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Family-centred practice and family outcomes in residential youth care: A systematic review

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Abstract

Family-centred practice (FCP) has been suggested as a best practice for treating youth with emotional and behavioural difficulties in residential care. In this preregistered systematic review, we examined how FCP is operationalized and measured in residential youth care and which family outcomes are associated with FCP. Our systematic search in six databases identified 5784 articles. We analysed included articles by coding the operationalizations of FCP in the interventions and study measures. Further, we descriptively summarized relations between FCP and family outcomes. Thirteen articles met our inclusion criteria. In these articles, FCP was operationalized by five types of youth worker actions in interventions and was measured as five types of family involvement. Ten articles examined pre–post differences in family-centred interventions. Only four articles analysed relations between FCP and a family outcome. Studies found some support for a positive association between FCP and whole-family functioning, but overall, the association between FCP and family outcomes remains unclear. Our findings demonstrate that more research is needed that specifically examines different aspects of FCP and how they relate to family outcomes in residential youth care. Such studies can benefit from the conceptual model proposed for FCP in residential youth care interventions.

KEYWORDS
family involvement, family outcomes, family-centred practice, residential youth care, systematic review

1 | INTRODUCTION

Family-centred practice (FCP) is a service model that focuses on the family system, rather than on only youth, in delivering youth care (Johnson, 1999). Rather than only considering the professionals' expertise in making treatment decisions (professional-centred practice), youth's and families' information, feelings and needs are taken into consideration (Knorth et al., 1997) in FCP. FCP has been suggested as a best practice for treating youth with emotional and behavioural difficulties in residential care (Walter & Petr, 2008). Higher levels of family involvement in the treatment of youth are associated with better treatment outcomes for youth in residential care (e.g., Carr, 2019; Curry, 1991; Frensch & Cameron, 2002; Hair, 2005; Knorth et al., 2008) and with greater stability of these outcomes (Frensch & Cameron, 2002; Hair, 2005). For instance, contact between youths and parents during residential treatment is linked to improved youth functioning and completion of residential treatment (Robst et al., 2014; Sunseri, 2001). Additionally, a meta-analysis shows

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that parental engagement in residential youth treatment is associated with a greater likelihood of family reunification (Maltais et al., 2019). Moreover, the importance of growing up in a family-like setting has been stated by multiple researchers and policy-makers (e.g., Whittaker et al., 2016) and the right of youth to have regular contact with their parents is protected by law (United Nations Convention on the Rights of the Child, 1989).

The increased attention for family involvement in residential youth care may be explained by the fact that youth in out-of-home care often come from families with multiple and complex needs. Difficulties in these families are related to the child (e.g., dangerous behaviour towards self or others; Bartelink, 2013; Leloux-Opmeer et al., 2018; Whittaker et al., 2016) or the parents (e.g., mental illness, poor parenting skills and high parenting stress; Griffith et al., 2009; Harder et al., 2018; Leloux-Opmeer et al., 2016). In addition, difficulties of youths and parents can be found in problems in the interaction between these family members (e.g., problematic parent–child relationships or emotional or physical neglect; Leloux-Opmeer et al., 2016; Preyde et al., 2011) and for the whole family (e.g., poor family functioning, lack of a supportive social network or economic problems; Damen et al., 2018; Leloux-Opmeer et al., 2016; Preyde et al., 2011). These problems are often intergenerational, chronic (Bodden & Dekovic, 2010) and complex due to the interactive nature of these psychosocial and socio-economic issues (Bodden & Dekovic, 2010; Tausendfreund et al., 2016).

FCP emphasizes the relevance of these kinds of difficulties in youths' development by acknowledging the whole family as the unit of treatment, not just youths. Professionals actively engage the youth's network during treatment and promote the continuation and stability of healthy relationships and supportive connections at home. In addition, families are treated using a strengths-based approach that focuses on parents' competencies rather than problems (Ainsworth, 1991; Allen & Petr, 1998; Dunst et al., 1991). Professionals allow parents to continue their caregiving role as much as possible, intervening only when necessary. Professionals also enable parents to manage their family life according to their own views by being flexible to the family's wishes and cultural views (Allen & Petr, 1998; Dunst, 2002; Dunst et al., 1991; Foster et al., 2016; Geurts et al., 2012). Activities consistent with this family-centred view range from treating families, for instance with multisystemic therapy or by providing parenting support, to involving families in the formal processes of service delivery for their children (e.g., treatment planning meetings), involving families in children's daily lives in the residential setting (Geurts et al., 2012) and to professionals' efforts to build a strong alliance (Foster et al., 2016).

Other operationalizations of FCP are, for example, the participation ladder of Thoburn et al. (1995) or the taxonomy of Dunst et al. (1991), shown in Figure 1. These different operationalizations of FCP similarly conceptualize the degree of family involvement on a scale with multiple levels, and their levels can be aligned (Metselaar, 2011). On the lowest level (Level 1) is professional-centred practice, which is characterized by professionals making all decisions about a youth's

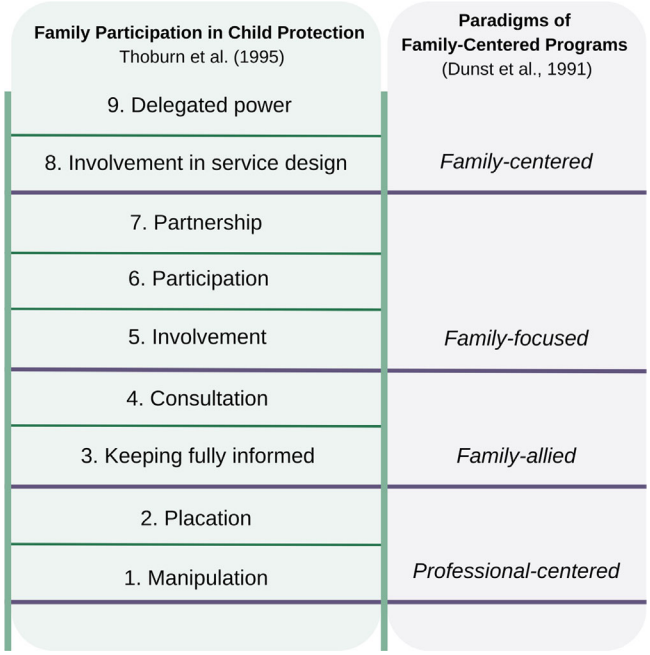

FIGURE 1 Levels of family participation.

treatment. On the highest levels (Levels 8–9) is FCP, which entails viewing the family as the unit of attention and close collaboration between professionals and parents through a true partnership in which the family determines the goals and appropriate means of treatment. Between these two extreme ends are family-allied practice (Levels 3–4) and family-focused practice (Levels 5–7), which represent levels of involvement in which the family is not seen as the unit of attention. In these intermediate levels, professionals involve families by, for example, keeping them informed about the youth's well-being, consulting with them about treatment options or inviting them to participate in treatment.

