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# STAFF ATTITUDES AND BELIEFS ABOUT FAMILY INVOLVEMENT OF DELINQUENT CHILDREN IN RESIDENTIAL PROGRAMS

By

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ABSTRACT

STAFF ATTITUDES AND BELIEFS ABOUT FAMILY INVOLVEMENT OF DELINQUENT CHILDREN IN RESIDENTIAL PROGRAMS

By

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This project is an exploratory study using a convenience sample of 51 employees of a mid-sized, Mid-West residential treatment facility for court-referred delinquent children. The study utilizes a mixed-methods approach which consists of both quantitative and qualitative elements and enables a comprehensive understanding of staff attitudes and beliefs about family involvement with delinquent children in the participating agency. Descriptive data shows that the mean age of the participants is 36 years (SD = 10.6) with the range 22 to 57 years of age. The majority of the participants were Caucasian (72%) with nearly statistically insignificant representation of other ethnic groups. The sample was also dominated by male staff (68.6%) with a fair representation of female staff members.

Overall, the findings suggest that staff members support family involvement. It seems clear that the staff recognized a link between a child's return home and the activities designed to involve families during the child's placement. The findings also indicate that family involvement is not viewed as important if the delinquent child is not planning to return to the parental home.

As expected, the correlational analysis indicates staff members who have positive beliefs about the youths' families are also those who support family involvement. The correlation between negative beliefs about families and support of family involvement is

statistically insignificant, however. The correlational analysis does not support the expected variation of support for family involvement across the staff age groups.

The One-way Analysis of Variances (ANOVA) suggests there were differences in the support of family involvement of direct care staff and administrative and clinical staff (including social workers and family therapists). However, there was no difference between administrative staff and clinicians. In addition, the ANOVA analyses of demographic factors (education, age, gender, and marital status) are statistically insignificant.

This study offers suggestions for further research and outlines implications for policy and social work practice.

# DEDICATION

I dedicate this work to my family for their unflinching support and encouragement

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## KEY TO ABBREVIATIONS

| | |
|---|---|
| ANOVA | A One-Way Analysis of Variance |
| CASSP | Child and Adolescent Services System Program |
| FFT | Functional Family Therapy |
| GGI | Guided Group Interaction |
| IEPs | Individualized Education Plans |
| ISP | Individual Service Planning |
| JCCA | Jewish Child Care Association |
| JJDPA | Juvenile Justice and Delinquency Prevention Act |
| MST | Multi-Systemic Therapy |
| NCASA | National Center on Addition and Substance Abuse |
| NCMHJJ | National Center for Mental Health and Juvenile Justice |
| NIMH | National Institute of Mental Health |
| SED | Severe Emotional Disturbances |
| SPSS | Statistical Package for Social Sciences |
| YOC | Youth Opportunity Camp |

# Chapter 1: Introduction and Problem Statement

## 1.1 Introduction

Since the birth of civilization scholars and scientists from the social to the natural sciences have theorized about and attempted to find solutions to alleviate human problems and to improve the general conditions of human life. It is important to point out that each generation has its own set of problems and it is only when these problems are identified that society marshals its resources to tackle them. Historically, society attempts to solve identified problems through various tactics, including the introduction of policies describing such conditions and prescribing the necessary remedies. Consequently, the concept of youthful delinquency has been identified and accepted by society as a problem requiring societal attention. This attention led to the establishment of the first juvenile court in the United States at the turn of 20th Century (Binder, Geis, & Bruce, 2001; Britt & Gottfredson, 2003; Hess & Clement, 1993; Shoemaker, 2000; Siegel, 1992; Siegel & Senna, 1994; Tuell, 2002).

Since the inception of juvenile courts, American society has strived to solve delinquency by methods such as holding juveniles accountable for their criminal acts and/or attempting to rehabilitate them (Siegel & Senna, 1994; Tuell, 2002). In order to provide treatment for young offenders, the juvenile justice system adopted a variety of intervention strategies including both residential and nonresidential treatment programs (Bartollas & Miller, 2001; Bates, English, & Kouidou-Giles, 2001; Siegel & Senna, 1994). Juvenile residential treatment programs range from maximum-security (total lockdown) facilities to low security community-based facilities (e.g. youth live at the facility but attend school in the community). Nonresidential programs are the least

restrictive community-based alternatives and are grounded in an ecological model that assumes that "...children are best understood in the context of the family, and families are best understood within the context of community" (Ryan, 2006, p. 511).

The residential treatment programs which are the focus of this study are facilities that offer 24-hour supervision in a highly structured environment. Timothy L. Fitzharris offers a definition of residential treatment program as "...24-hour care provided in a facility of any capacity outside the licensee's family residence, with such services provided by staff employed by the licensee." (1985, p.6). Therefore, the aim of staff members in residential facilities is to help the children placed in the care of the facility (Scholte & van der Ploeg, 2000). These staff members carry out the well-defined treatment plans that are designed for each of the children. As Scholte and van der Ploeg (2000) state, residential staff first assess the psychosocial problems of the children and then aim at providing the basic care and specific treatment addressing the problems identified. Based on such initial assessments, some residential treatment programs aim at working with youth individually rather than the whole family (Kumpfer, 1999; Mannes, 2000; Osher & Hunt, 2002). This practice stems from historical approaches to rehabilitation where it was assumed that it is the youth who has the problems and not the family. Also assumed was that, in many cases, the family was dysfunctional to the point that the child must be isolated from the home environment in order to be rehabilitated (Kumpfer, 1999; Mannes, 2000; Osher & Hunt, 2002; Scholte & van der Ploeg, 2000).

Scholte and van der Ploeg (2000) suggest that contemporary views state that a child's family of origin is central during the child's treatment. Furthermore, family

involvement is the main predictor of a child's progress both while in residential care and after discharge. In addition, this paradigm shift supports family strengths and preservation of the family unit. This, in turn, has led residential treatment programs (both private and public), as well as community-based treatment programs, to change their policies to focus more on family-centered practices (Jivanjee, 1999; Jivanjee, Friesen, Kruzich, Robinson, & Pullman, 2002; Northey, Primer & Christensen, 1997). This paradigm shift was further bolstered by the federal government's National Institute of Mental Health (NIMH) Child and Adolescent Services System Program (CASSP) goal in 1983 calling for improvement in mental health care for children (Knitzer, 1982). The philosophy of CASSP has always been to develop an infrastructure for providing services which are family-centered, family reunification oriented, community-based and culturally competent (Bogrov & Crowel, 1996; Carlo, 1985; Collins & Collins, 1994).

Research suggests that the increase in family involvement in residential treatment is due, in part, to the efforts by the federal government to institutionalize family involvement through policymaking (Banes, 1998). Banes pointed out that in 1985 CASSP staff added a family goal to their program. This goal translates into a requirement that state applications for CASSP funds must describe how families would participate in service planning efforts at the child and family program and systems levels. Banes (1998) outlines the policies that Congress enacted to enhance family participation in service delivery to children. He points out that in 1986 Congress passed the State Mental Health Services Comprehensive Plan (Public Law 99-660), which mandates family member participation in the development of state mental health plans.

Banes (1998) emphasized that the mandate of Public Law 99-660 continues today through the Alcohol, Drug Abuse and Mental Health Administration Reorganization Act (Public Law 102-321).

A substantial body of literature supports Banes' (1998) argument. It is noteworthy that family involvement is a key component in each of two bills passed in 1975 by Congress. These bills emphasize early intervention services for infants and young children with disabilities or who are at risk of developmental disabilities (Public Laws 99-457 and 105-17) (Allen & Petr, 1996). Special education law also calls for direct involvement of family members in the individualized education plans (IEPs) for their children (Public Laws 94-142, 101-476 and 105-17) (Banes, 1998). Given this long list of laws, one cannot but agree that from a policy perspective there is a substantial effort being made by the federal government to make family members part of the planning and decision-making process in their children's development. Family involvement, therefore, has been the largest paradigm shift in the field of child welfare, juvenile justice, mental health, education and all forms of out-of-home placement in the last 30 years. We have moved away from a "child rescue" philosophy of saving children from their "wicked parents" toward seeing parents as potential resources in their children's care (Maluccio, 1981; Sinanoglu, 1981; Whittaker, 1981).

The paradigm shift from focusing on youth to the entire family and to integrating family members into the treatment ultimately depends on the behavior of staff members toward families. As research shows, ". . . the measure of a treatment program lies in the quality, training and commitment of its staff . . ." (Finkelstein, 1981, p. 89). In the same line of thought focusing on staff, Baker and colleagues (1995) state that

staff members who have negative beliefs about parents whose children are in placement may not be receptive to such families. The same authors suggest that if staff members do not support family involvement, their behavior toward parents will likely reflect attitudes which could be measurable.

Despite the fact that policies mandate family involvement, the effects of residential treatment staff beliefs have not been thoroughly explored. This gap in the literature does not mitigate the extensive literature that is compiled on professional-client relationships or professional attitudes toward parental involvement. The argument for this study points out that, despite the long standing history of family preservation and strengthening families in the U.S., staff attitudes toward family involvement with children placed in juvenile justice residential treatment facilities have yet to occupy a priority in service delivery systems. In addition, research suggests that experts continue to debate which goals should be prioritized in juvenile justice (Siegel & Senna, 1994; Streib, 1999). According to Siegel and Senna (1994), some claim that the most important goal is to protect potential and actual victims by deterring children from committing antisocial acts.

Others argue that social reform, legislative processes, and employment are the most practical methods to reduce youth crime. Researchers continue to point out that some experts argue that the threat of stigma and labeling by the juvenile justice system is an overriding problem that needs attention. Siegel and Senna (1994) state that other experts spend considerable time theorizing how to respond to the children with special needs—such as uneducated, mentally ill and mentally challenged youth—that enter the juvenile justice system. These different and sometimes conflicting points of view on

how best to address juvenile delinquency allude to the complexities of juvenile justice. Ample evidence can be found in the literature that demonstrates the tireless work of researchers, policymakers, and service providers to find solutions to this complex problem called juvenile delinquency. The irony is that little is to be found in the literature which articulates the effect of the attitudes of residential staff in supporting family involvement in the rehabilitative process of delinquent youth.

### 1.2 Statement of the Problem

In 2003, law enforcement agencies in the United States made an estimated 2.2 million arrests of persons under the age of 18 years. These arrests accounted for 16% of all arrests for 2003 (Snyder, 2005). It is estimated that 2.4 million youth were arrested in 2000, which accounts for 17% of all the arrests in the United States (Gupta, Kelleher, Pajer, Stevens & Cueller, 2005). Following arrest, there are a number of responses the juvenile justice system may pursue. A juvenile may be sent home without charge or he/she may be held in a detention facility until formally adjudicated. Following adjudication by the court, the youth may be placed into a correctional/rehabilitation facility, assigned to a community-based program, or admitted to a mental health treatment facility or program (Kopiec, Finkelhor & Wolak, 2004; Lundman, 2001; Lyman & Campbell, 1996; Mann, 2000; and Siegel & Senna, 1994). According to recent statistics, 104,413 juvenile offenders were committed to juvenile correctional/treatment facilities in 2001 in the United States (Sickmund, Sladky & Wei, 2004).

In Michigan, the total number of juveniles taken into custody in 2001 was 3,504, of which 2,739 were committed and 756 were detained in juvenile detention centers. Only nine juveniles were placed in diversion programs. Michigan is one of the states with the highest number of juveniles taken into custody and placed into private residential facilities (Snyder, 2005). Of the 3,504 Michigan youth taken into custody, 1,932 youth were placed in private facilities and 1,572 youth were placed in public (state operated) facilities. Youth who are arrested but not adjudicated, committed, or placed in treatment programs, are held in detention centers within which the violation of the law took place. Thus, a detained youth is held in a detention center operated under auspices of the county and located within the county where the crime occurred until the youth is committed for treatment. According to 1973 PA 116 section 3, the detention home or facility must be contracted or established as an agency of the county and be operated under the direction of the board of commissioners or, in a county with elected county executives or under the county executive direction (Michigan Legislature, www.legislature.mi.gov retrieved 1/19/2008). The law mandates that the detention home will provide diagnosis, treatment, and care for the detained youth

Kumpfer (1999) cited a study conducted by the Center for Study and Prevention of Violence, where it was projected that by the year 2010, the rate of juvenile arrests will more than double. Kumpfer suggests that this prediction is based on the escalating trends observed in juvenile arrests and increases in the actual population of youth in the 10 to 17 year range. Other studies suggest that the juvenile offenders are becoming much younger that than a few decades earlier (Hawkins, Herenkohl,

Farrington, & Harachi, 1998; Stouthamer-Loeber, Loeber, Farrington, & Wikstrom, 2002).

In addition, these child delinquents are two to three times more likely to continue their criminal involvement at later ages than their counterparts who may come in conflict with the law at an older age (Hawkins, et al., 1998; Lyons, Terry, Martinovich, Peterson, & Bouska, 2001; Snyder, 2001; and Stouthamer-Loeber, et al., 2002). Research also indicates that 12% of the U.S population younger than 18 years of age has a diagnosable mental illness (Gupta et al., 2005; Institute of Medicine, 1989). Federal data suggests that 70-80% of these children either end up in the juvenile justice system or do not receive adequate care and, if they do, the services are uncoordinated and incomplete (Institute of Medicine, 1989). An additional concern is that while the number of juveniles in residential treatment is rising, the cost of care is also sky-rocketing. According to Lyons and colleagues (2001), residential treatment represents one of the largest and the most expensive components of the juvenile justice system. Furthermore, Gupta and colleagues (2005) suggest that about 88,000 juveniles with diagnosable acute medical and psychiatric problems, including chronic substance abuse, are being released back into the community without any connection to supportive community services. In order to address delinquency problems effectively, high quality prevention, intervention, and reintegration programs that stress family involvement must be developed, funded and utilized.

Research suggests that the growing juvenile crime problem stems from a complex array of causes. These causes include a lack of adult supervision and strong role models, and limited opportunities for youth. The negative conditions associated

with poverty, abusive backgrounds, and a host of other social ills add to the influence of these factors (Feld, 1990; Hirschi, 1969; Kumpfer, 1999; and Shoemaker, 2000). To address these social problems that are contributing to delinquency, it is critical to understand the family dynamics influencing the behavior of an individual child as the family is the first social contact for each child. Social theorists such as Bandura (1969) and Nye (1958) claim that children learn ways of behaving through observations. Consequently, it is important that families are included in any intervention and are helped to understand their role in their children's development. Including families is contingent upon staff attitudes and beliefs regarding family involvement.

Despite the knowledge base that supports the involvement of families in therapeutic intervention, research has shown that the rate of family visits in residential care programs, even in community-based treatment centers, is very low (Baker & Blacher, 1992; Baker, Heller, Blacher, & Pfeiffer, 1995; Jivanjee, et al.,.2002; Maluccio, 1981; Sinanoglu, 1981; and Whittaker, 1981). While the lack of participation of families may be due to many non-staff related factors (such as having family members in the criminal justice system, a family of history mental health and poverty, or deceased/ deserted family members) there is also the influence of staff attitudes toward family participation that must be considered (Baker, et al., 1995; Leone, 1990; Osher & Hunt, 2002).

Traditional practices in juvenile justice facilities and programs assume a potentially collaborative but inherently unequal relationship between the parent and the clinician. It is likely that this results from issues with power and authority as well as a presumed expertise integral to a professional, as opposed to the presumed failure of the

parent whose child requires intervention from the juvenile justice system (Alexander & Dore, 1999; Jivanjee, et al., 2002). Alexander and Dore (1999) outlined four barriers of partnership, which are: 1) negative beliefs about parents by clinicians; 2) a lack of clinician's knowledge and skill in differentiating and treating a full range of family functioning; 3) racial and cultural differences; and, 4) a discrepant view of the component of parenting. A study by Collins and Collins (1994) suggests that parent-professional collaboration in working with children is useful in determining etiology. This observation reinforces Alexander and Dore's (1999) argument that a lack of parental involvement of children in residential treatment centers stems from negative staff beliefs about and attitudes toward families. While other researchers have pointed out that transportation difficulties and scheduling issues are hindrances to family involvement (Harvell, Rodas, & Hendley, 2004; Jivanjee, 1999), it is argued that historically, residential agencies do little to encourage family involvement in treatment (Nickerson, Brooks, Colby, Rickert, & Salamone, 2006). Therefore, in order for parents to participate meaningfully in their children's treatment, facility staff must be willing to work with families and the families must be provided the tools necessary to participate in the process.

### 1.3 Purpose of the Research

In order to improve policies and practices in residential treatment facilities, specifically with staff members working with children and their families, it is necessary to examine the workers' existing attitudes toward family involvement. The purpose of this study is to gain insight and knowledge about (a) staff support for family

involvement and reunification; (b) the beliefs of staff members about families of adjudicated juveniles; and (c) the staff members' perceptions of the effects of family involvement. This study is unique because it gathered information from staff members who work with juvenile delinquents and court-referred youth for treatment in a residential setting while other studies have examined children only in non-juvenile justice programs. The research project uses a mixed-method approach, consisting of both quantitative and qualitative components, in order to provide a comprehensive understanding of staff members' attitudes and beliefs about family involvement in residential treatment for delinquent children.

### 1.4 Theoretical Framework

The theoretical framework used in this study is the Ecological Systems perspective that draws from research on interactions between living organisms and their environments (Bronfenbrenner, 1979; Friedman, 1999; Johnson, 1999). Using an Ecological model, Urie Bronfenbrenner (1979) seeks to explain individuals' development in relationship to their environments in the present and over time (Johnson, 1999). Bronfenbrenner (1979) states that individuals are affected by overlapping interactions of ecosystems that include systems such as microsystems, mesosystems and an exosystem and macrosystem. Whereas primary microsystems for a delinquent, as well as for that of any child, include the family, peer group, classroom, and neighborhood, the mesosystem is an interaction that includes the parent's attempt to coordinate efforts to educate their child. The exosystem includes all external networks such as community structures and local educational, medical, employment and

communications systems. Influencing all the systems is the macrosystem which includes cultural values, political philosophies, economic patterns and social conditions. In addition to the identification of the different ecosystems by Bonfenbrenner, the ecological perspective is defined in The Social Work Dictionary (Barker, 2003) as "An orientation in social work profession and other professions that emphasizes understanding people and the nature of their transactions" (p.136). The same source states that the important concepts of an ecological perspective include "adaptation, transactions, goodness of fit between people and their environments, reciprocity, and mutuality. In professional interventions, the unit of attention is considered to be an interface between the individual (or group, family, or community) and the relevant environment" (p.136). As Maluccio (1981) states, the perspective shifts from a narrow orientation to a broad view of the child in placement and emphasizes a multifaceted method of intervention for children and their families within the context of their own situation and environment.

The assumption is that the ecological perspective is a "...theoretical model where variety of inputs enter the (unit of analysis) and interaction takes place within the system (intervention) resulting in an output" (Friedman, 1999, p. 3). The input is comprised of the type of behavioral problems (aggression, antisocial beliefs, severe parental conflicts, child/family conflicts, etc.) of delinquent children admitted to residential treatment programs (Friedman, 1999; Scholte & van der Ploeg, 2000). At the interaction level, the residential staff has responsibility for mobilizing and assessing the situation while offering therapeutic interventions with the ultimate goal to help the child reunite with his/her family.

In the application of the Ecological Perspective to this study, the idea is to involve parents as equal partners in the process in order to examine the variety of characteristics that describe delinquent children's completion of their residential treatment and successful reentry to community. While the study looks at staff attitudes and beliefs to determine their support for family involvement, it is worthwhile to note that there are a number of factors that operate within the entire system to facilitate successful completion of residential programs. Therefore, this descriptive, exploratory study employs a triangulated approach in order to address the following questions posed to the staff members included in this study:

1. What training have you had to prepare you for working with youth and families?
2. Based upon your experiences working with youth in residential settings, do you think that staff members believe family involvement is an essential component in the treatment of juvenile delinquents?
3. In your opinion, what are some of the issues or concerns surrounding families' involvement with their delinquent children in residential treatment?
4. What is the program or agency's position regarding family involvement?
5. In addition to what you have previously mentioned, do you have any comments about family involvement with juvenile delinquents in a residential treatment program?

The following hypotheses were formulated regarding the relationships among the variables of this study:

$H_1$ There is a positive relationship between staff support for reunification and family involvement with delinquent children in residential treatment.

$H_2$ Staff members who hold positive beliefs about families are more supportive of family involvement.

$H_3$ Clinicians (social workers, family therapists and psychologists) have more positive attitudes toward family involvement than direct care staff.

$H_4$ Administrators have more positive attitudes toward family involvement than direct care staff members.

$H_5$ The level of support for family involvement varies with socio-demographic characteristics: race/ethnicity, gender, age, and education.

### 1.5 Significance of the Study

This study is significant in that it has the potential to illuminate staff attitudes, specifically toward family involvement with children who have come in contact with the law and are placed in residential facilities. Although not clearly established in the literature for the juvenile justice population, there is a body of research in education and mental health that shows that there are policies in place at the federal level that recommend family participation (Banes, 1998; Bogrov & Crowel, 1996; Carlo, 1985; Collins & Collins, 1994). In turn, these policies influence family and child outcomes for these programs (Allen & Petr, 1996; Baker & Blacher, 1992; and Baker, et al., 1995).

This project is also significant because existing juvenile justice research shows that reentry of youthful offenders requires a reexamination of the role of the institution in relation to the community and the victim (Mears & Travis, 2004; Snyder & Sickmund, 1999). Coincidentally, institution policies, procedures, and programs are based on and operate under the influence of the roles and values of staff within the institution (National Council of Disability--U.S., 2003). It is significant, therefore, to have an understanding of the attitudes, beliefs, skills and training of those facility staff members. Many studies show that most residential treatment models assume that direct-care staff members possess the necessary skills and the knowledge to implement

the treatment plans developed by clinicians since they have daily contact with the youth in residential facilities (Doom, 1999).

Michael C. Doom, (1999) cites a study initiated by the Ohio Support Living Training Initiative through the University of Cincinnati Center for Developmental Disorders which covers areas in which direct-care staff members are expected to be efficient and proficient. The study lists 69 competencies across 11 general areas that are required of direct-care staff in order to function efficiently in their roles (Gannon, 1996). According to Doom (1999), one of the 11 general areas was "Behavioral Challenges In Supported Living," which includes the below staff competencies. Direct Support staff:

1. demonstrate an understanding that their job is to support behavior that is appropriate to the setting and situation rather than to maintain control of the person receiving support;
2. understand that expectations of the community in regard to behavior are different than standards applied within based programs;
3. describe behaviors of the individual which may be a barrier to participation in the community or which may require intervention. This would include knowledge of any behavior plan which has been developed and approved by the Individual Service Planning (ISP) team;
4. demonstrate a general understanding of the principles of positive support;
5. understand his/her responsibility is to determine the behavioral needs of the person receiving support so that he/she can act to prevent problems and manage the environment so that it supports the person; and
6. can identify any new behaviors which may require a planning meeting, further assessment, or notification of a supervisor (Doom, 1999, p. 3, as cited in Gannon, 1996, p. 14).

