented to best serve youth in the community.

Building upon the Stroul and Friedman (1986) concept of the need to establish purpose and direction of a program, Junek and Thompson (1999) discuss problems with the current system of care approach.

There are few regular indicators of outcomes relevant to clients or the general population that would measure some facet of goal attainment...the system of care

in most jurisdictions has problems both focusing on where it is going and determining whether it is getting there (Junek & Thompson 1999, p.67).

It seems that many researchers in the field have identified barriers to the current system of care model being used and are emphasizing the need to restructure provisions of care.

In addition, Anderson (2000) discusses the need for multiple agency service for children with emotional and behavioral disabilities. The author highlights the issues of, multiple definitions of mental health used by different agencies, description of variance in those definitions as they relate to eligibility requirements for services and the lack of agencies working together do determine effective treatment of children with mental health concerns.

The author begins by discussing the passage of the Individuals with Disabilities Education act (IDEA) and how although it has been active for over 25 years, children with mental health disabilities are not receiving adequate care outside of their school environments. The author highlights that although multiple services may be referred to work with a child, agencies often work independently from each other which results in lackluster care of the child. Discussions of his or her environment outside of the classroom are also important to ensure overall effective care of the child. Anderson refers to a study done by Stroul and Freidman (1986) in which, the need for a system of care is defined as: a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to the multiple and changing needs of

children and adolescents with severe emotional disturbances and their families (Stroul & Freidman 1986).

Anderson also discusses the misuse of terminology when referring youth to outpatient services. The author follows by giving the definitions of the Center for Mental Health Services and their preferred definition and subsequent eligibility requirements and the definition used by IDEA and other special education service providers. The Center for Mental Health Services definition is based solely on diagnosis of an individual whereas the definition used by special education services is based on the individual's performance in the classroom only. Among barriers to developing interagency collaborative, perhaps the most serious is the variation in how different community agencies define emotional and behavioral disabilities and use these definitions to establish service eligibility criteria (Anderson, 2000).

Anderson concludes by saying that it is up to service providers to collaborate with each other in order to attain appropriate levels of care for youth. Although agency eligibility may differ, conversations between providers are crucial to assure that all mental health needs of youth are being met in every aspect of their environment (home, school, community etc). This study includes a focus on discrepancy at multiple levels. The author highlights the importance of continuing care and the need for agencies to communicate in order to effectively treat youth.

Outpatient Service Utilization after Discharge

A study conducted by Brookman-Fraze, Haine, Gabayan, and Garland (2008) discusses prediction of frequency of visits for outpatient services among children and families. The authors considered parent and child expectations of outpatient treatment as well as consideration of how often families continue to use community based mental health services before termination. They also examined how and when families terminate from services.

The authors noted significant predictor scores in the areas relating to youth clinical characteristics as well as treatment entry characteristics. The study shows that the more severe youths perceive their socioemotional issues, the more likely they are to consistently attend outpatient treatment (Brookman et al., 2008). The study's main finding that youth who are educated about their mental health issues and can perceive them as issues that need to be treated, are more likely to participate in outpatient treatment is critical for treatment planning in community-based settings (Brookman-Fraze et al., 2008). This study also found that although therapist characteristics, such as therapeutic alliance and technique, were important, they were secondary to the importance of treatment goals and expectations determined by both the parent and child. This finding reinforces the need for clinicians to be skilled in assessing youth and parent treatment goals and facilitating parent/youth goal agreement in the early stages of treatment to promote attendance (Brookman-Fraze et al., 2008). This article can be beneficial to mental health workers in thinking about what client expectations are for

continuing treatment and how those expectations are considered when preparing a child/adolescent for discharge.

Reducing Costs and Improving Treatment Outcomes/ Levels of Treatment

A study by Sunseri (2005) discusses the importance of assessing levels of residential care in an effort to reduce multiple placements and overall care costs. This study examined placement stability among 8,933 children and adolescents and compared their levels of treatment to their behavior success after discharge (Sunseri, 2005). Placement instability is a problem for public placing agencies, since multiple failed placements are costly in terms of both dollars spent on ineffective treatment settings and time consumed by crisis-driven searches for available beds (Sunseri 2005). This study shows that children and adolescents placed in high-intensity settings at the time of evaluation have greater success when returned to their community offsetting the need to return them to treatment at a later time and thus saving costs and preventing multiple failed treatment attempts.

In a study done by Bickman, Summerfelt & Noser (1997), the authors compared children with emotional disturbances who were discharged into a system of care to those children discharge with no service system in place and were simply placed back into the community. In addition, they assumed that these youths would experience better outcomes if they were treated in the least restrictive, most normative environment (Bickman, et al., 1999) The system of care that was used in the study described the system as the child receiving initial assessment by their service providers, development of a treatment plan and coordination of the delivery of services (Bickman et al., 1999).

Results of this study show that youth system involvement was a predictor of success post-discharge. In addition, youth had higher rates of functioning over time. In addition, they were more likely to receive mental health services and multidisciplinary care than their counterparts. It will be important for social workers and other mental health providers to be considerate of these results when planning for discharge of youth from inpatient or residential settings.

A study conducted by Epstein (1998) proposes a strategy to improve outcomes for youth with emotional and behavioral problems. The initial proposal for this strategy would be that the child will have access to services, that the child receive appropriate services, and that the services will be provided in a way that is likely to result in benefit, for example, the child will be at lower risk upon reentering the community and the child's environment will be able to support him or her adequately without having to return to higher levels of care (Epstein 1998). In addition, the author discusses the support needed to fund research to provide empirical data to clinicians in an effort to afford adequate care.

The article highlights other areas for improvement to further develop care for children and adolescents. Current policy, for example is discussed as an area for development as well as continued implementation of CASSP (Child and Adolescent Service System Program) which was originally created by Stroul and Freidman in 1986. In addition, the allocation of funds for mental health services are discussed as a potential obstacle and the author states that to a great extent, CASSP values (e.g., less restrictive care) have been in conflict with fiscal incentives which are more likely to drive decisions about service provisions (Epstein 1998). Other areas highlighted are the amount of

money spent in certain areas of mental health that show the least effectiveness, residential treatment for example. Similarly, the distribution of money versus the distribution of youth in certain placements does not match up. There are more youth in the community attempting to access outpatient services and the majority of the funds are secured more restrictive settings such as inpatient or residential. It is important as mental health workers to be aware of these barriers and to advocate with insurance companies to provide the best treatment which has been shown effective at the outpatient level.

Epstein also stresses the need to retrain clinicians. There are clinicians currently who have been in the field for many years with varied training experiences. It is imperative that as policies and research change, so do the practices of clinicians. Clinicians need to be educated regarding the most effective interventions based on research, in contrast to the limited evidence on institutional care (Epstein 1998). Strengthening and improving the quality of services is also discussed as a step to improve outcome for youth. By using current statistics of accessibility to care and consideration and participation of families in treatment are just some of the ways that outcomes can be improved.

Summary

Multiple factors are influential in providing a successful discharge for adolescents returning to their communities from residential treatment. The major factor appears to be the role of the social worker in an effort to create and help to maintain low-risk behaviors upon discharge. It is also important that youth are not only taking part in but also being

referred to continuing care services to prevent an all too common return to residential care.