Although these operationalizations of FCP allow for some differentiation among specific practices, they are not fully adequate for measuring family-centredness. Thoburn et al.'s (1995) ladder of participation is limited in that it only describes levels of participation in (shared) decision-making but does not include other dimensions of family involvement. FCP is a multidimensional construct (Johnson, 1999) that also includes, for example, involvement in youths' daily lives and family therapy (Geurts et al., 2012). Dunst et al.'s (1991) taxonomy of four levels, ranging from professional to FCPs, cannot effectively assign each residential intervention to a particular level, as it is not clear which practices correspond to which level. In fact, family involvement may be simultaneously present in one dimension (e.g., promoting parent–child contact) and absent in another (e.g., shared decision-making) in a residential intervention. Finally, viewing the FCP as a ladder (Thoburn et al., 1995) or taxonomy (Dunst et al., 1991) is problematic because higher levels are easily interpreted as superior to lower levels (Hart, 2008), but this may not be true for all families, especially those with more complex problems.

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It is therefore important to study what activities of FCP work for whom, but family involvement practices in youth treatment have not received much research attention (Affronti & Levison-Johnson, 2009; Merritts, 2016). Partly due to the unclarities in operationalizations of FCP, knowledge of the effectiveness of FCP remains limited. Though we can outline various activities consistent with FCP, our grasp of how these activities actually occur in practice is limited by the way they are being measured. For instance, most measures of FCP often only include the frequency of contact between youth and family (e.g., phone calls, visits or furloughs) or family attendance rates in therapy sessions (Lindsey et al., 2014; Merritts, 2016). The quality of these contact moments, however, cannot be determined from the quantity (Robst et al., 2014). Moreover, the mere contact between youth and parents or the mere encouragement of family involvement is not necessarily related to better youth outcomes (Huefner et al., 2015; Sen & Broadhurst, 2011; Sunseri, 2004). It can therefore not be assumed that youth who have more contact with their parents also have better relationships. In addition, the number of treatment outcomes commonly measured in residential youth care is limited in itself and additionally tends to be focused only on youth (e.g., decrease in problem behaviour, reunification, or length of treatment) rather than the family (system). This practice is limited because it is likely that the potential benefits of FCP on youth treatment outcomes are related to changes in families, such as improvements in parenting skills, family functioning or the parent–child relationship (Affronti & Levison-Johnson, 2009). Unfortunately, families have been largely overlooked in research on youth residential treatment (Knorth et al., 2008; Smulders et al., 2018).

The impact of residential care, including FCP, on the family therefore remains a 'missing link' (Knorth et al., 2008, pp. 136–137). As a result, it remains unclear how family members are impacted by their involvement. Currently, there is no overview of how FCP is conceptualized across studies and what family outcomes are associated with different aspects of FCP. However, understanding how and which family outcomes (at the levels of individual parental functioning, parent–child relationship quality and whole-family functioning) are affected by which aspect of FCP is critical to the development of guidelines to promote youth and family outcomes. A review of current operationalizations of FCP can clarify what practices this construct entails and provide input for a new conceptualization that encompasses all aspects of FCP and is consistent with current practices in residential youth care to involve families. In addition, a review of current knowledge regarding the effectiveness of FCP on family outcomes may identify potential gaps in the literature regarding FCP and family outcomes. Our research aims are therefore twofold:

I. To provide a comprehensive overview of current operationalizations of FCP, by
   a. Describing how FCP is articulated in interventions.
   b. Describing how FCP s are measured across studies.
II. To provide a comprehensive review of the associations between FCP and family outcomes.

2 | METHOD

The current review was preregistered in PROSPERO (www.crd.york.ac.uk/prospero) and conducted according to the PRISMA guideline for systematic reviews (Page et al., 2021). The search was conducted using the PICO method (Lefebvre et al., 2022). The search string was constructed by combining the synonyms for population ('youth with behavioral and/or emotional difficulties in residential care'), intervention ('family-centered treatment') and outcome (e.g., 'output' or 'result'). We did not specify family outcomes in our search strategy to avoid bias in expected outcomes. The full search strategy is included in Appendix A (Table A1). We used the following electronic databases for our search: CINAHL, PsychINFO, PubMed, SAGE journals, SCOPUS and Web of Science.

2.1 | Literature search and selection

There were no restrictions regarding the year of publication or the countries in which the study was conducted (see Table 1). However, we indirectly excluded non-Western countries because the residential setting had to be (comparable with) Western youth care. To clarify this setting, we used Whittaker et al.'s (2016) working definition of therapeutic residential youth care. We did not limit our search to either qualitative or quantitative papers in order to provide a comprehensive overview.

The search was conducted in October 2020 and updated in June 2022 to include studies published between October 2020 and June 2022. We used the online tool Covidence (www.covidence.org) to screen articles (see Figure 2). All articles resulting from the search were independently screened for title and abstract by two researchers. Records with conflicting decisions by two researchers were included unless an obvious error was made. Full-text screening and eligibility assessments were performed by the first author under the supervision of the research team. Following this protocol, 13 articles were included in this review. This included 12 quantitative studies and 1 qualitative study.

2.2 | Data extraction and quality appraisals

We extracted data from the studies using a standard form for all included articles. We constructed the form using the Cochrane checklist (Li et al., 2022). The form included data extraction on study context, research methods, participant characteristics, intervention characteristics and results. To address our research objectives, we extracted information on the operationalization of family involvement in the residential intervention and measures of family outcomes (Aim I) and estimates of associations between FCP and family outcomes in quantitative studies and relevant themes or subthemes in qualitative studies (Aim II). Data extraction was performed by the first author and reviewed and confirmed by the research team. The overall quality assessment was included as a (descriptive) study characteristic. No

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TABLE 1 Eligibility criteria.

Category	Inclusion criteria	Exclusion criteria
Publication type	Studies that report on original empirical data are available in full text, written in English or Dutch and published in peer-reviewed journals.	Studies that did not report on original empirical data (e.g., reviews), of which no full text was available, not written in English or Dutch or not published in a peer-reviewed journal.
Setting	Therapeutic residential youth care (e.g., group homes, family-style group homes and adolescents' substance abuse treatment).	Ambulant services, non-professional residential youth care, mental hospitals and orphanages (e.g., home-based after care services, foster care, adopted youth and paediatric psychiatry).
Target group	Families with school-aged children (6–18 years) with emotional and/or behavioural problems.	Families with only children under the age of 6 years or above 18 years and families with children without emotional or behavioural problems.
Intervention	Family-centred treatment.	Professional or child-centred treatment (in which youths' family is not involved).
Outcome	Focusing on the family as a whole (e.g., family functioning), on a specific dyadic relationship between family members (e.g., parent–child interaction) and/or on individual parents (e.g., parental stress).	Focusing on youth, or on reunification. Reunification was not seen as a family outcome, because reunification does not indicate what, how or to what extent behavioural changes occurred in the family.

studies were excluded on the basis of the overall quality assessment. Quality assessments were performed independently by two team members for all included studies using a tailored form (see Appendix B; Table B1) based on the Joanna Briggs Institute instruments (Moola et al., 2020). Conflicting assessments were discussed in team meetings.