These competencies require that the duties of direct-care staff include treatment responsibilities such as an ability to implement behavioral treatment plans and to

provide environmental management. Yet there is no literature supporting these skills and knowledge for direct-care staff members in juvenile justice facilities. There is a noted absence of literary work discussing how the attitudes and beliefs that influence residential staff behavior with juvenile delinquents and their families' impacts treatment outcomes for these clients. Themes in two empirical research projects on staff attitudes and beliefs about family involvement from Baker et al. (1995) and Coleman (1999) partially illuminate this correlation but these studies were limited to mental health clients rather than juvenile delinquents.

Furthermore, this study is significant to the field of social work in that it may help social workers who work in multi-disciplinary environments to evaluate their own beliefs and values toward families and to increase their level of compassion and fairness in their work with families. This study is based on research that suggests that parents of institutionalized children are often faced with seemingly insurmountable barriers which include poor staff-parent communication and a lack of resources (Baker, et al., 1995; Jivanjee, 1999; Jivanjee et al., 2002). The findings of this study support an increase in staff-parent communication so that realistic expectations can be established and appropriate resources identified to enable families to participate in their children's treatment while in residential facilities. Such an improvement would give the delinquent child an opportunity to complete the treatment program successfully and be reunited with his/her family.

The findings may also demonstrate that an increase in the level of staff support for family involvement may assist staff by providing a better understanding of the juvenile delinquents in their care. Subsequently, this improved understanding may lead

to more successful rehabilitation attempts. Above all, family participation may make the service providers' job easier which in turn may result into better treatment outcomes for the child (Osher & Hunt, 2002).

### 1.6 Definition of Terms

The following definitions are provided in order to provide clarity. Also refer to (Appendix G) for a glossary of terms particular to juvenile justice.

Family: Bogenschneider and Corbett (2004) argue that the definition of family can be categorized in two ways which are structural and functional in nature. The authors state that structural definitions are based on blood relationship, legal ties, or residence. Functional definitions take into account such things as sharing resources and responsibility for caring for the young, elderly, and disabled. For the purpose of this study, a delinquent child's family is composed of individuals who support that child both emotionally and physically, provide learning opportunities, moral guidance, financial assistance (Anderson, 2001), and help build the child's self-esteem while in residential treatment (Osher & Hunt, 2002; Kumpfer, 1999). Thus, a family includes individuals of various ages who may be related by biology or marriage or not related at all but who are performing functional activities as a family system.

Family Involvement: Family involvement with their children may mean different things to different people and may depend on the situation. In this study, family involvement is any role or activity that enables those identified as family members to have direct and meaningful input into, and influence on, systems, policies, programs, or practices affecting services (Anderson, 2001) for the delinquent child referred by the

court system to receive treatment in a residential setting (Retrieved December 30, 2006 from the World Wide Web:

http://www.cmpmhmr.cog.pa.us/glossary.htm, 2006).

Direct-Care staff/Frontline staff: Direct-care staff is defined as a person who is employed in a residential facility whose job description includes care and supervision of delinquents referred by the court system for treatment (Doom, 1999).

Clinician: In this study, a clinician is a masters level social worker or psychologist or other mental health professional who works with delinquent children referred by the court system for treatment in a residential setting. The clinician works with individual children, groups and families helping them to find ways to deal with their psychosocial and emotional problems (Retrieved December 30, 2006 from the World Wide Web:

http://www.cmpmhmr.cog.pa.us/glossary.htm, 2006).

*Parens Patrie*: *Parens Patrie* is a Latin term meaning "parent of his or her country." As the state has sovereignty over everything within its jurisdiction, *parens patrie* refers to the power of the state to act as the parent of any child or have authority over any individual who is in need of protection such as an incapacitated individual (sometimes called a person in need of protection) or a child whose parents are unable or unwilling to take care of the child (Binder, et al., 2001; Siegel & Senna, 1994; Wikimedia Foundation, 2001, 2002).

# Chapter 2: Literature Review

Any study that examines family engagement practices within the juvenile justice system, particularly within residential programs, must begin with an understanding of the history, philosophies and policies of that system. Consequently, the existing literature on the history of residential services, the history of juvenile justice philosophy and policies (including the oscillation between rehabilitation and punishment), and the systemic changes that have occurred since the inception of the juvenile court system are reviewed. Complementary behavioral theories involving family dynamics will also be reviewed in order to provide an understanding of the importance of family engagement in residential treatment through an ecological perspective. There is only a small body of scholarly work available on the topic of parental and staff collaboration in treatment of children who come in conflict with the law and are placed in residential treatment facilities as compared to that which is found in both the education and mental health arenas.

## 2.1 What is the Juvenile Justice System?

The American juvenile justice system is the legal system that consists of agencies and institutions whose primary responsibility is managing juvenile offenders (Binder, et al., 2001; Roberts, 1998; Siegel & Senna, (1994). Roberts (1998) and Siegel & Senna (1994), identify the following components that are often observed under the umbrella of a juvenile justice system: the police, pretrial diversion projects, a juvenile court, children's shelters, short-term detention facilities, residential treatment programs, group homes, juvenile correctional facilities, wilderness programs, family

counseling programs, multi-systemic treatment providers, restitution programs and aftercare.

The initial implementation of a juvenile justice system in the United States was enacted in Cook County, Illinois in 1899 with their separation of juveniles from the adult criminal justice system. This separation came about as a result of social reforms and societal changes that swept the United States during the latter part of the nineteenth century. Included in those changes were philosophical assumptions that children are inherently different from adults and, therefore, must be treated differently than adults (Bartollas & Miller, 2001; Binder, et al., 2001; Carey & McAnany, 1984; Faust & Brantingham, 1974; Lou, 1927; Roberts, 1998). Research suggests that many schools of thought during this era argued that younger offenders are more inclined to eliminate their criminal behavior than adults (Binder, et al., 2001; Roberts, 1998; Siegel & Senna, 1994). Consequently, a rehabilitative approach (versus a punitive mode) was the major aim of juvenile justice practice. Streib (1999) suggests that the goal of rehabilitation of young offenders was first envisioned by Jane Adams and other reformers in order to divert young offenders from the destructive punishment of criminal courts and to encourage rehabilitation based on individual needs. This effort recognizes that children are different from adults in terms of cognitive development, impulse control, emotional control, and judgment capability (Binder, et al., 2001; Streib, 1999; Tuell, 2002).

### 2.2a History of Residential Facilities for Juvenile Delinquents

The notion of residential treatment for delinquent youth is a recent concept in the United States. Prior to the nineteenth century, there were no residential facilities for

troubled youth. Troubled youth and orphans were most frequently put into apprenticeships with tradesmen. The children were more like indentured servants who had to earn their keep (Binder, et al., 2001; Musick, 1995; Rosen, 1999; Siegel & Senna, 1994). Those youth who committed crimes received the same punishment as adult criminals. The 1800's brought the dawn of the industrial revolution and mass immigration into the United States. The American society now was faced with the many challenges of urbanization—namely poverty and juvenile crime. Private philanthropists began to establish almshouses for the poor and orphanages for widows and orphans (Musick, 1995; Rosen, 1999).

In addition to efforts by wealthy citizens to care for the poor, public charitable organizations established juvenile reformatories to take care of the growing number of wayward and homeless children that could be found roaming the streets of large cities (Musick, 1995; Rosen, 1999). Such early residential programs were called "houses of refuge" (Binder, et al., 2001; Hess & Clement, 1993; Lou, 1927; Rosen, 1999; Sigel & Senna, 1994; Streib, 1978). The first house of refuge was established in New York City in 1825. The New York House of Refuge was created by the Society for Reformation of Juvenile Delinquents (the society) whose members did not believe that prison was good for children (Downs et al., 2004; Rosen, 1999). The goal of the New York House of Refuge was to provide an environment that would ensure the positive development of youth by focusing on their basic needs and instilling the youth with the value of work, education, and moral development. In other words, the primary objective was to reform poor, delinquent youth and to turn them into productive members of their community (Downs, et al., 2004; Rosen, 1999).

Houses of refuge were widely used at the beginning of the nineteenth century for the placement of delinquent children. The available literature on residential placement at the dawn of the nineteenth century shows that the houses of refuge in New York, Philadelphia and Boston provided an important model for responding to juvenile delinquency in other parts of the United States (Binder, et al., 2001; Downs et al., 2004; Musick, 1995; Rosen, 1999; Siegel & Senna, 1994).

The house of refuge model was not without flaws. By the middle of the century, some major problems of the model became apparent. Critics argue that the houses of refuge failed to rehabilitate youth and were much more prisons than places of refuge (Binder, et al., 2001). Binder and his colleagues (2001), submit that, in the Boston House, the proportion of juveniles adjudicated for committing crimes was growing higher than those considered incorrigible or otherwise at-risk. Furthermore, within a few years of opening, the New York House became distinctly prison-like, surrounded by high stone walls and included buildings with individual jail cell-like rooms. In addition to cell-like rooms, the refuge model housed its children in dormitories, employing what was called a "congregated system." According to Binder and colleagues (2001), ". . . the prison-like refuge houses and reformatories, contrary to intent, were perpetuating the same problems they had intended to solve by mixing corruptible with already corrupt" (p.202). The failure to meet the ideal intent of rehabilitating children led to other reformers seeking alternatives to the houses of refuge model.

One such alternative, the cottage system, also known as the "family system," was developed in the 1850's. The cottage system was first introduced in 1854 at the

Massachusetts Industrial School for Girls. The Ohio Reform School followed in 1857. The cottage system sought to depart from the prison-like and congregated systems that were prevalent in the older institutions (Bartollas & Miller, 2001; Binder, et al., 2001). Rather than housing delinquents in dormitory facilities, this new model brought youth together in groups of one to three dozen inmates having similar characteristics in small houses under the supervision of a surrogate father or mother. The "family" created was intended to work, live and attend school together, rarely mixing with the members of other "families." Binder and his colleagues report that the proponents of the cottage system believed that it would provide opportunities for closer supervision of housed youth and opportunities for higher quality individual attention as opposed to the impersonal congregated system. Proponents further argued that the cottage system would closely approximate the kind of family atmosphere and the guidance that delinquents needed most. Cottage system proponents stressed that ". . . in the true language of *parens patriae*, the cottage system enables the state to come as near, the idea of a well-regulated, honest family as possible, under the circumstances" (Binder, et al., 2001, p.203).

The principle of *parens patriae* can be traced to earlier legal and social constructions on children and youth (Binder, et al., 2001; Siegel & Senna, 1994). The doctrine dictates the state has sovereignty over everything within its jurisdiction, and must act as the parent of any child or the authority over any individual who is in need of protection or a child whose parents are unable or unwilling to take care of him or her (Binder, et al., 2001; Downs, et al., 2004; Roberts, 1989; Wikimedia Foundation, 2001, 2002). The term has its origin in England's Chancery Courts of the 16$^{th}$ century

(Bartollas & Miller, 2001; Binder et al., 2001; Faust & Brantingham, 1974; Roberts, 1989; Siegel & Senna, 1994). The original doctrine had more to do with property law than it did a concern for children. Many studies indicate that the law was essentially a means for the Crown to administer orphans who had inherited land. *Parens patriae* established that the king, in his presumed role as the father of England, had the legal authority to take care of his people, especially those who were unable to do so for various reasons including age (Binder, et al., 2001; Downs, et al., 2004; Roberts, 1998; Wikimedia Foundation, 2001, 2002). By the nineteenth century, the legal doctrine evolved into the practice of the state assuming guardianship over minor children and, in effect, playing the role of parent if the child had either no parents or if the existing parents were declared unfit (Downs, et al., 2004).

In spite of advocacy based upon the *parens patriae* doctrine, the cottage model and home-like atmosphere that dominated American juvenile institutions during the nineteenth century was not without its flaws. Research suggests that the children became hardened while those responsible for their care tended to stress the punitive, custodial character of the institution over redemptive purposes (Binder et al., 2001). In other words, the cottage system, designed as an institutional alternative to the older house of refuge models, did not manifest in the direction that was envisioned by its proponents.

In the wake of the cottage model, Charles Loring Brace founded the New York Children's Aid Society in 1853, challenging the institutionalization of children in reform schools. Brace believed that the nature of a child's family had much to do with the child's fate and that poor urban parents were largely unfit to raise their children. He

promoted a system that evolved into what is known today as foster care homes. Children from the inner cities were relocated and placed with families in the Midwest (Binder, et al., 2001; Downs, et al., 2004; Rosen, 1999). About that same time Jane Adams, Julia Lathrop, and Lucy Flower were undertaking a movement in Chicago to establish settlement houses to address the impact of increasing urbanization and poverty on children and families. This inspired the Chicago Women's Club to seek improvement in the conditions for institutionalized juveniles. Their efforts resulted in the establishment of the first juvenile court (Downs, et al., 2004).

**2.2b Residential Facilities Today**

Unlike the 1800's when juvenile residential facilities were operated by religious, philanthropic organizations and wealthy individuals, today's facilities are administered by a wide variety of local, state, federal, and private agencies (Armstrong, 2001; Musick, 1995). Adjudicated juveniles may be held in various types of facilities such as training schools, detention centers, reception/diagnostic centers, shelters, boot camps and half-way houses (Musick, 1995). Additionally, delinquent children are separated into minimum, medium and maximum security housing groups (Family Independence Agency, 1997; Musick, 1995). These facilities differ considerably and their programs range from specialized sex offender treatment to mental health services and include many elements such as balanced and restorative justice (Family Independence Agency, 2004; Siegel & Senna, 1994). The physical structures also vary across the nation from outdated buildings to state of the art buildings equipped with amenities such as monitoring devices, cameras, etc. Most facilities also have indoor/outdoor leisure areas, libraries, academic/vocational education spaces, chapel areas, visiting areas,

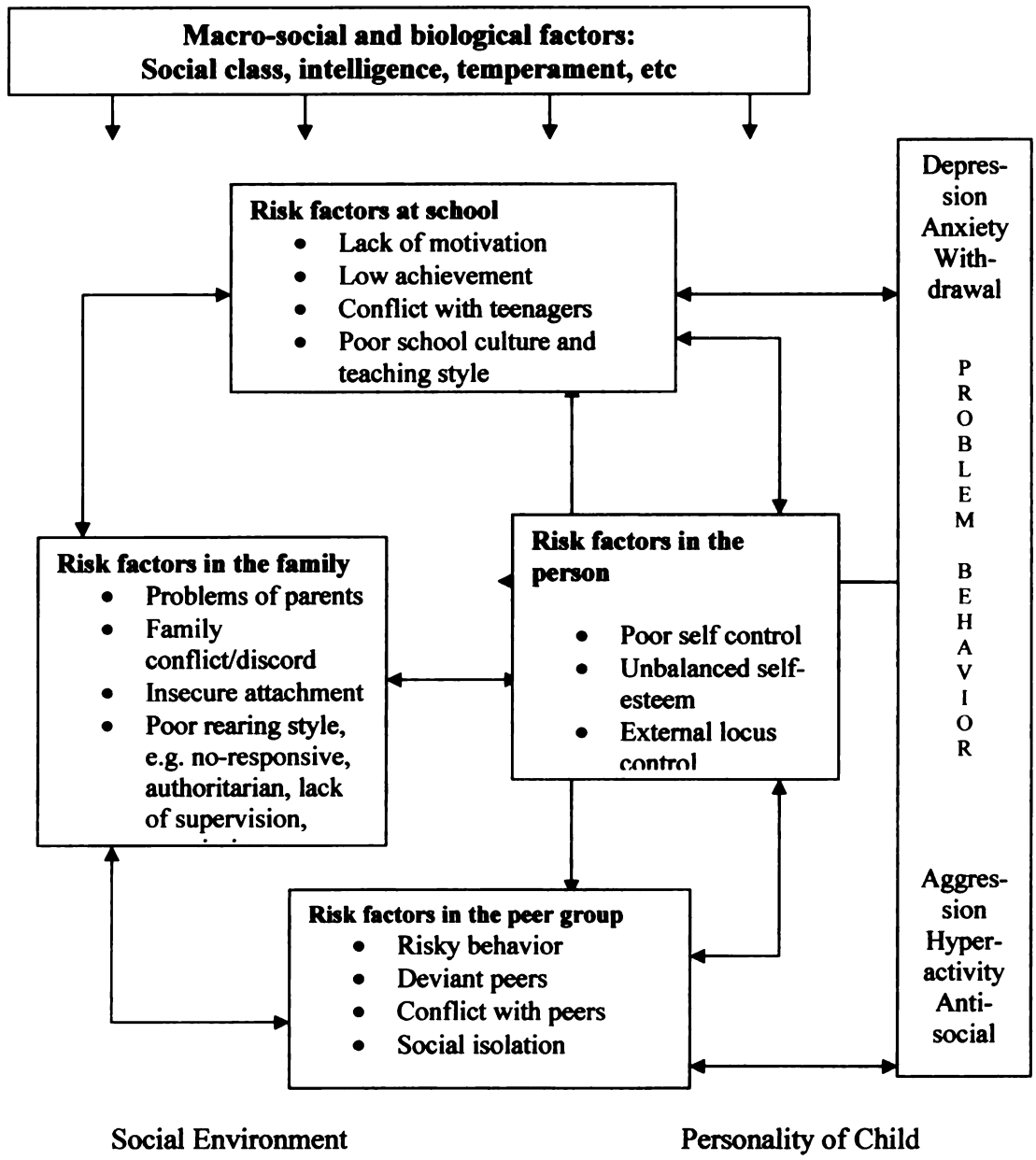
reception and processing rooms, security fixtures and fire safety equipment (Family Independence Agency, 1997, 2003, 2004; Musick, 1995; Siegel & Senna, 1994).

### 2.3 Juvenile Justice Population

Why children come in conflict with the legal system may be due to certain primary risk factors. These risk factors may be both personality traits of child as well as rearing and socialization conditions of the environment (Rosen, 1999; Scholte & van der Ploeg, 2000). According to the National Center on Addiction and Substance Abuse (NCASA, 2004), up to 80%of youths in juvenile justice residential facilities suffer from learning disabilities and need special education classes, a number which is at least three to five times the rate of that in the public school population. Furthermore, up to 75%of all such youth have a diagnosable mental health disorder, as compared to 20% of all 9-17 year olds (NCASA, 2004). Moreover, these juveniles often have numerous encounters with law enforcement officers well before an actual arrest occurs (Rosen, 1999). NCASA (2004) states emphatically that by the time children and teens are arrested, all other systems—family, community, school and government—have failed them. Though there is substantial disagreement in the literature on the empirical significance of broken homes, children and teens caught in the juvenile justice system are more likely than other youth to be from at-risk and/or troubled families and often were abused and/or neglected (Rankin & Wells, 1996; Rosen, 1999; Stouthamer-Loeber, et al., 2002). Additionally, these youths are more likely to have lived in poor, crime- and drug-infested neighborhoods and to have dropped out of school (Bartollas, 2000; Rosen, 1999).

Figure 1, adopted from Scholte & van der Ploeg (2000), summarizes a model of primary risk factors that can threaten healthy development and possibly influence delinquent behavior. These risk factors stem from the child's primary care environment. Severe parental conflict, poor parent-child communication, insecure parent-child attachment, inadequate supervision, and non-responsive, non-democratic and permissive childrearing are factors of utmost concern. Also of concern are factors related to school, including poor academic motivation or performance, conflictual relations with teachers, etc. Additionally, some school-related factors caused by negative peer group association, are shown in Figure 1. Personality traits that may contribute to delinquent behavior may be due to insufficiently developed cognitive skills and ineffective coping behaviors. As this model illustrates, the ecological environment extends beyond the immediate situation affecting the delinquent child and includes other persons present in the setting and their influence on the individual.

Figure 1: Psychosocial Risk Factor Model




Adopted from Scholte & van der Ploeg, (2000) "Exploring Factors Governing Successful Residential Treatment of Youngsters with Serious Behavioral Problems" Thousand Oak, CA: Sage Publications

## 2.4 Types of Juvenile Offenses

Juveniles are considered to be delinquent if they commit an act that, if committed by an adult, would be a crime. This includes homicide, assault, rape, robbery, burglary, larceny, auto theft, arson, and drug-related crimes (Roberts, 1989; Siegel & Senna, 1994). Status offenders are youth who engage in behaviors that are illegal based solely upon their age and, if committed by an adult, would not be considered criminal (Roberts, 1989; Siegel & Senna, 1994). The most common status offenses are running away from home, failure to attend school (truancy), refusing to obey parents (incorrigibility), drinking alcoholic beverages, using tobacco products, violating curfew, and engaging in consensual sexual activities (Roberts, 1989; Siegel & Senna, 1994). Rather than intervening only when juveniles commit crimes, the state believes that it is necessary to intervene when juveniles give any indication that they are heading down the "wrong path," a path that might lead to crime (Siegel & Senna, 1994). Status offense laws are directly tied to the view that juveniles are immature and in need of guidance or direction (Siegel & Senna, 1994).

During the late 1960's and early 1970's, juveniles who committed status offenses were frequently arrested and referred to juvenile court (Bartollas & Miller, 2001; Roberts, 1989; Siegel & Senna, 1994). They were formally processed and adjudicated as delinquents by the court. Status offense laws came under heavy criticism during this same period. According to critics, the status offense laws often subjected juveniles who had not committed any criminal acts to severe penalties, such as confinement in institutions (Siegel & Senna, 1994; Tuell, 2002). In response to indiscriminate confinement of young offenders, the federal government passed the Juvenile Justice

and Delinquency Prevention Act (JJDPA) in 1974 to discourage states from placing status offenders in institutions and mandating that adjudicated juveniles have a legal right to treatment. The JJDPA of 1974 is considered to be landmark legislation because it marks the first time the federal government enacted a law that provides a comprehensive approach to the problems of juvenile justice and delinquency prevention (Siegel & Senna, 1994).

The right to treatment clause of the JJPDA of 1974 requires that states provide suitable rehabilitation programs for children. Counseling, education, and vocational services are required under the scope of this requirement. These types of services resonate back to the original philosophy of the nineteenth century reformers of juvenile justice, most of whom emphasized rehabilitation and not punishment.

The original philosophy of rehabilitating the delinquent child was not without flaws. The philosophy was sometimes carried out through oppressive practices which were well-illustrated in the 1870 case of Daniel O'Connell in People v. Turner in Chicago. Daniel was incarcerated in the Chicago House of Refuge, not because of a criminal offense but because he was thought to be in danger of growing up to become a pauper. His parents filed a writ of *habeas corpus* with the court, charging that Daniel's incarceration was illegal. The Illinois Supreme Court concluded that Daniel was being punished and was not being helped by the institution. It is clear from the Court's decision that it rejected the *parens patriae* doctrine and favored due process in this case (Tuell, 2002). It could be speculated that this case encouraged and set in motion the wheels of due process for juveniles, mandating procedural guarantees for juveniles who come into contact with the law.

