Inventing a Wheel: A Case Study of Innovations to Boost Post Residential Treatment Outcomes

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Homeward Bound

Abstract

The Merriam-Webster dictionary defines innovation as "the act or process of introducing new ideas, devices, or methods," to which I would only add the critical phrase where a need exists. With respect to therapeutic schools and programs, the most glaring need has been to identify/devise a more effective means of transitioning a client from treatment back to his or her home or other real-world setting. In this article, I share a journey of innovation that led to increased success after treatment. At the heart of each innovation was the drive to create real change that lasts. Factors that influenced the success of each collection of innovations are outlined for each respectively.

This article shares a clinical journey of innovation that began during graduate school and has continued in different yet related fields for over 20 years. It presents factors that enabled innovation to occur, as well as some of the particular clinical advances made over the course of this journey. The autobiographical "voice" of the paper was chosen to present innovation from the perspective of an innovator, with a focus on the unfolding process of innovation: this is a case study. My goal is to provide practical ideas that can be adopted and adapted to fit different programs' needs while also shedding light on some of the conditions that empower innovators, facilitate innovation, and drive progress.

Backstory

My first attempt to apply creativity and innovation to a significant problem occurred while I was a Ph.D. candidate at Virginia Tech. Though I had a Masters degree in Marriage and Family Therapy and a part time private practice, I also had a keen interest in leadership and organizational development and wondered how these fields could be synthesized. So, I endeavored to explore my interests in applying marriage and family therapy to business organizations. My dissertation committee consisted of professors with backgrounds in Organizational Development, Business Management, Statistics, Management Systems Engineering and, of course, Marriage and Family Therapy.

Ultimately, I found myself working as a contract trainer and consultant to a large health care provider consisting of several hospitals, dozens of specialty care centers, and many advanced primary care practices. The job I was hired to do was to help heal a culture of distrust, resistance, and interdepartmental conflict that had grown during the acquisition and restructuring of regional hospitals and clinics that had been purchased and then placed under a large corporate umbrella. As it turned out, the ideas I had been developing for my dissertation research proved to be perfectly suited to this need. With the help of three corporate employees in the HR department, I delivered an intensive leadership program for all executive and management levels in the organization. Due to the health care provider's readiness for change and a commitment to the process, the program was considered a success and was given credit for healing a conflict-ridden culture and for bringing about trust and collaboration within the organization. Now, twenty years later, I can see how this experience of blending principles from different fields, applying research, and thinking creatively about how to solve a problem, has repeatedly shaped the course of my career.

Some of the facilitating factors that enabled an innovative model for organizational change to be successfully developed and implemented, and that have general applicability to the behavioral health field include:

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1. Motivation to see that the intervention would bring about real, sustainable change in the workplace and at home. This led to questioning traditional approaches to leadership development both in content and process. It was determined that the short-term motivation for participants in a traditional workshop process, if never applied, would be insufficient.
2. Interest in and curiosity around searching across disciplines for inspiration and research-based practices that could be creatively applied to a problem.
3. Timing that was right for a system to invest resources in a creative and non-traditional process due to the acuity of the pain the organization was experiencing and the previous failed efforts.
4. Supportive mentors and colleagues who were willing to share their ideas and influence to help fill gaps in knowledge, resources, and credibility.
5. Passion, enthusiasm, and belief in the model as the facilitator of the process, to convince each cohort to invest their effort toward change.
6. An eventual nucleus of "flag bearing," by passionate proponents who adopted the vision of the process as their own. Principles were internalized as they began to meet on their own and hold themselves and other workshop graduates accountable.

Career Crisis

A few years after the organizational/leadership intervention experience, a career crisis within the behavioral health field was the impetus for innovation. In contrast to the experience with the health care provider, where interest and curiosity motivated innovation, the crisis described below was the catalyst for the reorientation of my career mission and for the innovations that followed.

I was working as a therapist in a wilderness program when a new student presented with bright green hair, depression, school refusal, conflict at home, and a growing pattern of substance abuse. Like many of our students, he was initially resistant to therapy. However, he soon made a turn and did extremely well in our wilderness program. I was thrilled with his engagement and substantial progress. Near the end of our program, his educational consultant and I advised that he proceed to a therapeutic boarding school as the next step, and by all accounts he seemed to thrive there as well.