2.3 | Data synthesis

Due to the small number of articles that met the eligibility criteria, it was not possible to conduct a quantitative synthesis. Therefore, a convergent integrated synthesis (Lizarondo et al., 2020) of both quantitative and qualitative studies was conducted. To examine how FCP was operationalized (Aim I), intervention descriptions and operationalizations of study variables were compared and categorized according to similarities in their operationalization of family involvement, resulting in two overviews: how FCP was operationalized in intervention descriptions (e.g., inviting parents to treatment planning sessions) and how FCP was operationalized in study measures (e.g., frequency of parent attendance at treatment planning sessions).

To examine the relationship between aspects of FCP and family outcomes (Aim II), outcomes were first labelled as a parental factor, a dyadic (parent–child) factor, or a family factor. Three summaries of results were created based on the type of analyses in the included studies: (1) predictive relationships between family involvement and family outcomes, (2) differences between pretests and posttests on a family outcome and (3) descriptive and qualitative postintervention outcome reports. Only the first overview includes the results of associations between FCP and family outcomes. The remaining two overviews include findings from studies that examined treatment effectiveness in samples that received family-centred residential treatment, but did not examine the effectiveness of a specific FCP.

2.4 | Study characteristics

Table 2 provides an overview of the study characteristics. With one exception (Oxley, 1977), the publication dates of the studies ranged from 1993 to 2022, and the publications were fairly evenly distributed within this time period. All 13 included studies were conducted in Northern America and Europe, mostly in the United States ($k = 5$; 36%) and the Netherlands ($k = 5$; 36%). The residential settings in which family-centred interventions were studied were typically therapeutic residential treatment centres for children and adolescents. Specific types of residential settings included secure residential care for adolescents (2, 5 and 12), units for whole families (7, 13), and a family-style home (11). The study subject was most often a European or Euro-American adolescent male or a biological mother in her late 30s, although children (under 12), females, other relatives and other ethnic (minority) groups were also represented in the samples. The youths were mostly being treated for severe behavioural and/or emotional problems and came from families with multiple and complex problems and social disadvantages (e.g., low socio-economic background). In terms of research methods, a pre-experimental design with admission and discharge (and/or follow-up) measurements was most common. The included qualitative studies (13) used in-depth interviews at one point in time.

The quality of the included studies ranged from low to high according to our quality assessment. Most studies were of moderate (ratings 5–6; $k = 6$; 46.2%) or high (ratings 7–8; $k = 5$; 38.5%) quality, and two studies (15.4%) were of low quality (ratings 0–4; see Appendix B; Table B1). Sampling, setting and intervention, including the operationalization of how families were involved in interventions, were most often adequately described compared with the other quality indicators. Measures of the extent to which families were involved in treatment, or the quality of that involvement, were less likely to be rated as adequate.

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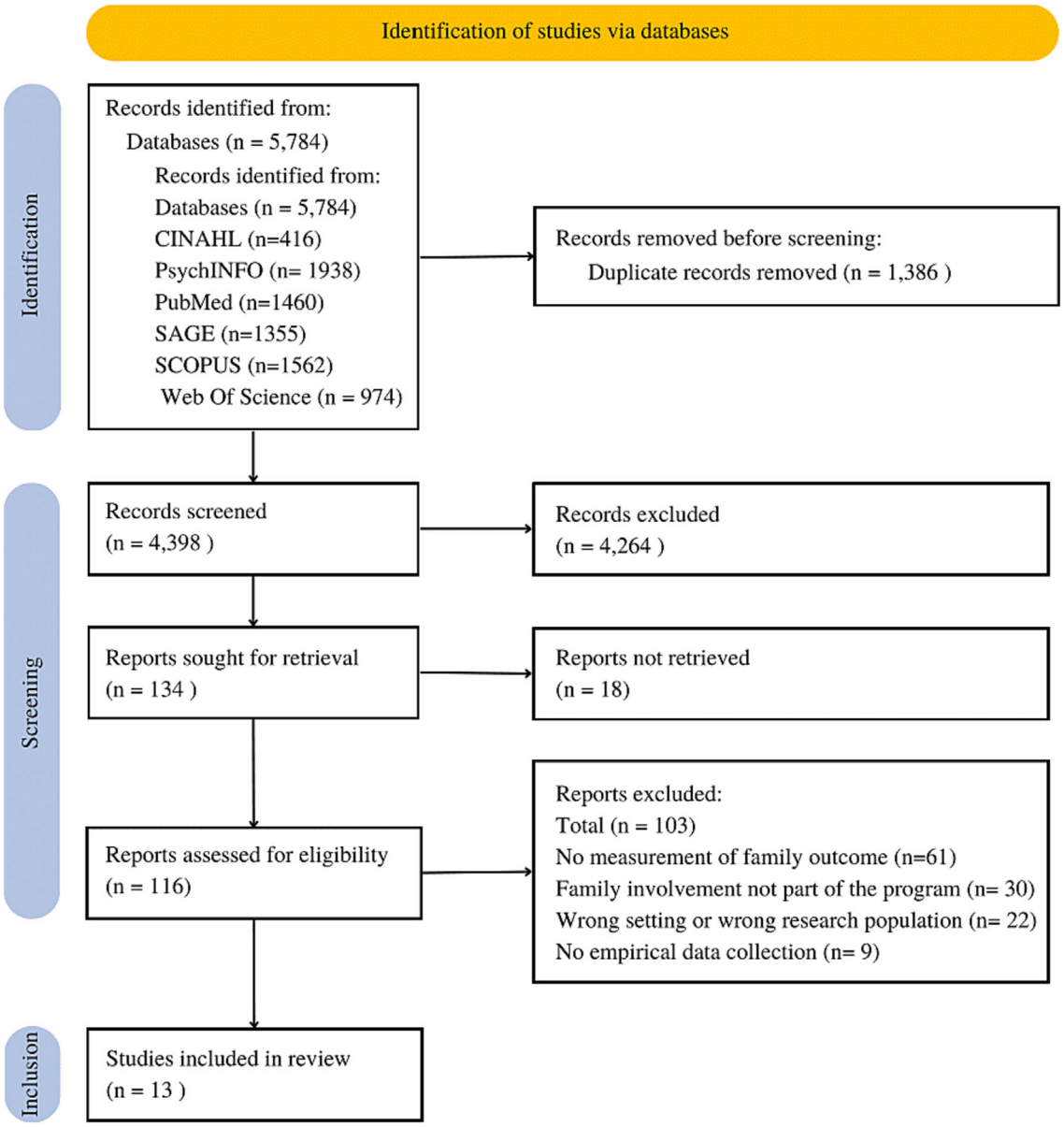

FIGURE 2 PRISMA flowchart.

