PURPOSEFUL PARTNERING - ESSENCE OF THERAPEUTIC CONNECTEDNESS: A PROCESS-ORIENTED SERVICE DELIVERY MODEL

by

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This dissertation is dedicated to people wanting to make a difference in preserving the innocence of childhood and promoting hope and contentment in families.

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Purposeful partnering is a way of engaging with children and families that involves the child and family in the planning process to determine a unique set of community-based services and natural supports individualized for that child and family. The planning process identifies the strengths of the child and family and determines needs across multiple settings including home, school and community. Purposeful partnering escalates the family role to a partnership role and families receive training to ensure they are comfortable to take on this role. There are several principles that guide purposeful partnering that are consistent with the wraparound initiative and integrative case management and they include: family-focused; community-driven; creative; unconditional; strength-based; individualized; culturally competent; cost effective; and outcome-driven. Persistence in finding the right approach and the right services is what distinguishes purposeful partnering from other service delivery models.

Purposeful partnering may be particularly useful for children with severe emotional and behavioural issues when residing in a rural community. It has been designed to reduce the cost and reliance on expensive (and somewhat difficult to access due to location) institutional care and to improve the fragmented system of care. It can be used effectively for early intervention as well as addressing more complex needs. As long as the essential three dimensions of purposeful partnering are included: the degree of family participation; the team composition and structure of the purposeful partnering; and the extent to which strengths across systems (home, school, community) and life domains are included.

Purposeful partnering is not an initiative it is a process to be embraced with all children and families that enter the social service sector.

CHAPTER 1
PROBLEM FORMULATION

Introduction

For most agencies the central duties for the practitioner assigned to the family are somewhat mechanical. The primary goal of case management with a purposeful partner with a child affected by behavioural and or emotional challenges and their family is more extensive. The very specific goal is to provide those services that will enable the family to remain a unit. Determining what those elements are and supporting the family obtain them is critical. Since it is the parents who are living with the child and the parents who are the experts on the child, they are the final determiners of what services are needed. The parents decide if therapy is effective. The parents help write the treatment plan so it is useful to them. The parents decide if medications are effective or not. The parents are pivotal members of the team and final arbiters of what is and what is not helpful to them in parenting the child in their care. The task of the purposeful partner is to create a "circle of support" for the family. This circle of support through purposeful partnering may include the following partners such as, respite providers, other family members, school, family physician, psychiatrist, psychologist, informal supports, therapist and others who are involved.

Background of the Dissertation

It requires a tremendous amount of courage for a family to contact a community agency hence declaring the need for family support. However it is comforting to know the efficacy of a well coordinated, managed team can be offered to families as they enter community –based programs in rural communities.

"It is believed that the first formal effort to de-categorize services and improve outcomes began over twenty-five years ago in Canada. John Brown's work with the Brownsdale programs influenced this new way of thinking. His program's underlying philosophy was based on needs driven, individualized services that were unconditional" (Vandenberg, 2006, p.1). "In 1975, Brown's program (and its use of normalization concepts popularized by the European-based Larch movement) was adapted by the founders of what became known as the Kaleidoscope Program" (Dennis, 1979, p. 4). Later when the Kaleidoscope program became an independent entity, the group home model was replaced with intensive in-home family support services and led to Kaleidoscope becoming known as the oldest wraparound initiative in the United States.

During the 1980's, the wraparound approach became more broadly known and adopted in the United States, primarily through its affinity with and incorporation in systems in care. It appears the wraparound process became a cornerstone of the largest federal conceptualization of children's mental health care, which was designed to establish multi-level community-based systems to serve children with emotional, behavioural, and mental health needs. Wraparound sought to address existing deficiencies in the mental health system including its fragmentation, overly professionalized service delivery and use of restrictive and out-of-home treatments.

"This federal initiative has directly established and indirectly influenced a host of child-serving community-based programs for children with serious emotional disturbances, all of which incorporate the wraparound process. The success of many community-based wraparound programs such as "Project Wraparound" in Vermont, led by John Burchard and Richard Clarke, was among the first to document the benefits of wraparound" (Leverentz-Brady, 1983, p. 17).

At the same time the Child and Adolescent Service System (CASSP) was funded,

two Research and Training Centres on children's mental health were established, "one at the University of South Florida at Tampa focused on systems change" (Hagen, Noble, Schick & Nolan, 2004, p. 83) and the other at Portland State University focused on family support and improving relationships between families and mental health providers (Walker, 2003). In addition, a Technical Assistance Centre was funded, initially through CASSP, at the Georgetown University Child Development Centre (Burchard, 1993). All three of these entities would disseminate wraparound strategies and contribute to their wide spread adoption. In 1986, the term "wraparound" was formally coined by Lenore Behar to describe the community-based method of providing individualized mental health services to youth with serious emotional disturbances (Behar, 1986).

Today, the "wraparound approach has been widely disseminated and is a central feature of almost every federally funded system of care demonstration site and one estimate is that over 200,000 youth receive some type of wraparound service" (Faw, 1999, p. 80). In addition, the approach has been widely adopted across the United States although, while wraparound has been identified as a "promising practice", the evidence-base defining its contours and evaluating its effectiveness is relatively sparse. Unlike other evidence-based practices, there are no nationally recognized standards nor any definitive blueprint or 'manual' to guide service delivery activities. Yet, there are strong indications that the approach does have merit and its adoption has been bolstered by possible recommendations that services for children with serious emotional disturbances be based upon an individualized service plan. I believe the indications are held by the core of the wraparound premise that, if children with emotional and/or behavioural concerns have needs that go

across systems, for example, mental health, juvenile justice, schools, child welfare, etc. by working together will produce better outcomes. I feel it is imperative to meet the family 'where they are' to encourage thoughtful change which would be indicated by the following outcomes or indicators of change occurring:

- Education (achieving personal success at learning);
- Finances (developing budgeting skills);
- Employment (obtaining a job or working toward a more desirable one);
- Transportation (obtaining license, understanding public transit);
- Household (obtaining furnishings, searching for a residence);
- Parenting (improving understanding of and skill in raising children);
- Health (learning sound nutritional principles, arranging for health screening); and
- Communication (obtaining and effectively using technology as a resource).

Although this sounds simple and makes intuitive sense, systems and agencies appear to have not evolved in this direction. "In this age of specialization, agencies and professionals have their own niches and the result has been fragmentation, duplication and lots of children being 'unclaimed'" (Vandenberg, 2006, p. 2). In efforts to disseminate information on wraparound which emanates from the research base, Portland State University hosts the National Wraparound Initiative (NWI), a collaborative effort that seeks to promote the implementation of high quality "wraparound" (Bruns, 1990). Currently, NWI is explicitly developing standards, strategies and tools for implementing these wraparound programs.

It appears, evaluation efforts have been challenged both by the complexity in the design and administration of wraparound services and by lack of standardization within a single program given the emphasis on individualized services. It seems that while there is a great deal of agreement about the definition of and the values underlying wraparound there is not one shared model of practice. The existing programs have not operationalized the values and components in the same ways and therefore, wraparound has not developed as a single manualized approach, therefore, assessing the evidence on wraparound has been challenged by the variety of approaches.

Wraparound programs have not used rigorous experimental designs and the sparse literature that is available describes outcomes of a particular program in very general or vague terms. There are non-existent comparative designs including pre-post studies, quasi-experimental studies and randomized trials. Yet possible outcomes may include improved functioning of the child in the family, social, school and community settings and the increased ability to live in less restrictive settings. More specifically, it seems individual wraparound programs, such as the Kaleidoscope Program, indicate a range of benefits which includes -

- "Wraparound tends to reduce the use of residential placement and has been successful in placing youth in less restrictive environments.
- Improvement in the functioning of youth served.
- Improvement in the parents or caregivers' functioning, such as reduction in stress.
- Cost reduction and individual-level improvements in functioning and positive community-level outcomes. Wraparound services have been shown to improve relationships among participating systems.
- Finally, wraparound programs which target youth involved in the juvenile justice

> system tend to report findings similar to those where legal offences of youth involved in the program are reduced from what they were prior to involvement in the program"(Dennis, 1979, p.7).

Therefore, it seems imperative that purposeful partnering needs to establish guiding principles, core values, role definition and standards of practice. I believe our time for developing the purposeful partnering concept is ripe with opportunity to strengthen families and engage families as equal partners. This dissertation will demonstrate how purposeful partnering involves families in decision-making to empower them as partners in their personal growth.

Statement of the Problem

Agencies or programs, which adopt the purposeful partnering approach, will possibly face challenges in both service delivery and program management, which requires the need for further research to reduce the following six potential challenges.

First, true collaboration may be a unique and challenging undertaking for all the team members involved in implementing purposeful partnering. It often is difficult to achieve consensus and create a shared understanding of what a particular family's strengths and needs are. Such collaboration may be constrained by competing philosophies, programmatic loyalties and fiscal constraints the formal partners experience. In addition, engaging families as equal partners with providers may be hampered by the family's distrust as well as by the provider's traditional training.

Secondly, some providers tend to think in terms of component programs rather than individualized services and transitioning into purposeful partnering requires them to change their operating philosophy. Rather than starting from an array of existing services and

using slot-based solutions, providers first must look to the strengths and needs of the child and their family whom they serve.