## 2.5 Processing Juvenile offenders

As indicated earlier in this chapter, the police form part of the system that deals with juveniles who come into contact with the law. Consequently, the first stage in a long process is usually police arrest. In the juvenile justice system, for all criminal procedures, the police are empowered to make arrests, whether serious or not (Faust & Brantingham, 1974; Siegel & Senna, 1994; Sutton, 1988; Vito & Simonsen, 2004). Lesser offenses may also require police action but, instead of being arrested, the child may be warned and the parents may be called to take custody of their child or a referral may be made to juvenile social service providers (Miller, Dawson, Dix & Parnas, 1976). The release of juveniles with less serious offenses or status offenses is dictated by the JJDPA of 1974. The recently amended version of the Act contains a provision for detaining children in cases of criminal (violent) offenses. When a police officer takes a child into custody, the child may be brought to the station house for lockup (JJDPA, 2001). The detained child is taken to a local detention facility or intake program while awaiting his/her court appearance. When the child appears before a juvenile court judge, the judge may make a referral to social service agency (Siegel & Senna, 1994). In such serious crimes, the juvenile court prosecutor initiates a petition against the child and the trial process is initiated (Binder, et al., 2001; Packer, 1968; Siegel & Senna, 1994; Tuell, 2002; United States Office of Juvenile Justice and Delinquency Prevention, 2001). Following the petition, the court may decide to waive a case (transfer it to adult court) or to adjudicate the youth in the juvenile court. During the adjudication or trial phase of the case, the court may initiate a psychosocial study of the child's background and, subsequently, recommend an appropriate disposition

leading to a correctional and rehabilitation program (Siegel & Senna, 1994; Vito & Simonsen, 2004).

Prior to adjudication, juveniles are subject to an investigation similar to adult criminals. The investigatory process is discretionary and is based on the nature of the crime and conditions prior to the arrest. Factors include the type and seriousness of the offense, the child's past contacts with the police, and whether or not the child denies committing the crime (Shelden & Hussong, 2003). Juveniles taken into custody by police have basic constitutional rights similar to adult offenders. They are protected against unreasonable search and seizure under the Fourth and Fourteenth Amendments. Constitutional limitations are also placed on police interrogation procedures under the Fifth Amendment of the Constitution (Faust & Brantingham, 1974; Shelden & Hussong, 2003; and Siegel & Senna, 1994). These procedural protections are the outcomes of legal fights mounted against the juvenile courts for past practices of depriving children of their constitutional rights under the legal conditions of the *parens patriae* doctrine (Siegel & Senna, 1994); Vito & Simonsen, 2004).

As indicated in the previous paragraph, if the child does not admit to the charges at the initial hearing and is not transferred to adult court, an adjudication hearing is held to determine the facts of the case. The court then hears evidence of the allegations in the delinquency petition. This hearing on the merits of the charges and evidentiary standards is the same as in adult criminal proceedings (Miller, et al., 1976). At this stage of the proceeding, the juvenile offender is entitled to procedural guarantees given to adult offenders. These rights include the right to representation by counsel, freedom from self-incrimination, the right to confront and cross-examine witnesses and, in

serious offenses such as murder, rape, etc., the right to a jury trial (Faust & Brantingham, 1974; Miller, et al., 1976; and Shelden & Hussong, 2003).

If the child is adjudicated delinquent, the court must decide what should be done to treat him/her. This is the disposition stage of the court's involvement. Dispositional hearings are less formal than adjudication hearings. The judge imposes a disposition on the juvenile offender, taking into account the serious of the offense, prior delinquency record, and family background (American Bar Association and Institute of Judicial Administration, 1980; Ashby & United States General Accounting Office, 2003; Bartollas & Miller, 2001). The judge has broad discretion and can prescribe a disposition ranging from a simple warning or reprimand to community service or probation to more intense social control measures, such as institutional commitment, including group home, foster care, or secure facility care. The judge's decision is rendered to serve in the best interest of the child, the family and the community (American Bar Association and Institute of Judicial Administration, 1980; Ashby & United States General Accounting Office, 2003; Bartollas & Miller, 2001). Disposition is one of the most important stages of the juvenile court process and is primarily concerned with treating the child while controlling antisocial behavior. Although social workers typically get involved during the post-disposition stage – the stage of rehabilitation – they often are involved beforehand during psychosocial background investigation and needs assessment.

## 2.6 Adult Criminal Justice System versus Juvenile Justice System

One may begin to wonder if there is any difference between the adult criminal justice and the juvenile justice systems as many of the components of adult and juvenile criminal processes are similar. Both include forms of police investigation, arrest, administrative booking, preliminary hearings, bails, plea bargaining, admission of plea, grand jury indictment, formal arraignment, trial, verdict, sentence, and appeal (Siegel & Senna, 1994). However, the juvenile justice system has a separate, complementary organizational structure. Juvenile justice is administered by people who bring special skills to the task. The juvenile justice professionals deliver treatment and attempt to rehabilitate young offenders. The similarities are a result of criticism of the juvenile court proceedings which were reversed by higher courts as violation of children's rights. Despite all the changes, the juvenile justice system, in theory and practice, remains to a large extent, not only to prevent juvenile crime and to rehabilitate juvenile offenders but also to provide for abused and neglected children (Downs, et al., 2004; Howell, Kelly, Palmer, Mangum, 2004; Lundman, 2001). In essence, the juvenile justice system provides services to promote the normal growth and development of all adjudicated young offenders including abused and neglected children.

## 2.7 The Swing of the Pendulum Between Rehabilitation and Retribution

Society's continuous struggle and quest to deal with juvenile offenders is hinged on societal values. As research indicates, it is without a doubt that societal values have recently changed, giving rise, to the swing of the pendulum from rehabilitating and

treating the child to holding the child accountable for her/his action (Mooradian, 2003; Siegel & Senna, 1994; Tuell, 2002). Barry Feld (1990), one of the leading scholars of juvenile justice court, believes that the juvenile justice system has taken on more of the characteristics of adult courts. He refers to these characteristics as the "criminalizing" of the juvenile court.

During the 33 years since the enactment of JJPDA (1974), the juvenile justice system has become increasingly more consistent with adult procedures, evolving away from its original paternalistic procedures that were less concerned with constitutionality. For example, the rights of due process – such as representation by counsel, jury trial, freedom from self-incrimination, and freedom from unreasonable search and seizure – were not previously considered in juvenile court because the primary purpose of the system was not punishment but rehabilitation (Siegel & Senna, 1994). Robert Dawson (1990) suggests that since the two systems are becoming more alike, it may be time to abolish the juvenile court and merge it into one large criminal justice system. While there is no evidence in the literature that states have abolished the juvenile courts, there is also no evidence that they retain the inviolable, legal distinction between the status of "juvenile" and "adult." Instead, the age threshold for trial in adult court seems to fall every time a new incident of juvenile violence captures the nation's attention (Butts & Harvell, 1998).

Since the 1980's, legislators have turned away from the traditional offender-centered treatment and rehabilitation-oriented philosophy that dominated the field in the better part of the twentieth century. Their focus is now on emphasizing law and order, protecting the public and individual accountability. Trojanowicz and colleagues

(2001) identified five areas of recent change in states' statutes that reflect the pendulous swing toward punitive juvenile justice:

- Transfer provision—Laws make it easier to transfer juvenile offenders from the juvenile to the criminal justice system (45 states).
- Sentencing authority—Laws give criminal and juvenile courts expanded sentencing options (31 states).
- Confidentiality—Laws modify or remove traditional juvenile court confidentiality provisions by making records and proceedings more open (47 states).
- Victims' rights—Laws increase the role of victims of juvenile crime in juvenile process (22 states).
- Correctional programming—As a result of new transfer and sentencing laws, adult and juvenile correctional administrators have developed new programs (Trojanowicz and colleagues, 2001, p.212).

The reform of holding children accountable is a turning point in the history of the juvenile justice system. The new direction of policy-makers since the 1980's is one where juveniles must take responsibility for their actions. This responsibility is accompanied by punishments typically reserved for adults (Shelden and Hussong, 2003). This paradigm shift echoes back to the punishment that occurred before the end of the nineteenth century when the child savers' movement sought to soften the response to juvenile crime, ushering in the era of rehabilitation (Henggler & Schoenwald, 1998).

Michigan is one of the states that has seen changes in its juvenile justice system. Public Act 374 of 1996 shifted responsibility for adjudicating juvenile cases from probate to family court (a division of circuit court) (Michigan in Brief, 1998, Retrieved December 30, 2006 from the World Wide Web:

http://www.michiganinbrief.org/edition06, 2006). The reform legislation, a package of nine bills, changed the manner in which juveniles charged with crimes are dealt with by the courts and criminal justice system in Michigan. Some of the changes include lowering the age at which a juvenile may be tried as an adult for certain crimes from 15 to 14. The changes expand the list of crimes for which a waiver to adult court is permissible and children of any age involved in those crimes are to be tried in family court as an adult with a 12-person jury. Among the list of crimes are arson to a dwelling, assault with intent to murder or inflict bodily harm, attempted murder, first degree murder, second degree murder, rape, criminal sexual conduct, etc., (Michigan in Brief, 1998. Retrieved December 30, 2006 from the World Wide Web: http://www.michiganinbrief.org/edtion06, 2006).

The 1996 reform also makes it possible for juveniles convicted of an adult crime to be sentenced as an adult and sent to an adult prison unless the judge finds a preponderance of evidence that it is in the best interest of society to assign probation or refer to a juvenile facility. The changes also require parental involvement in the court proceedings and the treatment of the young offender. Above all, the burden of proof, prior to release, is placed on the juvenile to prove that s/he is no longer a threat to society. The policies were well illustrated in 1999, when Michigan's Nathaniel Abraham was charged with second degree murder at the age of eleven, and he became the youngest child in American history to be prosecuted as an adult (Tuell, 2002). The youth's defense attorney maintained that, at the time of the shooting, the child's intellectual ability was at the level of a six-year old and his language skills were that of an eight-year old and yet he was still found guilty of second degree murder. Nathaniel

was convicted and sentenced to a high security juvenile justice residential facility until the age of 21 (Shelden & Hussong, 2003; Tuell, 2002).

Toughening policies for juvenile offenders are viewed as a deterrent for out of control juveniles and a means of protecting society. But research indicates that incarcerating children in correctional facilities can be detrimental (Shelden & Hussong, 2003; Tuell, 2002). A large body of research indicates that children who have been prosecuted and punished as adults are more likely to re-offend, as compared to those dealt with in the juvenile justice system (Shelden & Hussong, 2003; Streib, 1999; Thorton & Voigt, 1992; Weijers & Duff, 2002). The change in society's values and the increasing reliance upon harsher penalties for juveniles constitute a challenge to the social construction of consideration of children and adolescents as a unique group and the notion that children are less criminally responsible than adults. Critics of retributive justice argue that society views criminal justice through "retributive lens" and that this process fails to meet the needs of either the victim or the offender (Zehr, 1990). Despite this pendulous swing from rehabilitation to punishment, there is a recent paradigm shift to restorative justice principles which prescribes making amends for the harm done to victims and the community. The principles also encourage holding the young offenders accountable for their criminal behavior and to teaching better skills to the offender (Trojanowicz, Morash, & Schram, 2001; Walgrave, 2002).

### 2.8 Restorative Justice and Impact on Practice

Restorative justice is a new paradigm arising from the failure of retribution-based justice (Cavanaugh, 1998; Mooradian, 2003; Zedner, 2002; Zehr, 1990). Trojanowicz

and colleagues (2001) pointed out that restorative justice provides an entirely different theoretical framework for responding to crime. According to these authors, the approach of restorative justice is fundamentally different from the retributive focus of punishment-based approaches. Restorative justice focuses on what needs to be healed, repaid, and to be learned in the wake of the crimes committed (Bazemore & Umbreit, 2001; Bazemore, Zaslaw, & Reister, 2005; Cavanagh, 1998; Zehr, 1990). According to the prolific writers on restorative justice, Bazemore and Umbreit (2001), most divisionary reforms in practice flow out of the restorative justice movement. Restorative justice programs may take a variety of forms and often include victim-offender mediation, community reparation boards, family group conferencing, and circles of sentencing (Bazemore and Umbreit, 2001). Restorative justice shifts the focus of the interventions from solely the offender to the offense and its effects on the victim as well as the large community of family and friends who support both victim and offender (Bazemore & Umbreit, 2001; Bazemore, et al., 2005; Cavanaugh, 1998; Trojanowicz, et al., 2001; Zehr, 1990). The goals of restorative justice are to educate participants about the harms—especially the emotional harm and fracturing of relationships—caused by the offense, to repair the harms, to rebuild relationships and to strengthen systems of informal social control (Cavanaugh, 1998; Trojanowicz, et al., 2001; Zedner, 2002). Although research shows that the establishment of restorative justice programs in the United States has not kept pace with development in Western Europe, Australia, New Zealand, and Canada, substantial progress in the U.S has been made in some jurisdictions (Bazemore & Umbreit, 2001; Bazemore, et al., 2005).

Figure 2 is a summary of the restorative justice framework based on the Balanced Approach to juvenile justice. Assumptions of restorative justice differ from the assumptions based on retributive justice.

**Figure 2: The Balanced and Restorative Justice Approach**

| | | |
|---|---|---|
| Victims | Accountability | When an offense occurs, an obligation to victims and community incurs; |
| Youth | Youth Competency development | Offenders who enter the juvenile justice system should exit more capable than when entered; |
| Community | Community Protection | Juvenile justice has a responsibility to protect the public from juveniles in the system. |

Source: Gordon Bazemore and Mark Umbreit, *Balanced and Restorative Justice for Juvenile: Framework for Juvenile Justice in the 21st Century* (Washington, D.C: Office of Juvenile Justice and Delinquency Prevention, August, 1997) p. 14, cited in Trojanowicz, et al. (2001) p.393

The impact of restorative justice in practice is well illustrated by its processes that involve offenders, their families, victims, and other interested members of the community. For example, the prospect for achieving treatment objectives associated with cognitive therapy can be linked to restorative justice. One of the goals of conferencing is to encourage empathy for the victims by helping young offenders to put themselves in the role of the victims. Also, conferencing provides a way to restore equilibrium in damaged relationships (Bazemore & Umbreit, 2001; Bazemore, et al., 2005; Cavanagh, 1998; Trojanowicz, et al., 2001; Zedner, 2002; and Zehr, 1990). In the long term, the impact of restorative justice on practice lies in the vision and reality of the empowerment and involvement of the three relevant entities discussed herein. The impacts also include the possibility of developing pro-social, informal social

control, and support based upon the involvement of these three entities (Bazemore & Umbreit, 2001; Bazemore, et al., 2005; Cavanagh, 1998; Trojanowicz, et al., 2001; Zedner, 2002; Zehr, 1990). The restorative justice approach emphasizes involvement of family treatment with the delinquent youth. In other words, the practice of restorative justice cannot be accomplished when professionals choose to deal only with the child-offender and exclude the family.

### 2.9 Child-Centered Not Family-Centered Treatment

Since its inception at the turn of the nineteenth century, the juvenile justice system has had the unique challenge of balancing the interests of the child with those of the family as a primary source of socialization and as the goal of public safety. This struggle is evidenced in the constant oscillation between rehabilitation and punishment, as discussed earlier in this chapter. Although balancing the interests of the child and family with public safety is a challenge, the distrust of families to actively be involved with troubled children has been part and parcel of some prominent schools of thought in resident treatment. Whittaker (1979) describes three schools of thought that dominated the field of residential treatment during the mid-twentieth century. The three schools of thought are: psychodynamic, behavioral modification and peer group approaches, none of which are family-centered.

Psychodynamic Approach: Psychodynamic treatment programs were commonly found in the U.S. midwest, northwest and the far western states (Mayer, 1960; Whittaker, 1979). Psychoanalytically-oriented residential treatment in the U.S. was pioneered by Bettelheim at the Sonia Shankman Orthogenic School where the premise was a child must be removed from his/her pathogenic family in order to be helped

(Bettelheim, 1974). Studies indicate that this early psychodynamic approach expected parents to surrender their parental rights and hand over control in making decisions regarding their child's treatment and religious practices and, in extreme cases, forbid communication between the family and the child (Mayer, 1960; Whittaker, 1979).

Behavioral Modification Approach: The behavioral modification model was adopted beginning in the 1960's and continued through the 1970's. This approach was pioneered by a group of social workers and psychologists from the University of Washington and educators at the University of Washington's preschool (Whittaker, 1979). Behavior modification is based upon the theory that all behavior is learned and that present behavior can be shaped through a system of rewards and punishments (Siegel & Senna, 1994). According to Zimmerman (1990), behaviorally-oriented residential treatment usually involves four phases: 1) identification of behavioral difficulty, 2) clarification of the reinforcement patterns, 3) specification of behavioral goals, and 4) application of behavioral techniques. Siegel and Senna (1994) asserted that the behavior modification approach is an effective model only in institutional settings. In other words, the problems of children are from faulty family patterns and, as such, children can be expected to recidivate when they return home as a result of negative modeling by family members.

Peer Group Approach: This approach relies upon a youth group to facilitate the expression of feelings, to solve problems, and to teach members to empathize with one another (Siegel and Senna, 1994; Whittaker, 1979). Guided Group Interaction (GGI) is based on the theory that through group interactions, a delinquent can begin to realize and solve personal problems. Positive Peer Culture (PPC), on the other hand, uses peer

leaders to get other group members to conform to acceptable societal behaviors. The PPC model emphasizes the power of the group to orchestrate change through positive modeling and group confrontation of negative behavior (Zimmerman, 1990). Using group members to confront negative behavior and model positive behavior does not provide room for family involvement.

The theoretical orientations of the three treatment models presented briefly here do not lend themselves to family involvement and most likely will lead to staff considering parents as part of the problem rather than part of the solution. The focus is on the child rather than the entire family even though the possibility of the child returning to his/her family is higher than those in the adult prison population.

### 2.10 Importance of Family Involvement

Until recently, the focus has been to treat the delinquent child without the family being involved; however, the paradigm shift to family-centered practice suggests that the family, staff and child are all crucial to the success of rehabilitation (Jenson & Whittaker, 1989a, 1989b). These authors identified three factors that have encouraged interest in the importance of family involvement in residential treatment. They are: 1) empirical evidence linking regular visits with shorter lengths of stay and family involvement with maintenance of positive changes after discharge, 2) changing professional perspectives which emphasize the importance of family, and 3) changes in legislation and public policy.

The ecological perspective provides residential treatment programs the unique opportunity to assess the role of environment while considering other theories such as control, attachment, and stress-theories. This perspective may contribute to

understanding the child's delinquent behaviors and coping skills within his/her environment (van der Ploeg & Smit, 1992). Whittaker (1981) argues that the study by Wells and her colleagues provides empirical evidence of the importance of family involvement and post-discharge adaptation by the youth. In other words, children who have little family involvement do not fare as well after they have graduated from the program as those whose family was involved. Therefore, in order to rehabilitate the delinquent child, the residential treatment program must support family involvement. The support will enable staff to assess the potential stressors and the stability of the environment the youth will return to after discharge (Whittaker, 1981).

The importance of family involvement can be assessed through control theories as well. Control theories of delinquency cover a wide range of topics that focus on strategies and techniques which regulate human behavior (Shoemaker, 2000; Welch, 1998). Control theories have a long history, dating back to the 1950's and 1960's. Interest began with Albert Reiss' noted article which examines a number of factors relating control perspectives to prediction of probation revocation among juveniles, and with F. Ivan Nye's study that focuses on family and social control of adolescents (Vold, Bernard, & Snipes, 1998; Welch, 1998). Most important to this study are Travis Hirschi's social bound theory, and Walter Reckless' containment theory of self-concept (Vold, et al., 1998; Welch, 1998). Welch (1998) states that Hirschi and Gottfredson pinpointed the role of parents as the most essential source of socialization. Additionally, Hirschi and Gottfredson (2003) have written supplemental material regarding the dynamics of the family's important role in reducing delinquency. Thus, according to Hirschi and Gottfredson (2003) the basic model of parenting from the

control theory perspective is easily described as "Proper socialization of children requires that adults monitor their behavior and correct misbehavior when it occurs" (p. 150). They have outlined four elements in their model of control and childbearing: 1) parents' interest in the outcome of their children in the form of affection, 2) attachment of children to caregiver, 3) parental supervision; and 4) discipline.

1. Interest in the Outcome

   The parent, caretaker, or guardian must care enough about the child's behavior to devote the immense amounts of time and energy that monitoring and discipline require. Interested guardians do not allow serious accidents, whatever their teaching potential, and they tend to protect their child from the more severe penalties of the legal system; however, in some sense penalties might be deserved.

2. Attachment to Caregiver

   This theory assumes that attachment to the caregiver is a requisite to successful socialization. The caregiver must be interested in the child and the child must have affection or respect for the caregiver. A major source of attachment is assumed to be a result of the attention, time and effort devoted to the child by the caregiver.

3. Supervision

   The concept of supervision in parenting takes on a broader meaning when extending beyond misbehavior to concern for the child's happiness, safety, and well-being. For control theory, abuse is the principal cause of punishment and especially excessive punishment and is the primary source of violence by the parent for misbehavior by the child. The theoretical centrality of neglect (supervision) is supported by research, where it is routinely found to be a major predictor of delinquency. It also supported by actions of the juvenile justice system, where children who are neglected by their parents or guardians make up a substantial part of the case loads.

4. Discipline

   Research in literature reports that care of children is an important predictor of delinquency, where care implies supervision and discipline as well as affection. And the quality of supervision is typically gauged as much by the imposition of rules or discipline as by parental awareness of the child's whereabouts or behavior. Thus, expectations and use of techniques of discipline are routinely found to be positively correlated with delinquency (p.150).

Other research suggests that Nye's study in 1958 showed that the family was the most important source of social control and formed the basis of understanding and helping the troubled youth (Shoemaker, 2000; Vold, et al., 1998). Shoemaker (2000) states that Nye found delinquents were most likely to come from homes where there was freedom or no freedom at all. Consequently, family involvement, though not the only factor, is an important determining factor of delinquent behavior because it is a suitable device for explaining both personal and social forms of control (Shoemaker, 2000; Vold, et al., 1998).