An additional factor appears to be a lack of proper assessment when considering the mental health needs of youth. It is up to clinicians to properly address the multiple needs of youth in an effort to provide organized and effective treatment as well as to prevent recidivism. Moreover, youth involvement in treatment, as well as their family support is also important to maintaining stability after returning home. Youth and families should be assessed for strengths and weaknesses as a part of the discharge planning to help to coordinate relevant and efficient care.

CHAPTER III

METHODOLOGY

This project is an exploratory study designed to elicit clinicians' perspective on perceived barriers to discharge planning for children and adolescents transitioning out of residential or inpatient programs. The goal of the project is to identify what factors clinicians understand to be imperative to successful discharge from inpatient or residential programs in an effort to prevent recidivism. The specific research question guiding this study is: "What factors do clinicians take into consideration when planning for discharge from inpatient or residential programs?"

Participants

I recruited 8 clinicians in the mental health field in an attempt to get a broad overview of discharge practices in and around the Boston area. Clinicians were recruited from multiple areas of clinical work (program directors, treatment coordinators, social workers, psychologists and psychiatrists and Master's level mental health clinicians). Participant eligibility was determined by the following characteristics: 1) clinicians were either licensed clinical social workers (LCSW or LICSW), those holding a Master's degree in education and working as therapists, licensed clinical psychologists holding a PhD, or psychiatrists; 2) clinicians provided therapeutic treatment to adolescents between the ages of 8-19; 3) clinicians had at least 2 years of post-graduate experience working with adolescents; 4) all participants had experience working in an in-patient or residential facility. Years in the field ranged from 3-35 years. Participants ages ranged from 27-61

and all were currently employed in either a hospital, residential or community-based setting.

Eight clinicians participated in this study; 4 woman and 4 men who were employed across a wide mental health spectrum. Two of the female participants were licensed clinical social workers holding their MSW; one works as a clinician on an inpatient unit at a major hospital while the other works as a clinician for a home-based therapy agency. This particular participant interacts regularly with children and adolescents leaving inpatient or residential care and also has past experience working at a residential treatment center in the Boston area. Another female participant holds her Master's degree in education and works as a mental health clinician at community-based residential and home-based program that also focuses widely on adoption services. The final female participant works as a program director for an inpatient child and adolescent program also at a major hospital in the Boston area. She is a registered nurse and has spent many years in an administrative position overseeing the functionality of the program. The men interviewed for this study were employed in multiple areas of the mental health field as well. Two participants are attending psychiatrists at a major hospital in Boston. One participant is currently the acting medical director. Another male participant is a licensed clinical psychologist, holding his PhD and working with children and families both on an inpatient unit as well as in private practice. The final male participant is a mental health counselor holding his Master's degree in education and works as a therapist at a residential treatment center for adolescent girls. All participants identified as white although varied in age. An attempt was made to gather participants from multiple backgrounds and ethnicities by recruiting people from personal and

professional contacts however those who responded to the recruitment process and subsequently participated in the study were self-identified white clinicians.

The Recruitment Process

Participants were indentified through personal and professional contacts. As my second year placement was working on an inpatient unit, I sent out a recruitment email to social workers, clinical mental health specialists, psychiatrist, psychologists, post-MD child psychiatry fellows, and program directors to inquire about participating in my research endeavor. Through these contacts, I asked them to pass along any names of people with similar credentials who may be interested in participating in this study. I then followed up with the same recruitment letter via email to see if people were willing to participate in my study. People who responded to my email were contacted and sent initial screening questions to assure that they met criteria for this study. These questions asked about age, profession, years in the field and degree. Following the receipt of these screening questions, again via email, I sent them an informed consent letter for their review and then set up a mutually convenient time and place to meet for an interview. I reviewed the informed consent at the beginning of the interview process.

Participants were emailed a letter of consent explaining the purpose of the study and discussing, in detail, steps to ensure confidentiality. In an effort to ensure diversity, I attempted to identify clinicians from as many racial and ethnic backgrounds as possible. In an effort to not pass judgment, or assume how individuals identify, part of the interview process included basic demographics and include questions on race, ethnicity and preferred identity. I asked that the participants bring a copy of the signed consent to

the interview. I also brought blank copies should they have forgotten to bring their signed copy.

Informed Consent Procedures

Informed consent letters were sent to all participants via email after it was determined that they met criteria for the study, that they had decided to participate and following their completion of the initial screening questions. The informed consent letter highlighted the benefits and risks of participating in the study which in turn was signed and returned to myself to the email address provided or in person. In addition participants were asked to keep a copy of this letter for their records. At the beginning of the interview process, participants reviewed again the risks and the benefits of participating. I then asked participants to complete a demographics form (age, identified gender, profession, years in the field, race/ethnicity) to identify the diversity of participants. Forms were immediately coded and sealed in an envelope for use during the transcribing process.

The Nature of Participation

I conducted semi-structured interviews lasting between 35 and 45 minutes with questions focusing on topics reflective of my research question. For example, participants were asked to take into account what they believe to be barriers to effective discharge planning. Specifically, clinicians were asked to reflect on their process of discharge planning and whether or not they involve multiple disciplines in the process. In addition,

I asked clinicians what characteristics they believe are necessary to successful discharge planning.

As I recruited within the location of my current internship, many of these interviews took place on the unit in the clinicians' office. Although confidentiality was discussed, it was felt among these participants that their office was the most convenient place for interviews to occur. Other participants who do not work in the hospital were asked to identify a comfortable, neutral location where they felt that they could respond honestly to questions without jeopardizing their confidentiality.

Precautions Taken to Safeguard Confidentiality and Identifiable information

All names of participants were removed from initial surveys and codes and numbers used in their place. Informed consents and any additional paperwork with identifying information on it were kept in a secure and locked location in addition to being separate from transcribed interviews so as to protect the identity of the participant. Interview tapes were secured and locked during the course of this research endeavor to ensure confidentiality and standard to Federal regulations will be kept for three years following completion of this research project and subsequently destroyed.

I completed the transcribing of all interviews and did not share any identifying information from these interviews with outside sources with the exception of my research advisor. Electronically stored information was password protected on both a USB drive as well as on a personal computer and was not able to be accessed by individuals other than myself. Upon writing up and presenting my findings, I assigned the tape and transcript an ID, I changed any identifying information, and though I used quotes from

the interviews in my write-up I did not use identifying information or people's names. During the transcribing process, all names and identifying information were removed. Transcripts were not shared with anyone and all information was presented in aggregate without identifying information. The difference between anonymity and confidentiality was discussed with each participant in an effort to identify any potential risk to participating in this study. Anonymity could not be assured as some of these interviews were held in office settings around people who may have been aware of this research project. Confidentiality was assured as I took multiple steps to remove names and identifying information from responses received.

Data Collection Process

Data was collected using a semi-structured individual interview. Interviews were held in locations that were most comfortable and convenient to the participant. Confidentiality, anonymity and federal regulations regarding the tape recording and transcribing of personal information was reviewed prior to the interview process while reviewing the informed consent form. Participants were notified that their statements may be used for publication at some point in the future and that this Master's thesis was part of graduation requirements for the Smith College School for Social Work.

Each participant was sent an informed consent letter during the recruitment process which they were encouraged to bring with them to the interview. This writer brought extra copies of the informed consent letter in case a participant forgot his or her copy. In addition to reviewing the informed consent, this writer also reviewed basic demographic questions with each participant that included age, race/ethnicity, years in

the field and profession and degree. This questionnaire was explained as an attempt to illicit diversity in the sample and that this information would kept separate from any paperwork with identifying information.