Third, programs often find themselves either in competition for scarce resources or with no resources available. In either case, programs are challenged to be creative and often develop new partnerships or identify new avenues for providing alternative treatment and/or informal supports. Practices that broaden perspectives may enhance problem solving and decision-making and the practices that generate multiple options may increase the quality of the options selected. Both of these strategies can enable participants to gain greater insight into the issues at hand and produce a better match between the goals and the resources identified.

Fourth, purposeful partnering may be seen as a special program that is favoured by the agency and or the funding source. If this occurs, the program's initiators may not have spent time achieving consensus and community buy-in or processing which permit the open discussion of the purposeful partnering philosophy and its collaborative use of resources.

Fifth, programs, which use the purposeful partnering approach, may find that outsiders (the public as well as policy–makers and providers) are not familiar with and may even be at odds with this philosophy. Since the approach requires that programs sustain funding and partner with constantly changing teams of professionals, case managers may need to anticipate resistance on the part of those new to the process of purposeful partnering.

Incorporating school systems into purposeful partnering programs may present unique challenges, often due to workforce issues. Therefore, purposeful partnering will

likely confront an ongoing need to educate new personnel about the philosophy and operations of the process. A related challenge is that the high caseloads of these counselling professionals may impede their active and creative participation in purposeful partnering service provision.

Sixth, there may be relatively high turnover of facilitators and care coordinators as trained purposeful partners. Not only does a program's ability to retain their workforce affect the quality of care that individual children and families receive, but also it directly influences the fidelity of purposeful partnering being implemented. Therefore, in the initial planning of implementing this concept, attention needs to be paid to developing realistic job descriptions, providing adequate supervision and support and supply ongoing training for the partners in this process.

Finally, as the process matures, implementation and sustainability will continue to be a challenge. Partnering teams can learn from others' past experiences and the value base and purpose should be revisited frequently; family members should be included in all aspects and all levels of operation; outcome data should be shared among stakeholders; and continued training is necessary to ensure the ongoing presence of skills in the partnering teams.

Families who participate in purposeful partnering services may need to be educated to become strong advocates for their children. Many parents and other caregivers of children with serious emotional disturbances appear to be placed in the position of having to become instant experts in multiple service systems when their children seek services or are placed in treatment. Yet parents may be guided to build upon their existing strengths

and to incorporate new strategies, through sensitive and empowering ways, that will increase their ability to successfully navigate the multiple systems operating in purposeful partnering. Some programs may use other parents as partners, while case managers in other programs take on this role.

There is the need for ongoing research of purposeful partnering as there is a lack of resources for families and effectiveness of service is paramount as some families have multiple barriers already existing. For example, families may have difficulty enlisting the assistance of natural supports. In some cases, the families may have few pre-existing supports (both for the family as a whole and for the child) and other times, potential participants may be resistant to participating. Additional barriers facing families are: isolation and a lack of social connectedness; absence of emotional support; difficulty accessing services and manoeuvring through the social service system; social, economic and other stressors that make self-sufficiency challenging, including illiteracy, teen parenthood, limited education and job skills, inadequate or unstable housing, lack of transportation and child care; and low self-esteem.

Purpose of the Dissertation

The purposeful partnering approach for children with emotional and behavioural concerns and their families could be implemented in many rural communities however, achieving consensus on what purposeful partnering is elusive. Through the development of principles, role definitions and standards of practice a purposeful partnering process will integrate the strengths of and overcome the challenges of the current integrated concepts, such as, wraparound, integrated case management and mentoring.

Purposeful partnering will become recognized as an effective approach to providing community-based comprehensive services to families whose needs fall outside of the boundaries of traditional social programs and which span a variety of child-serving agencies. Purposeful partnering will be described as a process, not a service, which maximizes the use of formal and informal supports to create a comprehensive, integrated and individualized treatment approach for families.

The goals of purposeful partnering will be to reduce the use of institutional care and to replace a fragmented approach with children with high-risk behaviours with a more community-based, comprehensive program. The purposeful partnering process will provide services with children with behavioural health issues by placing the child and family at the centre and identifying the family's strengths and then identifying and coordinating mental health and other (e.g. educational, recreational and other social welfare) community-based resources to meet their need. Purposeful partnering will wrap these services and resources around the child and family to enable the child to continue living in the community through a holistic approach. It appears an ongoing criticism of the wraparound approach is that it is not manualized or standardized in the way in which it is implemented. Furthermore, I feel because the approach is based on values, the concrete steps that are used to operationalize these values can differ as it appears current wraparound programs vary tremendously in terms of program quality and adherence to wraparound principles. It appears, common shortcomings, for example, may include:

- Omitting key members of a child's life from the wraparound team, especially school professionals, family, friends and other advocates;
- Not maximizing the use of community activities which the child enjoys and in which they excel;

- Not using family and/or community strengths to identify resources; and
- Limited use of flexible funding.

Given the salience of these and other issues related to fidelity this dissertation will be devoted to discussing maintaining fidelity in implementing a purposeful partnering approach.

Hypothesis/Questions

The purposeful partnering process for children with emotional and behavioural concerns and their families may be difficult to achieve consensus on, as stated previously it is a process that is subtle. However, despite the challenge of understanding purposeful partnering, the concept will be defined and the process will be designed to improve family capacity to enhance the child's development and learning and to increase the child's participation in family and community life. The following questions will be addressed:

- What is "purposeful partnering"?
- How are successful outcomes for families with children with severe emotional and behavioural concerns defined?
- What are the specific services or service responses that contribute to successful outcomes for children?
- What are the strategies that are effective in engaging and maintaining families' involvement in services?
- What characterizes the successful therapeutic relationship and how does this relationship contribute to successful outcomes?

This dissertation will systematically examine the extent to which certain organizational and system supports are in place and able to contribute to effective purposeful partnering. To date, service providers that I have approached appear very

supportive of the premise of purposeful partnering; however a refined process needs to be developed prior to effective implementation.

Importance of the Dissertation

Therapeutic issues when providing treatment in situations of children's emotional and behavioural concerns are complex and difficult to resolve, therefore, a range of techniques and treatment modalities are often required in these dynamic and serious circumstances. Family therapy is often the treatment or modality of choice as it "represents an outlook regarding the origin and maintenance of symptomatic or problematic behaviour, as well as a form of clinical intervention directed at changing dysfunctional aspects of the family system." (Corsini & Wedding, 1995, p. 378). Although purposeful partners along with expressive arts therapists:

> "cannot claim to be specialists in every artistic discipline, though some of them, in fact, have multiple competencies. What they claim, however, is to be specialists in intermodality; that is, to be capable of grasping the junctures at which one mode of artistic expression needs to give way to, or be supplemented by, another. This sensitivity to the specific creative needs of the moment is a particular goal of training in this field, sometimes expressed by the phrase 'low skill, high sensitivity'" (Levine & Levine, 2004, p. 11-12).

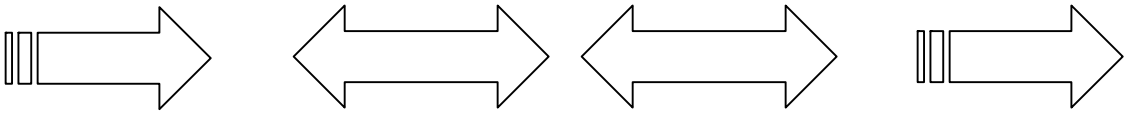
Therefore, in purposeful partnering it is critical to meet the family where they are and develop goals based on their needs and refer to other disciplines as required. Generally, several practitioners who have different roles because of the complexity of the family's need and the treatment process provide the therapy. This dissertation will focus more narrowly on the treatment phase of community coordination and will highlight key strategic decisions that are required in the provision of purposeful partnering with families with children who experience emotional and behavioural concerns residing in a rural

community. In terms of the range of treatment modalities a common goal of all partners is bridging the gap in service delivery, therefore the treatment team would have the following elements as paramount principles:

- Common vision;
- Common paradigm;
- Common language; and
- Common working agreement.

Purposeful partnering focuses heavily on teaming with informal (and formal) partners to strengthen their sustainability for the long-term. In developing and maintaining the team, the purposeful partners explore whether the right people are present; whether they are directly involved in the planning process; whether the goals and objectives of the care plan are monitored and implemented; and whether team members know their roles and are being held accountable for their roles.