3 | RESULTS

3.1 | Operationalization of FCP in residential youth care

The studies described five types of practices for involving families in residential youth care (see Table 3). The operationalization of *family therapy* in the interventions varied in terms of the intensity of sessions in the residential interventions and the use of a standardized therapeutic method. In four studies (30.8%), therapy sessions were a structural, mandatory part of the residential treatment (2, 4, 11 and 12), of which three (23.1%) included some form of multisystemic therapy (2, 4 and 11). The remaining studies ($k = 4$; 30.8%) described that parents were expected to attend family therapy sessions (5) or that these sessions were optional (1, 3 and 8), but the therapeutic method of these sessions is not specified in detail. *Parenting skills building* was most often ($k = 7$; 53.8%) provided in individual sessions (1, 5, 6, 7, 9, 10 and 12) and sometimes (30.8%) in group sessions (1, 5, 12 and 13). The content of these sessions was operationalized as educational and practical support. For instance, parents were educated about their child's disorder and how to deal with it, and parents were able to practice these skills in real life, often through home visits. Four studies (30.8%) mentioned that part of the family-centred intervention included *involvement in treatment planning* (4, 7, 10 and 13). The weight given to the family's perspective or how exactly they were involved in this process was not specified in detail, but the studies mentioned, for example, that professionals worked with or alongside the family in developing the treatment plan (7 and 10), consulted them (4) or offered them the opportunity to attend treatment planning meetings (13). Three studies (23.1%) specifically mentioned that

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TABLE 2 Study characteristics.

#	Study	Treatment setting	Study design	Participants				
				N	% female	Age	Ethnicity	Youth problems
1	Bertrand et al. (2013); Canada	Substance abuse treatment for adolescents	PE	199 youth	40	13–18 ($M = 15.5$, $SD = 1.13$)	87.4% French-Canadian origin, 6% French origin	Substance abuse n/a
				69 mothers	100	29–54 ($M = 42.6$, $SD = 5.17$)	91.8% French-Canadian origin	
2	Blankestein et al. (2022); Netherlands	Secure residential treatment for adolescents	PE	111 youth	48	12–18 (M 15.58; $SD = 0.11$)	71% Dutch; 29% > 1 parent born elsewhere	Emotional and/or behavioural problems
3	Coll et al. (2018); USA (NV)	Residential treatment centres for adolescents	PE	154 youth	45	12–18 ($M = 14.5$)	75% euro-American, 10% Latino, 10% native American, 5% African-American	Emotional and/or behavioural problems
4	Hoogeveen et al. (2017); Netherlands	Secure residential youth care for adolescents	RC	24 youth	45.8	12–18 ($M = 15.7$, $SD = 1.3$)	62% Dutch origin, 38% non-Dutch (42% Surinam and Dutch Antilles, 26% Morocco and Turkey, 21% Eastern Europe)	Emotional and/or behavioural problems
5	Lakin et al. (2004); USA (NM).	Residential treatment centre for youth	RC	89 youth	34	5–17 (80% 9–14)	51% White, 24% Hispanic, 11% native American, 7% multi-racial, 3% African American, 1% Filipino	Emotional and/or behavioural problems
6	Mevissen et al. (2020); Netherlands	Inpatient unit for families	SC	10 youth	40	2–16	Not reported	Post-traumatic stress disorder and mild intellectual disabilities
				9 parents	66.7	33–48		
7	Mihalo and Valenti (2018); USA (WV)	Residential treatment centres for youth	RM	114 family members (72% birth parents)	76	$M = 39$	92% White, 5% other and 3% black	Emotional and/or behavioural problems
8	Oxley (1977); USA (CA)	Therapeutic residential treatment for boys	LT	68 youth and their parents	0 (100% male)	6–11 ($M = 8.5$)	21% of minority origin	Emotional and/or behavioural problems
9	Riemersma et al. (2022); Netherlands	Residential and outpatient treatment for youth	QE	31 youth (exp.)	38.7	$M = 13.79$ ($SD = 2.11$)	88.5% of the parents were born in the Netherlands	Mild intellectual disabilities
				24 parents (exp.)	85	$M = 43.52$ ($SD = 7.31$)		
				24 youth (control)	37.5	$M = 14.43$ ($SD = 2.95$)	88.9% of parents born in the Netherlands	
				17 parents (control)	77.8	$M = 44.44$ ($SD = 7.11$)		
10	Ringle et al. (2015); USA	Community-based family style residential program	PE	89 youth	28.1	12–18 ($M = 15.7$, $SD = 1.4$)	31.8% African-American, 27.3% Caucasian, 23.9% Hispanic, 12% other, (4.5%) Asian	Emotional and/or behavioural problems
11	Rovers et al. (2018); Netherlands	Secure residential youth care for adolescents	PE	86 youth	37	$M = 15.16$ ($SD = 1.20$)	51% Dutch, 49% of minority background	Emotional and/or behavioural problems
12	Sundelin& Hansson (1999); Sweden	Full-day treatment setting for families	PE	109 families	Not reported	Children: $M = 10.8$ ($SD = 3.8$) Mothers: $M = 37$ ($SD = 7.3$)	Not reported	Problems in family functioning
13	Tahhan et al. (2010); Canada	Residential treatment centre for youth	QL	8 parents	100%	Not reported	Not reported	Emotional and/or behavioural problems

Abbreviations: D, dyadic factor; F, family factor; LT, longitudinal case study; P, parental factor; PE, pre-experimental design; QL, qualitative study; RC, retrospective cohort study; RM, repeated measures design; SC, single case study.

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TABLE 2 (Continued)