All interviews were recorded using a digital voice recorder. In addition this writer, at times, took hand written notes or asked participants to elaborate on certain topics. Immediately following the interviews, this writer would copy the file onto a secure personal computer and zip drive and erase the interview from the recording device. The interview was then coded with a number and a letter and immediately transcribed by this writer. Interviews focused on clinician perspectives on what they think results in recidivism back into inpatient or residential treatment. Questioned considered team approaches to discharge planning (multidisciplinary); also, if/what assessments are being made regarding resources available in the community and clinician examples of successful discharges as defined as not having the client return to placement within a year of discharge.

Data Analysis Process

Data collected from participants was analyzed by this writer. Demographic questions and interview responses were analyzed separately with interview responses being transcribed and coded for common themes. Miles and Huberman (1984) as referenced by Anastas (1999) explain the analysis of narrative data as consisting of three concurrent activities: data reduction, data display and conclusion drawing or verification (Anastas 1999). For example, it was found that some clinicians are very passionate and opinionated about the current status of mental health and the access to care. There were times that some respondents spoke more about certain issues, such as out of state

insurance procedures and although these views are important, they strayed from the overall focus of in-state care.

Data was reviewed and common themes were highlighted as they emerged throughout participant response. Participant responses were color coded and placed into categories that materialized through constant comparison method , described by Anastas (1999) as comparing indicators (feelings, attitudes, events, statements) with each other. As a result, this writer reduced the data received to focus on the content of the semi-structured interviews that were conducted. With these reductions, categories were more easily formed and conclusions more easily drawn.

CHAPTER IV

FINDINGS

Introduction

This exploratory study aims to highlight the experience of clinicians working in the field of residential treatment and explore what they believe to be some of the biggest challenges in discharge planning with a focus on the prevention of recidivism.

Findings are presented according to themes identified with a method guided by grounded theory analysis, which assumes that a core category will emerge from the coding process and become the major focus of the analysis (Anastas, 1999). The major themes identified are as follows: the need for “buy in” from both patients and families as a way of them being invested in the treatment and discharge plan, the need for individualized, case-by-case treatment and discharge plans to fit the need of the child and family, the family’s perception of the information that is given to them by providers, involvement of community providers (i.e., individual therapists, schools), lack of outpatient resources in the communities, insurance companies and managed care policies, intractable problems of the child and family and an effort to implement a continuum of care model.

“Buy in” from patients and families

Many clinicians talked about the importance of the family being invested in the plan in order for it to work best following discharge. There are often multiple referrals made to the family and clinicians felt that the family can feel coerced into a plan that may not fit their needs. Many clinicians feel that although supporting the family is ideal, it does not always happen. One participant speaks to the idea that lack of family

involvement is a major barrier to effective discharge planning and the recurrence of recidivism:

“So the perfect discharge would include the patient and the family designing the treatment plan and designing the goals for the hospitalization and then participating throughout in reaching those goals... But I think most of the time when somebody comes back is because either we have not clearly defined for them what we think the work should be in the outpatient community so they haven't bought into it or we haven't done it together because I shouldn't even say we haven't defined it for them because that's certainly not inclusive but I think that we, I think sometimes they come back we have a different agenda for the outpatient than the family does and so they don't follow through with the plan because it's our plan and not their plan.”

“And I think the families need to be more involved with that. When I'm saying negotiate and compromise, I'm thinking [all] staff and the case clinician and all of a sudden I'm like, 'where is the family in that?' because often, the family is not part that negotiation and I see what happens a lot of the time when the team, the team that sits in the meetings and designs the plan, hopefully includes the people that will carry it out on the floor and it often does but not all the time. I think we've got to do a lot better job in getting the family involved in designing those plans. It's going to take a lot of time but I think that outcome will be better.”

Another participant talks about the importance of race, culture and gender as a major factor to the “buy in” needed from families. This suggests that although it is not always possible, clinicians should have conversations with their clients about the impact of race and culture on treatment, including how families make meaning of the fact that some providers may not identify with them racially or ethnically:

“I think I do see the families, I think you know, pulling them in, I'd like them to see, I don't know, if there was ways of options but that's an ideal world. Specifically I know that families have had reactions when there's been differences in culture and gender and I tell parents I can't pick the race of the person you're going to get and there's a lot of anxiety about that. I think the biggest piece is communication, I think that more often than not, parents will be forced upon this plan of family work that, they weren't in that discussion when it started and a lot of it has to do with the case management from day 1 and getting the meetings and talking about that.”

It appears that participants personally view family involvement as critical to effective discharge planning. It seems that there is great effort on the part of clinicians in the field to help foster the family's involvement in the plan and that involvement is directly related to success upon return to the community. One participant notes:

“well I think the essential features is making sure that people are invested in the plan, so all participants need to be invested in the plan to really sustain it; cause it takes a significant amount of work and participation to make any plan and any process work, so family members, providers, I think that's key... yeah. I think that one of the things you'd want to do is involve families as stakeholders in system development. You certainly would want their input in what their service experience has been and what worked and what didn't work for them. so, I think really being able to partner with them and kind of, measure what their experience of outcomes and results and you know, what was effective would be very important to be able to pull them in. so, kind of like what we do, you know we ask families, 'how might we be of help?' or what do you think we should be working on?' or 'what are your goals?' I think it's important to follow up with them as well and ask them what worked or didn't work, so we can kind of understand what we're delivering, get a better handle on our outcomes as well.”

Another major factor of patient and family “buy in” appears to be the families' relationship with the clinicians that they are working with and whether or not it is a collaborative approach. One participant talks about how to balance psychoeducation and intervention without being perceived as trying to tell the family what to do:

“I think that people need to realize that the family knows their family better than anybody else. We can make our assumption and stuff but as for how the family actually works, home base we're lucky because we get to see them actually in their environment but it's just a snap shot and they know there's a social worker there. Some people show you everything they got when you're there, some people act differently because they know you're there but to not act like we're the expert on their families. We can be an expert on behavior management or on mental health diagnoses and like educating the families for stuff but we have to get more answers from the families as to what dynamics are like in their household, like when does Joey, you know, explode? Are there certain things? Because they're the ones who have been watching the kids over the years. They might not realize that they have some answers so we I think illicit more answers from them instead of just assuming that we know to tell them what to do.”

This clinician seems to be addressing the issue of self-determination by families. Although clinicians may be seen as experts in certain areas, it is important that the clinician work collaboratively with the family and emphasize strengths and abilities that they family already possess.

Family Perception of Information

Similar to family involvement in treatment and discharge planning, some clinicians also spoke to the importance of how information is perceived by families and whether or not that affects their willingness to participate and/or their role in the treatment process:

“...And the principle that you hope to embrace in treatment planning and discharge planning is that, it’s really driven by the family’s perception of what’s going on informed by information, guidance provided by professionals with expertise, experience, technical skills. But certainly written in a way that is meaningful and understanding to the family. And that the family can use in a practical way for the benefit of the kid, for the benefit of the family. You know, one would hope that, ‘does that get, does that happen uniformly?’ no, it doesn’t happen uniformly market wide.”