### 2.11 Family Involvement and Delinquency

Family has received increasing attention in research as both a risk and a protective factor for the adjustment of adolescents (Unger, McLeod, Brown, & Tressell, 2000). However, according to Unger and colleagues, what has been studied is only the functioning of the dyad in relation to adolescent development. Despite the dearth of research regarding child outcomes in juvenile residential programs, there is an abundance of literature in the education arena that suggests that a the youth's perception of family cohesion and the quality of the parent-school relationship are important components that may mediate the effects of interpersonal conflicts on academic adjustment of the youth (Wierson & Forehand, 1992). In other words, a supportive family environment and positive parenting behaviors are positively related to academic achievement. In their national Center for Mental Health and Juvenile Justice (NCMHJJ) research brief on involving families in juvenile justice, Osher and Hunt (2002) state ". . . the successful rehabilitation of youth in the system, and their sustained reintegration into the community rely upon the support of juvenile justice systems and families in the accomplishment of their goals" (p.4). Similarly, other

family-focused interventions have shown positive impacts on child and family functioning, delinquent behavior, and recidivism (Harvell, et al., 2004). Many studies confirm that establishing or preserving positive family ties while youth are incarcerated correlates with successful transition back into the community (Harvell, et al., 2004; Henggler & Schoenwald, 1998; Herbert & Harper-Dorton, 2002; Juang & Silbereisen, 1999; Osher and Hunt, 2002).

The family participation accrues benefits to the youth, the family, the juvenile justice system and the community (Osher & Hunt, 2002). From the perspective of the youth, supportive family involvement can reduce anxiety and reinforces treatment. It also provides the youth with advocates who can help articulate their needs and desires. From the family's perspective, evidence indicates an ability to participate may reduce the family's anxiety by knowing where their child is and by allowing them to retain some form of influence over the treatment of their child (Osher & Hunt, 2002).

Above all, families know their child best and can provide information that is critical to keeping the child stable and safe. Families can provide background on:

- The child's diagnosis and treatment history, including the use of medications.
- The strengths and needs of their child.
- The family's capacity to participate in treatment.
- Circumstances that affect the child's well-being.
- Their child's patterns in responding to people and events in their surroundings.
- Their child's educational history and status, including any Individualized Educational Plans for special education services.
- Transition and on-going support services essential for successful and permanent re-entry into the community (Osher & Hunt, 2002, pp.1-2).

Families have a wealth of information about the strengths and needs of their children and should be involved in the development of treatment plans, individualized education plans and aftercare plans for their children (Cunningham, Henggler, Brondino, Pickrel,1999). Cunningham and colleagues (1999) followed this up with ". . .families and surrogate families of emotionally disturbed children should have full participation in planning and delivery of services." (p.21). A policy statement by the Federation of Families for Children's Mental Health (a leading national family advocacy organization involved in reform efforts) notes that families should be empowered to make decisions about their own issues (Cunningham, et al., 1999).

Family support interventions have been promoted as a viable means of addressing a broad range of issues facing at-risk children and families. Family support has been used as a way of strengthening parental involvement in their child's academic life as a means of preventing academic failure and problem behaviors including drug use (Curry, Fischer, Reifman & Harris, 2003). Others have found that delinquency can be reduced through child-parent attachment, household rules, and parental supervision (Wright & Cullen, 2001). These studies are consistent with Hirschi's (1969) social bond theory which stresses the importance of indirect or relational control. Wright and Cullen (2001) suggest that parents who support their children are also parents who control and are attached to their children. These authors do not hesitate to state that support and control are conceptually distinct but, in real-life parenting, they are often intertwined. In other words, both control and support require the investment of parental time and energy.

Despite the strategies and advantages discovered during the literature search on involving families in treatment, the search would not be complete without addressing some problems that staff and the agency may encounter during the process of family involvement. Some of these problems could be that of a seriously dysfunctional family – such as when a parent is incarcerated or psychiatrically hospitalized or has simply deserted the child (Baker et al., 1995).

Children and teens caught in the juvenile justice system are more likely than other youth to come from troubled families and to have been abused or/and neglected (Grant, 1998; Whipple & Richey, 1997; Whipple & Webster-Stratton, 1991; Wierson & Forehand, 1992). Consequently, proponents of the child-centered approach argue that asking parents to be involved in the treatment of the abused child is akin to reliving the abuse all over again (Siegel & Senna,1994; Whittaker, 1979). Parental psychopathology has been linked to increased rates of psychiatric disorders among school children. The psychopathology of such parents often reduces their ability to assume responsibility as heads of the family hence, it may be futile to invite them to be part of their children's experiences while in the residential facility (Hawkins, et al., 1998; Stouthamer-Loeber, et al., 2002). Thus, child-centered proponents argue emotional disturbance, drunkenness, criminality, physical ailments or mental deficiency may make it difficult for such parents to be a resource, let alone equal partners in the treatment and reintegration of the young offender into the community. Additionally, delinquents have been found to be victims of indifferent or hostile parents and, as a consequence, they are less attached to their parents. In the homes of the delinquents, the pattern of discipline is often erratic, ranging from extreme physical

and mental punishment to extreme laxity (Hirschi, 1969; Hirschi & Gottfredson, 2003; Whipple & Richey, 1997; Wierson & Forehand, 1992).

The observation of lack of parental responsibility is well articulated in literature where parents turn a blind eye and deaf ear to siblings' psychological abuse (Whipple & Finton, 1995). Acute stressors lead to minimal parental response to siblings' behavioral problems. This supports the assumption that parents who are dealing with their own psychological problems may be unable or reluctant to assume the responsible role as head of the household (Whipple & Finton, 1995; Whipple & Webster-Stratton, 1991). Under such circumstances, it will not be beneficial for the juvenile system to make them part of the healing process of the young person. In such situations, physical, sexual or emotional abuse is often minimized and the victim is blamed for things that are beyond his/her control, including parental retribution. Most juvenile offenders may have experienced one or all of the types of mental, physical, and neglect discussed by Whipple and Finton (1995). Whipple and Webster-Stratton's (1991) findings in their article entitled *"The Role of Parental Stress in Physically Abusive Families"* corroborate extensive findings in the child welfare literature that physical abuse is a contributing factor for future delinquent behavior (Garbarino & Kelly, 1986).

Given all the problems associated with parental behaviors and deficiencies, one may conclude that involving parents in their children's treatment while the children are held in juvenile justice residential facilities may not be worth the effort. However, from a practical perspective, focusing on the family as a unit and working on the family's strengths (instead of focusing on weaknesses) is more likely to pay off and

lead to a safer community and more successful reintegration than when parents are shut out of the lives of their child offenders.

McNown M. Johnson (1999) suggests that the role of family indicates that genetic transmission, parental stress, parenting style, the personality of child, parental attachment, bonding and other socio-economic factors may contribute to juvenile anti-social behavior and ultimate entry into the juvenile justice system. If this brief analysis demonstrates that the family is the most important factor in the behavioral outcome of their child, then it would be possible for one to take a strong position on making parental involvement a component of the treatment modality of children held in juvenile justice residential facilities. Research has shown that the many family-focused models that are based on attachment theory and ecological perspectives which work with the entire family instead of the child alone show positive results in reducing juvenile delinquent behavior (Johnson, 1999; Mendel, 2000). Among these models are Functional Family Therapy (FFT), Multi-systemic Therapy (MST), and the Wraparound Milwaukee (Mendel, 2000).

Proponents of family-based prevention and intervention models maintain the position that the advantages of parental involvement outweigh the disadvantages. According to Mendel (2000), FFT has been applied successfully in a variety of contexts treating a range of high-risk youth and their families. The FFT model allows for successful intervention with complex and multidimensional problems through clinical practice that is flexibly structured and culturally sensitive. The primary focus to uncover the family's strengths and weaknesses and subsequently build on the strengths to help rehabilitate the youth will not be fully addressed if parents are

excluded in the treatment. Within the FFT model, the family is the best source of constructing the social history of the young offender and, as such, it does not make sense to exclude the parents in the treatment process. FFT first demonstrated its impact in 1973, when a randomized trial found that only 26% of juvenile offenders who participated in it were re-arrested within 18 months, compared with 50% of a non-treatment control group (Mendel, 2000).

In addition, when parents are part of their children's treatment, juvenile justice caseworkers may become aware of the family's experience. Understanding their experience will enable the caseworker to effectively engage family members as partners in treatment that could result in an increased number of youth completing the treatment program and improved outcomes. Studies show that an empathetic understanding of the family experience is the first step towards building trust and opening channels for communication between families and service providers (Herbert & Harper-Dorton, 2002; Lyman & Campbell, 1996; Muisener, 1994; Shinke, Botvin, & Orlandi, 1997; and Unger, et al., 2000).

Another conceptual model of parental involvement in residential treatment is based on the Evanston Children's Center of Chicago's Children Aid Society (Stein, 1995). The goal of engagement is to form partnerships, alliances and working relationships within a treatment plan. According to Stein (1995), up to 30 children were served using this model in 1983. These children, just as other children in the juvenile justice system, had multiple problems and failed other programs. The model enabled social workers and program administrators to plan the future placement of the children based on family dynamics.

The assumption is that parental involvement may preserve the juvenile's relationship with parents and others with whom the youth has bonded. In turn, this may help the youth to complete the treatment program. It is important to note that unless parental rights are terminated, program staff members do not replace biological parents or whomever is significant in the child's life prior to coming in contact with the law. It is the job of the program staff to nurture family relationships and to provide help when the child is held within a residential facility (Stein, 1995; U.S. Department of Health & Human Services, 1983; and Walton, Sandau-Beckler, & Mannes, 2001).

# Chapter 3: Methodology

This chapter provides an overview of the research method utilized for this study, research procedures agency setting and programs, the study participants selected, and the sampling techniques employed. Included herein are the possible risk and benefits of the study to the various participants. The chapter also restates the hypotheses and focus group questions. The reliability tests and the adequacy of the quantitative instrument including data collection and data analysis procedures are described.

## 3.1 Overview of Research Method: Mixed-Methods

This exploratory study utilizes descriptive data analysis and includes both quantitative and qualitative methods. This mixed-method approach enables the capturing of information which may not have been possible with a single-method design. The quantitative approach was used to clarify the impact of (1) direct care staff beliefs about families; (2) the amount of staff training in family-centered practice; (3) the types and length of professional experience of staff members; and (4) the demographic characteristics of the employees of a medium-sized, rural juvenile residential facility in the Midwest. The qualitative component utilized both focus groups and individual interviews to elucidate the subjective experiences and interpretations of the direct care staff. The focus group interview process sought an understanding of how staff members attended to families and if the staff's opinions differed about family involvement from that of the administration, based on a review of the agency's official documents.

The quantitative and qualitative elements of this study increased the validity of the results, allowing a synthesis to be formed from the information gathered through multiple data sources. Triangulation of multiple data sources assisted in neutralizing the bias that may have been inevitable if a single method had been employed (Ackroyd & Hughes, 1992; Alston & Bowles, 2003). Cowger and Menon (2001) postulated, ". . . research that integrates qualitative and quantitative methods has an advantage in that it (a) proffers increased validity due to triangulation of methods; (b) provides an opportunity to take advantage of the strengths of each approach; and (c) allows congruence with the principles of social work to study things holistically, in context, and from more than one frame of reference" (Cowger and Menon, 2001, p. 477).

In their 2001 study, Rubin and Babbie give an example of using multiple methods to collect information on practitioner responsiveness to chronically mentally disabled persons. Rubin and Babbie offered three ways to collect and validate the same information. First, the attitudes of the practitioners regarding the treatment of mentally disabled persons could be assessed via a self-report. Secondly, disabled clients could be interviewed about the amount of contact they had with the practitioner and how satisfied they were with the help they received. Finally, an examination of case records could be used to tabulate the amount of actual service practitioners provided to disabled clients. The authors state that through the use of data triangulation a researcher is able to say with a level of confidence that the study was as accurate and thorough as possible.

To ensure thoroughness in this study, the researcher conducted the quantitative and qualitative components using ethnographic techniques (e.g. surveys, interviews

and focus groups) during various phases of the data collection. The participants of the first phase included members of upper management (Agency President/CEO, Director of Human Resources, and Director of Residential Programs), Unit Supervisors, clinicians and direct care staff. The second phase consisted solely of focus group interviews of direct care staff. A physical review of existing agency documents comprised the third phase.

The variables describing whether staff members supported family involvement of adjudicated juveniles were examined. There was a dearth of information regarding the opinions of employees working with juvenile delinquents in residential settings about the youths' families and the families' involvement in their children's treatment. Baker and colleagues (1995) conducted research on family involvement by examining that relationship with employees who work with mentally retarded children and adults in residential centers. Frances Claire Coleman (1999) based a study on Baker et al. (1995) by using a modified version of the same instrument to collect data from staff members of three residential centers for children with severe emotional disturbances (SED). In both Baker et al. (1995) and Coleman (1999), findings indicate that staff members were more supportive of families when programs put staff members in helper roles and when they also provided guidance for therapy. This current study targets staff members specifically who work with juvenile delinquents, which adds knowledge about the field of family-centered practices with children, while emphasizing residential treatment for juvenile delinquents. The findings also provide knowledge for both policymakers and service providers to correct staff-related hindrances in effective family involvement.

### 3.2 Research Procedures

The research procedures for this study began with a follow up visit to the facility after the proposal and the letter of recruitment were submitted (Appendix B). During the visits, this researcher was introduced to the administrative staff and the staff member designated to coordinate the study activities for this study. This coordinating staff member, in collaboration with unit supervisors and team leaders, scheduled the data collection sessions. The survey questionnaires were distributed by the designated staff member who also helped facilitate the dates of focus interview sessions.

At the time of data collection, a consent form (Appendix C: Consent for Questionnaire), consistent with the Michigan State University Institutional Review Board standards was given to each participant. This consent form explains the purpose of the study, the basic content of the questionnaire and the ability to egress from the study at any time. After signing the consent form, participants were given the questionnaires and an envelope in which they were instructed to return the questionnaire to the administrative office upon completion. Names and other identifying information were not included on the survey or envelope. Each individual who completed the questionnaire and returned it sealed in the envelope received a ten-dollar compensation for his/her time and effort. The distribution process of the questionnaires and the provision for returning the envelopes with the completed surveys assured anonymity of participants.

The second phase of the study involved both focus groups and individual interviews (which was limited to a random selection of staff identified as direct care staff). There was a separate consent form (Appendix D: Consent for the Use of Audiotape and Individual Interview Sessions) for focus groups. This consent form explains that

the researcher would conduct focus group interviews with only the direct care staff. Additionally, the consent stated that focus group questions inquired about the participants' beliefs, feelings and attitudes, as well as how they felt about the agency's formal position on family involvement. The consent form also requested permission to audiotape each focus group session. The focus group interview consent form includes a clause which ensures confidentiality and delineates any potential risk, as well as possible uneasiness of disclosure of personal thoughts and beliefs in the presence of co-workers.

Participation in focus groups and individual interviews, just as in the written questionnaire, was totally voluntary and participants were free to withdraw at any time from the study. The focus group participants were randomly selected from the list of employees who were identified as direct care (frontline) staff by drawing names from a hat. During the focus group sessions, participants were given an overview of the research and it was reiterated that the participants had the right to discontinue participation totally or refuse to answer any of the questions. The interviews consisted of five open-ended questions (Appendix F: Focus Group Interview), and took approximately 20 minutes for each participant to complete.

The focus group discussions followed immediately after the written segment. The researcher offered a raffle ticket to each staff member who participated in the individual interview and focus group sessions as an expression of appreciation for the time and effort of the staff. The prizes for the drawing were: one (1) $100 First Place Prize; two (2) $50 Second Place Prizes; and four (4) $25 Third Place Prizes. The researcher described the rules and purpose of the exercises. There were two sessions of focus

group exercises which were comprised of five to six participants (for a total of 11 participants) and were conducted on two different days. The written and the discussion sessions lasted 90 minutes. The total duration of the two sessions was 180 minutes.

### 3.3 Agency Setting and Programs

The agency is a Midwestern, multi-service nonprofit organization that serves children, youth, families and individuals. The agency has been a service provider for 45 years (incorporated in 1962). The agency offers programs that are clustered under three categories that are distinct yet interdependent: (1) Family Interventions, (2) Residential Treatment for youth referred by the court system, and (3) Learning Opportunities for delinquent youth.

The Residential Treatment program at the agency delivers both individual and group psychotherapy sessions to the placed youth in a structured environment. There is evidence in the agency public relation materials that the treatment modality encourages family participation while the child is in placement with the goal of reuniting him with his family. Successful reintegration of the youth into his home community is often based on parental involvement and interaction. This level of parent/child interaction also provides a medium for both the youth and the family to set realistic goals toward what will be expected when the youth is released into his parents' custody. Additionally, the multidisciplinary treatment team is afforded an opportunity to update treatment plans to meet both the youth's and the family's needs. The agency utilizes a multidisciplinary team for treatment that is comprised of residential and family

counselors and a special education teacher, recreational specialist, cook, custodian, and a treatment coach or director.

Resonating with youth in residential programs across the nation, most of the adolescents at the agency are high school dropouts or truants and are likely to have used illegal substances at a much earlier age than their non-institutionalized peers (Morehouse & Tobler, 2000). Consequently, virtually every youth admitted to the agency residential program attends the Malcolm Williams School (which is staffed by the Ingham Intermediate School District) and receives counseling in areas identified as problematic during the intake assessment. The generalized approach utilized at the agency includes many treatment modalities prevalent in both social work and criminal justice literature. Figure 1 is a summary of the various programs and services the agency provides.

The first of the Youth Opportunity programs was launched in 1967 and was known as the Youth Opportunity Camp (YOC). Today it is called the Phoenix Program. The program was initially a 24-bed residential program providing year-round care for males, ages 12 to 17. This program serves disruptive, potentially dangerous youth whose behaviors require structure in order to begin making needed behavioral changes (Agency Program Information, 2005). In 2000, the program's capacity doubled to 48. Another residential program is the Respite/Stabilization Program, which was created through a contract with the Ingham County Circuit Court-Family Division. As part of the agency's residential services, the Phoenix Program is intended to be a short-term residential program that combines intensive family therapy with community services.

Other programs under the Youth Opportunity category of the agency's services for the delinquent boys are: Special Families Foster Care, Juvenile Diversion, and the Family Intervention (see Figure 3, Community-Based Intervention Services (C-BIS) grid). The Special Families Foster Care program provides a permanent home for youth who do not have biological family members available to them and who are not candidates for adoption. The Juvenile Diversion program is a community-based, weekend program for youth who have been issued tickets by Ingham County law enforcement officials. The program focuses on helping these youth to connect their actions with consequences and to motivate them to make better choices in the future.

**Figure 3: Services and Programs Offered at the Agency**

| Service/Program | Description | Location |
|---|---|---|
| Alternatives-Domestic Violence | Promotes safety and minimizes risk. Services include development of Contracts of Non-violence, assessments, home-based counseling and offender groups for partners whose behavior is threatening, violent and/or destructive and therefore interferes with the ability to raise children safely. | Lansing |
| Alternatives- Family Violence | Promotes safety and minimizes risk. Services include development of Contracts of Non-violence, assessments, home-based counseling and groups for youth and their parents. This service is designed to intervene with youth who are committing domestic violence against family members and whose parents retaliate in similar manners. | Lansing |
| Breakthrough | Experiential training, adventure education and therapeutic services for schools and corporations. | Onondaga |
| Community Diversion | Gives youth an opportunity to nullify tickets upon successful completion of skill building and community service activities. | Onondaga |
| Community-Based Intervention Services (C-BIS) | A six week long program with services that includes home-based counseling, skill groups for youth and parents, and behavioral workshops | Lansing |

| **Figure 3: Services and Programs Offered at the Agency** (continued) | | |
|---|---|---|
| **Service/Program** | **Description** | **Location** |
| Family Group Decision Making (FGDM) | FGDM serves families with Child Protective Services involvement but who are not court involved. Also serves at-risk adoption placements and youth who have aged out of foster care. In an effort to prevent the need for out-of-home placement. Services include a "Family Group", the development of a family plan, and up to a year of ongoing home contact. | Onondaga |
| Family Reunification Program (FRP) | Offered by the Department of Human Services (DHS), to families with children returning home from foster care, residential care, hospital care, etc. Includes: (1) an in-depth family assessment within 30 days with possible two month extension; (2) Three to five hours of weekly counseling and in home support for four months with possibility of a two month extension; (3) 24-hour availability for resolving re-adjustment issues and related crises. | Onondaga |
| Foster care | Intensive foster care for adolescent youth. | Lansing |
| Families Together Building Solutions (FTBS) | Targets families experiencing difficulties parenting their children. Services include: Assessment and family plan written with family; three hours of in-home counseling/week for up to three months. Parent Group arranged on monthly basis through DHS. | Lansing & Jackson |
| Outreach | For parents involved in possible abusive or neglectful child-rearing practices; They face removal of their children through DHS | Lansing & Jackson |
| Phoenix Program | Focuses on boys age 12-17 from all counties in lower Michigan. The program provides 24:7 supervision and serves youth whose behavior has become so disruptive and anti-social that this level of structure is required in order to begin making behavioral changes. | Onondaga |
| Pride, Respect, Opportunity School (PROPS) | For expelled youth in Jackson County schools. Focus is on anger management, leadership development. Is a four to six month program. | Jackson |
| Respite/Stabilization Program | For boys, aged 12-17, from lower Michigan counties. It is a 14-30 day program | Onondaga |
| Skills of Success | Operates with school using nine-week semesters; can serve up to 12 kids per program; teaches life skills (interpersonal, problem-solving, anger control) welcomes parents and teachers. | Onondaga |
| Wraparound | Family Team developed with family to identify ways to: 1) become stronger; and 2) use the support and guidance of their friends, neighbors and relatives in the community. | Lansing & Jackson |

The Family Intervention category of services offers the following programs: Family Reunification, Outreach Counseling, Wraparound, Behavioral Health Services, Family Together/Building Solutions, Family Preservation Program and Home-based Mental Health counseling.

The Learning Opportunities Programs are offered through the Malcolm Williams School and are staffed by the Ingham Intermediate School District. The school serves youth placed in the Youth Opportunities Camp program and is considered to be one of the most successful alternative education programs in the state of Michigan.

The summary of the spectrum of programs (Figure 3, B-CIS) offered by the agency indicates that the organization is committed to family programs as well as to the betterment of children and families, both in the community and in residential placement.

