An exploration of caregiver engagement in residential treatment for youth

Raquel Moriarty Derrick

University at Albany, State University of New York, raquel.moriarty@gmail.com

The University at Albany community has made this article openly available. Please share how this access benefits you.

Follow this and additional works at: https://scholarsarchive.library.albany.edu/legacy-etd

Part of the Criminology Commons, and the Social Work Commons

Recommended Citation

https://scholarsarchive.library.albany.edu/legacy-etd/2126

This Dissertation is brought to you for free and open access by the The Graduate School at Scholars Archive. It has been accepted for inclusion in Legacy Theses & Dissertations (2009 - 2024) by an authorized administrator of Scholars Archive. Please see Terms of Use. For more information, please contact scholarsarchive@albany.edu.
An Exploration of Caregiver Engagement in Residential Treatment for Youth

By

Raquel Moriarty Derrick

A Dissertation
Submitted to the University at Albany, State University of New York
In Partial Fulfillment of
The Requirements for the Degree of
Doctor of Philosophy

School of Criminal Justice
2018
Abstract

Support for caregiver engagement in their child’s residential treatment is widespread and growing because of the benefits of caregiver engagement to a youth’s treatment process. This dissertation explores the construct of caregiver engagement, defined as caregiver motivation and expectation for their child’s treatment, caregiver bond with staff and caregiver collaboration on treatment goals and tasks among a cohort of 101 caregivers with a child in a Residential Treatment Center (RTC). Mixed methods were used to qualitatively and quantitatively explore caregiver perspectives and experiences that contribute to or detract from their level of engagement in their child’s treatment process. Findings reveal that the caregivers’ experiences and perspectives relating to out-of-home placement of their child are complex and often relate to their level of engagement in their child’s treatment process. The exploration of this construct from the caregiver perspective, which has been largely overlooked, facilitated a deeper exploration of caregiver engagement than would be accomplished using strictly quantitative methods, illuminating the themes that underlie components of engagement. Implications for policy and practice are discussed.
# Contents

Chapter 1: Introduction .................................................................................................................. 1

Chapter 2: Literature Review ......................................................................................................... 8
- Paradigm Shift: Youth-Centered to Family-Centered ................................................................. 8
- Family Reunification and Engagement ....................................................................................... 10
- Caregiver Role in Youth Treatment ............................................................................................ 17
- Engagement in Treatment ........................................................................................................... 19
  - Client’s motivation and expectation about treatment ................................................................. 19
  - Relationship between client and therapist .............................................................................. 21
  - Client’s behavior in therapy ..................................................................................................... 24
- Benefits of Caregiver Engagement ............................................................................................ 25
- Barriers to Caregiver Engagement ............................................................................................. 26

The Current Study ....................................................................................................................... 28

Chapter 3: Methods ....................................................................................................................... 32
- Data Collection Setting ............................................................................................................... 32
  - SOAR Partnership .................................................................................................................... 33
  - Agency Policy on Caregiver Engagement ................................................................................. 35
- Data Collection .......................................................................................................................... 39
  - Sample Recruitment ................................................................................................................ 39
  - Data Collection Challenges .................................................................................................... 44
  - Data Collection Strategy ......................................................................................................... 46
- Sources of Data for Current Study ............................................................................................. 47
  - Semi-structured Interviews ..................................................................................................... 47
  - Benefits of Interview Data ....................................................................................................... 50
  - File Data .................................................................................................................................. 51
- Measures .................................................................................................................................... 53
- Mixed Methods .......................................................................................................................... 55
  - Data Limitations ....................................................................................................................... 56
  - Correction of Problematic Transcripts ..................................................................................... 58
- Analysis Strategy and Measures ............................................................................................... 59
- Qualitative Methods .................................................................................................................... 60
- Quantitative Methods .................................................................................................................. 67
- Sample Characteristics ............................................................................................................... 76
Chapter 4: Motivation and expectation about treatment

Purpose of Placement

Qualitative exploration of purpose of placement

Services

Quantitative exploration of purpose of placement

Agreement with Placement

Qualitative exploration of agreement with placement

Ability of RTC to Help Youth

Qualitative exploration of ability of RTC to help youth

Quantitative exploration of ability of RTC to help youth

First Impressions of Agency, Staff or Services Offered

Qualitative exploration of first impressions of agency, staff or services offered