Another aspect of this process-oriented approach would include the following steps to ensure, a comprehensive acknowledgement of the family's needs are ever present. Purposeful partnering would include a response sequence that would involve the following fluidity of connectedness with the family:



Meeting dates set, purposeful partnering team developed, referral information, research	Social history prepared and circulated to team	Family meets, psychological, educational, medical data collected, all domain information gathered	Mutual care plan development meeting
…-6 weeks	-4 weeks	0	+3 weeks…

Example of Possible Time Span for Activities

Through this systematic and comprehensive approach the purposeful partnering team would collaboratively develop the care plan including the following ever important elements of a healthy therapeutic relationship: building trust, developing rapport, unconditional positive regard, empathically listening, person-centeredness, open-minded, sensitivity and congruency. I feel attempting to describe the almost imperceptible but nevertheless fully present subtle nuances characteristic of a shared relationship with a family is a bit like trying to pick up Jell-O with your fingers. Therefore, I believe relating…of truly experiencing being with a family with the permission of the child and family to know their inner world, is not learned by training or by sharpening our intellect. It is learning open only to the heart. Respect for the family and a prizing of the family's world are not activities of the mind. I believe they are genuinely felt and experienced in the inner person of the purposeful partners and are sensed and felt by the family, who deeply appreciates and values the team for such unconditional acceptance. Bearing this in mind the following is an example of the different domains that would be addressed in formulating a care plan with a family:

Domains of the Care Plan

Life Style Issues	***Home Life Issues***	***School Issues***
Vocational	Setting (e.g. foster home)	Cognitive Functioning
Social and Family	R'ship with Caregivers	Social Relationships
Self Care	R'ship with Signifi. Others	School Placements
Health	Home Responsibilities	
Education		
Behavioural/Emotional Development		
Sexuality and Identity		
Spirituality		

A purposeful partner must have a solid working knowledge inclusive of several skills and techniques to engage with families to support the purposeful partnering process. These skills include:

- ✓ Assessment;
- ✓ Planning and establishing goals;
- ✓ Case management, referral and service coordination;
- ✓ Facilitation, supervision and monitoring of partnering plan;
- ✓ Individual, family and group counselling;
- ✓ Education regarding medical and psychosocial aspects of DSM-IV;
- ✓ Outcome evaluation;
- ✓ Research;
- ✓ Consultation services among multiple disciplines; and
- ✓ Negotiation.

It would be helpful if some of the rural practitioners have a generalist background capable of providing a variety of interventions, because the rural community generally cannot afford many specialists or different referral sites. It is difficult therefore to mobilize treatment resources in which boundaries of professional identity and role are rigidly maintained. In rural settings, because professional expertise is at a premium, more flexibility in treatment roles is required if rural purposeful partnering is to be developed. This can create stress in service providers who feel their time, energy and therapeutic skills are stretched to the limit. On the other hand, those professionals who tend to be bored with narrow service responsibilities may find such generalist treatment services stimulating and

energizing, as well as an opportunity to expand their therapeutic abilities and widen their professional contribution in their home community.

Fortunately, the context of human service practice in the rural community is understood by those of us involved in isolated settings. However, I believe while rural areas share many unique features when compared to urban locales, it is important to acknowledge that there is tremendous diversity across rural communities. Rural areas can vary widely in terms of their population size and density, agricultural base and economic infrastructure, religious and cultural homogeneity, level of crime and social disintegration or political conservatism. This means that general statements regarding rural life or human services in rural settings must be qualified when considering any particular community or geographic locale. This dissertation will consider the attributes of rural community settings that can come into play when considering the coordination of treatment services in response to children with emotional and behavioural concerns.

Scope of the Dissertation

A formal acknowledgement of struggles in a family may trigger a state of uncertainty in children and their caregivers. It may mobilize professionals across a number of human service sectors. It is sometimes viewed as a crisis within a family because it exposes them to the outside world, a situation that has possibly in the past been managed and carefully masked to avoid any further exploration, discomfort or embarrassment in the belief that the family may need support.

It seems children whose families were unable to care for them were placed in institutions. However, more recently from my experience, it appears child welfare services

have focused on the provision of aid to families so children may remain in their own homes. Through my experience one of the newest services provided to families under stress is access to day care, family support and respite. Yet the linking of traditional child welfare and community-based systems does present program and theoretical challenges.

It is through this dissertation that the purposeful partnering concept will include the formulation and refinement of a value base, definition of challenges, client-partner relationships, nature of professional action and agency arrangements of flexibility.

Limitations of the Dissertation

I believe purposeful partnering is innovative and sound as it represents the collaboration between the public and private sectors to meet the pressing and complex needs of families at risk. To do this, systems will be linked and boundaries will be crossed between theoretical bases, educational bases and historical precedents for models of care and practice. Purposeful partnering has been developed to address several limitations existing in the social service sector. These limitations include minimal effectiveness, low accountability of service providers for outcomes and high cost. It seems treatment efforts, in general, have failed to address the complexity of family's needs, being narrowly focused and delivered in settings that bear little relation to the challenges being addressed. Therefore, purposeful partnering is delivered in the natural environment (e.g. home, school, community) and the care plan is designed in collaboration with family members and is family driven rather than 'therapist' driven. The primary goal of purposeful partnering is to empower families to build an environment through the mobilization of the child, their family and with the community resources that promotes health.

The ultimate goal of this dissertations' author is to explore the necessity for changing our current service delivery model as families are slipping through the cracks of service due to, lack of including primary caregivers as partners in facilitating change in their family. One limitation of provoking a change in service delivery is that most services are one-person programs. Therefore initial time for training may be a challenge. The second limitation is being able to promote the purposeful partnering concept as an effective manner of service delivery and ensuring sustainability of the process in a rural community with the least amount of disruption for current service providers. Lastly, testing the sustainability will be challenging as service providers are already operating in a taxed environment of feeling stretched and under supported. However empowering one another through learning and making shifts in our approach can be energy enhancing!

CHAPTER 2
REVIEW OF THE LITERATURE

It appears the focus of supporting families has moved from an almost exclusively institutional base to one that includes community-based practice, which is expanding rapidly, with excellent prospects for future growth. The movement toward community-based practice is a reflection of a number of separate developments, such as the wraparound initiative and integrative case management each representing an opportunity in supporting families.

I believe increased involvement of service providers in the community is the realization that the post-discharge, out patient or outreach environments are perhaps the key determinant of successful adaptation after institutional placement. Regardless of success during residential placement, what happens after placement will determine whether gains will be maintained or existing challenges overcome. In the light of this understanding, institutional programs (e.g. B.C. Children's Hospital-Inpatient Psychiatry Unit) have developed aftercare components designed to make the post-discharge environment more supportive to the child. In my experience, the therapists from the hospital appear to be frequently involved in aftercare programs, continuing their involvement with children individually and in groups and offering their services to parents, especially in the area of child behaviour management. The involvement of therapists in aftercare services is a logical expansion of their role, as it builds on the relationship formed during the child's hospital stay and takes advantage of therapists' expertise in child behaviour management.

A related development has seen the 'supporting' professions increasingly favour ecological, rather than child-centred, approaches. Recognition of the potential hazards of

institutional care and the related prominence of the normalization movement has also been factors in this trend (Shyne, 1973). As a consequence, services have been moved closer to the child's natural environment thereby increasing the opportunity for influencing key systems such as the family, school and peer group.

Undoubtedly, these professional trends have also influenced legislative and policy developments. As a result through my experience I have recognized that in the 1980's, the Family Support Worker Program was established in British Columbia primarily as a means of reducing the need for specialized forms of institutional services. Subsequently, in Ontario a consultation paper issued by the government by the Ministry of Community and Social Services (1982), referred to: prior to the drafting of the current Children's Act declared that one of the principles of the new act would be that: services to children should support, enhance and supplement the family, whenever possible, rather than compete with the family by providing alternative care and supervision. Provisions such as these have had a major impact on childcare, legitimizing and encouraging family-oriented and community-based programming.

In the 'family support' field, this move toward the community appears to have resulted in two types of program changes. First, institutional programs, which tend to be relatively isolated, have increasingly given way to group home programs. In Ontario, for example, "the number of children in institutional placement declined by over 27 percent between 1970 and 1980" (Ministry of Community and Social Services, 1983, p. 156). Secondly and perhaps more profoundly, a new class of programs, community-based child care programs, have developed to take their place beside the more familiar residential

programs, in some cases as adjuncts and in others as alternatives to group care programs. For example, the move to group homes has meant that children were more likely to attend schools in the community rather than remain in in-house school programs. From my experience, this change appears to have prompted the creation of school liaison programs, which support children to adjust to the community and, in turn, assist the community to improve services for children with particular needs. Similarly, life skills and community activity programs (e.g. Art Night for Teens, Free Meal Night, Breakfast Club) have been developed to help children function more effectively in the community while continuing to live at home; these programs may increase the resources the neighbourhood can offer children who might otherwise need group care placements.

I have noticed in our community that more and more adolescents have left their homes and have seen the establishment of a permanent core of youngsters living on their own with marginal resources. Many of these children have left behind unsatisfying home situations and they often appear unprepared which then results in them being unable to make constructive use of their independence. Consequently, they are not only vulnerable to such dangers as prostitution, drug and substance abuse and delinquency, but they also tend to miss out on their education and on developing work, social and life skills. A high proportion of these children seem in need of social services and a range of community programs offering both emergency and long-term services to respond to their needs. The people who staff such programs are not always clearly aligned or identified with any recognizable professional group, but many staff members have been designated as support workers. These programs include runaway and street worker programs, life skills training

programs and outreach to attempt to address some of the needs.

In addition, it is imperative to provide culturally competent care, which is important in an increasingly diverse society. I believe culturally competent partnering is an essential element in Canadian social services. The cross-cultural context of partnering presents both challenge and opportunity; this context requires a careful assessment of the applicability of existing knowledge and practice theories for working with children, youth families and community groups who have diverse cultural backgrounds. Teaching and learning from a multicultural perspective will contribute to the development of culture competence for the purposeful partner and the creation of culturally relevant service delivery systems. In my experience it seems regardless of the setting, there are more adverse outcomes among marginalized populations therefore ensuring that partnering services are available and relevant to vulnerable populations is an important obligation. I believe particular populations at risk include people from diverse cultural backgrounds, those with minimal education or economic base, people whom abuse substances and people from minority groups. There is a need to examine social service settings and practice philosophy for cultural dissonance since the way purposeful partnering is delivered may potentially create barriers, for example, language, failure to honour traditional practices and religious observances and failure to understand the stigma that may be attached to receiving any type of support.

