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Staff Attitudes toward Family Involvement and Reunification in Residential Treatment Centers

By

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1999

A Doctoral Project Submitted in Partial Fulfillment of the Requirements for the Degree of Doctor of Psychology in the Department of Psychology at Pace University

NEW YORK

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Acknowledgements

I would like to express my appreciation of Dr. Beth Hart's ongoing support throughout my seven years at Pace. Dr. Graciela Carbajal has been wonderful to take on this project and worked very hard very quickly in order for me to be able to complete this project. Dr. Elizabeth Schnur at Jewish Child Care Association gave me the idea and the push that I so desperately needed to do this project. Steve Salbod has also been very helpful in interpreting my results and organizing this project into a more readable document. Additionally, I would like to thank my colleagues and classmates for their support, encouragement, and for sharing our successes and failures together. There are some people, such as Karen Muller, Dr. Angelynn Pinto and Dr. Susan Silverman from Adelphi University who have been particularly helpful in providing motivation and keeping me on track. Of course there have been people in my life who have nothing to do with Pace, but have been very supportive and understanding as I followed my dream. My family, especially my older brother, encouraged me throughout the dissertation process, and close friends offered unending support, including Lynn Tripodi, DVM, who inspired me by example as she pursued her dream. It is very much appreciated.

Abstract

There has been a federally mandated shift in child welfare policy in the past two decades to more family centered and community-based approaches. Family involvement in treatment is mandated even within the most restrictive level of care within the child welfare system – the residential treatment center. Additionally, family reunification should be the primary goal of treatment. Nevertheless, if staff who are providing services do not embrace these policies, then the likelihood that they will be incorporated into practice is substantially diminished.

The current study examined staff attitudes towards parental involvement and family reunification for children who live in residential treatment centers (RTCs). A 102-question survey, which was adapted from Baker, Heller, Blacher, and Pfeiffer (1995), was administered to 102 staff members from three sites of a child welfare agency. The hypothesis that there is a positive relationship between support for family involvement in residential treatment and family reunification was confirmed by a significant positive correlation (r =. 26, $p < .01$). The hypothesis that staff who hold more positive beliefs about families and how much they can be helped would be more supportive of family involvement in treatment was confirmed ($r = .57, p < .01$). The third hypothesis that administrators endorsed more positive items on the attitudes toward family reunification than clinicians and child care staff was supported, [F (2,96)= 5.64, $p < .005$]. The hypothesis that years of experience ($r = .32, p < .01$), amount of training respondent had

prior to employment at the agency ($r = .24, p < .05$), and amount of training in family work at JCCA ($r = .54, p < .01$) were positively correlated with Attitudes toward Family Involvement was supported. Overall these three variables accounted for 30% of the variance in staff members' support for family involvement.

The results of this study indicated that staff who work in residential treatment centers are committed to family involvement and believed that reunification is a realistic goal in many cases. Further study could focus on what staff perceive as obstacles toward reunification and this may help to guide treatment. It would also be useful to research the efficacy of family treatment and success of reunification efforts.

CHAPTER I

Introduction

This study examined staff attitudes towards parental involvement and family reunification for children who live in residential treatment centers (RTCs). While there has been a paradigm shift in child welfare policy, it is possible that the child care workers and professional staff working most directly with children in residential placement may not share this philosophical perspective. Recent research (Baker, Heller, Blacher, and Pfeiffer, 1995) has found that while most of the staff support increased family involvement in treatment, 56% of the respondents believed that reunification should be a primary goal for only up to 33% of the children.

Review of the Literature

The Scope of the Problem

In 1994, the child poverty rate in the United States was 21.2%; the number of children reported abused or neglected was almost 3 million or about 43 reported cases per 1,000 children; the number of children in foster care was 466,038. There were 58,658 children in foster care in New York, which is about 13% of the total for the U.S.; almost 211,000 cases of abuse or neglect were reported in NY, which is about 7% of the national total (Children's Defense Fund, or CDF, 1997). DiLeonardi (1993) noted that neglect is the most common form of mistreatment of children in the US and that there is a correlational relationship between poverty and neglect. It is estimated that in 1996 between 4-5 million children and adolescents had serious emotional difficulties that

interfered with their ability to function at home, in school and/or in the community. However, less than one in four had received mental health services in the recent past. The prevalence rate for emotional problems was found to be higher for children from lower income families. (HHS' Center for Mental Health Services as cited in CDF, 1997)

The U.S. Department of Education (1994) noted that 18% of children with serious emotional disturbance (SED) are educated outside of their local schools; in comparison to 6% of all students with disabilities. In the 1992-93 school year, children with SED accounted for about 8.7% of all students who received special education services in the United States. Knitzer, Steinberg and Fleisch (1990) estimated that approximately 8-12% of school age children have behavioral symptoms that warrant intervention, but perhaps only 3-5% have very serious disabilities.