What Led to Placement

Qualitative exploration of what led to youth’s placement

Quantitative exploration of what led to placement

Prior Placements

Qualitative exploration of prior placements

Quantitative exploration of prior placements

History of Getting in Trouble

Qualitative exploration of youth’s history of getting in trouble

Frustration with the Systems

Qualitative exploration of frustration with the systems

Discussion

Purpose of Placement

Agreement with Placement

Ability of RTC to Help Youth

First Impressions of Agency and Services

What Led to Placement

Prior Placements

History of Getting in Trouble

Frustration with Systems

Conclusion

Chapter 5: Bond with Staff
Bond with Staff .............................................................................................................................. 143
  Qualitative exploration of bond with staff ............................................................................. 143
  Quantitative exploration of bond with staff ......................................................................... 147
Qualitative Exploration of Dissatisfaction with Staff .............................................................. 149
Qualitative Exploration of Communication with Agency Staff ............................................... 151

Summary ..................................................................................................................................... 153

Conclusion .................................................................................................................................. 155

Chapter 6: Client’s behavior in treatment .................................................................................. 156
  Treatment Planning ............................................................................................................... 157
    Qualitative exploration of treatment planning ............................................................... 157
  Caregivers’ Feelings Leading up to Placement ................................................................. 159
    Qualitative exploration of caregivers’ feelings leading up to placement ................... 159
    Quantitative exploration of caregiver’s feelings leading up to placement ................. 164
  Caregivers’ Personal Expectations ....................................................................................... 166
    Qualitative exploration of caregivers’ personal expectations ..................................... 166
    Quantitative exploration of caregivers’ personal expectations .................................. 168
  Barriers to Caregiver Engagement ...................................................................................... 170
    Qualitative exploration of barriers to treatment involvement .................................. 170

Summary ..................................................................................................................................... 173

Chapter 7: Conclusion .................................................................................................................. 176
  Study Overview ...................................................................................................................... 176
  Motivation and Expectation about Treatment ..................................................................... 180
  Bond with staff ..................................................................................................................... 184
  Client behavior in treatment ................................................................................................. 185
  Data Limitations ................................................................................................................... 187
  Conclusion ............................................................................................................................... 189

References .................................................................................................................................. 192

Appendix A .................................................................................................................................. 200

Appendix B .................................................................................................................................. 202

Appendix C .................................................................................................................................. 203
  Caregiver Measures ............................................................................................................... 203
    Caregiver engagement (CW1) ......................................................................................... 203
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregiver motivation and expectation (CW1)</td>
<td>204</td>
</tr>
<tr>
<td>Caregiver bond/rapport with staff (CW1)</td>
<td>205</td>
</tr>
<tr>
<td>Collaboration on goals &amp; tasks (CW1)</td>
<td>206</td>
</tr>
</tbody>
</table>
Chapter 1: Introduction

The American juvenile justice system has greatly evolved since its establishment in 1899. Prior to the 1970s, there was a strong emphasis placed on removing a child from his home to isolate him from his family and work to address delinquent behaviors. During this period, keeping the family intact or engaging the family in treatment was not a priority of the child welfare or juvenile justice systems (Nickerson, Salamone, Brooks & Colby, 2004; Robinson, Kruzich, Friesen, Juvanje & Pullman 2005; Saint-Jacques, Drapeau, Lessard & Beaudoin, 2006). It was not uncommon for a large degree of blame to be placed on the parents for a child’s delinquent behaviors. This ideology of blaming the parents for their child’s delinquency continued throughout most of the history of the juvenile justice system, thus facilitating a youth-centered approach to juvenile residential treatment (Guterman & Blythe, 1986; Hornberger & Smith, 2011; Jenson & Whittaker, 1987; Lakin, Brambila & Sigda 2004; Nickerson et al., 2004), in which caregiver engagement in the juvenile justice process was deemed irrelevant (Lakin et al., 2004). The parents were often blamed for the misbehavior that led to their child’s removal from the home, so it was believed that the child would fare better with no further influence from the parents (Robinson et al., 2005).