	Participants		Family outcomes		
#	Family structure	Economic background	Construct	Instrument	Quality
1	Blended families (44.1%), nuclear families (36.3%), single parent families (18.6%)	Not reported	Youths' self-disclosure (D)	Stattin and Kerr's questionnaire	High
			Mothers' psychological distress (P)	Psychiatric Symptom Index (IDPESQ)	
			Parental warmth (D)	Stattin and Kerr's questionnaire	
2	Variety of caregivers: Bio parents, step parents, foster parents, siblings or other relatives	Not reported	Parental distress (P)	Parenting Stress Index (PSI)	Moderate
			Parental empowerment (P)	Family Empowerment Scale (FES)	
3	Family situations varied widely.	80% low–low/middle	Cohesion (F)	FACES-III	Moderate
			Adaptability (F)	FACES-III	
4	Not reported	Not reported	Family functioning (F)	Case report observations with self-designed checklist	High
5	36% one parent household; 16% step- family; 16% relatives; 12% nuclear family	Not reported	Family functioning (F)	The Family APGAR	High
6	3 single parent families, all mothers were divorced	None of the mothers had income from work	Number of trauma symptoms of parents (P)	Diagnostic Interview Trauma and stressors–Intellectual Disability (DITS-ID)	Moderate
			Daily life impairment of parents (P)	DITS-ID	
			General psycho-pathology of parents (P)	DITS-ID	
			Experienced parenting load (P)	*Opvoedingsbelasting-vragenlijst* (OBVL)	
7	Not reported	Not reported	Family functioning (F)	Protective Factors Survey	Moderate
8	43% single parent families, 16% adopted, 10 boys had stepfathers, 2 boys had stepmothers	Slightly above average for the area	Quality of parent–child-relationship (D)	Semi-structured interviews (82 items for the boys and 66 for parents)	Low
			Youths' obedience (D)		
			Youths' self-disclosure (D)		
9	38.5% one-parent family	51.9% unemployed; 70.% low income; 20.8% medium income; 8.3% high income	Perceived social support (P)	SSL-12-I	High
			Perceived parental competence (P)	The Parenting Self-Agency Measures, PSI	
	66.7% one-parent family	55.6% unemployed; 50.0% low income; 16.7% medium income; 33.3% high income	Positive parenting behaviour (D)	Parenting Scale	
10	Not reported	Not reported	Poor supervision (D)	Alabama Parenting Questionnaire; (APQ-9); 9 item short version	Moderate
			Inconsistent discipline (D)	APQ-9	
			Positive parenting (D)	APQ-9	
11			Parenting stress (P)	OBVL	High
12	53% were single-parent families, 31% nuclear families and 16% step-families	Under-privileged	Family climate (F)	The Family Climate Test	Moderate
			Family functioning (F)	Family Relations Scale (FARS)	
			Adaptability (F)	Clinical Rating Scale- Turbo (CRS-Turbo)	
			Cohesion (F)	CRS-Turbo	

(Continues)

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TABLE 2 (Continued)

Participants			Family outcomes		
#	Family structure	Economic background	Construct	Instrument	Quality
			Hierarchy (F)	CRS-Turbo	
			Family competence (F)	Beavers' Observational System scales	
			Family style (F)	Beavers' Observational System scales	
13	Not reported	Not reported	Understanding of youth disorder (D)	Semi-structured interviews	Low
			Family functioning (F)		

Abbreviations: D, dyadic factor; F, family factor; LT, longitudinal case study; P, parental factor; PE, pre-experimental design; QL, qualitative study; RC, retrospective cohort study; RM, repeated measures design; SC, single case study.

TABLE 3 Operationalizations of FCP in interventions.

	Operationalization of FCP	Frequency	
		n	%
1	Family therapy	9	69.2
2	Parenting skill building	9	69.2
3	Involvement in treatment planning	4	30.8
4	Promotion of parent–child contact	3	23.1
5	Building strong parent–staff alliance	2	15.4

Abbreviation: FCP, family-centred practice.

parent–child contact was promoted (4, 5 and 8). This encouragement was aimed at informal contact, such as telephone calls, visits and participation in residential activities, as well as mandatory leave for youths on weekends or holidays. Finally, two studies (15.4%) specifically reported that *building a strong parent–staff alliance* was part of the family-centred intervention (4 and 7). For example, in one study forming and maintaining an alliance was explicitly described as a goal of a specific intervention phase (4). In another study, youth workers structurally solicited feedback from families about the quality of the working relationship (7).

Seven studies (53.8%) reported some measure of FCP. FCP was usually measured as the extent to which the family was involved. Five types of involvement emerged: number of sessions attended, quality of family involvement, family–child contact, family–staff contact and staff's family-centred attitudes and behaviours (see Table 4). The first three types of measures observe the behaviours and attitudes of family members (usually parents). Type 4 measures the interaction between family and staff, and Type 5 measures staff behaviours and attitudes towards family involvement. Only Type 2 (quality of family involvement) includes qualitative measures of family involvement, the other types are quantitative.

3.2 | Associations between FCP and family outcomes

A total of 17 different family outcomes were measured in the 13 studies. Five outcomes that were identified measured an outcome on the level of the parent. These outcomes related to the parents' psychological well-being and parenting self-efficacy. Five outcomes measured an outcome on the dyadic level, which all referred to the relation between the parent and their child. These outcomes can be characterized as a parenting skill (e.g., supervision) or youths' obedience (e.g., self-disclosure). Finally, seven outcomes were measured on a family level. These outcomes were measured as a component of family functioning (e.g., cohesion) or as family functioning in general.

Four studies (30.8%) examined associations between FCP and family outcomes (see Table 5). Mixed results were found for the relationship between FCP and parenting stress and parental empowerment (2). No significant relations were found between FCP and

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TABLE 4 Operationalizations of FCP in measures.

Operationalization of FCP	Frequency	
	k	%
Type 1: Number of sessions attended	4	57.1
Therapy sessions (1, 4 and 5)	3	42.9
Treatment planning meetings (2)	1	14.3
Type 2: Quality of parental involvement	3	42.9
Beneficial use of therapy sessions (8)	1	14.3
Parents' recognition of involvement in youth's problems and parental wish to resolve something in therapy (8)	1	14.3
Parents' self-ratings of their involvement (9)	1	14.3
Type 3: Parent–child contact	2	28.6
Physical contact with youth through family visits or youths' furloughs (2 and 5)	2	28.6
Contact with youth by phone (2 and 5)	2	28.6
Type 4: Parent–staff contact	2	28.6
Contact between parents and staff by phone (2)	1	14.3
Quality of parent–staff relationship (alliance) (7)	1	14.3
Type 5: Staff's family-centred attitudes and behaviour	1	14.3
Staffs' family-centred attitudes and behaviour (2)	1	14.3

Note: Numbers behind outcome variables correspond with studies.
Abbreviation: FCP, family-centred practice.

TABLE 5 Associations between FCP and family outcomes.

FCP measure	Family outcome			
	Parental level		Dyadic level	Family level
	Parenting stress (2)	Parental empowerment (2)	Youths' self-disclosure (1)	Family functioning (5 and 7)
Number of sessions attended	0	−/0[a]	+	+
Family–child contact	0	−/0[a]		+
Family–staff alliance	+/0[a]	0		+/0[a]

Note: Numbers behind outcome variables correspond with studies; +, increased; −, decreased; 0, no significant change.
Abbreviation: FCP, family-centred practice.
[a]The result is moderated by a third variable.

parenting stress or FCP and parental empowerment. However, when families received treatment with a strong evidence base, more parental empowerment was related to less involvement in treatment and more parenting stress was related to more staff's family-centred behaviours and attitudes (2). One study found that youths' self-disclosure to their parents was related to higher parental attendance (1), and two studies found positive results for the relationship between an aspect of FCP and family functioning (5 and 7).

Ten studies examined pre–post differences in family-centred interventions (1, 3, 4, 6, 8, 9, 10, 11, 12 and 13). Two of these studies reported descriptive or qualitative findings (8 and 13). In Tables 6 and 7, these results are presented by family outcome variables and sorted by the family-centred components of the intervention in which the results were reported. Results represent positive changes, negative changes or no change.