In addition, “it has been noted that traditional Western mental health approaches have often not been effective with immigrants and refugees, who often underutilize mental health services.” (Dean, 2001, p. 626). Purposeful partners need to develop knowledge of

each particular oppressed or marginalized group they may be involved with and proactively acquire the necessary skills to knowledgably and respectively support. I believe purposeful partners must also work effectively to transform the social structures that perpetuate racism, ethnocentrism, classism, sexism, heterosexism and all other forms of discrimination. Purposeful partners assisting diverse populations must develop an understanding of culture, traditions, beliefs and culture-specific family interactions and form working partnerships with communities in order to become family-centred. I feel that some examples of barriers with families who have immigrated and are attempting to access service may include:

- stigma associated with family concerns;
- an absence of purposeful partners who speak their language; and
- a lack of knowledge or personal resources to locate services.

The communities that provide a purposeful partnering process with a child and family may be a source of strength. A key to the success of the purposeful partnering process is how well they are connected with established, accepted and credible community supports. From my experience, the more this is the case, the less likely families may view such support as threatening or carrying stigma--this is particularly true for families who are members of racial and ethnic minority groups. The availability of naturally occurring social support systems can ameliorate emotional distress and offer vital support to children and families who are receiving purposeful partnering interventions. One of the fundamental requirements of culturally appropriate services is for purposeful partners to identify and then to work in concert with natural support systems within the diverse communities they are involved in. For example, community and neighbourhood-based

social networks can act as important resources for easing emotional stress and for facilitating the process of seeking professional help. As well, any intervention suggested by services has a greater likelihood of success if it is consistent with, or at least accepting of the natural supportive environments that reflect family's values and support-seeking behaviours. Purposeful partners that are not adaptable to work from a culturally competent perspective may find that families resist the use of diagnostic categories, theories and styles of reasoning that appear to be taken for granted in social services theory and practice. As a result, they may not comply with suggestions or follow an intervention plan. However if the purposeful partnering process is culturally appropriate, services can transcend the traditional focus with the identified child and family to embrace the community, cultural and socio-economic context of that family. I believe it is critical to consider this larger cultural context as it offers important insights into how the needs of the child and family are perceived by people in their life and how these culturally-based communities have developed ways of coping with similar situations—an opportunity to learn share, value and accept one another.

I have noticed through my own practice another trend, which appears to have had a strong impact on the delivery of family related services and that is the increasing focus on the prevention of problems, a distinct shift from the apparent earlier preoccupation with cure and treatment. Associated with this trend I feel are the awaited efforts aimed at encouraging healthy development, enhancing well-being and competence, an outlook that is characteristic of holistic approaches. I am a supporter of a proactive focus, however need to bear in mind that implementing a change in focus is usually in stages and takes time:

"Most people eventually adapt and are reconciled to change, but not before passing

through various psychological stages. One way to think about those changes is through the concept of risk. According to one theory, change requires people to perform or perceive in unfamiliar ways, which involves risks. Those risks potentially threaten a person's self-esteem. Understandably, people are uncomfortable with risk and tend to avoid it when they can. When they cannot, however—as when they're roped into a change initiative—adaptation to change tends to proceed through predictable psychological stages. In some respects, these stages resemble the grieving process a person experiences after the loss of a loved one. The four stages are:

1. **Shock.** In the shock phase, people feel threatened by anticipated change. They may even deny its existence: "This isn't happening." They become immobilized and often shut down in order to protect themselves. People feel unsafe, timid and unable to act, much less take risks. Needless to say, productivity drops during this stage.

2. **Defensive retreat.** Eventually people caught in a change vortex move from shock to defensive retreat. They get angry and lash out at what has been done to them, even as they hold on to accustomed ways of doing things. They attempt to keep a grip on the past while decrying the fact that it's changed. This conflict likewise precludes taking risks; the situation is perceived as too unsafe.

3. **Acknowledgement.** Eventually, most people cease denying the fact of change and acknowledge that they have lost something. They mourn. The psychological dynamics of this stage include both grief and liberation. Thus, one can feel like a pawn in a game while also being able to view that game with some degree of objectivity and psychological distance. At this point the notion of taking risks becomes more palatable and people begin to explore the pros and cons of the other new situation. Each "risk" that succeeds builds confidence and prepares people for more.

4. **Acceptance and adaptation.** Most people eventually internalize the change, make any needed adaptations and move on. They see themselves "before and after" the change and even if it's a grudging acknowledgement, they consider the change "for the best." In some cases, people actively advocate for what they had previously opposed. Acceptance and adaptation means relinquishing the old situation, as well as the pain, confusion and fear experienced in the earlier stages of change." (Harvard Business Essentials, 2003, p. 87).

Purposeful partners may be viewed as change agents who are catalysts who get the ball rolling, even if they do not necessarily do most of the pushing. Purposeful partners may be described as figures with one foot in the old world and one in the new—creators of

a bridge across which others can travel—a process to communicate. They support others to see what the concerns are and encourage them to grapple with them.

It is important to understand the various levels within the service context and where purposeful partnering fits in. I have realized that institutional (e.g. medical social work) and other group (e.g. treatment programs) care approaches seem to concern themselves primarily with reducing the seriousness and impact of already identified problems, referred to in the field as a tertiary prevention approach. More preventive approaches involve interventions in the environmental systems in which people live. Such interventions may involve identifying problems early in order to minimize consequences, or they may focus on working with high-risk groups to prevent the occurrence of issues in the first place. For example, in public health these approaches would be considered secondary and primary prevention, respectively. Increasingly, there is also an emphasis on making social environments more responsive to people's needs, "as illustrated by helping models such as the mediating model" (Shulman, 1984, p. 47). Another example is community family support programs may be viewed as operating on the secondary and primary prevention levels. Also, contract workers and runaway services are examples of secondary prevention programs and street worker and community activity programs serve primary prevention purposes. The following chart identifies additional examples of programs in all levels of prevention services:

Service Context

Primary For example,	**Secondary** For example,	**Tertiary** For example	**Super Tertiary** For example,
Physicians	Community Child & Youth Mental Health	Adolescent Psychiatric Units	Children's Hospitals
Schools	Private Practice	Urban, Residential Programs	

(Maples Adolescent Treatment Centre, Vancouver, British Columbia 2006)

Finally, supporting families in rural communities appears to have been affected, no less than other social services, by the increased cost consciousness which has accompanied the recent troubled economic times as realized through my experience here in British Columbia. More and more, funders likely scrutinize the costs of services and seek less expensive alternatives such as, residential treatment programs at they tend to be relatively costly because of the need to staff around the clock. It is my belief funding sources, hoping to realize savings, will increasingly favour the community-based model. While community programs are usually less expensive than residential programs, it is important to recognize that not all community-based programs can be viewed as alternatives to residential care. In fact, community projects come in many different forms and vary greatly in costs, ranging from relatively inexpensive recreation programs to highly sophisticated ventures providing intensive services. It may be legitimate to compare these various programs to residential care, but a comparison of costs will likely reveal that the community alternative, while less expensive, is still a relatively costly operation—it seems funding sources will likely opt for less expensive alternatives. For example in British Columbia, the continuum of child welfare resources often has gaps in the area of more intensive, treatment-oriented programs and a proliferation of less expensive programs (Kootenay's, 2006).

In my experience over the past several years both in Alberta and British Columbia, community-based programs have changed significantly--years ago family support was almost always practiced in residential settings: today there are numerous community agencies that employ a variety of people supporting families. The development of the wraparound initiatives and community-based programs has been accelerated in the helping

profession, most notably with the ecological concepts and the growing preference for family- and community-based services. As well, increased cost consciousness on the part of funding sources has helped community-based programs support families.

For example, "out-of-school youth development programming is ripe with opportunities to strengthen families and engage families as equal partners with youth development staff. Youth serving organizations, programs and initiatives have several distinct advantages in engaging families:

- Many youth development agencies embrace and share values that are core to a family strengthening approach, such as engaging youth as resources; working from an assets-based approach that recognizes the competencies and wisdom of youth; working with youth as partners to develop their leadership capacities instead of "doing to" and "doing for" youth; and acknowledging that the experience and development of young people is rooted in the communities where they live. Youth organizations that already apply this philosophy to their work have an advantage over other agencies to expand this approach to partnering with adult family members to help them develop leadership skills and learn about their own needs.

- Youth organizations and programs serve millions of youth and connect with or have the potential to connect with adult family members of these youth." (Goldberg, 2005, p. 1).