Over the 15 months of his treatment, I grew close to his parents. Occasionally, when they came into town to visit him, we went to dinner. In my mind, this young man was one of our program's great success stories in the making. Then he went home.

Within a month, away from the structure of residential treatment, he fell back into old habits, his depression resurfaced, and he returned to the destructive friendships he had had prior to treatment. In tears, his mother said, "We have done everything we were asked to do. It's not working. Now what?"

It was true. They had followed the professional recommendations precisely. They were engaging in family therapy, individual therapy for their son, and having him attend substance abuse group therapy. All of these efforts were falling short.

In an attempt to help the family, I flew to the family's home to visit their son. I believed that the relationship forged between us in the wilderness would endow me with the influence needed at this critical time of transition. Instead, he locked his bedroom door and refused to come out. I spent the day with his parents, at a loss as to how to guide them.

The family's crisis had now become my own and I realized there was a conspicuous need for a better solution for transitioning from treatment. On the plane ride back that night, I decided to take action. I felt it was both my duty and a unique career opportunity to bridge this gap.

Driving Mission and Vision

In the early 2000's, within the private pay niche of adolescent treatment, little attention was being paid to the factors research suggested were most significant in maintaining gains after discharge, namely: family involvement during treatment, the stability of the environment the adolescent returns to, and aftercare for the teen and his or her family (Burns, Hoagwood, & Mrazek, 1999; Frensch & Cameron, 2002).

Conventional aftercare protocol involved a discharge plan that generally recommended individual therapy for the teen or young adult, a 12-step self-help group for those with addiction issues, family therapy, and medication management under the care of a psychiatrist. An obvious omission, however, was a lack of case management by someone dedicated to aftercare who understood the importance of continuity of care between professionals. Someone other than a parent needed to oversee this, but it rarely happened.

Another weakness was the absence of a coherent aftercare model based on best practices that focused not only on the teen, but on reshaping and strengthening the family in key ways. Given that treatment programs are typically hundreds if not thousands of miles away from where the client resides, it was believed that professionals local to the family would be better suited to fill this role so treatment programs did not see it as their job. Yet, too often, no one was "owning" the outcome and providing the required level of collaboration and support needed.

Conscientious treatment programs had always strived for long-term success, but few extended their services past discharge. Similar to the decision I made as a graduate student to develop a model to bring about organizational change, I decided to design a better way to manage this transitional gap through intensive processes that would be applied and practiced in the client's real world settings.

Three Innovations of Our Continuing Care Model

At the founding of our transition services program in the early 2000s we had a compelling vision, a small and passionate team, clinical research that provided a starting point for our philosophy, and a blank slate. With these resources at our disposal, we faced the significant challenge of creating an effective transition process that would work no matter where the client resided. Our model had to work from a distance. This fact lies at the heart of most of the innovations we have implemented over the last decade. As a side note and word of caution to innovators: an even larger hurdle existed that I was unaware of that easily could have been the undoing of our fledgling organization—timing. It would take several years before the practice of intensive continuing care and case coordination would be generally adopted as best practice within our field.

Below are three tenets or philosophies to which we subscribed in our model. We built our model on the tenets because we believed they offered promise to increase long-term success.

Parents as Game Changers

In our work with teens and young adults after treatment, the research highlighting the central role parents play in long-term success was verified. When taking into account the key factors identified by a meta-analysis of the then existing research on long-term success after treatment (Hair, 2005), it became clear that outside the student themselves, parents have the potential to have the greatest influence on the eventual outcome.

To address this, we interviewed dozens of parents who had children in treatment. Most parents reported feeling depressed and angry, exhausted, hopeless, and out of ideas when they placed their teen in treatment. They were often at odds with their co-parent and their personal mental health was at an all-time low. Though parents generally had improved their mental health status during the treatment program, they reported that they still were not sure about their role during and after treatment and had significant anxieties about the upcoming transition. They also reported that they tended to lack a concrete plan, key skills for their resumed but modified parenting role, realistic expectations, and efficacious coaching and case coordination to help them play their role through the phases of transition. This interview data served to identify our job. We would provide that missing piece by first elevating the focus of the parent's role during and after treatment and then intensively supporting them in that role through education, timely support, practical advice, and assisted practice over time.

In-Home

Given the evidence base that existed as to the efficacy of in-home treatments such as Multi Systemic Therapy (MST; Henggeler, 2012), we believed the best setting in which to assess and intervene during

the transition would be with the family in their home(s), and/or with the young adult where he/she would be living.