Although the study did not include the review of personnel and/or residents records, the literature review and information gleaned under Act 280 of the Public Acts of 1939 (as amended giving the Bureau of Children and Adult Licensing the authority to regulate residential facilities (http://michigan .gov/dhs/0,167,7-124_27716_27722-43396--,00.html retrieved 1/16/2008)) suggested the participating agency has had its share of difficulties with the licensing department of its home state. During a 2003 Department of Consumer and Industry Services inspection to determine compliance with applicable licensing statutes and administrative rules for Child Care Institutions, a few violations were discovered. One violation included a lack of educational records on file for an employee who was hired almost a year previous to the inspection. In other words, the employee file lacked a transcript or a diploma showing that the

employee had a high-school diploma, as specified in Rule 121, Direct Care Worker qualifications,

http://www.dleg.state.mi.us/brs_cwl/dt_cwl.asp?CWL_NBR=CI330201171&cnty_name=INGH retrieved on January 16, 2008). The Licensing Consultant also discovered that an initial dental examination was not completed until four months later than the three month time frame specified in Licensing Rule 400.4336. A special investigation was conducted at the agency which indicated that, despite the agency policies of completing incident reports in congruence with Rule 400.4109, a direct care staff failed to complete a report when a youth alleged being attacked by another with shampoo and bathing materials. The youth allegedly were pretending that they were "horseplaying." At other times the agency was investigated regarding the use of profanity by staff in front of the youths, staff bringing pornographic materials to work, and misuse of the youth clothing allowance by one staff member in order to purchase items for himself. Some of the allegations were unsubstantiated. However, the facility was temporarily shut down at one point and all the residents in the facility removed due to a substantiated claim of abuse and possible neglect by staff. As a plan of corrective action the agency reorganized, fired the former President/CEO and hired a new senior management team. Out of the reorganization came the Phoenix Program which used to be called Youth Opportunity Camp (Organizational Chart, 2004). The agency reorganization led to firing many long term employees and hiring new ones. Consequently, many of the employees in this study have been hired within the last four months to a year.

### 3.4 Subject Population and Sample selection

The participants of this study were employees of the participating organization (referred to as "agency" or "the facility") located in rural Michigan. The study, which was conducted on agency premises, included direct care staff, clinicians and administrators. Additionally, direct care staff members were asked to participate in a focus group and separate, self-administered written individual interviews.

Participants were recruited through a non-probability sampling method. Recruitment began with a meeting with the Residential Director of the Agency. At such time, the researcher submitted a proposal and an executive summary of the study to the Residential Director. The proposal included a cover letter (Appendix A: Recruitment Letter to the Residential Director) that explains the purpose of the study and that staff must have had at least 90 days active experience with the agency before participating in order to ensure an adequate knowledge-base to answer the questions.

### 3.5 Potential Risks and Safeguarding Confidentiality of Participants

This research project carried with it minimal risk. The research participants were not engaged in any activity – mental or physical – that is out of the range of a normal day. The participants were asked to answer questions on issues that they discuss or deal with on a regular basis as part of their employment. This researcher followed the National Association of Social Work's Code of Ethics and Michigan State University's IRB standards regarding confidentiality. Participants, especially the focus groups, were informed many times during the process that they were free to withdraw from the study at any time and for any reason.

Participants were assured that all information provided by them in this data collection would remain confidential and would be reported in an aggregated manner. Therefore, a supervisor or administrator looking at the study would not be able to tell which workers participated and what information was provided by whom during the various sessions. All written questionnaires were returned to the researcher in sealed envelopes which prevented individual identification of any participant. Although the focus group questions were audio-taped, participants' names were not used and the tapes were never played for anyone other than the researcher during transcription. The tapes were destroyed upon completion of transcription. Furthermore, additional steps to ensure confidentiality were taken through careful data management, which included storage of all records and data in a locked cabinet in a secure office. Once all the information was reported in aggregate form, the tapes and paper records were destroyed.

### 3.6 Potential Benefits

The findings of this study will enable staff working in residential treatment programs to evaluate their own expectations, treatment plans, and attitudes toward families who have their children in these programs. It is anticipated that the findings will also increase staff-family communication so that more realistic goals are set for youth and families. These improvements will enhance youth opportunity to complete the treatment program successfully and be reunited with their families.

At the societal level, it may also lay a framework for changes in policy and the need for government-supported early intervention resources. It may also lead to

residential facilities staff developing more realistic treatment plans that involve family participation. This would, in turn, support and strengthen families. Empowering parents to become partners in the treatment of their children increases the rate of completion of residential treatment programs and contributes to successful reentry into the community (Osher & Hunt, 2002). It cannot be emphasized enough, as Osher and Hunt (2002) reported, that working with parents in successfully rehabilitating the juvenile delinquents and reuniting families will benefit society as a whole. Overall, this research increases knowledge of staff attitudes toward family involvement in the field of social work practice, the juvenile justice system and residential treatment for juvenile delinquents and their families.

### 3.7 Research Questions and Hypotheses

The research hypotheses were derived from an intensive literature review, including a close look at the works of Baker et al. (1995) and Coleman (1999). These two studies examined staff attitudes toward family involvement with children with mental retardation and severe emotional disturbances in residential treatment centers. The overarching question of the study was: What are staff attitudes toward families' involvement in their children's treatment when these children are adjudicated delinquent and are court-ordered to receive treatment in residential facilities? The questions that guided the research fell into four categories. The first concerns direct care staff's support for family involvement and reunification. The second question concerns direct care staff's beliefs about families. The third concerns the differences in attitudes toward family involvement in relation to an employee's position within the

organization. The final category was whether demographic factors influence the attitudes of staff toward family involvement.

Hypotheses:

$H_1$ There is a positive relationship between staff support for reunification and family involvement with delinquent children in residential treatment.

$H_2$ Staff members who hold positive beliefs about families are more supportive of family involvement.

$H_3$ Clinicians have more positive attitudes toward family involvement than direct care staff.

$H_4$ Administrators have more positive attitudes toward family involvement than direct care staff.

$H_5$ The level of support for family involvement varies with socio-demographic characteristics: race/ethnicity, gender, age, and education.

### 3.8a Instrumentation for Quantitative Methods

The quantitative measure used for this study was first developed by Professor Bruce L. Baker at the University of California, Los Angeles, and used in the 1995 Devereux Foundation Family Involvement Study (which will be referred to as Devereux from this point forward). A modified version of the instrument was later used by Frances Claire Coleman (1999) to study the attitudes and beliefs among the employees of the Jewish Child Care Association (JCCA). The instrument was used to enhance our understanding of why, despite the efforts of social policy to support family involvement, families are not more involved in their children's treatment and care (Baker, et al., 1995).

A 6-point Likert-type scale, such as Baker and others (1995) used in the Devereux Foundation Family Involvement study, was utilized to collect data. Professor

Bruce Baker, the developer of the original instrument, was contacted for permission to use his scale and for an original copy of the instrument. Professor Baker verbally granted permission to this researcher and stated that he would track down the original copy of the instrument for the study. Unfortunately, the original instrument was not received by the time of data collection. While minimal modification was done to the Coleman's version of the questionnaire, there were exceptions. These exceptions include: the rephrasing of double-barreled questions to create separate questions; maintenance of a 5-point Likert-type scale for one question; and rephrasing of some items to more clearly articulate the objectives of the present study. The revised instrument, "Staff Attitudes and Beliefs about Family Involvement and Reunification Survey", contains 98 items, distributed unevenly across five scales and measured broad areas of attitudes of staff working in a residential setting. The 98 items include socio-demographic questions. The quantitative instrument took approximately 35 minutes per participant to complete (see Appendix E).

A. Attitudes Toward Reunification: This scale includes two measures of attitudes toward reunification. The first measure, borrowed from Baker et al. (1995), inquires about the respondents' approximation of what percentage of children should be returned to their homes. The second measure was developed by Coleman (1999) and was based on Baker et al.'s (1995) scale of "Reasons to Discourage Involvement Scale." This scale includes 21 items that describe characteristics about family (13 items) and the child (eight items). While the Coleman measure was rated on a 5-point Likert-type scale, the current author utilizes a 6-point Likert-type scale, wherein a ranking of "six" indicates the strongest belief that a child could return to his/her

family. The internal consistency was recalculated using Chronbach's Alpha ($\alpha$ = .86) after removal of two items ("Child is reluctant to have parent(s) re-enter his life or perhaps disrupt his living and relationships with other adults" and "Parents have history of substance abuse and are willing to change"). Coleman's (1999) calculated reliability was $\alpha$ = .85. The measures are relevant to use in the analysis of staff attitudes and beliefs in the participating agency.

B. Beliefs about Families: The scale for staff thoughts about family involvement was adapted from the Devereux Family study which employs a 6-point Likert-type, 11 item scale with an $\alpha$ = .88 (Baker et al., 1995). Reliability to establish internal consistency was recalculated due to some revision of the wording in the adaptation from Coleman's (1999) study. This was a replication of the Baker et al. (1995) study and maintains the original 6-point Likert-type scale. The Beliefs about Families Scale obtained an $\alpha$ = .67 (Baker et al., 1995) while Coleman's (1999) modified 5-point Likert-type scale obtained an $\alpha$ = .51. This measure consists of seven items and includes a subscale, the Helping Beliefs Scale. The Helping Beliefs Scale includes four items that inquire about how staff members believe families can be helped (Baker et al, 1995). The alpha coefficient for this scale in the Baker et al. study was .74 while Coleman's (1999) recalculated reliability and total for the Positive Belief Scale obtains an alpha of .66. The reliability of the seven items in the current study was recalculated ($\alpha$ = .71).

C. Support for Family Involvement Scale: This is a 22-item scale which asks respondents "What should we do to encourage family involvement?" In the Devereux study (Baker, et al., 1995), this was a 6-point Likert-type scale and the Chronbach

Alpha was .88. The JCCA study was a 5-point Likert-type scale and reliability was $\alpha$ = .90 (Coleman, 1999). The current study uses a 6-point Likert-type scale and some of the questions were rephrased and the reliability is $\alpha$ = .86.

D. Advantages of Family Involvement Scale: The scale has nine items that inquire about staff perceptions of the advantages of family involvement. The reliability of the subscale from Baker et al. (1995) is an alpha of .82 and .88 in Coleman's (1999) 5-point Likert-type scale. The current study uses a 6-point Likert-type scale. The initial reliability for this study was $\alpha$ = .80. After removing two items, "Make the child feel loved, wanted," and "Facilitate communication between family members and staff," the Chronbach Alpha is $\alpha$ = .86

E. Disadvantages of Family Involvement Scale: This scale inquires about staff perceptions of the disadvantages of family involvement in terms of having a negative impact on children. An alpha of .71 was obtained by Baker et al. (1995) while Coleman (1999) obtained an alpha of .83. The reliability was recalculated for this study and obtained $\alpha$ = .83.

F. Demographics: About You and Your Job: This scale was also adopted from Baker et al.(1995) and seeks to obtain basic demographic information such as gender, race, level of education, years of experience at the facility, and current job activities. A single question inquires about the amount of time each respondent spends working with families in a typical week. Ten items inquire about whether or not staff engages in specific family-related activities (See Appendix E).

### 3.8b Instrumentation for Qualitative Methods

The qualitative component of the study includes focus group interviews of direct caregivers (frontline staff) and an agency document review. The method of focus group interviewing has been found to be effective in gathering opinions from homogenous groups about the reactions of the group members to particular issues and policies (Denzin & Lincoln, 1998). The focus group sessions, which involve convening groups of direct care staff in open-ended discussions, inquires about their work life within the organization. The individual interviews were neither rigidly controlled with a fixed-format questionnaire nor were they wholly unstructured conversation (Aubel, 1994). In addition, research suggests that focus group interviewing is an effective tool for gathering group reactions to issues and policies, and revelations of the groups' knowledge, opinions and concerns about specific subjects (Aubel, 1994; Denzin & Lincoln 2003; Fontana & Frey, 2003). This study, by including a qualitative component which utilizes both focus group questions and an examination of agency documents, adds details, as well as corroborates and disputes some of the findings obtained through quantitative methods (Alston & Bowles, 2003; Ginsberg, 2001; Neuman & Wiegand, 2000, Patton, 1987; Tracy, 2001). This mixed-method approach was intended to fully illuminate staff attitudes and perceptions regarding family involvement, which has been frequently glossed over in the literature.

The second component of the qualitative data collection includes a review of official agency documents. The documents reviewed are: Residential/Campus Operation Manual, Rev. 06F staff manual; personnel policies (revised 6/14/06); mission statement; Family and Youth Services Overview; Residential Care Phoenix and

Stabilization Programs program descriptions; and grievance policies. There is no identifying information, (such as case records) included in this study. The exploration of these materials contributes to an understanding of the agency's purpose, goals and beliefs. Additionally, this study provides a description of the components that help corroborate the information obtained from the employees on family involvement with delinquent children in residential treatment.

The focus groups questions and instructions are inserted in the appendices as Appendix F (Appendix F: Focus Groups Instructions and Questions).

The guiding questions are:

1. What training have you had to prepare you for working with youth and families?
2. Based upon your experiences working with youth in residential settings, do you think that staff members believe family involvement is an essential component in the treatment of juvenile delinquents?
3. In your opinion, what are some of the issues or concerns surrounding families' involvement with their delinquent children in residential treatment?
4. What is the program or agency's position regarding family involvement?
5. In addition to what you have previously mentioned, do you have any comments about family involvement with juvenile delinquents in a residential treatment program?

### 3.9 Data Analysis Procedures for Quantitative and Qualitative Methods

The Statistical Package for Social Sciences (SPSS) Version 15, Graduate Pack was employed for the quantitative data analysis (SPSS, Inc, 2006). As there is some modification of the scale from Baker, et al. (1995) and Coleman (1999), Cronbach's Alpha was used to recalculate the internal consistency of those scales. In reference to the validity of the quantitative instrument, there is yet to be established any agreement

on responses across samples. The instrument, as mentioned earlier, was developed by Professor Bruce L. Baker to be used in the Devereux Study. The instrument is standardized on measuring residential staff. Looking at the 1995 study of Baker and his colleagues and the subsequent 1999 study of Coleman, it could be said with confidence that the measures are internally reliable. Therefore, the sample is found to be adequate and complete for analysis of attitudes and beliefs about family involvement.

Descriptive statistics are also used (i.e. calculating means, standard deviations and frequency). Pearson Product Moment Correlations are used to examine staff members' demographic characteristics, attitudes and beliefs about families. Tables were created to illustrate the statistical analyses. Transformation and data collapsing are used to capture the significant values of the subscales within the five scales. Additionally, Independent t-Test and Analysis of Variance (ANOVA) are computed to test differences between means across the scales.

The content analysis of focus groups and individual written interviews focuses on identifying common themes and patterns to describe the direct care staff perceptions and beliefs about family involvement, level of training, work experience with youth and families, and issues surrounding family involvement, as well as opinions about the agency's position on family involvement. The major themes were assigned codes consisting of a few descriptive words and were placed next to them during the reading of the transcribed data. Next, agency documents were reviewed (i.e., the policy and operating procedure manuals) and analyzed qualitatively in order to assist in describing the agency's support for family involvement of delinquent children in residential

treatment. This also allowed this researcher to determine if any congruity exists between the mission and values of the agency and that of its employees.

# Chapter 4: Results

This chapter presents the data analysis used to evaluate the research hypotheses and other questions as stated in Chapter 1. The chapter begins with a description of the sample and an overview of the representative years of experience in human services of the participants. The number years of employment with the current agency is also discussed. Summaries of both the qualitative and quantitative analyses are presented. The qualitative analyses include focus group questions and a review of the official agency documents.

## 4.1 Description of the Sample

Staff age by groups is depicted by Table 1. The sample consists of 51 employees, of which 34 (67.3%) are direct care staff, 5 (10.2%) are clinicians, and 12 (22.4%) are administrators. Forty-nine of the 51 total participants reported their ages, with a mean age of 37 years old (range from 22 to 57, SD = 10.2).

**Table 1: Age Grouping of Respondents (N =51)**

| Age Group | n | % |
|---|---|---|
| 20-25 | 9 | 17.6 |
| 26-30 | 7 | 14.3 |
| 31-35 | 9 | 17.6 |
| 36-40 | 6 | 11.8 |
| 41-45 | 9 | 17.6 |
| 46-50 | 4 | 7.8 |
| 51-55 | 4 | 7.8 |
| ≥56 | 1 | 2.0 |
| Missing | 2 | 3.9 |

Of the total sample of 51, 68.6% are male and 3 1.4% are female. In regard to marital status, 45.1% of the sample are single, 43.1% married, 7.5% divorced and only 3.9% reported living with a partner. Table 2 illustrates the demographic characteristics by employee classification and also provides data on race/ethnicity.

**Table 2: Demographic Characteristics by Employee Classification (N = 51)**

| | **Direct Care Staff** N = 34 | | **Clinicians** N = 5 | | **Administrators** N = 12 | |
|---|---|---|---|---|---|---|
| | n | % | n | % | n | % |
| **Gender** | | | | | | |
| Male | 24 | 47.5 | 4 | 7.8 | 7 | 13.7 |
| Female | 9 | 17.7 | 1 | 2.0 | 5 | 9.8 |
| **Marital status** | | | | | | |
| Single | 16 | 32.7 | 2 | 4.1 | 3 | 6.1 |
| Married | 12 | 24.5 | 3 | 6.1 | 7 | 14.3 |
| Living w/a partner | 2 | 4.1 | 0 | 0 | 0 | 0 |
| Divorced | 3 | 6.1 | 0 | 0 | 1 | 2.0 |
| Widowed | 0 | 0 | 0 | 0 | 0 | 0 |
| **Race/Ethnicity** | | | | | | |
| Caucasian | 20 | 43.5 | 4 | 8.7 | 10 | 21.7 |
| African American | 11 | 23.9 | 0 | 0 | 1 | 0 |
| Native American | 0 | 0 | 0 | 0 | 0 | 0 |
| Asian American | 0 | 0 | 0 | 0 | 0 | 0 |
| Other | 0 | 0 | 0 | 0 | 0 | 0 |

Many of the staff members (60.8%) report having children of their own while (39.2%) do not. The mean difference between those having children and those not is 1.4. Those individuals with children report having from one to six children. Six respondents (22%) report having one child; ten respondents (37.0%) have two; five

respondents (19%) have three; three respondents (11%) have four; one person (4%) has five; and two respondents (7%) have six children. The reported mean is 2.6 (SD = 1.4).

With respect to race/ethnicity, only three racial and ethnic groups are represented in this sample. One person does not indicate his or her racial/ethnic background. Seventy percent self-identified as white, while 24% are black and 4% are of Hispanic/Latino origin.

Table 3 illustrates the highest level of education completed by employee classification. The levels range from High School graduates to one person who reported holding an Advanced Degree (beyond Masters). Nineteen respondents report that they have a Bachelors-level degree.

**Table 3: Level of Education by Employee Classification (N=51)**

| | **Direct Care Staff** N = 34 | | **Clinicians** N = 5 | | **Administrators** N = 12 | |
|---|---|---|---|---|---|---|
| **Level of Education** | n | % | n | % | n | % |
| Less than High School | 0 | 0 | 0 | 0 | 0 | 0 |
| High School Diploma | 4 | 7.8 | 0 | 0 | 0 | 0 |
| GED | 1 | 2.0 | 0 | 0 | 0 | 0 |
| Some college (1-3 years) | 4 | 7.8 | 0 | 0 | 0 | 0 |
| Associate Degree | 1 | 2.0 | 0 | 0 | 0 | 0 |
| College (4 year degree) | 19 | 37.3 | 3 | 5.8 | 4 | 7.8 |
| Master's Degree | 3 | 5.9 | 2 | 3.9 | 5 | 4.8 |
| Advanced Degree | 0 | 0 | 0 | 0 | 1 | 2.0 |
| Missing | 2 | 3.9 | 0 | 0 | 2 | 3.9 |

Table 4 illustrates the number of years of experience in human services as well as the number years of employment within the current agency of the sample. Experience

in a human services environment ranges from less than six months to 12 or more years. The mean number of years working in human services related positions is 10.01 (SD = 8.8). While 48% indicated that they have at least 12 years or more of experience, 30% of the participants indicate they have been working with the agency for less than six months. The mean number of years working with the agency is 6.5 (SD = 8.0). The highest number of years with the agency is 28 and the lowest is four months at the time of the data collection. The fact that only 26% of the participants report that they have been with the organization for at least five years suggests that there is a possible high rate of employee turnover. One respondent did not supply answers regarding his/her experience.

**Table 4: Number of Years in Human Services and at Current Agency (N = 50)**

| **Years in Human Services** | n | % |
|---|---|---|
| Less than 6 months | 2 | 4 |
| 6 months to 1 year | 6 | 12 |
| 2 to 3 years | 3 | 6 |
| 4 to 5 years | 10 | 20 |
| 6 to 7 years | 2 | 4 |
| 8 to 9 years | 6 | 12 |
| 10 to 11years | 7 | 14 |
| 12 years and over | 14 | 48 |
| **Years in with the Agency** | n | % |
| Less than 6 months | 15 | 30 |
| 6 months to 1 year | 11 | 12 |
| 1.5 to 2 years | 3 | 6 |
| 2.5 to 3 years | 1 | 2 |
| 3.5 to 4 years | 2 | 4 |
| 4.5 to 5 years | 3 | 6 |
| 5 years and over | 13 | 26 |

## 4.2 Test of Hypotheses

This section presents the results of the statistical analyses that were used to investigate staff attitudes about families and support for family involvement as well as toward the reunification of delinquent children in residential treatment programs with their families. The Pearson Product-Moment Correlation was used to test hypotheses one and two because it presents possible correlation coefficients between the sets of variables that describe or predict agency staff attitudes about families and support for family involvement and reunification. The one-tailed test was used to test the hypotheses since it was expected there would be a relationship between positive attitudes about families and staff support for family involvement. It was further expected that support of family involvement would vary along with socio-demographic characteristics, including; race/ethnicity, gender, age, marital status of respondent, number of own children and level of education. Other pertinent analyses include the relationship between the number of years in the human services sector as well as the number of years working within the current agency. A One-Way Analysis of Variance (ANOVA) was utilized to test hypotheses three and four in order to determine if there are differences between direct care staff, clinical staff (family therapists) and administrators in terms of supporting family involvement with delinquent children. For the statistical methods, an acceptance level of .05 was used. The SPSS v.15.0 software package was used to perform all the statistical analysis.

### 4.3a Support for Family Reunification with Children under 18 Years of Age

Overall, staff supported family reunification as a primary program objective. The same question ("What percentage of children (who are under 18 years of age) should have the primary objective of reunification with their families?") asked by Coleman and by Baker et al. in their 1995 studies, respectively. In the current study, 56.9% of the staff sampled respond "most or all" (75-100%) and another 33.3% respond "many" (50-74%). The mean is "most or all" (4.39 out of 5) with a standard deviation of .92 rounded to the nearest decimal. This is a significant change from the Baker et al. (1995) study where only 22%of the sample endorsed the goal of reunification of children in residential treatment with their families. While Coleman's (1999) study shows that 41% of the sample endorses the primary objective of reuniting children in residential treatment with their families, it is still less than half of the respondents. In this study, only 2% of the staff members respond "none" of the children should return home to their families. In the Baker et al. study (1995), 8% of the sample responded "none" of the children should be reunited with their families. A one-sample T-test was performed in order to test the mean of the question and it was found to be significant ($t = 34.16$, $df = 50$, $p < 01$).