However in New York State, about 14% (or 43,077) of students with disabilities were designated as having a serious emotional disturbance (U.S. Department of Education, 1994). This is the second largest category of designations in NYS, with specific learning disabilities accounting for 60% of classified children. It is unclear if New York is over-identifying students or if there is a greater likelihood that accurate diagnoses are applied. It may be that New York acknowledges the risk factors associated with poverty and minority status. As there are over 1.6 million children living in poverty in New York (about one third of the population of children), it is surprising that the number of identified children is not greater. Eamon (1994) noted that, "considerable data link poverty and minority status with psychosocial stress and higher rates of mental health problems in children. Other risk factors include poor physical health and

development, homelessness, single parenthood, welfare dependency, and emotional disorders in parents." (p. 593)

New York leads the nation with the highest percentage of children who are designated as needing special education receiving services in separate classes, schools or residential facilities, according to Advocates for Children of NY (1993-1994). While the policy of NYS may be to place students in a general education class unless it is demonstrated that they will be unable to benefit from the education therein; current practice indicates that this policy is not being implemented.

The above-cited statistics belie the fact that we know relatively little about the children who are having difficulties in their homes, whether due to familial, and/or personal problems. We know even less about the children who are served in residential treatment centers - the most restrictive form of foster care - usually for children who exhibit severe behavior problems and family dysfunction. Edwards (1994) researched, "Children in Residential Treatment: How Many, What Kind? Do We Really Know?" His brief answer to these questions was "no". More specifically, he responded to the question of, "how many children are there?" with "... the number of children and adolescents in residential treatment is substantial." (p.86) In a comprehensive review of the literature, Bates, English and Kouidou-Giles (1997) noted that since there are neither established guidelines nor standardized diagnostic tools used when making placement decisions, it is unclear why children are placed in RTCs (rather than less restrictive form of substitute

care) and the nature of their problems. Kiesler (1993) estimated that the number of placements into residential treatment centers increased from 34,000 in 1980 to 169,000 in 1986.

While it is apparent that there is a large discrepancy between policy and practice in the residential treatment of children, it remains unclear why this divergence exists. Berliner (1993) has asked a thought provoking question in her commentary article, "Is family preservation in the best interest of children?" She notes that this is an empirical question that cannot be answered fully by the current research. Gelles (1993) has also wondered whether children are really being protected through family preservation and reunification programs. He argues that there is not enough research to determine for whom and under what conditions family preservation services are appropriate.

The Advocacy Movement in Children's Services

In 1982, Jane Knitzer of the Children's Defense Fund issued a scathing indictment of the mental health system available to children with emotional disabilities and their families ("Unclaimed Children"). This report also included examples of innovative and effective programs. In response, the federal government developed standards for the treatment of children with emotional disabilities and their families, the Child and Adolescent Service System Program (CASSP) in 1983, within the National Institute Mental Health (NIMH) to improve mental health care for children.

Stroul and Friedman (1986) proposed a system of care model that included the following ten guiding principles:

1. Emotionally disturbed children should have access to a comprehensive array of services that address the child's physical, emotional, social and educational needs.

2. Emotionally disturbed children should receive individualized services in accordance with the unique needs and potentials of each child, and guided by an individualized service plan.

3. Emotionally disturbed children should receive services within the least restrictive, most normative environment that is clinically appropriate.

4. The families and surrogate families of emotionally disturbed children should be full participants in all aspects of the planning and delivery of services.

5. Emotionally disturbed children should receive services that are integrated, with linkages between child-caring agencies and programs, and mechanisms for planning, developing, and coordinating services.

6. Emotionally disturbed children should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner, and that they can move through the system of services in accordance with their changing needs.

7. Early identification and intervention for children with emotional problems should be promoted by the system of care in order to enhance the likelihood of positive outcomes.