Based on that literature, as well as our parent interviews, we set the following goals for an in-home or on-site visit, which we viewed as an essential aspect of the transition work.

1. Gain a nuanced level of understanding of the family's culture, dynamics, strengths and weaknesses;
2. Customize the family transition plan after having experienced the family in action;
3. Unify members of the family around their vision and plan;
4. Infuse the family system with confidence through practical knowledge, key skills, and clarity on their roles and the path forward;
5. Strengthen the support network (friends, family, and professionals) through education, coordination, inspiration, and encouragement

We also decided to complete a full assessment of the graduate and their family after spent time at their residence, in order to address gaps in the teen's or young adult's discharge plans and help parents navigate conflicts and challenges within their co-parenting or around specific issues such as schooling, employment, and boundaries..

Informed by both research and the clinical feedback of parents, we believed that the key was to ensure that everyone had a clear plan for moving forward, skills required to do their part, and the support needed. Our goal was to facilitate and coordinate the execution of the transition plan during the first few months after discharge.

Natural Mentors

The next significant decision was to adopt a philosophy of a community-based support team. Many evidence-based mental health programs are founded on the premise that a positive, multi-faceted support system is critical in promoting and maintaining positive treatment outcomes (e.g., Assertive Community Treatment, Wrap Around, etc). One program, MST, has the strongest parallel to transition care in the private mental healthcare system. MST is typically delivered in the public mental health system. It involves working with the youth and family in their natural environments (e.g., home, school, community) with the goal of creating and maintaining seamless support. MST intervenes at the family level, empowering families with skills and resources to effectively communicate with, monitor, and support their child and create a community of social support amongst the family, adult role models, peers with pro-social leanings, and community leaders (Henggeler, 2012).

The research support for MST suggests that youth who receive this multi-level, multi-system support have reduced rates of suicidality, improved family functioning, improved school attendance, and reduced rates of externalizing behavior (Henggeler, et al., 1999; Huey et al., 2004; Rowland, et al., 2005; Schoenwald, Ward, Henggeler, & Rowland, 2000). MST offers a model that we believed generalized to the new level of care we sought to add to the private mental healthcare system. Based on such research, we decided to use a "Home Team" approach. The Home Team concept involved fostering a network of support that extended beyond mental health professionals. The program encouraged parents and the son or daughter in treatment to identify individuals who were a positive influence, who cared about their family, and who were naturally in their lives. This group was comprised of immediate and extended family, neighbors, friends, members of the clergy, coaches, etc. In addition, a Home Team included paid professionals such as therapists, nutritionists, physicians, and, if they chose, the treatment program therapist. Parents and students were encouraged to share appropriate levels of information about their time in treatment as well as their goals for the future so that Home Team members could play a supportive role within their sphere of influence. Based on the research, we believed that these natural systems of support were critical because they appeared to extend further and last years beyond professional support (DuBois & Silverthorne, 2005). During the course of service, it was common for the Home Team to meet in the client's home to celebrate the growth that occurred and remove shame or stigma around having undergone treatment. Given the extensive research on the association between shame and mental health treatment (Hinshaw, 2009) we believed this to be an important aspect of the program. Furthermore, it provided an occasion for affirming the client's decision and acknowledging his or her progress.

The overarching goal during the creation of this model was to employ any principle that had power to significantly reduce recidivism and increase long-term success. Sometimes features initially included in our model, though powerful, were not easily adopted, and had to be modified or dropped altogether, i.e. video coaching (Thayne, 2013).

Over time, the Home Team concept remained in the model, in spite of the fact that some parents had initially been distanced or cut off from their natural support system as their child's problems or poor behavior mounted. Through proper education and increased communication, however, these bridges were reestablished and strengthened.

Upon reflection, a number of factors facilitated the process of implementing a transition model. The facilitating factors included the following:

1. Most innovations do not flourish if the timing is not right. In this case, a focus on aftercare was not timed right. We believed that the field was not experiencing enough pain related to client relapse and parents were not necessarily asking for this kind of support either. Over time, that changed, but the initial years were particularly challenging. The facilitating factor was perseverance.
2. Confidence was necessary. Belief in our approach was founded on knowing that it was based on true principles, a real need, and upon having a team of people who were dedicated to finding the answers.
3. Emotional and financial resources were needed to endure a significant period of time before there was greater adoption within the field.
4. As a small organization, we were able to pivot when something was not working or when we had planned wrong. We could start and stop and innovate, without red-tape restricting us to "the way it is done." However, in hindsight, we held onto certain methods far longer than we should have. A better approach would have been to listen to clients and constituents more quickly and make pivots early. We learned from this process that flexibility was a facilitating factor.