### 4.3b Relationship Between Support for Reunification and Family Involvement

The first hypothesis states that there would be a positive relationship between staff support for involvement and for family reunification. The Reunification Scale is adapted from Coleman's study (1999) correlated with family involvement. Pearson Product-Moment Correlations indicate that there were moderate positive correlations

between the Support for Reunification Scale extrapolated from Baker et al. (1995) and the Reasons to Discourage Scale and Family Involvement Scale ($r = .35$, $p = 01$, $n = 51$). In Coleman's study (1999), the Family Reunification Scale and Percentage of Reunification of Children Scale correlated with the Family Involvement Scale. In this study, none of the p values were statistically significant. The correlation between the Support for Family Involvement and the Percentage of Reunification of Children Scale ($r = .03$, $p = .85$, $n = 51$), and the correlation between the dependent scales (Reunification Scale and Percentage Reunification Scale ($r = .16$, $p = .27$, $n = 51$).

**4.3c Beliefs about Families and Support for Family Involvement**

As reported in Table, 5 the second hypothesis states that staff members who hold positive beliefs about families are also more supportive of family involvement in the delinquent child's treatment in a residential program. As in Baker et al. (1995), the Beliefs Scale includes items expressing positive and negative views. For example, one positive item includes the statement "Most parents sincerely want to do what is best for their children" while a negative item was "Children in residential treatment have been maltreated by their families." The scale also includes items such as "Helping parents should be an integral part of the program." New subscales were created in order to test the assumptions of positive and negative beliefs about families and support for involvement. The hypothesis that there is a positive correlation between staff beliefs about families and staff support of family involvement was confirmed. By using transformation to collapse items into a single subscale, this researcher found indications that there is a significant positive correlation between positive beliefs and support

for family involvement (r = .45, p = 001, n = 51). Also, there is a positive correlation between helping families and support for family involvement (r = .36, p = 001, n = 51).

Table 5 also indicates that, whereas there was a significant positive correlation between the Advantages to Family Involvement Scale and the Support for Family Involvement Scale (r = .62, p = .01), the Pearson Correlation indicates that there is no relationship between the Disadvantages Scale and the Support for Family Involvement Scale (r = -.175, p = .08). Similarly, there is no correlation between the Negative Subscale and the Support for Family Involvement Scale (r =-.05, p =.27). Overall, this suggests that staff members who have positive views about families maintain positive beliefs about helping families and involving families in the treatment of their delinquent children.

**Table 5: Correlations Between Support for Family Involvement and Beliefs (N = 51)**

| Scales | Pearson r with Support For Family Involvement |
|---|---|
| Positive Beliefs about Families | .45** |
| Negatives Beliefs about families | -.04 |
| Helping Families | .36** |
| Advantages to Family Involvement | .62** |
| Disadvantages to Family Involvement | -.17 |

**Correlation is significant at the .01 level (2-tailed)

### 4.3d Category of Professionals and Attitudes Toward Family Involvement

The third and the fourth hypotheses concern the differences in attitudes of clinicians and administrators versus direct care staff. ANOVA was utilized for the different

categories of professional ratings of support for family involvement (see Table 6). It supports both hypotheses that clinicians and administrators are more likely to support family involvement more than direct care staff [F (2, 46) = 13.72, p = .01]. As result of using three categories of professionals and the significance found on the Support for Family Involvement Scale, a Tukey HSD test was used. The post hoc pair-wise comparison using Tukey HSD reveals mean differences between direct care staff and clinicians (F(2, 46)=-18.59, p = .001)] and between direct care staff and administrators [F (2, 46) = -15.15, p=.01)]. There is no significant difference between clinicians and administrators [F= (2, 46) =3.44, p= .81)]. The test, therefore, confirms that clinicians and administrators would likely support or endorse family involvement whereas direct care staff may not support the idea of family involvement.

**Table 6: Categories of Professionals and Their Attitudes Toward Family Involvement (n = 49)**

| | SS | df | MS | F | p |
|---|---|---|---|---|---|
| Between Groups | 2877.38 | 2 | 1438.69 | 13.72 | .000 |
| Within Groups | 4822.86 | 46 | 104.85 | | |

### 4.3e Socio-demographic Characteristics and Attitudes Toward Family Involvement

The fifth hypothesis states that the level of support for family involvement varies based on socio-demographic characteristics such as race/ethnicity, age, marital status, years of experience in a human services environment, and number of years working at the agency. Table 7 presents the correlations of socio-demographic characteristics based on age, number of years in human services sector and number of years the

respondent has worked at the agency groupings at the time of data collection. Age of respondent, number of years of experience in human services environment and number of years working at the agency were recoded into groups into different variables transforming them from categorical to interval levels of measurement. Pearson Product Moment Correlations were used to determine relationships between these variables and the attitudes toward support for family involvement scale. The demographic variable of age group does not correlate with attitudes toward support for family scale. However, there are significant positive correlations between the number of years in human services ($r = .04$, $p = .004$, $n = 51$) and the number of years working at the agency ($r = .36$, $p = .01$, $n = 51$).

**Table 7: Correlations of Socio-demographic Characteristics and Family Involvement**

| Variables | n | Pearson r with Support for Family Involvement |
|---|---|---|
| Age | 50 | .248 |
| Number of years in Human Services | 51 | .398** |
| Number of years at agency | 47 | .363* |

*Correlation is significant at the .05 level (2-tailed)
**Correlation is significant at the .01 level (2-tailed))

An Analysis of Variance (ANOVA) was performed on race/ethnicity, gender, marital status and level of educations and attitudes toward family involvement scale. As reported in Table 8, there are no significance differences between the variables (race/ethnicity, marital status, level of education) on the attitudes toward family involvement scale.

**Table 8: ANOVA- Demographic Characteristics and Support for Involvement (N=51)**

| Variable | SS | df | MS | F | p |
|---|---|---|---|---|---|
| **Race/Ethnicity** | | | | | |
| Between Groups | 144.48 | 2 | 72.24 | .42 | .66 |
| Within Groups | 8006.50 | 47 | 170.30 | | |
| **Gender** | | | | | |
| Between Groups | 128.148 | 1 | 128.14 | .78 | .38 |
| Within Groups | 8102.61 | 49 | 165.36 | | |
| **Marital Status** | | | | | |
| Between Groups | 210.29 | 3 | 70.09 | .41 | .75 |
| Within Groups | 8020.46 | 47 | 170.35 | | |
| **Level of Education** | | | | | |
| Between Groups | 1599.28 | 6 | 266.55 | 1.74 | .14 |
| Within Groups | 6596.64 | 43 | 170.35 | | |

### 4.4a Results of Focus Groups Sessions

There are five questions that were designed for the focus group exercises and individual responses. Two focus group sessions were conducted and a total of 11 participants were randomly drawn from the employees identified as direct care staff. The first session was composed of five participants and the second included six participants The first question concerns employee training, which participants disclosed in both individual and focus groups exercises. This includes on-the-job training as wells as formal education in child and family-centered related fields (such as social work). The second question explores staff members' beliefs in family involvement as an essential component of the treatment of juvenile delinquents. The third question asks the participants their opinions on issues or concerns surrounding families' involvement with their delinquent children in residential treatment. The fourth question addresses participants' perceptions of the agency's or the program's position regarding family

involvement. The fifth question provides an opportunity for participants to offer additional comments in relation to family involvement with juvenile delinquents in a residential treatment program. In all cases, names and other identifying information of the participants were not used. All verbatim quotes have been referenced as interview numbers or are presented in third-person pronoun.

### A. Training and Preparation to Work with Children and Families

For the inquiry as to the level of training and education, staff answers reflect agency sponsored in-service training; formal education in Social Work, Criminal Justice and Anthropology; and considerable experience working in the field. Most of the agency-based training related to working with youth and families are on the following topics: Conflict Cycle, Life Space Crisis Intervention, Cognitive Restructuring Therapy, Anger Replacement therapy, Child Care and Development, First Aid and CPR.

One of the respondents answered the question on training by stating, "I do not have a lot of on-the-job training with the agency but I have a BSW and a MSW." Another respondent said

> "*My training came from experience and in-house training. We are required to have 25 hours of training a year. Being here for 27 years enabled me to learn different things. I have 36 hours of cognitive behavioral training which included how to deal with problem youth, life skills and anger management. Most important is listen to the child. You get a lot out of the kid. I acquired some of the skills through on job training.*"

The overall recurring theme in relation to preparedness to work with youth and families is on-the-job training and years of experience in human services related fields. The most notable areas of training, as one would expect in the field of juvenile justice,

are mainly child-centered. The training is oriented toward working with the delinquent child and helping him/her rather than working with the child in the context of the family unit. Although only 11 staff members participated in the direct interview and focus group session portions of the study, the examination of the level of staff training reflects the cross-section of all 34 direct care staff members who participated in the quantitative survey. Of this set of direct care staff, only two people have a formal education in Social Work or Criminal Justice. The agency has invested its resources in training staff to help the delinquent child in their custody. There is hardly any focus on training staff to help work with families.

## B. Staff Beliefs about Family Involvement as an Essential Component of Treatment

The second qualitative question explores the beliefs of the participants regarding family involvement as an essential component of the rehabilitation of juvenile delinquents in placement. The participants state overwhelmingly that family involvement is supported. Almost all the participants think families must be part of the treatment and should contribute to the rehabilitation of the child. One participant states

> *"We encourage families to visit, stay and play games with their children. Families must work together to learn their problems [sic]. The importance of family involvement was evidenced when three staff (during one of the focus group sessions) simultaneously said, "Only families know the history of their children." One staff member spoke at length, lamenting that although staff members see family involvement as an essential component of treatment, they do not have the resources to implement family involvement activities that are meaningful and beneficial to youth and their families:*

> *"Family involvement is important. I think it is essential because when the juvenile comes into the program the family must have a say on what the behavior plan is, and also they need support. I also think it can be very difficult*

*to achieve this goal. The reasons why the family component is important but difficult to work with is that you have to have the family come up and to do family workshops, something like that you know [sic]. Something like family building, we don't do that very much. Families live about an hour and half, two hours away. We might get families here once or twice during the six months stay. That is frustrating. We make phone calls to their parents and that is very minimal. The kids get home visits once they reach a certain level and some of them don't necessarily have a home. Also, we are dealing with behaviors constantly and can attribute that to parents. We try to improve parents in whatever way we could because it does no good for these kids to go back to the same situation. We just do not have a lot of time or the power to force them to do certain things [sic]."*

Some participants, although not the majority, argue that the importance of family involvement as part of the treatment plan depends on where the child will be going after graduation from the program. One member of the group said,

*"If the child is going to be put in foster care or independent living, family involvement does not matter much. Some of the kids who come have been severely abused and they don't know they were abused. You have to teach to them to recognize the abuse and to move forward with their life so that one day, they can forgive their family."*

It was interesting to observe how the study participants went back and forth with each making his or her point on why they believe or disbelieve that family involvement is an essential component. One staff member, who was quiet for most of the focus group, spoke up and said,

*"When we developed our program, it was not only for the youth but for the family too. It is to build stronger relationships between the families and staff so that we can help the child [sic]. If you want to solve the problem, you have to involve the family. You know, my thing with this part of the program is the parents have to learn, see what we are trying to provide the kids so that when the kid goes home the parents know what he has learned here [sic]."*

The person who brought the discussion to a close made an important point. The participant reminded his colleagues of the clientele they serve and the reason why family involvement should be central to their program:

Some parents don't know how to parent children. If you involve them, provide them with parenting skills and training, they may learn how to parent. As Mr. 'X' said,

> *"...we have had in the past when we bring parents here, played games with the kids and their parents [sic]. Yes, the Breakthrough Program was the best part of our program. Everybody is involved, everybody is learning. You know, the kid never saw his parent play. All they see is the parent as a disciplinarian but not once they see their parents hit a beach ball, yea my dad is actually playing [sic]. My mom is here, too. Everyone is getting along. Ah, this is a beautiful thing [sic]."*

Content analysis of the participants' individual interviews and narratives supports the assertion that family involvement is taken as a serious component of the treatment model for juvenile delinquents in placement. The dominant themes gleaned from the participant narratives are: that parents must be trained in parenting skills; parents have important information about their children's behavioral history; and parents also need to receive help. There is, however, an absence of the theme of making parents equal partners in treatment. Parents are thought to serve as informants rather than co-equals in therapeutic intervention. It is clear that the interpretation of family involvement was limited to parents telling about their children and that staff members, in turn, develop a plan to help the child. The ultimate decision of what happens to the delinquent child in residential treatment seems to be based on parental cooperation with the program.

### C. Issues Surrounding Family Involvement

The third qualitative question asked the participant about issues and concerns surrounding the involvement of families with their delinquent children who are placed in residential treatment. The themes that emerged from this question overlap with some

of the themes in question two, with the major themes being: barriers of involvement, familial distrust of the system, distrust between parents and staff, and families resistance to change.

The narratives are reflections of the staff who participated in the focus group exercises and of those who participated in individual interviews. The focus group participants unanimously agreed that most of the clients they serve are both socially marginalized and are poor. As a result of poverty and lack of a means of transportation, families are often unable to visit their children in placement. Another concern is the distance of the program's location in relation to the state's larger cities from which many of the children originate. This is compounded by the need for childcare for younger siblings when a parent has to be away from home for any length of time in order to participate in the residential program; parents often cannot afford this additional expense. Both groups affirm that parents have a distrustful view of the juvenile justice system and have little trust for the staff members and agency. One of the staff members interjected

> *"There is a big distrust of the system. Some of the parents have been through difficulties with the system, and now, instead of working with you to see what can be done to improve their children's life, they finger point — such as you are this, you are that and you lousy [sic]. That is when the kid reached this point they were already tired of the system and they really do not want talk to anybody [sic]. Without cooperation, you are not going to get to the issues that brought them here."*

There were other themes that were thought to be problems originating with the parents and having negative impacts on the children. For the example, one of the participants (who had more than a decade of experience with the agency) said

> *"Some of the kids were severely damaged by their parents, and it is a difficult decision to involve them in his treatment. We have a kid that is going through*

*that right now. He's been living in foster care since he was young. He knows who his real father is; he knows who his real mother is. They have a lot drug issues. You have to understand that his mother doesn't want anything to do with him. She is not in a position to show any love, you know. That's a big concern [sic]."*

A co-worker added

*"We have a kid call home and his mother started yelling, she's yelling at the kid [sic]. The kid is in placement and he was looking for nurturing from mom but she was yelling at him so long that he hung up the phone. And for the whole day we had to process what was going in hindsight [sic]. This does not help the kid." Another observation made was that even when parents show up for visits they have problems with setting boundaries with their children. One staff said, "A lot of time I see they do not set boundaries with their child. You have to make rules and set boundaries with your children. If you cannot do this, then you have problems. They want to be friends with their kids instead of being parents. For example, a kid calling a parent 'do' or 'nigga' [sic] is inappropriate and irresponsible to it highest degree."*

### D. Agency's Position on Family Involvement

The fourth focus group question attempts to explore employee perceptions of the agency's position regarding family involvement. The question is crucial to understanding the context in which the workers carry on the daily activities in fulfillment of meeting the organization's goals, including the provision of services to the children's families. The content analysis of the narrative of the direct care staff during the two focus group sessions points to the mission statement of the agency. To better understand the results of the narrative, it is important to know what is contained in the mission statement:

*"To provide opportunities to children, families, and individuals to be responsible for their own lives and strengthen their relationships with others (Agency Handout, 2005)."*

This mission statement and the accompanying vision statement are very important to the agency and deviation from these values could lead to dismissal, according to the focus group members. Since there appears to be so much emphasis on the mission statement, the researcher asked the focus group members to interpret the mission statement as they perceive it. One of the staff responded by saying, "I think the mission of the agency is to help people grow and to become successful." Another staff interjected and continued the importance of the mission statement:

> *"You can check it out. The agency goal is to help people to learn to enjoy their own lives without harming and being harmed by others. Also, we can't do our program without their involvement. They are resources that we should use more. We want families to be involved from day one in the whole treatment process, from visiting the camp to having home visits before release. We want them to learn and to benefit also [sic]."*

Despite overall agreement that the agency supports family involvement, some of the participants lamented that financial constraints prevent the agency from doing more for the children and their families. One the staff member said

> *"We need funding. We lack the resources, you know. Poverty is a big issue with the families whose children we serve. If we have funding we can have those families up here to organize parent classes. Matter of fact, training is important for parents. We can even organize regional workshops in Detroit because many of our kids come from Detroit, too, but don't have the resources [sic]."*

The view of the program's support for family involvement is consistent across the various study participants. However, staff members reported overlapping themes of familial poverty; lack of transportation; an unwillingness of caseworkers who place the children with the agency to involve families; the existence of parents who have given up on their children; and distrust of the servicing agencies as hindering participation. One long-term staff member stated

*"The program supports family involvement. The problem, I think, is some parents look to others to raise or their fix their child. We've never been in a program where we do not want parents to be involved. We want the whole total [sic]. Yes, you can fix one thing and expect the others are going to fix themselves. We bring parents out. We have picnics. The family unity is what the agency is all about [sic]. We have features around the campus that show family unity. Parents who cannot make it up here, we go to out of our way to pick them up, no matter what. We used to do it a lot a while ago. We picked them up from bus stations. It has become our second nature. Your kid is here. You should be here and learn the way he is learning. That's the way it has been and I have been here nine years."*

Another important theme regarding the agency's position on family involvement involves allowing the residents to go on overnight home visits when they achieve a certain level in their treatment. According to the staff narrative, the agency policy on home visits includes the youth staying home and interacting uniquely with family during the first two visits. The youth was not allowed to go out and socialize with his friends. Additionally, drug screens were conducted when the youth returned from the home visit. One participant highlighted the importance of home visits by saying that when the youth began to enjoy the reward of going home, they began to see that they have a home and, as such, developed a greater sense of belonging. Even though some children run away while on a home visit, they almost always end up returning to the facility. As this staff member said,

*"It is true that some kids don't come back. And it also true that some kids ran for two weeks and when they returned, the caseworker would ask what we did want to do, and most of the time the agency takes them back [sic]. In my twelve years here, we have given kids second chances and third chances. That's what I like about our program."*

### E. Additional Comments

The last qualitative question gave the participants an opportunity to offer additional comments about family involvement with juvenile delinquents placed into their residential treatment program. Once again, themes in this last question reaffirm the patterns observed in the answers to questions three and four. The staff narrative emphasizes the making of family involvement a mandatory program component and striving to include parents throughout the process, from the day of admission to the program until the child is released or transferred to another facility. The major themes hinge upon the families' reluctance to be involved and upon the lack of positive role models available to children returning home. When probed about what they consider to be a positive role model, staff answered that a positive role model is someone – a man or a woman – who can set limits with the youth and show appropriate concern toward his/her well-being. As one worker said,

> *"When we don't have programs in the schools or outside school, wha'st a kid gonna do [sic]? He gonna hang out in the streets [sic]. He will end up causing harm to the community and somebody has to stop him before it is too late. No one sets boundaries for these kids. The boundary is television, bling-bling and fast money [sic]."*

## 4.4b Document Review

Analysis of the agency's official documents includes the organization's Mission Statement, Vision Statement, values, bulletins, and brochures regarding the agency's services, customers and staff. Some of the core values gleaned from the corporate materials highlighted the importance of family involvement in that every child that is admitted to facility must have a family plan that supports his maturation into a

responsible adult. The analysis of the documents also shows that the agency customizes the program to meet the uniqueness of the individual, as determined by each youth's needs and strengths.

# Chapter 5: Discussion, Implications, Limitations and Conclusion

This final chapter highlights some of the results presented in Chapter 4 in relation to empirical literature on staff attitudes and beliefs toward family involvement. This chapter also provides a summary and discusses the limitations of the study. The implications for social work practice, policy, social work education, suggestions for the participating agency, and research are addressed, as are possible areas for future research. The dissertation concludes by reiterating that, despite the recognition that family involvement is an essential component of residential treatment, there are still barriers that constrain the effective engagement of families in treatment-oriented activities.

## 5.1 Discussion

In the literature review conducted for this project, only two studies were found in the empirical literature that address staff attitudes and beliefs about family involvement of children in residential treatment. Those studies explore the attitudes and beliefs of staff working with severely emotionally disturbed (SED) children (Coleman, 1999) and of staff working in residential treatment for children and adults with mental illness (Baker, et al., 1995) rather than with delinquent youth. The present study uses a modified version of the same instrument used by both Coleman and Baker in their studies but instead examines staff attitudes and beliefs regarding family involvement in residential treatment for delinquent children.

Until recently in the empirical literature, the focus has been on child-centered approaches to the treatment of children in residential treatment rather than family-centered approaches (Mayer, 1960; Whittaker, 1981). Child-centered approaches are rooted in various psychodynamic and behavioral modification models and traditionally support the removal of the child from the parental home based on the assumption that the family has played a major role in the child's current problematic behaviors (Alexander & Dore, 1999; Jivanjee, et al., 2002). Even with the advent of the National Institute of Mental Health and the Child and Adolescent Services System Program, which encourage partnerships between parents and professionals, there is still little evidence in the literature regarding clinicians' (social workers, psychologists, psychiatrists, and/or direct care staff) perceptions of treating family members as co-equals in the treatment milieu. The Baker et al. study (1995) suggests that staff members who support family involvement want to provide guidance or therapy to families. The position of being expert and wanting to provide guidance and therapy is an indication of staff not willing to treat families as equals or partners. Baker and colleagues' 1995 study also notes that staff members are less supportive of activities that empower families to be represented in decision-making or that did not involve families in residential treatment daily activities.

The current study has a number of goals. First, as a result of the limited scope of the literature on residential staff in juvenile delinquent treatment programs, this researcher explores the attitudes and beliefs of these workers within the participating agency. Secondly, the hypothesis that staff attitudes and beliefs contribute to whether family involvement will be valued at the residential facility was tested. Thirdly, as is

consistent with social work principles of professional integrity and competence, the study assesses the performance of the professionals working with the youth and families entrusted to their care. Next, the study examines the effectiveness and the extent of the support of the paradigm shift in service delivery to children from a child-centered approach to the family-centered practice and encouragement of reuniting families by those in the field of child welfare services. Lastly, the study intends to assess the implementation of recent federal and state policy-making which has prioritized family involvement in child welfare and treatment. It is important to expand the knowledge base regarding the attitudes and beliefs of staff working with juvenile delinquents in a residential setting in order to determine to what extent policies and established best practices are integrated into the practices of employees

### 5.2 Summary of the Study

The current research project utilizes a mixed-methods approach which consists of both quantitative and qualitative elements in order to enable a more comprehensive understanding of staff members' attitudes and beliefs about family involvement. The staff questionnaire, which was first developed by Professor Bruce L. Baker at the University of California, Los Angeles, for the Devereux Foundation Family Involvement Study (1995) and later adapted by Frances Claire Coleman (1999), was revised and used to collect data from 51 participants of a mid-sized, Midwestern juvenile delinquent residential treatment facility. Questionnaire participants include members of all levels of staffing at the facility. Focus group interviews were conducted as another

data-gathering method. Focus group participants were uniquely direct care staff in order to maintain homogeneity.