No direct association with FCP was measured. Different parental and dyadic factors were observed in these studies, with mixed results. Family functioning was measured most frequently and was generally found to improve during the residential treatment that included an aspect of FCP.

4 | DISCUSSION

The aims of this systematic review were to identify FCPs in residential youth care (Aim I) and related family outcomes (Aim II). We identified 13 studies that examined family outcomes in family-centred residential care.

Regarding Aim I, we found that FCP in residential youth care includes the following intervention components: family therapy,

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TABLE 6 Differences between pretests and posttests in family outcomes.

Family outcome	FCP in intervention				
	Family therapy	Parenting skills building	Involvement in treatment planning	Promotion of parent–child contact	Building strong family–staff alliance
Parental level					
Parenting stress (6 and 11)	−	−			
Perceived parental competence (9)		0			
Perceived social support (9)		0			
Psychological distress (1 and 6)	−	−			
Dyadic level					
Inconsistent discipline (10)		0	0		
Parental supervision (10)		+	+		
Parental warmth (1)	0	0			
Positive parenting (9 and 10)		0	0		
Family level					
Adaptability (3 and 12)	+/0[a]	+			
Cohesion (3 and 12)	+/0	0			
Family climate (12)	+	+			
Family competence (12)	+	+			
Family functioning (4 and 12)	+	+	+	+	+
Family style (12)	+	+			
Hierarchy (12)	0	0			

Note: Numbers behind outcome variables correspond with studies; +, increased; −, decreased; 0, no significant change.
Abbreviation: FCP, family-centred practice.
[a]The result is moderated by a third variable.

TABLE 7 Descriptive and qualitative findings on pre–post intervention differences.

Family outcome	FCP in intervention			
	Family therapy	Parenting skills building	Involvement in treatment planning	Promotion of parent–child contact
Parental level				
Understanding of youths' disorder (13)		+	+	
Dyadic level				
Youths' obedience (8)	+			+
Parent–child relationship	+			+
Youths' self-disclosure (8)	+			+
Family level				
Family functioning		+	+	

Note: Numbers behind outcome variables correspond with studies; +, more than 50% of participants reported improvement or satisfactory results.

parenting skill building, involvement in treatment planning, promoting parent–child contact and building a strong parent–staff alliance. These components correspond to the three domains of work described by Geurts et al. (2012): involvement in formal care processes (involvement in treatment planning), involvement in the daily lives and activities of children in residential care (promotion of parent–child contact) and intervention with families in the context of their daily lives to provide support and guidance (family therapy; parenting skills building). Consistent with FCP described by Foster et al. (2016), we conclude that building a strong parent–staff alliance needs to be added as a fourth FCP domain.

In addition, FCP was measured most often as a quantitative measure, including the number of (therapy or treatment planning) sessions attended, frequency of parent–child contact, quality of parent involvement and parent–staff contact. These 'objective' FCP measures consisted mostly of the frequency of parent-attended therapy

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sessions and the frequency of parent–child contact. Only two studies measured the 'subjective' quality of parental involvement (e.g., parental attitude during treatment). Thus, current measures mostly fail to address the *emotional involvement* of parents by mainly focusing on quantity (e.g., number of parental visits or youth furloughs) rather than quality of parent–child and parent–staff contact. This limits the study's ability to identify effective elements of FCP. Moreover, it is important to include the quality of parent–child and parent–staff contact because, as observed from previous research, this quality can be critical to achieving both positive short-term outcomes during residential care (with a positive parent–staff alliance) and longer-term outcomes (with positive parent–child contact) after youths leave residential care (Harder et al., 2011; Mihalo & Valenti, 2018; Shalem & Attar-Schwartz, 2022).

It is critical that researchers not only describe the characteristics of the intervention being studied but also measure the quality of how it was implemented in a particular case in order to learn what works, for whom and why in family-centred interventions in residential youth care. That is, although welfare organizations may express family-centred views in their policies, resistance by youth workers to adhere to these policies may create a gap between expressed family-centred attitudes and actual practice (Robinson et al., 2005). In addition, counting phone calls or visits does not effectively distinguish high from low emotionally involved families because it does not indicate the nature or quality of contact (Lakin et al., 2004). For example, Oxley (1977) found that parental involvement in therapy was more beneficial for youths when parents wanted to resolve something in therapy and when they recognized their own contribution to their child's problems. However, it was not disclosed how professionals determined parents' attitudes in therapy, and similar results have not yet been replicated in other studies. Thus, a gap in the literature remains on how best to operationalize families' emotional involvement in youths' treatment and how it affects family outcomes in family-centred interventions.

Given the limitations in existing research, this review could not provide a meaningful distinction of the intensity of family-centredness that would confirm the existence of distinct independent family-centredness levels, such as the ones suggested by Thoburn et al. (1995) or Dunst et al. (1991). We did find that intervention types in which the family as a whole was admitted to the residential facility automatically showed higher levels of (potential) parental involvement in treatment activities and contact with youth and staff than interventions in which parents and youth were separated. This indicates that shared family care (i.e., interventions focused on the family as a whole; Barth et al., 2023) is a promising FCP in residential care. Nevertheless, we conclude that it is necessary to examine the effectiveness of the individual components of FCP in residential treatment, rather than FCP as a general overarching construct, in order to identify effective elements of FCP.

The operationalization of FCP is complicated by the variety of terms that exist for this construct in research literature, such as 'family engagement', 'family-driven practice' or 'family partnering' (McIlwaine et al., 2020). Furthermore, we found that the terms 'family-centred practice', 'family involvement' and 'family-centredness' were used interchangeably rather than interdependently. In accordance with Johnson (1999), we see that family-centred practice is a multidimensional construct. Family-centred practice and family involvement are components that both relate to the degree to which an intervention was family-centred, but these components should be studied as separate aspects of family-centredness. We propose that 'family-centredness' can be defined from three different perspectives (see Figure 3): (i) *intervention characteristics* (Table 3), (ii) *the family's emotional and behavioural involvement in youth's treatment* and (iii) *staff behaviours and attitudes* (Table 4). In addition, the family–staff alliance is a component of family-centredness that refers to both the family and the professional. This means that in operationalizing FCPs, it is important to include all these aspects of family-centredness.

Regarding Aim II, we found that only four studies specifically examined an association between FCP and a family outcome in residential youth care. Based on these few studies, we found only minimal support that FCP is related to family outcomes at the individual, dyadic and whole-family levels. We found the most evidence for a positive relationship between aspects of FCP and whole-family functioning. No conclusions can be drawn regarding parental or dyadic outcomes, given the lack of studies that measured these outcomes.