Technology and Licensing Model Innovation

In keeping with the requirement to be effective from a distance, the development of technology was a natural next step. Close on the heels of Facebook, we created a web based parent portal designed to facilitate greater family involvement in treatment, as well as social networking to build an informed and engaged Home Team. Our challenge was to find more ways to leverage and extend the support of the Home Team during and after treatment.

This use of technology to facilitate parental involvement and "Home Team-building", which research has shown to be essential to long-term success (Gorske, Srebalus, and Walls, 2003; Stage, 1999; Sunseri, 2001), constituted an additional innovation. The portal provided parent access to a library of materials to support them in gaining the knowledge and skills necessary to play a key role in their teen's recovery. It also allowed individual treatment programs to customize the curriculum and educate families according to particular diagnoses and challenges, while automating the scheduled delivery of curriculum. Programs that seek to provide transition care may want to consider a similar multi-faceted tool to facilitate transitions.

This model led to exploring ways to use "best practices" research through technology. We believed the Home Team concept was powerful, but that its reach needed to be extended so as to involve the Home Team in the treatment process as early as possible. Rather than wait until the final week or two of treatment or until after the client returns home, the portal allowed Home Team members to access information about the client's progress, facilitated communication, and enabled them to track, maintain and build their relationship.

Parents (or young adults over 18 years old) determined who would be on the Home Team and what information they could access via the platform. This boosted timely case coordination among professionals. One of the obvious benefits of time away in residential treatment is that young people can be separated from the negative influence of peers while therapeutic work is taking place. Unfortunately, treatment also indiscriminately separates them from positive influences. The portal

provided a means of maintaining and even deepening positive connections throughout treatment and beyond.

Upon reflection, we realized a number of factors facilitated this technology innovation.

1. A commitment to creating a program that was successful anywhere a client lived. We were pushed to find a way to increase success by coordinating cases, involving parents earlier in treatment, including natural mentors, and encouraging parent growth. We learned that challenges facilitate creativity and innovation.
2. A creative identity focused on a mission to increase the success of treatment allowed us to see ourselves as more than a provider of transitional services, opening the way for us to move into technology. We learned that a flexible, responsive professional identity facilitates change.
3. Advances in technology that make the second generation of the portal more user friendly and mobile. We learned to work towards continual development, which is especially salient in an online platform.

Licensing Model

A culture of innovation is commonly believed to be the most important source of growth, productivity and strength within an organization (Edquist, 2005) and is key to its longevity. Progressing within a changing landscape through innovation applies not only to clinical methods, but to the entire business model, including how clients find out about and gain access to products and services.

Good programs have their therapeutic plates full, maintaining focus on the day-to-day demands of intensive treatment for the young person, but are increasingly recognizing the need for transitional care. Given that continuing care processes are so divergent from those within a treatment facility and have previously been seen as outside the program's role, we came to believe that filling the gap could be done well by an outside entity that could focus its creativity, resources, and mission to innovate systems, technology, curriculum and processes. Therefore, we began to develop our consultative competencies and licensed a model to dovetail our systems with residential treatment models.

Through that process we have come to appreciate factors that facilitate business model innovations.

1. Timing and patience are essential in the process of organizational change. Innovation requires stepping out first, and then patiently but actively weathering the storm while the culture shifts.
2. Building credibility and respect within the infrastructure is key to weathering the storm during times of change.
3. Collaboration with stakeholders facilitates organization change. We found that continued communication and interaction with programs kept us responsive to the needs and shifts in the business climate.
4. Innovations sometimes require making changes in the way we partner. To innovate, we found ourselves pursuing depths and avenues for partnering with programs, which ultimately led us to the decision to seek licensing. We found it was beneficial to be open to new ways of partnering and applying our model.

Conclusion

Thirteen years ago my professional crisis spawned an innovation in continuing care after treatment. Looking back now at what has been accomplished I have come to believe that we will be successful more often than not, when our innovations address a painful need in better ways, are timed right, and are implemented strategically so that they anticipate future needs.

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