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STAFF SUPPORT FOR FAMILIES OF YOUTH INVOLVED IN JUVENILE JUSTICE SYSTEM IN RESIDENTIAL TREATMENT PROGRAMS

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Abstract

This study used a convenience sample of 51 employees of a mid-sized, Midwest residential treatment facility for children involved in juvenile justice system. Overall, the findings suggest that staff members support family involvement and recognize the link between a child's return home and the activities designed to involve family during placement but are constrained by limited resources. The findings also indicate that family members are not treated as partners but rather as passive participants in the treatment milieu.

Keywords

Staff, Families, Youth, Juvenile Justice System

Introduction

In the juvenile justice system, the doctrine of *parens patriae* gives state, local or federal government authority to make decision on behalf of children who committed crimes and are incarcerated or put on a type of probation with understanding parents did not provide appropriate supervision (Binder, et al., 2001; Taylor, 2014). Therefore, adhering to strictly the doctrine translates into minimal role of families in the rehabilitation of their juvenile justice-involved children (Osher & Hunt, 2002) However, emerging literature on the population suggests that family involvement is very important component of best practice because it reinforces treatment as well as provide youth with advocates to help to reintegration to their communities post out-of-home placement (OJJDP, 2012). Furthermore, parental involvement is very important because juvenile delinquency is a problem that has social, physical, and economic and impacts on communities. Juvenile offenders particularly those arrested and court ordered to receive treatment consume a large proportion of resources and when the intervention is not well delivered, offending youth behaviors could have repercussions in adulthood (Tarolla, et al., 2002) reinforces the importance enacting policies and strategies to help families understand juvenile justice system (Office of Juvenile Justice and Delinquency Prevention, 2012).

According to 2019 Census of Juvenile in Residential Placement (CJRP) 36, 479 were placed in residential facilities which in contrast with 104,413 juvenile offenders committed to juveniles to correctional/treatment facilities in 2001 (Hockenbery, 2022). In 2019, U.S. law enforcement made an estimated 424, 300 arrests of persons under the age of 18 years which accounted for 71% less than arrested in 2001(OJJDP, 2022).This recent OJJDP report suggesting reduction in the number of youth arrest, specially, those who have been adjudicated and placed in residential facilities in the past couple of decades does not translate into reduction in the resource consumption (Toralla, et al., 2002) There are a number of steps that juvenile justice system takes during the arrest which involve cost to society. For example, when a juvenile is arrested, the young person may be sent home without charge, or they may be held in a detention facility until formally adjudicated. Following adjudication by the court, the youth may be placed in a correctional/rehabilitation facility, assigned to a community-based program, or admitted to a mental health treatment facility or program (Kopiec, et al., 2001; Lyman & Campbell, 1996; Mann, 2000; Siegel & Senna, 1994).

There is growing body of research suggests that the role family engagement for youths involved juvenile justice system must a key component of rehabilitation (Martinez, & Abrams, 2013; Mendez et al., 2009) For example, the passing of Family First Prevention Services Act of 2018 is one of the recent policies that inform sweeping policy changes that aim to improve juvenile justice systems with a potential family engagement in child

welfare service delivery systems and the Child and Adolescent Services System Program (CASSP) formed in the mid-1980s which is both child-centered and family-focused (Banes, 1998). With example of policy and program centered on child welfare, 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 engagement, 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 40 years (Lindell, Sorenson & Mongold, 2020). This is a strong indication of a paradigm shift from a child-centered philosophy where families are excluded from rehabilitation of children in treatment facilities to one of a family-centered approach which sees parents as potential resources in their children's care (Maluccio, 1981; Sinanoglu, 1981; Whittaker, 1981).

Despite the recognition of family involvement, the strategies of engaging parents in the treatment of their children in the juvenile justice system are still a challenge. There is dearth information in literature that clearly articulate professional-client relationships or professional attitudes toward parental involvement (Friesen, Koren, & Koroloff, 2014). Most studies on professional-family decision explore attitudes and beliefs of staff working with children who are severely emotionally and the treatments for children and adults with mental illness (Baker, Heller, Blacher, & Pfeiffer, 1995; Coleman, 1999). Baker et al went further suggesting that staff members who support family involvement want to provide guidance or therapy to families and not as partners in treatment processes. The position of being expert and wanting to provide guidance and therapy is an indication of professional not willing to treat families as partners and less supportive of activities that empower families to be involved in decision-making.

This exploratory study is about staff attitudes and beliefs towards family involvement of youth who committed crimes and were adjudicated and court ordered to receive treatment in residential settings. The researcher set out with the assumption that staff attitudes and beliefs contribute to whether family involvement will be valued or not at the residential facility. It is important to expand the knowledge base regarding the attitudes and beliefs of staff about the families of youth in the juvenile justice system to determine to what extent policies and established best practices are integrated into rehabilitation of these young people. The study set out to explore the extent to which staff members of a residential treatment program in a mid-western state support family-centered practice.