The investigation is an exploratory study using a convenience sample. The participants are members of the agency and had been employed for at least 90 days at the time of the study. There are 34 direct care staff, five clinicians (family therapists) and 12 persons who worked in an administrative capacity, such as directors, secretaries, etc.) . The ages of the employees range from 22 to 57 years old. Most of the workers report having a four-year college degree and no one reports less than a High School education. The sample was dominated by male staff with a fair representation of females. Over 60% of the participants report having at least one child of his/her own.

Despite the dearth of information relating to staff members attitudes and beliefs toward families of delinquent children in residential programs, the findings in this study advance the existing literature regarding residential treatment from the perspective of staff. The findings are grounded in the staff members' perceptions of their experience of working with delinquent children and their families.

Overall, the findings suggest that the majority of the agency staff support family reunification and by a large margin, as compared to the previous studies on this topic (Baker et al., 1995; Coleman, 1999). Although family reunification is not the main focus of this study, the agency's objective of reuniting families is highlighted. It seems clear that staff recognize a link between a child's eventual return to his/her home and activities designed to involve families during his/her placement. For example, during the focus group sessions one recurring theme was the notion of bringing parents and

children together to learn pro-social skills and values. By the same token, the findings suggest that family involvement is not viewed as important if the delinquent child was not going to return to the parental home. The findings confirm what many studies suggest, which is that maintaining the family ties of youth in out-of-home placement correlates with successful transition into the community (Harvell, et al., 2004; Henggler & Schoenwald, 1998; Herbert & Harper-Dorton, 2002).

As expected, staff members who have negative beliefs about families are not strong supporters of family involvement. As depicted on the Disadvantage Scale, this does not correlate with the Family Support Scale ($r = -.175$, $p = .05$). The findings also support the theory that staff members who maintain positive beliefs about families also support the involvement of families in treatment. Consistent with other studies about family involvement, staff members who consider family involvement as an essential component in the treatment of the child want to play a helping role (Baker et al., 1995; Collins & Collins, 1994).

The findings strongly suggest that parents must receive training and help from the staff. The staff members in this study did not see family members as effective contributors toward the rehabilitation of troubled young persons without this help. The finding is consistent with Baker's (1995) finding that suggests staff members prefer to play a leading role and that parents were there to provide information that would enable them to help the child rather than being equal players in treatment (Collins & Collins, 1994). The role of parents, according to staff members, is to provide information that will enable the professional to determine the causes of a child's abnormal behavior(s) and provide the necessary interventions.

Another finding that constitutes a major theme in this study is idea that "treating the child means treating the whole family." Implicitly, that staff members consider family members as dysfunctional and lacking the ability to make sound decisions. As such, families are viewed as requiring therapeutic intervention to help them become functional. This suggests strongly that the entire family needs help because it is not beneficial to rehabilitate the child and send him back to the same environment. Taken together, the findings of the study contribute to an understanding of limited involvement of family members in decision-making regarding their child's treatment when s/he comes into contact with the law, is adjudicated and referred to receive treatment in residential facilities. More precisely, the study confirms other findings in the literature that suggest that professionals are reluctant to treat parents as equals and experts in the field of therapeutic interventions (Alexander & Dore, 1999; Collins & Collins, 1994; Leone, 1990; Osher & Hunt, 2002).

Finally, the current study shows that even when staff attitudes and the agency position are geared towards family involvement there are several barriers that prevent effective involvement of families. Among these barriers are the distance of the family home from the residential program site, a lack of resources to implement family engagement activities, and, to some extent, the families' distrust of the system and/or unwillingness to be involved in the treatment or their children. The findings from a staff perspective do not demonstrate a lack of family involvement due to staff-family conflict. In fact, according to staff, families are welcome to participate and take advantage of what the agency has to offer in terms of parenting skills and effective

management of family problems. Implicitly, family involvement is welcomed when staff members view families as part of the treatment plan.

### 5.3 Limitations of the Study

There are several limitations in the present study that need to be addressed. First of all, the modified version of the quantitative instrument utilized in this study was originally designed to measure staff attitudes in a mental health, non-correctional setting (Baker et al., 1995) rather than staff working with adjudicated delinquents. Baker, et al. (1995) used the instrument in three Devereux Foundation residential centers in California, Arizona and Florida, respectively. Coleman (1999) used a modified version of the instrument to collect data from three Jewish Community Centers that provide residential treatment for children with severe emotional disturbances. This researcher adapted the instrument to study employees who work with adjudicated delinquent children in one rural, mid-sized agency in the Midwest,. Also, the statistical methods used to collapse some of the variables and to create subscales may have influenced the outputs of the various scales tested.

Secondly, the current study uses a non-probability convenience sample drawn from one juvenile delinquent residential treatment agency and, for this reason this research cannot be generalized to residential treatment staff beyond those employed at that particular agency. In addition, the sample of participants themselves can be considered a limitation to this study given the small sample size (N=51) and limited representation of women and diverse ethnic groups. Furthermore, the participants were

from a private sector agency and their interactions with their environment may be different from those employed in the public sector with similar job descriptions

Thirdly, due to the small sample size and the close knit environment of the agency, some respondents may have felt obligated to participate. Even though attempts were made to have the participants write their answers to the qualitative questions before participation in a focus group interview in order to reduce peer influence, there is no guarantee that the goal was attained since the discussions mirrored the participant responses in the written format. The participants may have felt intimidated and pressured to provide what they believed were desirable answers as conversations were tape recorded by the researcher.

Additionally, while the investigator made all attempts to be non-influential and non-judgmental during the focus group sessions, there was a possibility of bias during the process. The researcher is a social worker employed at the same state's largest juvenile delinquent facility, which houses chronic and violent offenders. As such, the investigator admittedly holds some strong opinions about the topic, perhaps more so than an investigator who may not have been as intimately associated with the subject matter. Because of this intimate association with the subject matter, the researcher asked the focus group participants to respond to the interview questions privately and in written format before joining the group for discussion.

Finally, an inherent weakness of the study is the exclusion of input by the families and the delinquent children who received the services of the agency. It is possible that when scales that measure client satisfaction are included, the findings may yield different conclusions.

### 5.4a Implication for Social Work Practice

The study encourages a family-centered approach that is contingent upon staff attitudes and beliefs about the families of the delinquent children in residential treatment. It reflects the complexities of social work practice in which social workers work in a multi-disciplinary environment of professionals coming from different schools of thought and, hence, maintaining different attitudes and beliefs about families of delinquent children in residential treatment. Research indicates that family-based interventions are designed to help adolescents with the fundamental assumption that the family is paramount to child-development (Bandura, 1969; Gottfredson & Hirschi, 2003). The source of initial socialization is the parent and, consequently, addressing a child's delinquent behavior cannot be holistic without knowing the social history of the child and his family (Hirschi and Gottfredson, 2003). Remaining true to this practice depends upon the attitudes and beliefs about families of the involved staff members. An effort to maintain family connections for all children who come in conflict with the law, unless they have no family members as a result of death, incarceration or desertion, depends upon the willingness of staff (Baker et al., 1995). Furthermore, understanding staff attitudes and beliefs about family involvement facilitates a more effective planning process that is central to identification of family strengths.

### 5.4b Theoretical Implication for Social Work Practice

True to the theoretical framework of ecological perspectives, the current study recognizes that the delinquent child is part of a family and the family itself is a part of

a larger ecological system (Bronfenbrenner, 1979). Although derived from systems theory which is much broader and articulates transactions of individuals at different levels within the system, the ecological perspectives approach is an influential social work theory that informs practice and potential for understanding person-in-environment (Bronfenbrenner, 1979; Germain and Gittermain, 1996). Exploring staff attitudes and beliefs about family involvement in their place of work is compatible with the ecological perspectives approach of person-in-environment.

Despite volumes of research documenting the importance of involving families, the source of primary social contact, the problems of the delinquent youth may probably be traced back to the family dynamics of such involvement (Bandura, 1969; Hirschi and Gottfredson, 2003). This may not occur if staff members have negative beliefs about families (Baker et al., 1995). Staff attitudes and beliefs about families of the individual youth may determine whether the staff members are willing to understand the important influence of peers, school and the neighborhood on the development of the child's delinquent behaviors (Bronfenbrenner, 1979; Ungar, 2002). By involving family members, social workers or staff members are able to observe and identify family strengths/weaknesses during family interactions. The therapist could develop a goal targeting positive traits and attempt to reinforce them in treatment sessions. This approach ensures fidelity and measurement of effective outcomes within the framework of ecological perspectives. In other words, delinquent children are better served when staff members have a good knowledge base of their social environment.

### 5.4c Implications for Policy

The findings of this study are in line with policies enacted at the federal level, which emphasize family involvement with children – especially those in the special education and mental health systems (Allen & Petr, 1996; Banes, 1998). For example, the 2001 reauthorization of federal Juvenile Justice and Delinquency Prevention Act (JJDPA) stresses family involvement activities (Brock, Burrell, & Tulipano, 2006). However, no matter what the policies stipulate regarding engaging families in treatment, the stipulations cannot be met without appropriation of adequate funds for implementation. The findings in this study suggest that residential treatment programs are faced with a major limitation of underfunding of the design and implementation of activities that engage families. Many delinquent children in residential treatment have a myriad of problems, ranging from mental health to learning disabilities and outright criminal behaviors (Shireman, 2003). As Shireman (2003) points out, planning treatment to meet the needs of such children may require more financial and human resources than are currently available. Budget issues limit the ability of delinquent residential programs to involve families in the service planning process which can be both labor and financially-intensive, as evidenced in this study. Additionally, agency decision-making in residential programs is inevitably influenced by national and state policy, as well as the general public's perception. Public perception influences public policy and, as described in the literature, is demonstrated by the back-and-forth swing of policy between rehabilitation and the "get tough on offenders" attitude (Barry, 1999; Mooradian, 2003; Tuell, 2002). It is important for policymakers to understand the societal benefits that can be accrued when families are engaged in the treatment of

delinquent children so that they can include supportive policies and allocate the necessary monetary resources to design, hire, and train staff in family-centered practices leading to successful implementation of family involvement activities.

### 5.4d Implications for Social Work Education

A recurrent theme in the professional literature and this study has been the unequal relationship between families and clinicians. This is frequently attributed to issues stemming from professional attitudes that parents lack expertise or the assumption by professionals that parents have failed in their duties as parents (Alexander & Dore, 1999; Jivanjee, et al., 2002). Others suggest that professionals often assume that the parent-professional collaboration in treatment of troubled children is only useful in determining the etiology of the problems at hand and fail to recognize their potential for solutions (Collins & Collins, 1994).

Social work students need to be taught from an ecological perspective across the curriculum and be given the opportunity to develop the skills to work within juvenile justice residential programs. Such skills have applications in many other family-related programs. Social work is a discipline that traditionally draws upon a pool of multidisciplinary knowledge – piecing together information from many social and natural sciences to form a unique knowledge base in academia. Consequently, social work education should develop courses focusing on the organizational dynamics of juvenile justice practice. Such orientation must include field education where students are able to work with direct care workers and their chain of command. Though not explicit in the study, there is a possibility that many of the direct staff did not receive formal

training in family-centered practices. It was also evident in the study that there is a difference between direct care staff and clinicians, including administrators, regarding the support of family involvement and reunification of delinquent children with their families. The study suggests that clinicians and administrators favor family involvement and reunification. This difference may be due to differences in academic training. Social work education, among other things, is already focused on child welfare and interpersonal practice with children, youth and families. Incorporating a specific content area addressing family and staff dynamics in juvenile justice programs will prepare students who want to pursue a career in the juvenile justice arena. It is possible that when social workers specialize in juvenile justice practice (including the subgroup of institutionalized juvenile delinquents and their families) their beliefs and attitudes toward families may be positive and the potential for distrust between staff and families may be mitigated.

### 5.4e Implications for Future Research

While there is evidence that encouraging parental involvement in the education and mental health systems is a good thing, there is little empirical literature on staff attitudes and beliefs about family involvement with delinquent children in residential treatment who may also have learning disabilities and mental illness issues (Bogrov & Crowel, 1996; Carlo, 1985; Collins & Collins, 1994; Wierson & Forehand, 1992). This study represents a preliminary step in the exploration of staff attitudes and beliefs toward families of delinquent children in residential treatment facilities. The results provide support for positive staff beliefs and for family involvement. However, as

discussed in the limitations, this study does not include the consumers of the services. Further study is needed to explore the perceptions of families and of the delinquent children regarding staff members' attitudes and family involvement. Specifically, further work is warranted for targeting the efforts of juvenile delinquent residential treatment agencies to involve families in decision-making in treatment rather than merely employing families as providers of information and as passive onlookers in the treatment process. It is also important to compare the attitudes and beliefs of staff members in public versus private sector juvenile residential treatment programs to see if there are any significant differences in attitudes and perceptions relating to family involvement.

The findings also suggest that in-service training for juvenile residential staff is focused on child-centered, empirically validated programs rather than family-centered practices. Heightened family-centered training could equip staff members with the necessary skills needed to work with families and their delinquent children. Future research should develop staff training programs with specific components that will contribute to family-centered practice in residential treatment for juvenile delinquents. Future work also should include the development and refinement of instruments such as the one used in this study but designed for juvenile delinquent residential staff in order to explore the attitudes and perceptions of this segment of child and family workers. It was disturbing to discover during the literature review for this study that juvenile residential programs are among the most expensive in the juvenile justice system and yet there are no measures to assess the attitudes and perceptions of the professional who delivers services to the children and their families (Engel, Howe,

Fahey, & Finn, 2006; Walsh, Kastner, & Green, 2003). Despite the limitations of the study, the findings have made several important contributions to the body of social work knowledge describing staff attitudes and beliefs about families of delinquent children in residential treatment.

### 5.5 Suggestions for the Participating Agency

This study affirms that the agency and it employees make an effort to involve families in the treatment of delinquent children in residential programs. The staff members express genuine care about the juveniles with whom they are working and are committed to providing excellent care. But it is important to suggest to the agency administration that some of its limited resources should be directed toward providing formal training to staff in family-centered practices. With the recognition that families have an important role in the overall successful reintegration of delinquent children into the community, the agency should ensure parents receive training regarding the family-centered focus of the agency and emphasize the parenting skills training programs. Also, by providing open information to parents pertaining to their rights, the distrust between staff members and parents might be defused. Despite the rising cost of transportation, the agency could build much in the way of trust and demonstration of their care and concern toward families and their children if the agency provided transportation assistance for monthly family therapy sessions and training.

The research provides the following information regarding staff race and gender breakdowns. The overwhelming majority of the employees (73%) were Caucasians and less than 25% were African Americans. Two percent of the participating

employees did not indicate their race or ethnic affiliation. In terms of gender distribution, male staff members (68.6%) and female staff (31.1%) may be a fair distribution, but an effort by the agency to increase the number of female employees would be beneficial. The results also suggest that an increase in the recruitment of minority staff could improve staff-family relationships. It was apparent from the focus group exercises that many of the delinquent children the agency serves are from urban areas and possibly the majority belong to minority ethnic groups. Families might feel more comfortable when they meet individual staff members from their own ethnic group which may in turn lead to an increase in their involvement in the treatment of their child.

Additionally, the results show that the staff turnover rate at the agency is high. More staff were employed at the agency in the range of three months to a year than those who were employed there for two years and over at the time of the study. This phenomenon can quite possibly be explained by the reorganization of the agency in 2006. This issue must be addressed in a way that the agency is able to attract, hire and retain professionals with expertise in juvenile justice and child welfare policies and practice. In spite of these suggestions, the study affirms that the level of professionalism exhibited by the staff and their expressed commitment to providing services to the children in their care was excellent.

### 5.6 Conclusion

Despite the small size of the sample in this study, the findings provide information that resonates with findings in available studies on residential staff attitudes and

beliefs about families and their involvement with children (Baker et al., 1995; Coleman, 1999; Collins & Collins, 1994). The findings indicate that staff members support family involvement, especially when the child will return to his/her family. In contrast with earlier concepts of child-centered approaches of rescuing the child from his/her pathogenic family (Bettelheim, 1974), these findings suggest that staff members of the participating agency do encourage family involvement when the child is in residential treatment. In addition, the study contributes to the knowledge base which describes the characteristics of residential staff in the juvenile justice system such as gender, race/ethnicity, age, education, training and professional disciplines.

The qualitative reports suggest strongly that barriers of family involvement include a lack of transportation, distrust of the system, and family members giving up on their parental responsibilities. Also, some staff members view family members as dysfunctional. There was acute frustration among the workers regarding resource limitations. The problem of transportation was found to be a major barrier of adequate family involvement when a delinquent child is in residential treatment and this finding is congruent with other studies (Baker & Blacher, 1992; Baker et al., 1995; Kruzich, Jivanjee, Robison, & Friesen, 2003). Consequently, in order to increase family involvement, the agency must make the provision of providing transportation a priority.

In sum, while this study identifies many agency strengths, there is still room for improvement in involving families in the treatment of delinquent teens in residential settings. The role family is indeed pivotal

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# APPENDICES

# APPENDIX A

# MICHIGAN STATE UNIVERSITY INSTITUTIONAL REVIEW BOARD (IRB) APPROVAL

## MICHIGAN STATE UNIVERSITY

November 15, 2007

TO: Ellen WHIPPLE
244 Baker Hall

Re: **IRB # 06-665** Category: EXPEDITED 2-7
**Renewal Approval Date:** **November 15, 2007**
**Project Expiration Date:** **November 14, 2007**

Title: Staff Attitudes and Beliefs About Family Involvement of Delinquent Children in Residential Programs

The Institutional Review Board has completed their review of your project. I am please to advise you that **your project has been approved.**
**This letter notes for approval for data analysis on 9contact with subjects and data collection is complete). Any further recruitment, data collection or contact with subjects will require IRB review and approval via a revision before implementation.**

The committee has found that your research project is appropriate in design, protects the rights and welfare of human subjects, and meets the requirements of MSU's Federal Wide Assurance and Federal Guidelines (45 CFR 46 and 21 CFR Part 50). The protection of human subjects in research is a partnership between IRB and investigators. We look forward to working with you as we fulfill our responsibilities.

**Renewals:** IRB approval is valid until the expiration dated listed above. If you are continuing your project, you must submit an **Application for Renewal** application at least one month before the expiration. If the project is completed, please submit an **Application for Permanent Closure.**

**Revisions:** The IRB must review any changes in the project, prior to initiation of change. Please submit an **Application for Revision** with renewal application.

**Problems**: If issues should arise during the conduct of research, such as unanticipated problems, adverse events, or any problem that may increase the risk of human subjects, notify the IRB office promptly. Forms are available to report these issues.
Please use IRB number listed above on any forms submitted which relate to this project, or on any correspondence with IRB office.

Good luck in your research. If we can be of further assistance, please contact us at 517-355-2180 or via email at IRB@msu.edu. Thank you for your cooperation.

Sincerely,

Peter Vasilenko, Ph.D.
SIRB Chair
c: Tohoro Akakpo
3121-3D Trappers Cove Trail
Lansing, MI 48910

# APPENDIX B

# LETTER OF RECRUITMENT TO THE AGENCY

Brian Philson, LMSW
Director of Residential Services
Highfields, Inc.
PO Box 98
Onondaga, MI 49264

Date_____

Dear Mr. Philson:

As per our previous discussions, I am writing to request your formal permission to conduct research at your agency. The topic of the research project is the effect of staff attitudes and beliefs about youths' families upon the involvement of those families with juvenile delinquents placed into residential treatment. I am requesting to have contact with your staff as my case study. Currently, I am a Ph.D. candidate at the School of Social Work at Michigan State University and am working on my dissertation. My dissertation title is *Staff Attitudes and Beliefs about Family Involvement of Delinquent Children in Residential Treatment Programs.* It is the hope that project will help expand the social work knowledge base regarding Juvenile Justice System programs. Additionally, it is anticipated that the findings will encourage staff working with juvenile delinquents in residential settings to evaluate their attitudes and beliefs about family and support for family involvement.

During the months of November and December, 2006, I would like to come to your agency and meet with staff members, supervisors and directors who are interested and/or willing to participate in the study. The study will use a mixed methods approach and will involve surveying direct care staff, supervisors and administrators. Additionally, direct care staff will be invited to participate in focus group interviews in order to gather qualitative data. All activities involving your staff will take four days to complete. I am requesting to review your agency policy manuals, grievance procedures, etc. There will be no identifying information of staff or youth, including case records, that will be included in the study.

There are no known risks associated with this study but if at any time employees feel uncomfortable with the study, they are free to withdraw from the participation. .The Social Work of Code of Ethics regarding confidentiality will be strictly adhered to as will the guidelines of Michigan State University Human Research Protection Program.

If you have any further questions about the study, please contact Dr. Ellen Whipple, my Dissertation Chair by phone: (517)4320-3740, fax: (517)353-3038; or e-mail: whipple@msu.edu or regular mail: Michigan State University, School of Social Work, 244 Baker Hall, East Lansing, MI 48824.

Thank you for your time and consideration.

Sincerely,

Tohoro F. Akakpo, LMSW, MPA
PhD Candidate
School of Social Work, Michigan State University
517/882-5207
ftakakpo@msu.edu

# APPENDIX C

## STAFF ATTITUDES AND BELIEFS ABOUT FAMILY INVOLVEMENT SURVEY CONSENT FORM

## STAFF ATTITUDES AND BELIEFS ABOUT FAMILY INVOLVEMENT SURVEY CONSENT FORM

### Staff Attitudes and Beliefs about Family Involvement of Delinquent Children in Residential Treatment Programs

You are being asked to participate in a study regarding staff attitudes and beliefs concerning family involvement with delinquent children in the Highfields residential treatment program. The purpose of the study is to examine staff attitudes and beliefs, as well as to determine the level at which staff supports family involvement, and contributes toward a youth's successful completion of the treatment program and reintegration into the community.

If you agree to participate, you will be asked to complete an anonymous, written questionnaire entitled "Staff Attitudes about Family Involvement Survey." You will only be asked to complete this questionnaire once and it will take approximately 35 minutes to complete. This exercise will be conducted on site at Highfields, Inc.