Another clinician states:

“I think parents feel blamed, they feel stigmatized and so there’s a fine line that we constantly walk in terms of sharing education with them that may make them feel talked down to or being directed rather than engaging with but you have to share education so there is a fine line.”

Similarly, one clinician talks about when it is most likely in his experience that a family begins to pull back from services:

“I think the families get disappointed when it’s pitched as something that its not.” It seems that this clinician is emphasizing the need for transparency by both the clinician and the agency. If families are under the impression that they are getting a certain service then that is clearly a deterrent if and when they seek outpatient services.

One clinician discusses language capacity as an important factor of how services are interpreted by families similar to factors mentioned by other participants:

“Ensuring that there is language capacity. Where I work, there is a lot of families that English is not their first language or don’t speak English at all. A lot of Spanish speakers which is a little bit easier but also a lot of Cantonese, Khmer, Saudi Arabian or Iraq, these languages, Kurdish, we also have deaf families and need ASL but also this alternate sort of sign language, there’s only 1 or 2 translators in the state... So having language capacity to work with families also an increase in, language capacity for therapists for family therapy in particular”

It appears that participants really emphasized the importance of how a family understands the treatment process as a component to successful discharge. As the first participant mentioned, it really should be a collaborative process, guided by the family and in partnership with the treatment team. If a family is leaving treatment unsure of what resources are in the community, or are handed a list of follow-up appointments that they are expected to attend without having a discussion about the importance of outpatient connections, it does not have the same meaning and may not hold as much importance. If inpatient/residential and outpatient services are bridged prior to discharge, it seems that there will be less of a disconnect, in turn making it easier for families to succeed once back in their communities.

However, other participants talk about the fine line that needs to be walked between psychoeducation and making parents and families feel stigmatized. Clinicians need to be able to find a balance to help better engage families in both the treatment and discharge process. Similarly, a participant who speaks about the need for clarity and transparency when discussing discharge planning and outpatient treatment with families. If families are referred for FST (Family Stabilization Team) following discharge and they are only given the information that a team is going to come into their home once a week,

they may be under the impression that the therapy process will continue on a home-based basis when in reality, FST teams serve many different functions and since they are usually short-term, comprehensive therapy is not usually a main focus. It seems that this is a point in treatment when families begin to pull away. When things are not explained to them, or their expectations for discharge and outpatient treatment are not addressed directly by providers.

Although there are many clinical factors that create barriers to effective discharge planning, there is also the very basic subject of language. Many hospitals and clinics in the Boston area attempt to accommodate families who do not speak English as a first language. Unfortunately, the majority of languages that are available for translation only include Haitian-Creole, Portuguese and Spanish. If families speak another language, there is often a need to wait for an interpreter, if there is one even available for that language. If not, providers are forced to explain services and diagnoses that may not even have a meaning in certain languages. It is these types of situations that leave both families and providers feeling powerless and ineffective. How can we as clinicians expect to better engage families and help them to maintain success in the community when there appears to be an inherent barrier of language capacity even before discharge takes place?

Individualized plans

In addition to expressing the importance of family involvement and perception, clinicians also spoke to the fact that each case is individual. It appears historically, mainstream discharge plans have had an effect on recidivism as they are not always created for the child but for the problem. Children and adolescents are clearly presenting

to inpatient and residential treatment with an array of struggles so for them to be discharged solely to outpatient individual therapy or solely to a step-down program without a thorough assessment of his/her strengths and needs, that child will more than likely come back into treatment. In thinking about the individual needs of a client and how it relates to effective discharge planning, one participant states:

“It needs to be, fit the needs of the case first of all, so, there’s no set palate that you’d use for every discharge. Some people need less, some people need more; it’s tailored to meet the specific needs of the individual. One of the things that I would like to see is, ideally, it would be nice if the aftercare plan could be implemented prior to discharge so there is some opportunity to do some practice of what’s going to happen following hospitalization... One of the things you’d hope to be able to do is be able to accurately identify needs and tailor treatment to meet those needs.”

Another participant comments on the equal importance of alternative intervention service recommendations as part of the discharge process:

“I think some of the non-clinical services that we’ve put into place that I’ve been happy with and I know we’ve done, mentoring, big brother big sister, we have the group, ‘the gifts girls’ and things they have a mentor system now which is good and been a huge help. More recently I think girls that are trying to find mentors even just for, sort of work and life experiences, I had this one girl who was really interested in music and we got her hooked up in a program that was like a music education program that really didn’t have, I don’t think there was no social worker or therapist doing the program but it sort of an after school service that she got really in to. I had a girl who was just coming out who, I think really needed support around that so we hooked her up with an adolescent LGBT group and that was nice, things that feel nice. I guess, it all depends on the kids, I guess I can’t say there’s a prescribed, every kid needs this, but just look at all the different domains and assess what needs to happen now, what you would like to happen soon and insuring that the parent also has the resources to follow up with it if it’s not in place at that point.”

Most participants made reference to the individuality of all of their cases.

Whether they spoke specifically to the need to individualize treatment plans or they were reflecting on the diversity of the cases that they have overseen, it seems clear that current

standards of stabilize, assess and discharge are not always enough to ensure success one back in the community.

Resources and providers within the community

Aside from the family involvement in treatment and discharge plan, it also appears that clinicians in the field are struggling both with a perceived lack of resources as well as communication and collaboration issues with other providers in the community. One participant talks about wanting to involve some of the community providers early on in the treatment process:

“I think one of the things that I would like to do is break down the walls a little bit on the unit and get more community providers involved in the care. So you know, for example, getting some Family Stabilization teams involved in the unit to actually go out and be able to do some homework with people while they’re out on pass during the hospitalization; that might be one way to involve, to really kind of change the multidisciplinary nature of the discharge planning that we do. So kind of pairing up inpatient teams with outpatient teams.”

Another participant appears to support this idea:

“...I mean you know obviously the fact that the child is in the hospital implies that there’s been some ineffectiveness of the outpatient treatment so I think we could probably do more to include the outpatient team in our work and you know, it is very frustrating and everyone I know shares this frustration of, well my frustration off sitting in rounds and hearing that other people is getting on the phone, you call, you call, you call, no one calls you back, that may go on for a week and a half, 2 weeks where your trying to get in touch with somebody and they don’t return you r call, so you don’t have the information you need in those circumstances... So I think that the system that way is, people don’t have accountability, don’t own that piece on an outpatient basis to follow up. I’d like to see people in here more. I think we do a lot of systems meetings but the meetings tend to be more DCF, DMH, sometimes the school but not usually the school. I’d like to see clinicians in more to participate in that. It’s not needed all the time but I think there are cases where it’s really important and sometimes clinicians do come...”

Similarly, one participant talks about the need to be in contact with multiple collaterals stating that often times there is only contact with an identified case manager and no one else involved in the case:

“More contact with collaterals would be beneficial in that there’s very limited contact and the majority is, if you’re lucky, the DCF worker and potential and a guardian, if there is a guardian, so either DCF, if you’re lucky and the parents, if there’s a caretaker involved but other collaterals are often not involved the way they should be. Such as GAL’s, ed-surrogate parents, attorney’s, probation officers etc. so that everyone can work together and make informed clinical decisions.”