Methods

Participants

The participants of this study were employees of a participating organization (referred to as "agency" or "the facility") in a Midwestern state. The 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, explaining 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. The confidential data were collected using pencil and paper surveys self-administered survey on agency premises. The participants included direct care staff, clinicians (social workers, family therapists, psychologists etc.) and administrators. The convenient sample consisted of 51 employees of which 34 (67.3%) were direct care staff, 5 (10.2%) were clinicians and 12 (22.4%) were administrators. Forty-nine of the 51 participants reported their age of (M= 37 years, SD =10.2) with a range 22 to 57 years.

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Method of Data collection

The data were collected directly from the participants using a modified self-administered *Devereux Foundation Family Involvement Study* (Baker, 1995; Coleman, 1999).

The modified instrument contains 98 items, distributed unevenly across five scales and measure 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.

Attitudes Toward Reunification scale

This scale includes two measures of attitudes toward reunification inquired about the respondents' approximation of what percentage of children should be returned to their homes while the subscale sought know the Reasons to Discourage Involvement Scale." This scale includes 21 items that describe characteristics about the 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 should return to their family. The internal consistency was recalculated using Chronbach's Alpha (α = .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 α = .85. The measures are relevant to use in the analysis of staff attitudes and beliefs in the participating agency.

Beliefs about Families scale

The scale for staff thoughts about family involvement was adapted from the Devereux study which employs a 6-point Likert-type, 11 item scale with an α =.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 α =.67 (Baker et al., 1995) while Coleman's (1999) modified 5-point Likert-type scale obtained an α =.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 the total for the Positive Belief Scale obtains an alpha of .66. The reliability of the seven items in the current study was recalculated (α = .71).

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 used a 5-point Likert-type scale and reliability was α = .90 (Coleman, 1999). The current study uses a 6-point Likert-type scale and some of the questions were rephrased and the reliability is α = .86.

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) are alphas of .82 and .88, respectively, 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 α =.80. After removing two items, "Make the child feel loved, wanted," and "Facilitate communication between family members and staff," the Chronbach Alpha is α = .86

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 α = .83.

Data Analysis

The researcher used Pearson Product Movement Correlation to examine staff, attitudes and support for family reunification and family involvement. 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 Variances (ANOVA) are computed to test differences between means across the scales.

Results

Support for Family Reunification with Children under 18 Years of Age

Overall, staff supported family reunification as a primary objective of their program for children under 18 years. *The staff response the question "What percentage of children who are under 18 years should have a primary objective of reunification with their families*? Fifty-six percent of the chose "most or all" (75-100%) and another 33.3% respond "many" (50-74%). One the six-point Likert-scale (M= 4.5 SD = .92). Only 2% of the staff members respond "none" one" 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 (M= 4.5 SD = .92) and it was found to be significant (t = (34.1), df =50, p< 01). Furthermore, the Reunification Scale is suggested moderate positive correlations between the Support for Reunification Scale and the Reasons to Discourage Scale and Family Involvement Scale (r(49) = .55, p < 01).

Beliefs about Families and Support for Family Involvement

As reported in Table 1**,** 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 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." 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 = (49) .65, p < 01).

Table 1 shows that there is a significant positive correlation between the Advantages to Family Involvement Scale and the Support for Family Involvement Scale (r = (49) .62, p < .01) adapted from (author. 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. However, the scale of helping family though positive was weak

Scales	Pearson r with Support
Positive Beliefs about Families	.45**
Native Beliefs about families.	.-04
Helping Families	.36*
Advantages to Family Involvement	.62*
Disadvantages to Family Involvement	-0.17

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

Table 1: Correlations between Support for Family Involvement and Beliefs (n = 51)

Category of Professionals and Attitudes toward Family Involvement

One-Way Analysis of Variance (ANOVA) was utilized for the different categories of professional ratings of support for family involvement (see Table 2). The analysis indicates that clinicians and administrators are more likely to support family involvement than are 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.

	SS	SS	MS	F	p
Between Groups	2	2 877.38	13.72		0.001
Within Groups	46	4822.86		104.85	

Table 2: Categories of Professionals and Their Attitudes toward Family Involvement (n = 48)

Discussion

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). 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. 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 the 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's 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.

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 rather than staff working with adjudicated youth for delinquent or criminal offenses (Baker et al., 1995; Coleman, 1999.) This researcher adapted the instrument to study individuals working families of adjudicated youth committed to residential facility for treatment.

Secondly, the current study uses a non-probability convenience sample drawn from one residential treatment facility 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). 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

Implication for Social Work Practice

The study encourages a family-centered approach that is contingent upon staff attitudes and beliefs about the families of 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. There is evidence in research that family-based interventions are designed to help adolescents with the fundamental assumption that the family is paramount to child-development (Bandura, 1969; Hirschi, 1969; Hirschi & Gottfredson, 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/her family (Hirschi & Gottfredson, 2003). Remaining true to this practice depends upon the attitudes and beliefs about families of the involved staff members. Furthermore, understanding staff attitudes and beliefs about family involvement facilitates a more effective planning process that is central to identification of family strengths.

Implications for Policy

The findings of this study are in line with policies enacted at the federal level, which emphasizes 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 the 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 the 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. Thus, 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 (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.

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 regarding delinquent children in residential treatment who may also have learning disabilities and mental illness issues (Bogrov & Crowell, 1996; Carlo, 1985; 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 section above, 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, et al., 2006; Walsh, et al., 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.

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.

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