The practice of purposeful partnering may take place within a wide variety of settings, ranging from street corners to day treatment programs and including schools, homes and crisis centres. As a result, it is okay the boundaries are ill defined. As the social services field struggles to define itself more clearly, it may be tempting to cast a wide net and include all things within the definition of purposeful partnering. I feel purposeful partnering would be better served by defining itself, congruent with the beginnings of community-based programs. Purposeful partnering will build on a humanistic philosophical base, a holistic orientation and on the traditional ability of its service providers to engage and relate to people effectively. Purposeful partnering will remain a constant contact process that is person-centred and emphasizes the goal of supporting

people to transform the events of daily living into growth-promoting experiences. Further "there is a strong intersection between the values and principles central to family strengthening and youth development practice, in particular, the emphasis of the parent and youth as a leader and partner in the decision making process to create change in their life, that of their family and their community." (Goldberg, 2005, p. 3). The following principles will serve as a guide for developing approaches that promote the dual goals of family strengthening and youth development that will be woven into the process of family partnering:

Promote emotional connectedness by providing opportunities for young people and their families to have common experiences and structured activities devoted to stronger communication, and to talk with and express their feelings to one another.
Share goals and promote high expectations. Effective youth workers seek to expand the number of young people, parents and other adults committed to building a strong and positive community.
Help mediate between youth and families. Tensions and even conflicts with parents and others in guarding roles are common during adolescence. Staff in family strengthening/youth development programs are trained and experienced at helping families work through these disagreements and build common understanding.
Promote parental efficacy. Youth programs focused on family strengthening offer parents opportunities to develop and expand their own skills through workshops and classes and as volunteer and community leaders. Their competencies as parents also grow when they learn more about their own children's interests, goals and development. Connecting them to resources such as health or job training programs also increases parent efficacy.

*Peter Goldberg, *Policy Brief No. 6: Family Strengthening in Youth Development.* May 2005.

At the same time, it is important to recognize that purposeful partnering is different from residential care in two important respects: (1) the context of the practice is the community; and (2) interventions involve the child's family and/or others in the community. This suggests that additional skills and knowledge are required for the practice of purposeful partnering, and also that the work requires a shift from a primarily child-centred orientation to one that will include parents and other adults.

In addition, the treatment of families from a strengths perspective involves a commitment to work with the strengths and competencies of children, youth and their families, as well as with the strengths and competencies of the neighbourhood and community and the strengths of all involved child-serving systems. Purposeful partnering is strengths-based from the moment of first contact with the child and family. A discussion of strengths must be included in every psychiatric or psychological evaluation, treatment plan and case management summary. Obtaining all of the information contained in this recommendation requires time and the presence of a collaborative relationship with the child and family. In order to obtain the specific information, it is important that the child and family encounter a curious respectful partner that demonstrates and articulates the purpose of their involvement. The information obtained through this process that may have been previously unknown or under-valued may help the team discover important aspects of the child and family to enable the treatment to proceed in a constructive, empowering way--I believe, for treatment to be strengths-based, there must be an unwavering commitment on the part of the team to approach treatment in this manner. Strengths-based treatment can be viewed as encompassing two interrelated sets of factors: (1) attitude and beliefs; and (2)

specific practices. Attitudes and beliefs influence how individuals think while specific practices directly affect the treatment and services received by the child and family. Often, it seems the attitudes and beliefs that individuals bring to the table go unrecognized. Similarly, practices may occur routinely without careful consideration of its most and least helpful aspects. Through an inclusive, collaborative process among all partners, meaningful change can be achieved for children and their families.

It seems one of the challenges in shifting to a strengths oriented perspective is a tendency in this field to believe that *we know what is best* for people rather than accepting the notion that people ought to be seen as resilient individuals with inherent wisdom who have a unique understanding of the truth of their own lives. While I have been working front-line it appears there are several key issues facing the field at this time. Perhaps the most important is that few standards exist either for community programs or for practitioners. Compounding the problem is the fact that, as yet, few educational programs prepare people for purposeful partnering. Consequently, agencies may designate who is best equipped to facilitate the process of purposeful partnering through their hiring process. Too often under qualified people are hired, leaving the profession in a very precarious position and families potentially in a more risky situation and I recognize purposeful partnering takes a lot of community development work to establish the process and a lot of coordination to organize the meetings to have everyone attend. I feel in spite of these concerns, issues and lack of literature, the evolution of purposeful partnering is an exciting development for the field.

CHAPTER 3
RESEARCH METHODS

The trends and developments described in the previous chapter indicate, purposeful partnering could become a more significant branch of the profession, however, very little empirical research has been conducted on the topics of community-based programs and practice. It is not surprising, therefore, that as yet there is almost nonexistent literature in the area of community-based practice, although there are an increasing number of descriptive studies about related programs, such as, family mentoring, wraparound and integrated case management. In this respect, "community-based are not too different from residential care, which for many years lacked a research base" (Powell, 1982, p. 8). Therefore, purposeful partnering needs to take such exhortations seriously if it is to develop a solid professional base.

One part of the research agenda for purposeful partnering relates to two issues discussed earlier: (1) adequate educational preparation for practitioners, and (2) unclear boundaries for purposeful partners. Future studies aimed at describing and analyzing what purposeful partners do in the community would be helpful in determining the education required by them and would help define the role of purposeful partners and its relationship to other professions. Research is also needed to demonstrate the effectiveness and efficiency of purposeful partnering. Presumably such studies could elaborate on when, for whom, and in what circumstances purposeful partnering services are most appropriate.

Answers to such questions are by no means predictable. Purposeful partnering will be based on accumulated wisdom, not on an empirical base for the purpose of this dissertation. I am not suggesting that practice should develop only from an empirical base

but rather that more empirical research would be desirable. As more research results become available, there may be some surprises that will lead to the re-examination of widely accepted practices. For example, according to Stein (1981) reports on the results of a demonstration study, which attempted to provide community services to prevent residential placement found that parents of children who were maintained in the community were less favourable about results than were parents whose children received more traditional residential services. Undoubtedly such results may be interpreted in different ways, but they serve to underline the importance of research.

Undoubtedly, purposeful partnering may attract increased research activity in the future as funding sources may be interested in determining whether increased reliance on community-based programs is warranted. This type of research provides a starting point, but I feel it tends to be too narrowly focussed to provide the information required for the continued development of the profession. If the questions posed in Chapter 1 are to be answered, community-based programs will need to generate its' own research activities to ensure that the research is practical and useful and those who have the greatest stake in the development of the field—practitioners—must take an interest in this area, therefore there will be a thorough exploration of the questions as previously identified:

- What is the definition of "purposeful partnering"?
- How are successful outcomes defined for children with severe emotional and behavioural challenges and their families?
- What are the specific services or service responses that contribute to successful outcomes for children?
- What are the strategies that are effective in engaging and maintaining families' involvement in services?

- What are the supports and relationships most critical in promoting family success?
- What characterizes the successful therapeutic relationship and how does this relationship contribute to successful outcomes?

The above questions will be examined for the purpose of information gathering to heighten awareness of a proposed process in the field rather than attempting to assess and evaluate differences.

CHAPTER 4
RESULTS AND ANALYSIS

Thankfully, differences between rural and urban societies have been contemplated particularly in the field of sociology. I have noticed from residing in a rural community that despite obvious differences, social service delivery has often seen a mechanistic overlay of urban methods, procedures and policies to rural environments. The social service field has begun to practically define and create unique approaches to rural social problems and despite the fact that the type, quantity and often quality of community-based services in rural areas are still different from those in urban areas, it appears changes are occurring. I believe these trends appear to be privatization, decentralization, formalization, computerization, professionalization, and deinstitutionalization.

In my experience the development of a comprehensive integrated system of delivering services to children appears to be the focus of much attention based on previously developed service delivery models, such as family mentoring, wraparound and integrated case management. At this time I have had informal discussions regarding the merit of purposeful partnering and would propose an ongoing invitation for formal input from a variety of professional and lay groups who would be consulted on the development and implementation of this process. Community-based and residential practitioners make up one of these groups. As a result of this, this dissertation is written with six purposes in mind and is based on my firsthand experience of working in the field both in rural and urban environments and in residential, day-treatment, community and school based programs:

1) What is the definition of “purposeful partnering”?

2) How are successful outcomes defined for children with severe emotional and behavioural challenges and their families?

3) What are the specific services or service responses that contribute to successful outcomes for children and their families?

4) What are the mechanisms that are effective in engaging and maintaining families' involvement in services?

5) What are the supports and relationships most critical in promoting family success?

6) What characterizes the successful therapeutic relationship and how does this relationship contribute to successful outcomes?

A result of purposeful partnering will provide children with serious emotional and behavioural challenges and their primary caregivers a strength-based role model that provides unconditional support and guidance. Although case management and flexible funds are central features of the approach, purposeful partnering involves more than just these mechanisms. The following are essential elements that are the components of the purposeful partnering process:

- Build Trust - Families often feel alone and unsure of themselves. It is very important to support and motivate the family whenever possible. While this effort may take somewhat more time in the short run, it often leads to better outcomes in the longer term for the family.

Starting Points for Building Trust: Take the time needed to build rapport and trust with the family; and draw on that trust by being available at key points, (for example, co-facilitating team-based meetings, attending crucial appointments with the family).

- Be Flexible and Accessible - All services must be accessible to the family to be of optimum use. It appears to me that there are several barriers in accessing service for

families. These may include: the agencies admission/discharge policies, staff attitudes; overlooking important individual differences; and environmental barriers (for example, physical location of the service, stairs, lack of elevators for people who have difficulty walking).