In addition, if there is collaboration between inpatient and outpatient services, there seems to arise the problem of “what is available?” many participants spoke to the lack of services in the communities that they are discharging their clients back into. Moreover it also appears that practicing clinicians don’t have a good idea of what is available, seemingly only what is not available:

“Well, I think, once again its, this is another angle on how restriction occurs. So, market wide, there’s not enough services to meet demand. So, it makes it quit difficult to match services with indicated needs; indicated client needs. So you know, a lot often depends on what people are able to afford or where can they go in terms of transportation? Locality? etc. and a significant number of client needs remain unmet because of the lack of available services...I don’t think that happens all the time, no. I mean and I think it’s a reflection of what’s available. You know, there are, you know kids end up getting stuck in settings that they don’t belong in because there aren’t available, appropriate treatment settings for them. so you kind of default to what’s possible versus what’s indicated.”
Some participants spoke to their skepticism regarding the new proposed plan of

the Child Behavioral Health Initiative:

“And then the hindrances to this (successful discharges), the outpatient system is not there as we need it. I think that the, you know we need a continuum of care in the community that there have been attempts to provide, the new CBHI has huge goals to expand the continuum of care in the outpatient environment; I’m not sure how that’s going to work. But I think that a lot of the times what we really see

that what the child needs, it doesn't exist and then you have to piece it together as best you can or, you know go with a completely alternative plan that you don't always feel good about and I think we do that a fair amount of the time. The services are not in the community where the family lives and they have to travel. You know and then the wait is long to get them into some of the services, um, those are hindrances”

Likewise, another clinician talks about perceived barriers about how kids are passed around and within different agencies because the outside services don't exist:

“I'm very curious on what's going to happen with, I know there's changes happening in CBHI stuff is popping up and community service agencies are about to start and their mission is to start...learning about it, I'm skeptical. That was the lead agencies role it sounds like a duplicate of service. I think that there can be bureaucracy to a point but sometimes I have cases when there's not enough bureaucracy and that's where it comes in, and I've as a clinician I've changed my views on this dramatically since I've joined here, that it's a good thing that a kid becomes a problem to the department. When people are arguing with each other about what happens, I see that as, 'I did my job.' I think I get the most worried when there hasn't been discussion and there hasn't been conflict because there should be conflict about it and a kid will move quickly without the agencies really questioning alternatives or looking at it differently and I think that's where we can come in, in a lot of different ways.”

As often happens in Massachusetts, hospital and residential treatment centers often get kids from out of state as there is mental health parity law. One participant speaks to the difficulty of not only in state but, out of state kids and how to best meet their needs upon discharge:

“I think that we don't always know, have a good sense of what's available in the community as well and especially all these out of state kids you know, it takes weeks to get services for them and just investigate the system...DCF, DMH and DMR function very differently... We meet them on a monthly basis and ask them for updates and they never know what's going on in the other areas and so that's frustrating and I think an area that we could, it takes a lot to keep up with it but probably something that we could do better at is just being on the web and being updated.”

This same participant talks about the difficulty in finding enough services to meet the demand stating, “It makes it quit difficult to match services with indicated client needs.” He also talks about the frustration of only being able to refer clients and families

to services within their local and as other participants have discussed, finding adequate services in certain communities can at times feel impossible. He concludes this thought stating, “A significant number of client needs remain unmet because of the lack of services.”

One clinician discusses her use of the internet for finding resources as sometimes that is the only way to know that something exists. In addition she continues by talking about new initiatives in the mental health field that may jeopardize many agency funds to access some of these resources:

“Thank heavens for the internet I mean I think that that’s been more of a resource lately. I mean, even from when I first started which wasn’t that long ago but I feel like there’s almost just been, sometimes I feel like resource overload and sometimes you have to just file it away but it’s amazing what you can find just “googleing” something. I rarely even remember that I have a rolodex that’s chock full of stuff so I just hop online.”

This participant also talks about resources obtained through DCF as well as through attending trainings. It appears that some agencies make it a point to educate their staff on available resources in the community in an effort to best serve their clients. This participant also talks about new state mandates that may affect funding for some community resources and the anxiety that it creates among mental health providers as their options for referral will most likely decline.

“I don’t know how hard it’s going to be to access resources, you might be able to find out about things but we might be finding out that programs are cut and so then state funding you know like, do we find different funds that exist. Oh you can maybe apply for a grant here and there, I don’t know if those are going to fall by the wayside, I don’t know if we can use those either.”

It appears that there is consensus across the board that although there are multiple “lead” agencies that are often involved in a child’s care, that there can, at times be minimal communication or even understanding of the different roles that agencies and

providers are playing. Similarly, participants seem to be equally concerned about funding and how that impacts that care that is provided to you and families. One participant talks about localized agencies not collaborating with state agencies due to funding and distribution of those funds:

“You know I think, two things, I think that they should be more evenly distributed, the services across the state in terms of the continuum of care...”

This participant speaks more to this issue by suggesting alternative ways for state funded programs to utilize their funding:

“What I’m aware of is that you know, DMH and DCF each region gets a chunk of money and they use it for that region. DCF can transfer across lines if they want to and I know we’ve had that happen on rare occasions, DMH doesn’t transfer across lines is what I’ve been told so you know when somebody uses up their chunk of money, there’s nothing left for them so then what do you do? I think DMH, DCF, DMR, EOHS, they all should be under one umbrella instead of dividing up these pots of money and there should be oversight of all of them and have them work better together especially with for really complicated patients that we see; and that happens a little but it takes a long time to push it to that level, to get it to happen and you have to get this application and fill out this application and ‘blah blah blah’ before they’ll ever push it to that level and you know, often it happens that you have these big systems meetings... I think that at times we hold on to them (patients) too long and they regress and that sometimes we hold on to them wanting to find the perfect outpatient plan for them and it’s not there and so we end up settling for less than the perfect anyway. You know, I think that, can we use more advocacy? Definitely. Should we bump it up higher, earlier? I think, yeah.”

Many participants when discussing this lack of resources also commented on the fact that often times kids are getting “stuck” in placements due to the fact that services cannot be identified. Participants working in the hospital setting spoke a lot to this issue and discussed the frustration of not having a place for kids to step down to. One participant working in a community based setting also spoke about kids getting stuck at the lower levels of care. It seems that there is pressure from multiple sources to move kids through treatment and get them back into the community but resources are not

available and if they are, they are not well known and discharge planning becomes a research endeavor in an attempt to locate adequate services in the community.

Insurance Companies

The major theme of participant interviews was the pressure felt from seemingly all agencies from insurance companies. One participant talks candidly about the development of the stages of change model and how insurance companies base their policies off of this model:

“Okay. You know for the other stages of change model will that was evolved on a smoking cessation the whole was is developed by Jim Prochaska and was evolved on smoking cessation. The cost of making a mistake with smoking is, the person smokes again the cost of making a mistake with alcohol use or heroin use or psychiatric problems is somebody dies so the error cost is so much higher but insurance companies leapt on it and said that relapse is the norm is ‘oh, this person is in the pre-contemplation stage’ so they have go out and hit bottom somewhere before they can, then they shrunk days of treatment from 28 days to three days for inpatient , alcohol and substance abuse treatment of, also during which those remaining 25 days a lot of people “hit bottom” and some people lived.”