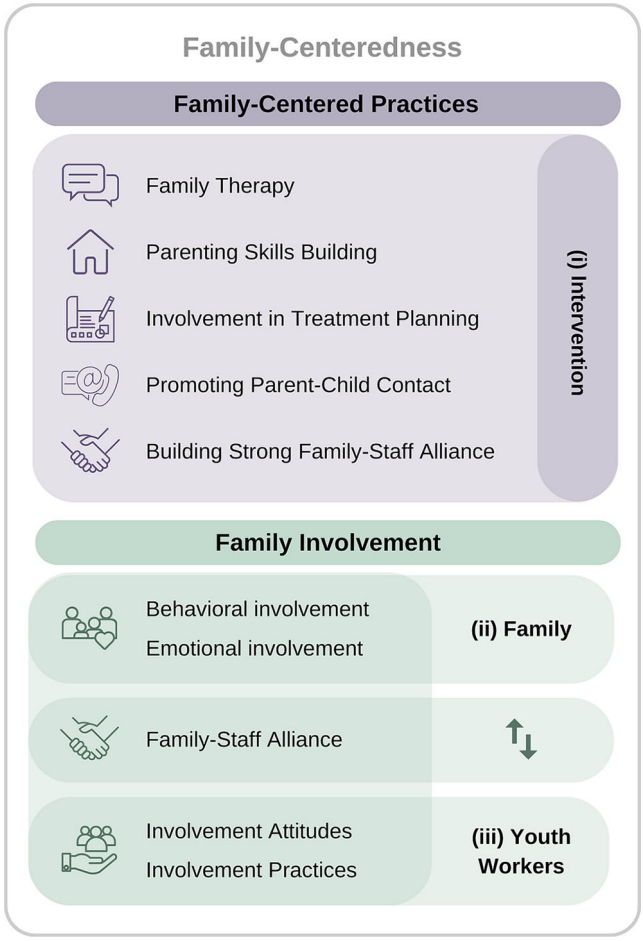

FIGURE 3 A model of family-centredness in residential youth care

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These findings drastically limit our knowledge of the effectiveness of FCP and underscore the knowledge gap in this area.

The lack of studies examining the association between FCP and family outcomes can be attributed to a scarcity of research in general on outcomes for families with multiple and complex needs (Holwerda et al., 2014) and for parents of youth in residential youth care (Van den Steene et al., 2018). Professionals often encounter various challenges when it comes to involving families in youth care treatment. These may include factors such as the geographical distance between the residential facility and the family's home (Geurts et al., 2012) or the unique challenges faced by the parents themselves (Nickerson et al., 2006). These barriers are also likely to affect family involvement in research. In addition, diversity within this population is not easily controlled for (Hair, 2005). There is currently no validated instrument available to measure the extent to which an intervention is family-centred or the level of *behavioural* or *emotional involvement* of families. Moreover, when the focus shifts from the youth to the family as the research subject, the number of potential confounding variables expands. While the distinct characteristics of families in residential youth care pose significant challenges for both research (Herbell & Graaf, 2023) and effective intervention (Tausendfreund et al., 2016), they also make them highly vulnerable. Therefore, it is crucial that future studies concentrate on exploring the relationship between FCP and family outcomes in residential care. Addressing this knowledge gap is needed to provide valuable insights into how best to serve this population.

All in all, there is a large knowledge gap regarding the effectiveness of FCP on family outcomes. Family functioning was the most frequently measured family outcome, but the absolute number of studies on this outcome is still small, especially considering that (family-centred) residential youth care interventions vary in type, content, treatment goals and specific target groups (Geurts et al., 2012; Nelson et al., 1990). It is surprising how scarcely outcomes are measured that relate to the parent or interactions between parents and their children (parental or dyadic outcomes), given that parents with children in residential care often report a lack of parenting skills (Griffith et al., 2009) and that problems such as emotional or physical child abuse are a common reason for out-of-home placement (Leloux-Opmeer et al., 2016). With respect to the family, we must conclude, in line with Knorth et al. (2008), that the effects of residential treatment in terms of family outcomes, particularly with respect to FCP in residential treatment, remain unclear.

4.1 | Limitations of the current study

This review has certain strengths and limitations that should be considered. The first limitation of this study is that the descriptions we found of the FCP that were used in the treatment method were often not thorough. The fact that little information on the interventions was provided is a significant limitation. We cannot be certain to what extent our categorization of youth worker actions reflect the true practice of the interventions. It is possible that the current interventions include additional FCP components that were not explicitly stated in the studies or that elements were practices differently than how they were described. For example, alliance building with families would be expected to be important in any intervention where staff are treating families in family therapy or coaching parents to learn parenting skills. However, because this practice was not often specified, it cannot be concluded that youth workers were expected to treat or work with parents according to family-centred principles. It was also not always clear to what extent the practices labelled 'family therapy' or 'parenting skills building' in this review were truly different in practice. Some family therapy sessions may better represent practices related to parenting skills building, and some home support visits may have been more therapeutic in practice. Another option is that described elements of FCP were not practiced at all because we did not had access to any raw data. For instance, Visscher et al. (2020) showed that routine practice of professionals often deviated from the intervention guidelines, according to professionals' own reported information.

Our understanding of how FCP is truly implemented is largely dependent on adequate descriptions of interventions in research. It is therefore crucial that all aspects of family-centredness are adequately operationalized in future research. Future research needs to focus on adequate measurement of FCP from both the youth workers' and families' perspectives, for which validation of new instruments in this welfare context is needed. For a more thorough conceptualization of FCP, research is needed that specifically addresses the multitude of possibilities of involving parents in their children's treatment and the families' experience of this involvement. Such work could, for example, use factor analytic techniques to disentangle which specific behaviours cluster together in aspects of FCP.

The second limitation of this study was that we were unable to investigate causal relationships between FCP and family outcomes due to the research designs of the studies included in this review. Therefore, the present study represents common elements implemented in FCP and commonly measured family outcomes in this context but does not provide information on the effectiveness of these elements on family outcomes.

Longitudinal studies in which family outcomes (measured at the parental, dyadic and whole-family levels) are examined repeatedly in families in residential youth care are needed to learn more about how FCP may affect treatment outcomes and the directions of these associations. For example, it is critical to learn whether facilitating and encouraging family involvement in residential treatment for youth can improve family outcomes or whether higher functioning families also tend to be more involved in their child's treatment.

Finally, the small number of studies included in this review and the varying ways in which family involvement and family outcomes were measured prevented us from conducting a statistical analysis of the relationship between FCP and family outcomes. Given the small number of studies that we were able to include in this review, the findings regarding the relationship between family involvement and family outcomes can also not be generalized to the population of families and youth in residential care. Furthermore, due to the limited research available on this topic, we cannot provide any specific implications for practice or policy. It emphasizes the pressing need for new

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research on FCP, which is crucial in establishing guidelines and best practices for effective family-centred residential youth care interventions, tailored to different circumstances and demographics. Future research may consider a multiple case study design to gain insight into how different aspects of FCP affect families and how family outcomes change over time. This type of research may be particularly relevant to this research topic because the populations of families in a family-centred intervention are often small and families in residential youth care differ from one another in several ways, including the severity of the youth's emotional and behavioural problems, care history, family composition and level of family functioning.