Starting Points for Creating Flexibility and Accessibility: develop a good understanding of the differences that can occur; recognize these differences but do not generalize to all families. Discover any gaps in or barriers to services for families in your community or region, by consulting with families and service providers who are familiar with the needs of families.

- Understand and Respect the Family: people demonstrate respect in many ways, including: acknowledging the family's needs for independence and healthy, balanced control over their own lives; the language that they use; and in the ways that they act towards families who are experiencing challenges.

I believe service providers demonstrate respect when they understand community values and perspectives and are sensitive to cultural and generational differences among families. I feel respect includes recognizing and building upon the family's life experience in treatment and health planning.

Starting Points for Demonstrating Understanding and Respect: listen to the family; reinforce that challenges are not a sign of personal weakness; avoid stigmatizing and labelling language such as "dysfunctional", or "enabling" when talking with the family or others; avoid imposing your own personal or professional values on the family when offering support; and recognize that ethical issues around risk, autonomy and paternalism

can arise in the context of supporting families. Address these with the individual, family or other service providers if the issues arise.

- Take a "Whole Person" Approach: I see there are frequently many interrelated difficulties in family's lives. For example, alcohol use is only one facet of the person's life and the person has strengths that he or she may draw on. When supporting the family, it is important to not focus exclusively on the issue. Look to positive parts of the person and take into account all aspects of the family's physical, psychological, social, financial and spiritual needs.

Starting Points for Implementing a "Whole Person" Approach: use approaches that will promote the family's physical, mental and social well-being; place any discussion of the issues, challenges in a normalizing context; do not talk with the family only about the issues, challenges—there are many sides to the family; use humour and other positive techniques to lighten up (but not to minimize) the discussion and to facilitate what can otherwise be an anxious atmosphere; give the family opportunities to express and show parts of their life, strengths, skills and capabilities; facilitate opportunities to use those personal strengths; and when evaluating previous purposeful partnering situations look at them from the family's perspectives, particularly for indicators of 'success'.

- Recognize the Diversity of Family's Needs and Their Lives: families have psychological needs, including the need to be wanted, needed and valued; families often experience many changes in their lives, including divorce, loss of friends, changes in health, loss of employment or other important roles; rural and urban families can have very different life experiences, circumstances, needs and

expectations from each other; and families of different ethnic or cultural minority groups can face significantly different social expectations around issues when compared to families in 'mainstream' groups.

- Actively Reach Out: I feel strongly that families experiencing challenges become very isolated because of their physical, psychological, social or economic condition; supporting will typically mean taking active efforts to reach and encourage them; purposeful partnering means providing services that are readily available, user-friendly, flexible and accessible; this may include offering outreach, home visiting or telephone support, as well as assuring there are reliable ways to match the family to services and assist them to reconnect with the community.

Starting Points for Actively Reaching Out: use approaches and opportunities to reach out to the person, rather than expecting the person to find you; start by assisting in meeting the family's basic needs or in other areas that the family feels is causing the most concern; focus on ways of reducing distress for the person; recognize and build on small successes with the family; recognize that changes which you or others feel are needed may not match the family's priorities; and recognize transportation can be a barrier, especially in rural communities—look at ways to address the transportation problem when developing programs.

- Understand Age and Other Relevant Differences: the educational needs and other needs of families with issues, challenges can be quite different from families who are perceived as healthy and functioning.

Starting Points for Understanding Age and Other Relevant Differences: recognize the

differences among families; be flexible in purposeful partnering requirements and expectations; be flexible when developing and using prevention and education materials—know your audience; and use age and gender appropriate materials.

- Be An Advocate: the needs of families are often overlooked or ignored—it is important to encourage families to speak on their own behalf, and support them to ensure their needs are being met; sometimes it will be necessary to speak on a family's behalf to have their needs recognized and addressed at an individual or system level; and from experience it appears policies in hospitals, emergency, long term care facilities, day programs, housing programs, etc. frequently act as a barrier to the person receiving required support and services.

Starting Points for Being an Advocate: recognize the stigmatization and common misconceptions that arise in this area; actively counter the stereotypes that exist about family challenges; and actively question 'neutral' policies in health and community services that can discriminate against families with challenges or act as a barrier to a family receiving support.

- Foster Common and Realistic Expectations: I have experienced some service providers having very different expectations about how best to support families who are experiencing challenges. It seems they sometimes focus on one particular aspect and overlook or resist offering other types of support the family may need. It is beneficial to recognize that for example, alcohol problems exist on a continuum. Abstinence is one of several possible goals; sometimes abstinence is not needed and in other cases, it may not be possible.

Starting Points for Fostering Common and Realistic Expectations: encourage families to openly discuss their understanding about the nature of their concern—individual family members' views often differ; and support families to understand the limitations of focussing on any one type of approach, particularly if it does not seem to be supporting the family.

- Work with Others: I sense that no one can tackle all the issues affecting a family alone. I believe through purposeful partnering and drawing on the skills of a variety of community resources, the family, professionals and support services will provide a comprehensive range of community-oriented services for the family; work towards collaboration between volunteer and formal organizations, as well as inter-agency cooperation.

Starting Points for Working with Others: whatever service you are offering, avoid working in isolation; look for natural partners in your community such as mental health workers, home support, health care and health promotion workers and housing services; become creative with the individual and community mechanisms utilized; provide people who are connected with the family with feedback to build hope; and promote the belief that change is possible for the family.

In addition to defining success that is meaningful to both families and service providers there are consistent themes that emerge to identify practices for achieving success. Certain supportive and therapeutic elements need to be mentioned, but these factors that are promising have to do with how services are delivered. The following are three promising practices that are functional categories that may be useful in creating

successful outcomes:

- Engagement - the process of connecting with and maintaining the involvement of children and families in services;
- Delivery of clinical services – service elements, such as professionalism, confidential, person-centred and strengths-based that lead to the development of effective family/service provider relationships; and
- Structural and operational characteristics – specific features of services that demonstrate system values, including flexibility and a family- and community-based orientation.

The families' definition of success could be measured by them describing the hopes they have for their children and their family as a whole and the accomplishments they have already achieved. The purposeful partnering process would identify and describe the service approaches and direct services that families and providers perceive to be the most important in helping them achieve their goals.

Purposeful partnering is about focusing on the entire family, meeting families "where they are", and emphasizing the connection between the family and the community. Although families tend not to use either the term "approach" or "system of care" terminology, their awareness of the format of system delivery is paramount and these three key principles are considered indispensable. The activity of purposeful partnering must be:

- Child centred and family centred;
- Individualized; and
- Community based.

In purposeful partnering, these principles must constitute the context for all aspects of service delivery. Strong bonds between families and providers is critical, whether the providers are case managers, therapists, parent advocates or other staff. These bonds have

their beginning in the engagement process. Purposeful partners build trust and confidence by listening carefully to what families identify as their primary needs and treat family members as full partners in the treatment process, focusing on their strengths rather than on their deficits. Meeting families' basic needs for housing, food and medical care early on will allow purposeful partners to devote attention to other important resources and issues.

Purposeful partners can build engagement through the relationships developed between the families and program staff. Families may identify these relationships initially, as their most important source of support as unlimited access to purposeful partners and a depth of caring are primary features of these relationships. Building on the importance of family involvement in service delivery and viewing families as partners will allow them to learn case management techniques themselves. Not only will they learn to seek their own support, but may use the process of planning and progress review as a way to achieve their stated goals and as an opportunity to build additional skills. Purposeful partnering identifies several promising practices and although there may be implications there is clearly no substitute for providing opportunities for family empowerment. Through the purposeful partnering process, families will be given the opportunity to solve their own issues independently while embraced by a supportive community network.

The phrase *the whole is more than the sum of its parts* is central to purposeful partnering. This concept accurately captures the reality that intervening in family life is a complex process that requires purposeful partners to simultaneously attend to the needs of multiple individuals as well as to the systemic processes that govern family interactions. Family-based interventions seem to be usually focused on modifying the way family

members interact, it is helpful for family members to accept a systemic view of family behaviours and an individual's symptoms. In purposeful partnering, family members are supported to identify and to understand how certain family behaviour can elicit or exacerbate the problematic behaviour. Assessing family functioning, including the presence of family conflict, the presence or absence of strong emotional bonds and support between family members, communication styles and parenting practices, is critically important in determining factors that may contribute to or maintain the behaviour of the family. "Central to all work with families should be that we neither imply nor present 'family causality as the rationale for family therapy but rather that 'we need to emphasize every family's importance as collaborators in problem resolution." (Walsh, 1993, p. 50). Parents and other family members must be seen as resources and collaborators who can be mobilized to act as an adjunct in therapy and treatment rather than as an impediment.

In discussing the therapeutic relationship in purposeful partnering it would be remiss to not explore boundaries. "The importance of boundaries in therapeutic relationships is widely recognized by mental health professionals." (Evans, 2004, p. 459). It is often a challenge to find the right level of engagement with children and their families and maintaining an appropriate professional objectivity. Finding a happy medium between empathy and objectivity is an important part of being a purposeful partner. Because we are human, it is difficult to distance ourselves from our clients' issues, however, the blurring of boundaries within the purposeful partner and family relationship can have serious consequences. Appropriate caution and planning are absolutely necessary if we are to remain ethical and maintain our commitments to our professional duty. Strategies to

achieve an ideal relationship can be learned through examples of healthy role models alongside clinical supervision and reflection. Although well-functioning boundaries tend to go unnoticed, most individuals recognize when someone has crossed the line and violated their duties to their clients (Epstein, 1994).