Alternatively, a participant working at a residential treatment center, a common step-down from a hospital, talks about the different funding contracts that his agency receives and feels that the private CBAT (Community Based Acute Treatment) insurance payers offer services more quickly than some state funded health insurance programs:

“Because we do STARR and CBAT cases, I think in some ways the CBAT kids it just seems a lot more straight forward to discharge plan with them. The insurance system seems to allow for that a little bit more easily. I’ve had more cases where the department has reported this service will be put into place following discharge and when we’ve requested the kids start prior to discharge, it’s been not to more often we go to say MBHP or MassHealth and ask if we can start the FST now and their always saying are saying “yes now” that’s sort of always their policy. You sign a form and 24 hours later there is somebody there. And I think that system, that model feels, at least for me personally, is so straight forward and there’s less bureaucracy I think sometimes in the offices, depending upon how things are

funded, there needs to be cuts here, cuts there and I think more often we're seeing the department looking to really trying to save money in that perspective."

In addition to the private insurance companies, state funding for public/state health care policies also seem to encounter similar bureaucracy in terms of what services will be paid for and for how long. One participant talks more about this issue:

"As far as a barrier...did I say funding? (laughs). If programs get cut, it's going to be much more stressful for us to help support a family. Now we don't have much of a time crunch because we have more than 2 weeks we have 3 months which is pretty much a minimum but it's going to be harder to support them. But I think that could also internalize for us, feeling like we're failing families. Some of us are more prone to feeling that way and especially if you can't put in concrete services, but if there not there, they don't exist, I think funding is, across the board probably the biggest barrier.

These factors, as discussed by participants seem to suggest that major work needs to be done on the part of the insurance companies to ensure that not only are resources available in the community but also that community resources are receiving enough funding the adequately meet the needs of clients and families.

Intractable problems

Some participants also spoke to the issue of "intractable problems" and that sometimes recidivism is a part of the treatment process. Intractable problems, refers to long-term issues that often times, many clients deal with. Mental illness for example and/or DCF involvement by families usually suggests that there is a long road ahead of treatment and providers. If a child has a mental health issue, there will most likely be many relapses in symptoms requiring inpatient or residential treatment and clinicians seem to accept that as a reality. Having this conversation with families however appears

to be hard, as discussed by some participants, many families are looking for a “cure” or an answer as to why their child is struggling. In discussing whether or not enough time is allotted to address the needs of clients/patients, one participant stated: “every [client] that comes in here, has a long, long road to travel by...” another participants states:

“Am I convinced that they will not be back in the hospital? You talked earlier about recidivism, absolutely not. No, I think they will be back in the hospital but I see it as a part of the process that they have to go through and that overall treatment that’s going to be years and years.”

Although there is mental health parity in the state of Massachusetts, there still remains a disconnect of services and equality of treatment. With medical and physical illness, people are consulted throughout their life on the effects and limitations of their illness or disability. The fact that these conversations are not translating into the mental health setting is a clear barrier to ensure that families will succeed after discharge. Families need to be constantly engaged in their child’s mental health treatment but there also needs to be an assurance that resources in the community are going to be available. Mental health policy favors ‘least restrictive’ levels of care for children and families. If community resources are not available, this barrier to effective discharge planning will always remain.

CHAPTER V

DISCUSSION

This qualitative study explored perceived barriers to effective discharge planning by clinicians in the field. Clinicians in a variety of settings were interviewed about what they viewed to be barriers to effective discharge planning and the reasons that youth sometimes return to treatment. While there is a fair amount of literature on transitioning youth back into the community, there is less about maintaining success following discharge. There is a lack of information that discusses the importance of thorough communication across adolescents' environment to help to maintain them once they have been placed back in the home as well as to ensure that there are adequate community resources available to support both youth and his/her family with this transition. This study sought to address what factors may be missing in clinician practices when approaching discharge in an attempt to identify thorough application to discharge planning.

Findings emerged in six major themes: (a) treatment “buy in” by patients and families (b) client and family perception of information that is being received (c) the importance of individualized plans (d) resources and collateral providers in the community (e) insurance companies and policies dictating mental health care and (f) the sometimes difficult realization that youth and families often have intractable, or long-term struggles and how to have that conversation with them.

Client and family “buy in” was talked about by most of the participants. It seems that without the investment of the client, the desired therapeutic outcome is not often attained. It is important that clinicians work to ensure that clients and families are being

thoroughly engaged in the treatment process both during inpatient or residential as well as once discharged back into the community as a way to help ensure success in the community following discharge. If clients are not given the psychoeducation about their problems and are not motivated to work towards a goal for treatment, it cannot be guaranteed, or even expected that they will follow through with treatment following their discharge. Some participants spoke to the fact that families have a tendency to feel coerced during discharge and may feel that they are being forced to follow a plan that they do not fully feel comfortable with. It is important for clinicians to ask themselves how involved they are keeping their families. What are providers doing to be most helpful to the family? Is work being done collaboratively with the family to set treatment goals? And most important, does the family feel comfortable with the plan?

The findings also suggest that past experience with providers is key to client and family “buy in.” If a family has historically felt pressured or forced into a plan, they may feel hesitant to follow through. It seems that the therapeutic relationship as experienced by the client and family is a major factor that influences a desire and motivation to continue with outpatient treatment. Similarly, race and ethnicity may play a major role in the comfort of clients. If they do not feel that the clinician can fully understand their experience, or feel that the treatment referrals being made are not relevant to the family system, they will be less likely to follow through with that plan. Participants spoke a lot about how cultural differences often serve as a barrier to accessing services in general as a part of their experience.

Participants also agreed to the importance of family perception of information. Similar to “buy in”, participants spoke about the importance of how a family perceives

the information that is being presented to them at discharge. One theme that emerged from the findings highlights families feeling disappointed when information is “pitched as something that it’s not.” For example, sometimes when youth are discharged from residential treatment, they are often referred to a Family Stabilization Team. Agencies need to make sure they are using language that families understand and that they are being clear about what types of services can be expected. For example, many FST workers are bachelors level clinicians specialized in a more focused, behavior-modification technique; yet they are still referred to as “therapists”. Although this technique is helpful to many families, they may be looking for a more long-term intervention with someone who is trained in a more clinical approach. If clients and families have expectations at the beginning of outpatient treatment that are not met, it is more likely that they will not follow through with the service.

Race and ethnicity also play a major role in this finding in the context of linguistic abilities of the clinician. Not only does the cultural background and experience of the clinician factor in to client comfort, but agencies also need to address the implications of not having interpreters to adequately serve their entire client population. Language capacity is so important for the actual therapeutic work and the benefits of treatment may be compromised if the client/family and the clinician/provider cannot communicate effectively. Agencies where interpreters are available may help to offset some of these challenges but it is also important to think about if and how an effective space for treatment is being created. It is imperative that clinicians are asking themselves what it would be like to have not only a therapist but also an interpreter in the room to keep client perspective in mind. That already sets up a very uncomfortable dynamic for

families and seems to also be a major deterrent to outpatient treatment following discharge from inpatient or residential treatment.