5 | CONCLUSION

The results of this review propose an operationalization of *family-centredness*, including *family-centred practice* (FCP) and *family involvement*, in residential youth care (Figure 3). By recognizing family involvement as a multifaceted construct, research can more accurately target the interactions between family and staff that together form the overarching construct of family involvement. This improves the research practice of family-centred treatment because we can more clearly understand and report which part of family involvement is being measured in relation to which family outcome, rather than calling each component 'family involvement'. In addition, future research should focus on elucidating the effective components of parental involvement.

The limited number of studies examining the effectiveness of FCP on family outcomes prohibits us from drawing strong conclusions about the effectiveness of (specific aspects of) FCP on parents, parent–child dyads and whole-family functioning. Although many studies of family-centred treatment report practices related to parenting skill building or family therapy, changes in parenting skills or the quality of the parent–child relationship are rarely measured. However, FCP may show promise for improving family functioning in families in residential youth care.

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CONFLICT OF INTEREST STATEMENT

All authors declare that they have no conflicts of interest to disclose.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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APPENDIX A: Search strategy

TABLE A1 Search strategy.

Search terms by category		Combined search string with Boolean operators
Population	('child' OR 'children' OR 'young person' OR 'adolescent' OR 'adolescents' OR 'adolescence' OR 'teen' OR 'teenager' OR 'youth' OR 'youths' OR 'young people' OR 'juvenile' OR 'juveniles' OR 'boy' OR 'boys' OR 'girl' OR 'girls' OR 'infant' OR 'toddler' OR 'kid' OR 'kids' OR 'young')	(('child' OR 'children' OR 'young person' OR 'adolescent' OR 'adolescents' OR 'adolescence' OR 'teen' OR 'teenager' OR 'youth' OR 'youths' OR 'young people' OR 'juvenile' OR 'juveniles' OR 'boy' OR 'boys' OR 'girl' OR 'girls' OR 'infant' OR 'toddler' OR 'kid' OR 'kids' OR 'young')) AND (('behavioral problem' OR 'behavioural problem' OR 'behavioral problems' OR 'behavioural problems' OR 'social emotional problem' OR 'social emotional problems' OR 'internalizing' OR 'externalizing' OR 'problem behavior' OR 'problem behaviour' OR 'aggression' OR 'aggressive' OR 'violent' OR 'violence' OR 'criminal behavior' OR 'criminal behaviour' OR 'delinquent' OR 'delinquents' OR 'delinquency' OR 'anxious' OR 'anxiety' OR 'depressive' OR 'depression' OR 'family functioning' OR 'family conflict')) AND (('residential treatment' OR 'residential care' OR 'residential placement' OR 'residential intervention' OR 'group home' OR 'congregate care' OR 'residential facility' OR 'looked after children' OR 'out of home care' OR 'therapeutic residential care' OR 'specialist residential care' OR 'residential children's home' OR 'residential home' OR 'edge of care')) AND (('family centred' OR 'family centered' OR 'family engagement' OR 'family involvement' OR 'parent involvement' OR 'parent engagement' OR 'parent support' OR 'family participation' OR 'family driven' OR 'family focus' OR 'family focused' OR 'family partnering' OR 'parent liaison' OR 'parent peer coordinator' OR 'family oriented' OR 'family outreach' OR 'family navigator' OR 'family oriented' OR 'family allied' OR 'family based' OR 'working with families')) AND (('outcome' OR 'outcomes' OR 'result' OR 'results' OR 'output' OR 'success' OR 'successes' OR 'drop out' OR 'product' OR 'evaluation' OR 'evaluations')) AND NOT (('geriatric' OR 'elder care' OR 'end of life' OR 'palliative'))
	('behavioral problem' OR 'behavioural problem' OR 'behavioral problems' OR 'behavioural problems' OR 'social emotional problem' OR 'social emotional problems' OR 'internalizing' OR 'externalizing' OR 'problem behavior' OR 'problem behaviour' OR 'aggression' OR 'aggressive' OR 'violent' OR 'violence' OR 'criminal behavior' OR 'criminal behaviour' OR 'delinquent' OR 'delinquents' OR 'delinquency' OR 'anxious' OR 'anxiety' OR 'depressive' OR 'depression' OR 'family functioning' OR 'family conflict')	
Setting	('residential treatment' OR 'residential care' OR 'residential placement' OR 'residential intervention' OR 'group home' OR 'congregate care' OR 'residential facility' OR 'looked after children' OR 'out of home care' OR 'therapeutic residential care' OR 'specialist residential care' OR 'residential children's home' OR 'residential home' OR 'edge of care'	
Intervention	('family centred' OR 'family centered' OR 'family engagement' OR 'family involvement' OR 'parent involvement' OR 'parent engagement' OR 'parent support' OR 'family participation' OR 'family driven' OR 'family focus' OR 'family focused' OR 'family partnering' OR 'parent liaison' OR 'parent peer coordinator' OR 'family oriented' OR 'family outreach' OR 'family navigator' OR 'family oriented' OR 'family allied' OR 'family based' OR 'working with families'	
Outcome	('outcome' OR 'outcomes' OR 'result' OR 'results' OR 'output' OR 'success' OR 'successes' OR 'drop out' OR 'product' OR 'evaluation' OR 'evaluations')	
Exclusion	('geriatric' OR 'elder care' OR 'end of life' OR 'palliative')	

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APPENDIX B: Quality appraisals

TABLE B1 Overview of quality appraisal scores.

	Study												
Question	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**
Were the criteria for inclusion in the sample clearly defined?	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Were the study subjects and the setting described in detail?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Was family involvement measured in a valid and reliable way?	Y	U	N	Y	Y	N	N	N	U	N	N	N	U
Was the way parents could be involved in their child's treatment clearly described?	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Were confounding factors identified?	Y	Y	U	Y	Y	U	N	U	Y	Y	Y	N	N
Were strategies to deal with confounding factors stated?	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	N
Were the family outcomes measured in a valid and reliable way?	Y	Y	Y	U	U	Y	Y	N	Y	U	Y	Y	U
Was appropriate (statistical) analysis used?	Y	Y	Y	Y	Y	Y	Y	U	Y	Y	Y	Y	U
Overall score	8/8	6/8	5/8	7/8	7/8	6/8	6/8	3/8	7/8	6/8	7/8	6/8	3/8
Overall appraisal	High	Moderate	Moderate	High	High	Moderate	Moderate	Low	High	Moderate	High	Moderate	Low

Note: The numbering of the studies corresponds to the numbering in Table 2.
Abbreviations: n/a, not applicable; N, No; Y, Yes; U, unclear.

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