It would also be remiss to not discuss ethical issues and decision-making in purposeful partnering. The complex ethical dilemmas that we sometimes see in social services rarely have only one preferred course of action. Often there is no single solution or there are several solutions that may prove to be effective. Thus, decision-making in these areas requires discernment and judgment. The challenge is to identify the best solution/answer by evaluating the reasons and evidence offered to support them. It seems when trying to determine which of the many courses of action to follow, three ethical perspectives offer important concepts for purposeful partners to consider: deontological theory, utilitarianism and virtue-based perspectives. These concepts direct attention not only to what one's duty is but also challenges us to focus on what one aspires to be, for example, a culturally competent and ethical purposeful partner. The focus of attention is on what one is and what one hopes to be, particularly in our relationships with others—promotion of ongoing growth and professional development.

There are inherent difficulties in incorporating pure ethical principles in the arena of child and family practice, as there are many complexities within each situation. I believe ethical decision-making requires moral deliberation and these moral deliberations are based in the *real world* of social relationships. "Accepting this view lays the foundation for engaging in a contextual ethical analysis, which recognizes that ethical decision-making

and action involve emotion as well as reason."(Doane, Brown & McPherson, 2004, p. 257).

CHAPTER 5
DISCUSSION, SUMMARY AND RECOMMENDATIONS

Discussion

The social service sector has strived to develop successful programs that include concepts such as family involvement, client-centred planning, strengths-based, community-based and collaboration. The idea of purposeful partnering has taken these basic concepts and moved beyond their standard definitions. Purposeful partnering is using some of the same language but suggesting that involvement is different—to change the way we serve people accessing community resources. However, I can imagine in many places, it may be a struggle to implement the initiatives because many supervisors and front-line workers may say, "We are already doing this", or "That's the way we've always done it and we are doing it now". The purposeful partnering process is defining and operationalizing familiar concepts in new ways and engaging as a partner to improve the way we serve families.

The client-partner relationship acknowledges that every person is unique. It is based on respect for the client's individuality and right to privacy and self-determination. Purposeful partners are expected to treat families fairly, without discrimination as to race, ethnicity, language, religion, marital status, gender, sexual orientation, age, economic status, political affiliation, nation ancestry, impairment, disability or handicap (Adapted: Ontario College of Certified Social Workers, Code of Ethics). In developing this process I would expect that purposeful partners follow these core values:

- Adherence to Ethical Practice

Purposeful partners are expected to espouse and adhere to sound ethical practices (as outlined in associations that they are registered with or in accordance with their

employer's code of ethics) in their working relationships with families.

- Protecting Child Welfare

At the onset of service, purposeful partners must clarify their professional relationship with each family. This includes areas where there may be a conflict of interest. Purposeful partners must avoid any relationship that would jeopardise any ethical action and/or place the family at risk—the children's safety is paramount.

- Client Respect

Discrimination on the basis of minority status—age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, language or socio-economic status—is unethical and unacceptable.

Providing service to families from diverse backgrounds and cultures requires sensitivity to unique needs. Purposeful partners must be aware of their personal biases and the possible impact these may have on the relationship. They must understand the unique needs of each family, family rules, traditions, history and culture and use different approaches as required for successful outcomes.

- Empowerment and Advocacy

Engaging the family in the purposeful partnering process, encouraging them, providing opportunities for them to participate is the responsibility of the purposeful partner.

- Informed Consent

Purposeful partnering is only provided to those individuals who have given informed consent; the family can give or withhold consent at any phase of the process.

- Confidentiality

The principle of confidentiality is central to ethical practice. "It respects a family's right to control personal information and access to it: given by the client, their legal guardian, or substitute decision-maker; required by law; and/or otherwise permitted or required by the Code" (CARP Code of Ethics, pg. 8).

The purposeful partner must define the parameters of confidentiality at the onset of offering services. In obtaining family consent for release of information, the information to be released and who will receive it must be specified, as well as the time period for which the consent is valid.

- Competencies in Practice

Purposeful partners are committed to being competent in all their professional activities, because competence combined with caring is believed to be beneficial for recipients of services and incompetence may result in no benefit or even harm.

- Appropriate Practices Related to Termination of Service

A purposeful partner will not discontinue services that are needed unless: the family requests discontinuation; alternative services are arranged, or reasonable attempts have been made to arrange alternative services; the family is given a reasonable opportunity to arrange alternative services; and/or restrictions in length or type of service are imposed by an agency.

<u>Common Threads – The Concepts of Core Values and Principles:</u>

<u>Family / Person Centred – "What Do You Need?"</u>

A service system that is driven by the needs of the family is a core value that is

universally accepted in purposeful partnering--a system that is family-centred means the needs of the family dictate the types and mix of services provided. The family-centred focus is seen as a commitment to adapt an array of services with the family. Even though this value is widely accepted in the social service field, it is still often practiced in a manner that fits clients into pre-exiting and pre-determined sets of services.

Purposeful partnering identifies the services that are easily accessible and offers these to the family. The innovative practice of purposeful partnering is viewed in a different manner. Purposeful partnering means that the family is asked to identify what they need to overcome their current situation to stay in their home and community. The question "What do you need?" does not automatically generate a list of specific readily available services like outpatient treatment or out of home care, but rather focuses the family and the purposeful partner on overcoming the barriers and situations they currently face. It builds services and supports "one family at a time". This approach has the advantage of respecting the family's wishes, maximizing the opportunities for the family to be involved in the planning and delivery of services and increasing the family's commitment and acceptance of the services. The family has a strong and legitimate voice in all aspects of their services and support. The "What do you need?" question may appear to be a slight difference, but it results in a very different way of serving families and developing services.

The care plan that is needs based, rather than service-based, may incorporate existing categorical services if appropriate to the needs of the family. But the plan will also combine traditional services with modified services, newly created services, informal

supports and community resources. In addition, the "What do you need?" approach focuses on multiple areas of the family's life not just the obvious presenting issue. These previously described domains may include living situation, financial, educational/vocational, social/recreational, psychological, health, legal, cultural and safety.

Family Involvement – "Nothing About Me Without Me" "Family is the Expert"

In purposeful partnering, family involvement means much more than including family members in the development of care plans and signing the plans. It means that families are full and active partners in all aspects of service planning and decisions that affect them. They are present at discussions that relate to their plans, have an opportunity to voice their preferences and ultimately own their plan. This "nothing about me without me" approach is markedly different than what usually occurs when staff determines the services and then informs the family about the perceived service plan.

Purposeful partnering also includes the notion that family members know themselves better than professionals who may be strangers to the family. The families know what they are willing and capable of undertaking, what will work for them and they understand their strengths, abilities and potential barriers. They also can identify and access their own informal supports better than professionals. Families are actively engaged in every aspect of planning, implementing and evaluating their services and supports. In this approach the family remains the expert. The purposeful partner is not seen as the expert that can "fix" or rescue the family. The role of the purposeful partner becomes one of facilitating and accessing resources. The family are also active participants in identifying and selecting the members of the team.

Families as Participants in Program System Level Operations and Quality Improvement

Purposeful partnering understands that families, as consumers of services, have insights, ideas and solutions that can be utilized to improve and enhance the quality of services for other families—therefore, feedback would be encouraged upon termination of their involvement in a purposeful partnering process. Purposeful partners would actively involve families in planning and decision-making because it helps ensure that the design of programs and services offered actually meet their needs. The feedback from families would be actively solicited and used to produce enduring changes to the organization and the services provided. Families would be offered training and given information that will support and encourage them to be effective participants, leaders and informed decision makers in ongoing evaluation of the purposeful partnering concept.

Strengths-Based

Moving to a strengths-based approach in partnering with families, conducting assessments and developing care plans will likely be the most difficult part of implementing and maintaining the purposeful partnering philosophy. I believe the deficit approach is so ingrained that it may be a struggle to turn it around and use a strength-based approach, however families are worth it! By acknowledging the resourcefulness and perseverance of children and families in managing difficult situations, purposeful partners have opportunities to affirm their capabilities and be liberated from stigmatizing diagnostic classifications that reinforce problems or disorders in individuals, families and communities. Listening to and accepting the family's definition honours their own internal knowledge of any given situation. The role of the purposeful partner then "can be to

nourish, encourage, assist, enable support, stimulate and unleash the strengths within people." (Cowger, 1997, p. 62).

The strength-based approach would require the purposeful partner to acknowledge that all families are capable and have strengths. It would mandate the use of non-judgmental, non-pathologizing and non-blaming language in both written documentation and communications with families. Purposeful partners using this approach would focus on strengths in order to learn about the family, get a balanced picture of the situation and discover the resources the family has available. The identification of strengths is the most significant part of developing, resourcing and supporting the care ('we care') plan.