Participants spoke to the importance of individualizing discharge plans to fit the client needs. Although it is thoroughly discussed by participants that treatment needs to be individualized to meet the specific needs of clients and families, many treatment models do not include specific interventions at discharge that will help to meet the needs of clients. For example, in addition to outpatient therapy, some clients may also need more extracurricular activities to keep them engaged once school is out. Some clients and families may need more state funded services such as food stamps, or daycare to help relieve some of the stress within the household. In looking at the model of stabilization, assessment and discharge, it is important that clinicians ask what is needed most by the client and family to ensure a successful transition back into the community. It is important that both agencies and clinicians are considerate of the multiple needs of clients and families. Because of these many needs, it seems clear that plans are individualized to fully support clients and families once they have transitioned back into the community. Participant responses seem to support the fact that if clients are assessed and treated with generic treatment plans, the possibility for recidivism is more likely.

In thinking about what resources would be available when looking at referring clients post-discharge, it is also important to assess the community that clients are returning to. It is important to assess whether that community has adequate resources to meet the client and family needs, whether resources are accessible if they are outside of the client community, and if they are not, whether or not there are similar services closer to the family that may meet their specific needs equally. If providers anticipate follow-

through of their clients, it seems imperative that they are also doing work alongside the family to best support them in their transition back to the community. These findings suggest that if the outpatient component is not readily available, the client will most likely return back to inpatient or residential treatment as a result of not having the supports needed.

Another theme highlights bridging inpatient and outpatient work and maintains that outpatient services should be practiced with the client and family prior to discharge. It seems that if clients and families can “practice” certain aspects of outpatient treatment or begin the transition with the support of inpatient service providers, there may be more support to help facilitate the eventual transition back into the community. Participants spoke to the desire to have outpatient services begin during the inpatient process so that the family can get acclimated to services. This process would also allow for providers across a system to begin communication with each other to ensure success and collaboration.

A problem with effective discharge planning, however, seems to lie in the ability to make sufficient contact with a client’s outpatient team. Many participants spoke to the fact that the more agencies involved with the client and family, the harder it is to have a system approach to discharge. Participants at the inpatient and residential level of treatment spoke about their frustrations with certain outpatient systems and indicated that it often takes weeks to get in touch with someone. It appears that this is a major factor in creating effective discharge plans if all involved systems are not in constant communication with each other. On the other hand, a participant from the outpatient level of care mentioned that it can get overwhelming with the amount of case work that she

carries and sometimes does not prioritize immediate contact with inpatient and residential collaterals if a patient has been stepped up to a higher level of treatment. It would be important for clinicians at all levels of care to understand the difficulties of maintaining contact and work together to find an approach that works best to serve the client in a time efficient manner.

One commonality on this topic was the frustration that state agencies (Department of Children and Families, Department of Mental Health and Department of Mental Retardation) all function differently, which makes it difficult to coordinate services. In addition, many of these agencies will not take on clients that are already involved with another agency. This makes identification and utilization of services difficult. Participants also spoke to the frustration regarding the disconnect between agencies and how often times, youth and families are faced with fewer options when the present with multiple issues. It is important that state agencies are thoroughly reviewing their allocated funds in an effort to best serve the client community. In addition, many participants spoke about “stuck” kids who often end up remaining in placement due to the fact that there are no services to adequately treat them in the community and they remain in inpatient or residential treatment and often times begin to regress in their behaviors. These findings speak clearly to the Massachusetts legislation on children’s mental health and highlights in ineffectiveness. Youth are faced with a dearth of services to support them following discharge which suggests the need for a thorough review in an effort to best meet the needs of clients and families. It seems that an additional barrier to effective discharge planning lies in state mandates that are already in place. There seems to be a large

disconnect between service providers and legislation which is greatly effecting the options for clients and families once they return to their communities.

Managed care and the model in which it works within is a definite barrier in the way that youth are treated in inpatient and residential settings. It seems that the current “stages of change” model that is being used by most insurance companies has created such a paradigm shift in the way that treatment is conducted. Based on this model, clients are restricted to short-term care which is defined in many different ways depending on funding sources. One of the longest terms of treatment available is the 45-assessment provided by private insurance companies as well as DCF; these options however are only available as a step-down from a higher level of care. Inpatient settings are restricted to even shorter time frames and many participants spoke to the fact that it is very difficult to identify client needs in such a short amount of time. The hospital medical model requires that cases are reviewed after a week and at this time it becomes harder and harder to justify inpatient services. There is a clear need to review this model to address the barriers that are undeniably present. In addition, it seems that more funds need to be allocated to community resources so that treatment can continue effectively after discharge.

Finally, some participants spoke to the concept of intractable or, difficult to manage problems that often require long-term treatment (as many mental health issues do). Specifically, youth with eating disorders or mood disorder diagnoses that require long-term observation. It seems clear that many clients and families are a part of a larger environment that is not always controllable by outside forces. Mental health issues are a long-term struggle and participants spoke to the importance of having these conversations

with families. It is important that the family not expect a “cure” from inpatient and/or residential treatment. Psychoeducation was emphasized across the board in participant interviews as something that does not happen enough. In thinking about the idea of psychoeducation, it needs to be made clear that it goes well beyond simply educating the client and family on diagnosis and outpatient resources. It is also important that families are aware of the long-road that many of them will have to travel. Sometimes, recidivism is almost guaranteed especially as there is not enough supply to meet the demand for services. Families need to be aware of these challenges up front and feel that they have the support they need to help address the needs of their child.

Limitations to this study include the need for a larger clinician sample. As there was such a small sample used for this study, findings only begin to address what clinicians in the field view as barriers to effective discharge planning. Similarly, all clinicians interviewed for this study identified as Caucasian. Opinion within greater racial and ethnic range would also change the findings of this study as clinicians of color may have a different experience and approach to discharge planning. Further research should consider a much larger sample as well as perspectives representative of a more diverse participant pool including participants from a wider range of clinical practice. Participants in a wider range of clinical practice as well as those from multiple perspectives such as race and ethnicity would allow for further insight into perceived barriers to effective discharge planning. For example, more social work participants working in hospital settings could provide more of a framework for how and why barriers exist in that particular setting. Similarly, it was interesting to see the how clinicians at lower levels of care (residential or outpatient) viewed perceived barriers. With more

participants from these levels of care, a clearer picture of the disconnect between inpatient and outpatient may be formed. Nonetheless, critical findings were derived from this study and would make a desirable framework for further study. Main points to take away from this research appear to be the lack of funding and resources available to adequately serve clients and families in their communities. Similarly, clinician ability to actively engage the client and family in the treatment process and addressing the obstacles so often created by insurance companies emerged as major barriers to effective discharge planning.

Recommendations for further research in the field are as follows: there is a need for assessment of current assessment models used by insurance companies in an attempt to bridge the gap between available services and client return to treatment. Also, there is a need for assessment of allocated funds to statewide agencies and the implications for mental health treatment as a way to review how money is being spent as an attempt to identify areas for improvement. Similarly, emphasizing the need to work collaboratively with clients and families to ensure success following discharge as a way to empower clients and families and provide the support needed to continue with outpatient treatment to guarantee success in the community; and addressing intractable problems, how to create a dialogue with clients and families about the complexities of mental health issues and in addition, work collaboratively with clients and families to develop a flexible treatment model that benefits the client. It is important that research in this area continues so that agencies can work mutually to effectively address the needs of clients and help to prevent recidivism to higher levels of care.