Although there are no known risks associated with this study, it is possible that you may find some of the questions about your job conditions sensitive and feel uncomfortable in answering. There is also a small chance that you may find some of the questions personal in nature or they may cause you to reflect on memories that are unpleasant or even upsetting in nature. However, procedures have been developed to minimize the risks and ensure confidentiality. The findings of this study will not contain any identifiable information about you. All information will be collected in a highly confidential manner and will be summarized in aggregate form (i.e., by groups rather than individuals). In lieu of names, an identification number will be assigned to each survey. Further, the data collected will be kept in a locked cabinet in the office of the Responsible Projector Investigator, Ellen Whipple, Ph.D. The surveys will be destroyed upon completion of the study. Your privacy will be protected to the maximum extent allowable by law.

There may not be any direct benefit to you from participating in the study. It is, however, anticipated that the findings may be beneficial to the clients served at your agency and for the field at large. It is anticipated that the findings of this study may lead to an increase of staff/family communication, which in turn will lead to more realistic treatment goals, and youth being reunited with their families sooner. At the societal level, the findings may lay a framework for changes in juvenile justice policy and programming and may reinforce the need for government support of early intervention.

Your participation is entirely voluntary. Your decision either to participate or not will not affect your employment status with Highfields, Inc. and you are free to withdraw your consent and discontinue participation at any time. Additionally, you may refuse, without penalty, to answer any questions that make you feel uncomfortable. You will receive $10.00 as a token of appreciation for your time and effort.

We appreciate your willingness to participate in this project, and are looking forward to learning from your experiences and perspectives. If you have any questions about this study, please contact Dr. Ellen Whipple, Responsible Project Investigator, by phone: (517) 432-3740, fax: (517) 353-3038; e-mail: whipple@msu.edu or regular mail: Michigan State University, School of Social Work, 244 Baker Hall, East Lansing, MI 48824.

If you have questions or concerns regarding your rights as a study participant, or if you are dissatisfied at any time with any aspect of this study, you may contact—anonymously, if you wish—Peter Vasilenko, Ph.D., Chair of Michigan State University's Institutional Review Boards (IRBs) by phone: (517) 355-2180, fax: (517) 432-4503, e-mail - irb@msu.edu, or regular mail: 202 Olds Hall, Michigan State University, East Lansing, MI 48824-1046.

Your signature indicates that you willingly agree to participate in this study and that you understand that you may withdraw your consent and discontinue your participation at any time, without penalty.

_____

Your Signature

_____

Today's Date

# APPENDIX D

# DIRECT CARE STAFF FOCUS GROUP INTERVIEW CONSENT FORM

## DIRECT CARE STAFF FOCUS GROUP INTERVIEW CONSENT FORM

### Staff Attitudes and Beliefs about Family Involvement of Delinquent Children in Residential Treatment Programs

As a direct care staff member of Highfields, you, along with some of your co-workers, are being invited to participate in a focus group discussion of your work experiences with the families of delinquent children in residential treatment at your organization. You have been chosen at random from the direct care staff at Highfields, Inc. The purpose of this study is to assess the level at which staff supports family involvement, as well as the beliefs of staff about the families of adjudicated juveniles and how these attitudes influence family involvement.

If you agree to participate, you will be asked to provide written answers to a survey entitled "Direct Care Focus Group Interview." The written interview consists of five questions and will take approximately 30 minutes. After the written portion is completed, the researcher will ask you to join other participants for a group discussion using the same questions. The entire process will take approximately 90 minutes to complete.

There may not be any direct benefit to you from participating in the study. It is, however, anticipated that the findings may be beneficial to the clients served at your agency and for the field at large. It is anticipated that the findings may lead to an increase in staff/family communication, which in turn will lead to more realistic treatment goals, and youth being reunited with their families sooner. At the societal level, the findings may lay a framework for changes in juvenile justice policy and programming and may reinforce the need for government support of early intervention.

There is a slight risk that you may find some of the questions about your job conditions to be sensitive or that you may not want to share your beliefs and experiences in the presence of your colleagues. In order to minimize these risks, we will encourage all the participants not to share the discussion with anyone outside of the group. In addition, the audiotapes of the sessions will not be played for anyone other than the researcher during transcription. All data, including the audiotapes, will be kept in a locked cabinet in the office of Responsible Projector Investigator, Ellen Whipple, Ph.D. The audiotapes, the self-administered questions and the interview notes will be destroyed upon completion of the study. The only evidence of your participation in this study will be this signed consent form. There will be no association between your identity and the information you provide in the interview. No identifying information will be used in this research project. Your privacy will be protected to the maximum extent allowable by law. Furthermore, you will receive a copy of this consent for your personal records.

Your participation in both the written and oral portions of the focus group exercises is entirely voluntary. Your decision either to participate or not will not affect your employment status with Highfields, Inc. and you are free to withdraw your consent and discontinue participation at any time. Additionally, you may refuse, without penalty, to answer any questions that make you feel uncomfortable.

As a token of appreciation for your time and effort, you will be given a raffle ticket. Tickets will be drawn and seven (7) prizes will be awarded: one $100 First Place Prize; two $50 Second Place Prizes; and four $25 Third Place Prizes.

We appreciate your willingness to participate in this project, and we are looking forward to learning from your experiences and perspectives. If you have any questions about this study, please contact Dr. Ellen Whipple, Responsible Project Investigator, by phone: (517) 432-3740, fax: (517) 353-3038; e-mail: whipple@msu.edu or regular mail: Michigan State University, School of Social Work, 244 Baker Hall, East Lansing, MI 48824

If you have questions or concerns regarding your rights as a study participant or if you are dissatisfied at any time with any aspect of this study, you may contact—anonymously, if you wish—Peter Vasilenko, Ph.D., Chair of Michigan State University's Institutional Review Boards (IRBs) by phone: (517) 355-2180, fax: (517) 432-4503, e-mail - irb@msu.edu, or regular mail: 202 Olds Hall, Michigan State University, East Lansing, MI 48824-1046.

Your signature indicates that you willingly agree to participate in this study and that you understand that you may withdraw your consent and discontinue your participation at any time, without penalty.

_____

Your Printed Name

_____

Your Signature

_____

Today's Date

# APPENDIX E

# STAFF ATTITUDES AND BELIEFS ABOUT FAMILY INVOLVEMENT AND REUNIFICATION SURVEY

## Staff Attitudes and Beliefs about Family Involvement and Reunification Survey

**Name of Program/Division**_____

**Name of Unit of Unit(s)** _____

**Code #** _____

### ATTITUDES TOWARD REUNIFICATION

In this section you will be asked whether you agree that children should be returned to their families in specific circumstances.

1. Reuniting a child (under 18 years of age) with his/her family should be a primary program objective for what percent of the residents we serve? (Please put check next to your response).

_____None
_____Few (1-24 %)
_____Some (25-49%)
_____Many (50-74%)
_____Most or all (75-100%)

Please put one of the following numbers in the space in the space before each statement, **indicating how much you agree that in this situation the child should return to his/her parent(s).**

1- **I strongly believe** the child **should not** return to the family.
2- **I somewhat believe** the child **should not return** to the family.
3- **I believe** the child **should not return** to the family.
4- **I somewhat believe** the child **should return** to the family.
5- **I believe** the child **should return** to the family
6- **I strongly believe** the child **should return** to the family.

2.____ Parents have been abusive toward the child and do not show a willingness to change.

3.____ Parents have a history of substance abuse but are working to change.

4.____ Parents abuse drugs or alcohol and do not show a willingness to change.

5.____Parents have a history of drugs/alcohol abuse but are working to change.

6.____Family member(s) are emotionally abusive towards the child.

7____Family member(s) are psychiatrically disturbed with active symptoms.

8.____Parent(s) have been known to CPS and continue to be somewhat abusive.

9.____Family gets into conflict with staff.

10.____Parent(s) do not want child to return home.

11.____ Parent(s) has marital conflict or there is domestic violence.

12.____ Family does not want any involvement with the child.

13.____Family has not participated in treatment with the child.

14.____ Family appears unwilling to change or accept help from the agency, that is, the family is "help rejecting".

15.____Child's behavior is difficult for parents to manage during visits at the agency and/or when child is at home.

16.____Child is reluctant to have parent(s) re-enter his/her life and perhaps disrupt his/her pattern of living and relationships with other adults.

17.____Children are fearful for their safety with formerly abusive parents.

18.____Child's behavior is so difficult to mange that you believe s/he presents a danger to others if s/he returns to the community.

19.____Child has a psychiatric disturbance that would make it difficult for him/her to manage the community.

20.____Child has substance abuse problem or has been violent while in placement.

21.____ Child has a history of fire setting, sexually abusing other children etc. and you are concerned about his/her behavior in the community.

22.____ Child does not want any involvement with the family.

## THOUGHTS ABOUT FAMILIES

This question asks you to think about the cause of the child's problem and relative effect of factors having to do with the child versus those that have to do with the family.

22. Consider the typical resident you work with. In your opinion, the problem behaviors that made residential necessary are (Circle one number):

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Factors totally in the child | Somewhat in the child & the family | Factors equally in the child | Somewhat in the family | Factors totally in family |

For the next set of questions, please indicate how much you agree or disagree with each of the statements about families by putting one of the following numbers in the space before each statement.

| 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|
| Strongly disagree | Somewhat disagree | Disagree | Somewhat agree | Agree | Strongly agree |

24._____ Most Children in residential treatment have been maltreated by their families.

25._____When parents put a child in residential treatment, they should expect to give up most control.

26._____ Most of the residents could live at home if only their parents worked harder to create a good environment for them.

27._____ Parents have the right to be involved in determining their child's program

28._____ Most families are not good for children to return home.

29. _____ Helping parents increase parenting skill should be an integral part of the treatment plan.

30. _____ Treating a child should mean treating a family.

31._____ Families can become better adjusted by involvement with their child's residential program.

32._____ Parents can learn to be more effective in raising their children.

33._____ Most parents sincerely want to do what is best for their children

## *ATTITUDES TOWARD FAMILY INVOLVEMENT*

The following are suggestion that have been made about family involvement. To what extent **do you think these things should occur at Highfields?** Indicate what you feel should or should not happen, regardless of whether it happens already. Please place one of these numbers in the space before each statement.

| 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|
| Strongly disagree | Somewhat disagree | Disagree | Somewhat agree | Agree | Strongly agree |

34.____ At admission, we should have a contract or plan with each family about the nature and extent of family involvement they will have.

35.____ We should try to learn about the family's environment, values and beliefs in order to individualize a treatment plan.

36.____Before discharge, we should plan with parents for transition of their child from Highfields back home or to another placement.

37.____ Parents' preferences should be considered in developing their child's educational and therapeutic program.

38.____ We should have a Parent Advisory Board that has input into administrative decision making.

39.____ There should be parents as members of the Board of Directors (other governing body)

40.____We should involve parents in fundraising.

41.____ We should try to involve parents in developing treatment plans and other case conferences regarding their children.

42.____ We should encourage parents to take their child for home visits.

43.____ We should encourage families to visit their child regularly.

44_____ We should encourage families to call their child regularly.

45.____ We should encourage families to call staff regularly.

46.____ We should set aside a place for parents and their child to be together in private.

47.___ We should encourage family members to participate in residential activities (e.g. preparing the dinner meal, supervision of homework) once or more per month if possible.

48.___ We should encourage family members to participate in activities in the community with their son or daughter (e.g. shopping for clothes with child, taking child for needed appointments).

49.___ We should conduct parent training group programs on behavior management.

50.____We should conduct parent training group programs for families on other topics of interest.

51.___ We should have a newsletter for families.

52_____ We should take an annual survey of family opinions about the program.

53.___ We should provide more treatment for parents.

54____ We should involve the children and their parents in family counseling.

55.___ We should collaborate with other agencies that serve the family.

**Advantages to family involvement** Please indicate to what extent you agree that each of the following can be an advantage when a family maintains regular involvement with their child's program.

| 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|
| Strongly disagree | Somewhat disagree | Disagree | Somewhat agree | Agree | Strongly agree |

**When maintains regular involvement with their child his/her program it:**

56.____ Strengthens the child's feeling of belonging to the family.

57.____ Makes the child feel loved, wanted.

58.____ Strengthens the social status of the child with peers.

59.____Provides activities for the child.

60.____ Makes the treatment program better.

61.____ Facilitates communication between family members and staff.

62.____ Maintains/increases parents' attachment to the child.

63.____ Increases parents' learning of more effective child rearing practices

64.____ Improves family adjustment.

65.____ other: _____

**Disadvantage to family involvement** Please indicate whether you agree that each of the following disadvantages occur when a family is involved with their child's program.

| 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|
| Strongly disagree | Somewhat disagree | Disagree | Somewhat agree | Agree | Strongly agree |

**When a family has regular involvement with their child in his/her program it**:

66.___ Increases stress/tension in the child.

67.___ Re-raises the child's negative feelings about placement.

68.___ Disappoints the child when family is unpredictable.

69.___ Family members model deviant behavior.

70.___ Family members clash with the staff over rules, practices.

71.___ Family members have a negative influence on other residents.

72.___ Family interferes with child's relationship with staff.

73.___ other: _____

74. Do you think that completing this survey has influenced your own attitudes toward family involvement in any way? Please indicate whether, compared to before you completed the survey, you feel

| 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|
| Less Likely | Somewhat Less Likely | No Change | Likely | Somewhat Likely | More Likely |

**DEMOCRAPHICS: ABOUT YOU AND YOUR JOB**

75. Your age ____

76. Sex: M F

77 Marital status
_____ Single (never married)
_____ Married
_____ Living with a partner
_____ Divorced
_____ Widowed

78. Do have children? ____ No _____ Yes (number: _)

79 What is the highest level of education you have reached?
_____ Less than high school diploma
_____ High School diploma
_____ GED
_____ College (1-3 years)
_____ Associate's degree
_____ College (4 year degree)
_____Master's Degree (Please circle) M.S.W., M.A., M.S.,
_____ Advanced degree (Please circle) Ph.D., Psy.D., Ed.D.,
_____ Other: _____

80. Are currently in school? No Yes
(If yes, what are studying and for what degree)

81. What is your Race/Ethnic Status?

_____ Caucasian (not Hispanic)
_____ African American
_____ Hispanic/Latino
____Native American
____Asian American
____Other _____

82. How many years have you worked in human services? _____

83. How long have you worked at the agency? _____ years

84. How long have you worked in current position at the agency? _____

85. What is your job title at the agency? _____

**Training and Work with families**

The following questions ask you about your training and experience in working with families. Please circle your response.

86. **The amount of training I have received to work with families <u>before</u> I came to the agency is:**

1.__I had no formal classes, workshops, or in-services on how to work with families; all my training was "life experience" of living in families

2.__I had some classes in school that discussed how families function, but not full courses on how to provide treatment.

3.__I had a course on how to work with families at college and attended a least one workshop on family work.

4.__I had several trainings on how to work with families including how work with family strengths in order to facilitate change.

**87. The amount of training I have received to work with families since I have come to the agency is:**

1.__I have not participated in any formal training or in-services on how to work with families since coming to the agency.

2.__I have participated in one or two agency-wide trainings which focused on family centered practice, but have not had full courses on family treatment

3.__ I have attended several trainings, seminars and workshops on family interventions and treatment issues from family systems perspective.

4.__have several trainings on Family Centered Strength Based Practice, and newer treatment model the agency has adopted.

The following questions ask you to indicate whether you are involved in specific family related activity. Please write in the appropriate number to next to each statement.

**Which of the following family related activities do you do during your typical work week.**

**1- No- I do not do this tasks**
**2- Yes- I do this task**

88._____Talking to children about family matter

89._____Taking phones calls from families

90._____ Making phone calls to families

91._____ Arranging visits with families

92._____ Talking with families when they visit

93._____ Providing support and advice to parents

94._____ Giving advice about behavior management to families

95._____ Conducting a treatment session for parents

96._____ Conducting family therapy sessions

97.____Sending written information home to families

The following question asks you to estimate how much time you spend working with families per week. Please put a check next to your response.

98. **In a typical week, how much of your time is spent in working with families or on family-related matters?**

_____ Less than an hour
_____ 1-2 hours
_____ 3-5 hours
_____ 6-15 hours
_____ 16-29 hours
_____ 30 plus hours

**THANK YOU FOR COMPLETING THE SURVEY**

# APPENDIX F

# FOCUS GROUPS EXERCISE INSTRUCTIONS AND QUESTIONS

**Staff Attitude and Beliefs about family Involvement of Delinquent Children in Residential Programs**

Thank you for participating in this focus group exercise on staff attitudes and beliefs about family involvement. My name is **Francis Akakpo** and I am a doctoral student at Michigan State University School of Social Work. As indicated in the consent form audiotape, I would like to reiterate that your responses will not be attributed to any individual in the room and you are free to leave the session at anytime or decline to answer questions you do not feel comfortable answering.

I would to suggest the following ground rules for our discussion today after we complete the written part of the exercise:

- One person talks at a time.
- Be respectful of differing views.
- No "side conversations"
- Stay on the topic.
- Confidentiality—what is said here, stays here.
- "Share the air time"—let everyone contribute.

Questions:

1. What training have you had to prepare you for working with youth and families?

2. Based on your experiences, working with youth in placement, do you think that staff members believe in family involvement as an essential component of treatment of juvenile delinquents?

3. In your opinion, what are some of the issues or concerns surrounding families' involvement with their delinquent children in residential treatment?

4. What is the program or agency's position regarding family involvement?

5. In addition to what you have previously mentioned, do you have any comments about family involvement with juvenile delinquents in a residential treatment program?

# APPENDIX G

# GLOSSARY OF JUVENILE JUSTICE SYSTEM TERMINOLOGY

## Juvenile Justice System Terminology

The following key terms relevant to children's issues and not associated with the adult criminal justice system will be defined (Florida Juvenile Justice Foundation, 1999).

**Adjudicate:** To hear and decide a case; to judge. An adjudicated delinquent is a youth who has been found guilty by a judge of committing a delinquent act. The court can commit an adjudicated juvenile or place the juvenile on community control.

**Adjudicatory Hearing:** Hearing for the Court to determine whether the facts support the allegation(s) stated in the Petition for Delinquency. The standard of proof is the same as in a criminal trial-beyond a reasonable doubt.

**Adjudication Withheld:** An order is entered by the court finding that the youth committed a delinquent act or violation of law, but adjudication of delinquency is withheld. The court may place the child on community control or other similar community program.

**Arrest:** An arrest is made when a law enforcement officer charges an adult with a criminal act, or violation of law and takes the adult into custody based on probable cause. A juvenile is not "arrested", but "taken into custody" under the identical circumstances.

**Case:** A case is determined by selecting the most serious offense committed by an individual youth on a specific date. Thus, the number of cases in the juvenile justice system is determined by counting only the most serious offense for which a youth is charged on any specific date; if the youth is referred for several offenses on the same date, this is considered *one case* and offenses committed by the same youth on another date are considered another case.

**Commitment:** The child is committed to DJJ at a restrictiveness level defined by statute for the purpose of exercising active control of the child.

**Commitment Program:** Rehabilitation program for delinquent juveniles, ranging from the least restrictive to the most restrictive. Higher restrictiveness levels compare to incarceration within the adult system, but with rehabilitative components.

**Community Control:** The legal status of probation created by law and court order in cases involving a juvenile who has been found to have committed a delinquent act. Similar to adult probation; it includes the supervision of juveniles by a case manager.

**Delinquent Act:** Any action taken by a juvenile under the age of eighteen years, who has not been previously transferred to adult criminal court and sentenced as an adult for a felony that would be a violation of law or ordinance if committed by an adult.

**Delinquent Youth:** A juvenile who has been found to have committed a delinquent act (equivalent of being found guilty of a criminal offense) by a judge. The juvenile may be adjudicated delinquent or adjudication may be withheld by the court.

**Detention Care:** The temporary care of a juvenile in secure, non-secure or home detention, pending a court adjudication or disposition or execution of a court order.

**Detention Center:** Facilities statewide, used primarily as a pre-disposition holding facility for serious offenders. By law, offenders may be held twenty-one days prior to their adjudicatory hearing and up to fifteen days following an order of adjudication. A juvenile may be held up to fifteen days following the disposition of the case, pending residential placement if the department has reason to believe that placement will be available within the fifteen daytime period. High risk and maximum risk offenders are held until placement in a commitment program. Detention is NOT a commitment program, and compares to a jail in the adult system.

**Diversion/ Alternative to Court:** A program designed to divert or keep a juvenile from entering the system and as an alternative to court; used at intake prior to adjudication.

**Intake:** Initial acceptance and screening of the child by DJJ. The emphasis of intake is on diversion and the least restrictive available services.

**Intervention:** Programs or services that interrupt the delinquency process and prevent a youth from penetrating further into the juvenile justice system.

**Juvenile/youth/child:** Any unmarried person under the age of eighteen alleged to be dependent, in need of services, or from a family in need of services, or any married or unmarried person who is charged with a violation of law occurring prior to the time that person reached the age of eighteen years. NOTE: The juvenile court has jurisdiction in delinquency cases until the youth's nineteenth birthday, or until the youth/adult completes restitution payment as ordered by the juvenile court.

**Juvenile Found to Have Committed a Delinquent Act:** A juvenile who is found by a court to have committed a violation of law or to be in direct or indirect contempt of court, except that this definition shall not include an act constituting contempt of court arising out of a dependency (child abuse, neglect or abandonment) proceeding.

**Outcome:** The status of a juvenile in relation to delinquent behavior after completion of a program or services, and the extent of the change in modifying the original conditions that led to the juvenile being referred for services.

**Prevention:** All prevention efforts are an investment in public safety and are those efforts that help prevent a juvenile from entering the juvenile justice system as a delinquent. Prevention includes arbitration, diversionary or mediation programs, and

community service work or other treatment available subsequent to a child committing a delinquent act.

**Serious or Habitual Juvenile Offender:** A juvenile who has been found to have committed a violation of law, in the case currently before the court, and who meets at least one of the following criteria:

1. The juvenile is at least 13 years old at the time of the disposition for the current offense and has been adjudicated on the current offense for arson, sexual battery, robbery, kidnapping, aggravated child abuse, aggravated assault, aggravated stalking, murder, manslaughter, unlawful throwing, placing, or discharging of a destructive device or bomb, armed burglary, aggravated battery, lewd or lascivious assault or act in the presence of a child, carrying, displaying, using, threatening, or attempting to use a weapon or firearm during the commission of a felony.

2. The juvenile is at least 13 years old at the time of the disposition, the current offense is a felony, and the child has previously been committed at least two times to a delinquency commitment program.

3. The juvenile is at least 13 years old and is currently committed for a felony offense and transferred from a moderate risk or high risk residential commitment placement.

**Status Offenders:** Status offenders are defined as juveniles, who have been accused of, or charged with, conduct which would not, under law, be an offense if committed by an adult such as truancy, running away or underage drinking.

**Taken into Custody:** The status of a juvenile when temporary physical control over the child is attained by a person authorized by law, pending the juvenile's release, detention, placement, or other disposition as authorized by law. This is similar to an adult arrest.

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## REFERENCES


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