Community-Based and Informal Supports

I believe the traditional view of community-based services tends to mean that services are not provided in an institution but are delivered in a less restrictive environment – the community. Community-based services for purposeful partnering means a commitment to providing services in the community within which the family lives, works and plays. This guideline uses out-of-area placements only to provide short-term services to stabilize the family member, with the goal of returning to his or her home community. The challenge of this approach lies in providing services in areas that have few services, such as rural communities. Accessing and maximizing the use of informal, family and community resources to meet the needs of the family is what makes purposeful partnering a reality. The preferences, choice, values and culture of the family—not what is administratively expedient or readily available—is the basis for developing purposeful partnering.

Role of the Purposeful Partner

The purposeful partners' role is to engage with the family to ensure that a strength-based plan is developed, monitored and adjusted as required to ensure success. The purposeful partnering process adopts the partnering values and philosophy that guides team development and oversees the process and tasks of the team in order to develop a comprehensive plan. While this may sound similar to other case management roles, it is different in that a purposeful partner works within a team structure that guides collaboration and consensus decision-making rather than coordinating services—it is a process driven practice! Different team members may take on the process of facilitation in conjunction with the primary caregiver (or youth when appropriate) and may be in a professional or non-professional role depending on the family and referral circumstance. The person in this role facilitates to ensure the presence of mutual respect, teamwork, shared responsibility and decision-making is family driven.

Purposeful partners will partner with agencies, systems, communities and families and their role includes:

- Shifting from a professionally-centred service model to a family-centred service model;
- Shifting from the "professional as expert" to the "family as expert";
- Shifting to a model of professional as facilitator;
- Shifting from prescribers of treatment to facilitators of family decision-making; and
- Shifting from service strategies that attempt to fit families into available options to service strategies that blend informal and formal service support options to create plans.

Team

The individuals involved and the manner in which a team functions is different from the typical community-based interagency team. The family identifies all the resource people involved with their family, as well as individuals the family knows who have supported them in the past and are concerned about their family. The team may include as deemed appropriate, all family members, natural supports to the family (includes relatives, friends…) and professional staff. The team may also include a family advocate if that is the family's desire. The team is not a group of professionals exclusively meeting to discuss cases, it is a team uniquely designed to support the needs of an individual family. Commitment to a common goal with the shared understanding of the goal is extremely important and effective teams go a step further—the team is committed to the goal. There is a big difference between understanding and commitment. Understanding assures that people know the direction in which they should work; commitment is a visceral quality that motivates them to do the work and to keep them working even when 'the going gets tough'.

The purposeful partnering process engages with the family to determine the family's vision and needs, identifies the needs and expectations of the team, develops strategies to meet all the needs, prioritizes strategies, determines outcomes to be realized, establishes a plan and assigns roles and tasks. The plan is disseminated to all individuals on the team. Team members are responsible to complete the tasks assigned and keep updated on the family's status through regular follow-up contacts. This process is fluid and matches with the uniqueness of each family.

Summary

"It is NOT the Way We Have Always Done It: Same Words—New Way of Doing It"

This sounds harsh but it is true: 'unless we are willing to change the way we engage with one another, we might as well not bother'. What will make purposeful partnering effective is that practitioners truly change the way of relating. The complex nature of working with children and families requires that all service providers be capable of working together with the child and family to understand and meet their needs. In order to be effective, purposeful partners need to demonstrate competence in his or her own clinical practice discipline, respect and have appreciation of roles and approaches of other disciplines, develop an understanding of the interdisciplinary/interagency context in the human service field and practise basic group processing skills—including effective communication and negotiation skills.

Integration of Core Values/Principles

This "new way of doing business" will work now that a set of core values/principles have been developed to guide services with families. However, use of these core values does not stop with the families, they are integrated into everything that takes place—the way we plan, allocate resources, conduct staff meetings, train staff, work with boards and approach people in the field. The principles are constantly and consistently modeled. We would use the same values and principles when engaging with families and applying them to the business side of what we do. For example, when using a strength-based approach, the approach is used not only with the families, but also with staff and in planning. The core values of purposeful partnering would be integrated into the procedures, practices and

principles of community-based programs.

People who are highly motivated and committed to purposeful partnering are essential to the implementation of this new practice. For example, they constantly model, partner and reinforce the core values to their staff and others around them. In addition, they would think creatively about how the values can be used and applied in different situations and how they can encourage others to move forward in their practice. Without "cheerleaders" of this process, reform efforts will likely stall because it would possibly be viewed as a process isolated from the regular way of doing business. This new way of thinking and doing needs to be supported from all levels from front-line workers to supervisors and regional directors. Important premises of purposeful partnering are: every family has strengths if nurtured; families can be supported to make sustainable change; and there is potential to bring them closer to stability and self-reliance. This process employs an empowerment approach to support families to contemplate or shift toward such goals as improving self-sufficiency and meaningful change.

To provide for the best interest of the child and family entails thinking differently about providing flexible services with families that are based on their needs, not on the dictates of services or programs. It includes a comprehensive approach that integrates multiple domains of life and builds interventions on strengths while also addressing unhealthy circumstances or challenges. Working together in a non-hierarchical, respectful and collegial manner towards the common good of the family requires careful attention to interpersonal and interprofessional issues. I believe for effective interprofessional practice, each service provider must understand the differences, not only in individual professional

practice approaches and expertise but also in the context in which practice occurs. A purposeful partner can be best prepared for interprofessional practice by fully developing the skills within the scope of their individual discipline, by adopting a stance of flexibility and openness and establishing effective communication skills, consensus building, networking and conflict resolution.

I believe the concept of family has expanded over the years to include many types. Through my experience I have observed that families may be as diverse as single-headed households managed by teenage mothers to widowed senior citizens residing in retirement communities. I feel the meaning of family has become quite broad that the term is no longer associated only with those who dwell together under the same roof, but is inclusive of individuals who share similar concerns and conflicts. For many families it seems this broad definition is significant, for as society and traditions change, larger numbers of families are having to rely upon their communities for support in addressing needs and responding to issues or challenges which are confronted by them daily.

I believe families and communities must respond to unprecedented changes and challenges. Social, economic, environmental and legal conflicts place some families at risk for meeting core needs and having coping skills necessary for survival. Both change and challenge are in some ways similar in that they both may present with seemingly insurmountable challenges. So it is with many communities especially in rural areas where poverty, social despair and fiscal distress are pervasive. Therefore, purposeful partnering would implement creative programming that would address the needs of families in a general context and also, more specifically seek to strengthen the resiliency of individuals,

youth and families by enhancing their coping and survival skills. General contextual goals would include: family resource management; senior lifestyles; parenting; family diversity; child care; family public policy; and community environments.

Recommendations

The following four recommendations provide guidance for the next steps of introducing and mobilizing the now defined principles of the process of purposeful partnering:

Establish Community Practice Philosophy and Guidelines

To develop in conjunction with service providers and families: (1) a community philosophy based on the purposeful partnering principles; and (2) a set of guidelines for the delivery of services with families. The guidelines will not supplement existing agency, program or service standards but would provide a foundation and direction for successfully meeting the needs of families, ensuring quality and maintaining accountability and efficiency of scarce fiscal resources.

The overall emphasis of the guidelines would be to promote and sustain a service delivery system that supports a family centred, strengths-based, culturally responsive, needs-driven planning process for creating individualized services and supports for the family's access to service. The guidelines would also promote family decision-making at all levels and involve a partnership between the family and agencies. Each element of the guidelines would be defined and explanations regarding how each is operationalized at the service delivery and administrative level would be provided.

Implement the Practice Philosophy and Guidelines

The agencies and families would work together to establish and implement a comprehensive and collaborative long-term plan (e.g. five years) to operationalize the purposeful partnering guidelines. Rather than separately outlining the tasks and efforts of

each service provider, the plan would be community focused and require all service providers to work together to implement the guidelines.

Utilize Champions/Cheerleaders

A pool of supervisors, front-line workers and administrators who espouse the purposeful partnering guidelines and philosophy in both their administrative and frontline based activities, would be accessed to provide partnering, modeling, problem-solving and support of the guidelines.

Develop and Implement a Single Unique Care Plan

To strive with the family for the development of a single comprehensive care plan. The plan would incorporate the services and goals from all the agencies involved with the family rather than separate service plans for individuals in the family or separate service providers. The agencies would work together to develop a format and process for an individualized care plan for families who are receiving services from more than one agency. This plan would incorporate all persons involved in the situation, formal and informal, so that the plan could be successful. The plan would address multiple domains in a person's life and include a description of the need, highlight the strengths and describe very specific goals, tasks and activities. It would also define who is responsible for implementing each task and who will fund the activity.

In conclusion, purposeful partnering is a process proposed to enhance the provision of collaborative, community-based services with families with complex needs. Purposeful partnering brings people together to determine the services a family needs and identifies provision and coordination of these services. Purposeful partnering includes partnering,

team building, family-centred planning, budgeting, outreach, detailed care plans and crisis and safety planning for the well being of children and their families in our communities. Children are worth it – let us leave no stone unturned!

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BIOGRAPHICAL SKETCH

Heather Nichol's passion for understanding children and their families has lead her to being a dedicated life-long learner. She has a three-year diploma in child and family studies, an undergraduate degree in social work and a graduate degree in psychology. In addition, she has completed certificate level programs and numerous trainings. For the past twenty-three years, she has been involved in residential, school and community-based programs, medical settings and day treatment programs.