Assessment of current models used by insurance companies would help to explore why barriers are occurring and ideally oblige managed health care companies to change their practices in an effort to best serve clients. If insurance companies are looking to model their policies after state guidelines, it will be equally important for state agencies to conduct a similar assessment. Similarly, if statewide agencies were able to better evaluate the allocation of funds, they may be able to spread money across multiple communities ensuring that equal services are available. The findings suggest that clinicians feel that funds are not evenly disbursed, resulting in some communities having fewer resources which, in turn, unfairly consequences clients and families from those communities.

If families were further engaged in the treatment process at the beginning of treatment, they will feel more motivated to continue with outpatient treatment. If clients and families are more motivated for treatment and are invested in the plan that has been created collaboratively with them, they will be more likely to follow through thus, optimistically preventing future return to inpatient or residential treatment. The findings suggest that being in constant dialogue with families is a great way to help them feel connected to the process. In addition, treating families as the experts and using clinical knowledge as an authoritative, as opposed to an authoritarian component to treatment. That is, interact with clients and families from a position of being able to offer specific knowledge (i.e. about diagnoses and community resources) but allow the client and family to retain the position of knowing what is best for them.

Finally, children and families are coming to treatment with seemingly obstinate problems, that is, a client and family may experience crisis repeatedly across the lifetime

and some providers expect to see recidivism with these families. It is up to both inpatient and outpatient providers to work in partnership to develop treatment plans that will ideally keep children and adolescents in the least restrictive forms of care. This may include outpatient providers taking a more active role when their client is in inpatient treatment; attending systems meetings and talking constantly with the family about expectations for outpatient treatment following discharge. In addition, if both inpatient and outpatient providers (school, outpatient therapist, extracurricular activities etc.) were able to create treatment plans together to help support the client both while in inpatient/residential as well as following discharge.

For those working in the clinical mental health field, this information implies that effective work can be done at the inpatient level to facilitate a successful transition back into the community. Both inpatient and outpatient providers can work collaboratively with clients and families and bridge the therapeutic work that has begun at the inpatient or residential level. It seems that recidivism is not always preventable but the findings suggest that there are many steps that providers can take to help support clients and families once they return to the community. The foremost theme appears to be collaboration between service providers. Practitioners need make a thorough effort to be in constant contact with collateral agencies (including the school) to help to create individualized plans that will maintain success following discharge. Similarly, clients and families need to be fully engaged throughout the process and looked to as consultants in their own treatment. It is the family that knows the client the best and this concept appears to missing from many features of successful discharge planning.

For those entering into the clinical mental health world, this research helps to emphasize the need for extensive knowledge of community resources as well as knowledge into how state funds are allocated and used by certain agencies. Participant responses speak to the importance of inter-agency collaboration in helping to identify community resources. In addition, clinician use of the internet to find what communities offer certain outpatient interventions. Furthermore, “thinking outside the box” seems to be a useful strategy in creating discharge plans. In thinking about the need for individualized plans, client and family referrals should be made to fit their individual needs. In addition to outpatient therapists and psychopharmacological evaluations once a month, clients and families also benefit from alternative interventions such as, art classes, information on free activities to do on the weekends and general psychoeducation about mental health.

The more information attained by mental health clinicians, the more effectively clients and families can be transitioned back into their communities as well as maintain that success for the long-term.

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Appendix A

HUMAN SUBJECTS REVIEW LETTER OF APPROVAL

February 26, 2009

Leah Jackson

Dear Leah,

Your amended materials have been reviewed and all is now in order. We are glad to give final approval to your study.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Luba Feigenberg, Research Advisor

APPENDIX B

Letter to Participants

Leah Jackson

Dear potentiel participant ,

My name is Leah Jackson and I am a graduate student at Smith College School for Social Work. I am contacting you as part of my research requirement, I am interested in clinician perspectives of perceived barriers to discharge planning and what factors are related to recidivism of children and adolescents being discharged from inpatient of residential treatment facilities. I received your name from a colleague who thought you might be interested in supporting this project.

If you choose to participate the interview would ideally be face-to-face at a mutually convenient time. The interview should take approximately 60 minutes, and would be tape-recorded. Any personal information would be kept completely confidential. I would be asking you questions regarding your personal approach to discharge planning as well as asking questions about the approaches of your agency and what you believe are areas which could be improved. In addition, I will be asking about perceived barriers to discharge planning and what factors, internal or external you believe to be factors in recidivism.

I am eager to hear if you would be willing to collaborate with me. I hope also that this interview would help you to gain perspective on aspects of your own professional experience.

Please feel free to contact me with questions, concerns or for more information. Thank you for your consideration.

Sincerely,

Leah A. Jackson

APPENDIX C

INFORMED CONSENT

Date

Dear Participant:

My name is Leah Jackson and I am a graduate student at Smith College School for Social Work. While working on my Masters in Social Work, I am required to complete a master's thesis. This master's thesis will be used to fulfill graduation requirements (presenting the results to the Smith community) and has the possibility of being submitted for publication. The purpose of my research is to assess the level of discharge planning among clinicians and how that process results in effective or ineffective discharge of the adolescent client. Through a series of interviews with multiple levels of mental health clinicians (program directors, treatment coordinators, social workers, psychologists, psychiatrists and possibly psychiatric nurses) I hope to address what barriers effect successful discharge planning and what steps can be taken to prevent recidivism among adolescents in residential placements.

I am asking that you be a participant for my study based on the fact that you meet the following criteria; 1) You work at a residential program for adolescents, 2) You are a clinical social worker, hold a master's degree in social work (MSW), 3) You are a psychiatrist or clinical psychologist and hold a graduate/medical degree 4) You are a Master's level mental health clinician, or 5) you are a Master's level administrator overseeing a residential program for adolescents. To be a participant in this study you will have to sit for an interview which will be conducted in approximately 50 minutes. In addition to the interview, you will also be asked to complete a demographics survey. The demographic survey asks about your age, sex/gender, race, number of years in the mental health field, and the amount of discharges that you have either participated in or overseen. The surveys will be administered at the beginning of the interview. The survey should take 5-10 minutes.

Minimal risk from participation is anticipated for this study. There may be stressful times when you are asked to reflect upon and evaluate treatment modalities used as well as considering times when your planning was not beneficial to the client. You may feel uncomfortable at times and feel that your opinions are being judged and/or compared to those of other clinicians or that your values and opinions will be shared and/or discussed outside of the interview as they will most likely be conducted at your place of work. Expectations for confidentiality will be discussed at the beginning of every interview.

A benefit of participation in this study would be that as an individual clinician or program administrator, you would be given the opportunity to further examine your own

level of successes and failures when it comes to discharge planning and will be able to reevaluate effective ways to implement services. At your request, I will send a summary of the results of this study. These findings may give useful information in terms of how other clinicians in the mental health field recognize and address the multiple issues that arise when planning for successful discharge. It is possible that the results of this study will generate further investigation into preventative measures of recidivism and increased awareness of clinicians to prevent multiple placements among adolescents.

The interview will be audiotaped. I will transcribe and analyze all the data.. I will keep all materials in the locked file cabinet for three years according to Federal regulations. The findings of this study will be presented in aggregate form. No identifying information will be included to ensure confidentiality.

Participating in this study is completely voluntary. You may withdraw before , during, or after the interview. You can contact me at the address and/or phone number provided below.

Thank you for your time and willingness to participate in this study.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Participant Signature: _____

Date:_____

Research Signature:

Date:

Researcher's contact:

Leah Jackson

Please keep a copy of this consent for your records.