Over time, especially in recent decades, there has been more recognition of the beneficial role that caregivers can play in residential treatment. A series of legislative Acts that were passed in the 1970s and 1980s (Wulczyn, 2004), as well as many scientific studies, have linked parental contact during residential placement with increased rates of family reunification (Carlo, 1992; Leathers, 2002; Robinson et al., 2005), therefore facilitating a shift toward family-centered services. Further, studies have found family involvement in child welfare or juvenile justice interventions to produce positive outcomes during treatment, as well as post discharge (Demitt &
Unfortunately, many factors have been identified that negatively affect the level of caregiver engagement in the residential treatment process (Bailey, Buysse, Edmondson, & Smith, 1992; Blacher & Baker, 1994; Israel et al., 2006; Stage, 1999; Kruzich et al., 2003; Nickerson, Brooks, Colby, Rickert & Salamone, 2006; Robinson et al., 2005; Sunseri, 2001). While there appears to be a clear deficit for achieving the goal of caregiver engagement in residential treatment for youth, the acknowledgement of its importance and benefit are widespread and growing. Therefore, it will be important to overcome the barriers of caregiver engagement to better meet treatment goals and serve youth. Perhaps, one of the gatekeepers for understanding these deficits are the caregivers of residentially placed youth, themselves.

Most studies that have assessed caregiver engagement in youth treatment have relied exclusively on the treatment agency staff perspective as opposed to the caregiver perspective (Cunningham, Duffee, Steinke, & Naccarato, 2009; Littell & Tajima, 2000; McWey, 2000; Yatchmenoff, 2005). Studies have typically relied on information provided directly by staff or on information that is found in the client record, a document that is prepared and controlled exclusively, or nearly so, by agency staff. Unfortunately, relying exclusively on the staff perspective to understand caregiver engagement only provides half of the story. It does not further understanding of how personal perspectives of caregivers might either contribute to or prevent caregiver engagement. The staff perspective also fails to recognize components of staff behavior or agency policy that might affect parental engagement.
The purpose of this study is to explore the concept of caregiver engagement by focusing on the perspective of the caregiver. Specifically, this study analyzed qualitative and quantitative data provided by caregivers 4-6 weeks after their child was court mandated to placement in a residential treatment center (RTC). Although the interviews were administered post-placement, caregivers were instructed to think about the time leading up to their child’s placement when responding. A mixed methods approach was utilized in the analysis of these data.

In order to better understand the concept of engagement from the caregiver perspective, this dissertation explored the perspectives described by caregivers during semi-structured interviews that directly relate to the three main components of engagement that were identified by Cunningham, Duffee, Huang, Steinke and Naccarato (2009); client’s behavior, caregiver bond with staff, and caregiver motivation and expectation about treatment. It is important to note that the term caregiver throughout this dissertation does not exclusively refer to the youth’s parent. Rather, caregiver refers to the individual that was identified as the youth’s guardian when he or she was admitted to the agency and was sometimes a member of the extended family, such as a grandparent. An overview of the specific relationship of the caregiver to the youth will be presented in chapter 3. This dissertation addressed the following questions:

1) What feelings and experiences related to residential placement do caregivers express during the early part of their child’s placement in a Residential Treatment Center (RTC)?

2) How do the perspectives expressed by caregivers regarding the time leading up to their child’s placement relate to their engagement in the treatment process?

The exploration of this subject from the caregivers’ perspective will provide a more complete picture of the complex feelings that caregivers with a child in residential placement often experience, while also providing some insight into additional predictors of involvement in
treatment that have not been included in previous research and can be used by the treatment community to inform practice and improve caregiver engagement. This dissertation analyzed interviews with 101 caregivers of residentially placed youths on a wide variety of topics relating to the period of time prior to their child’s placement, as well as immediately following placement. Prior studies have relied on much smaller samples of caregivers, discussing one particular topic related to their child’s placement, such as barriers to participation in treatment or bond with staff.

This dissertation provides a thorough exploration of caregiver engagement. First, a detailed overview of prior research related to caregiver engagement in youth treatment is provided in chapter 2. The methods used for analysis are outlined in chapter 3. Three chapters presenting results of analysis are provided following the literature review and methods. The three chapters of results are each dedicated to one of the specific components of engagement identified by Cunningham et al. (2009). Motivation and expectation about treatment is presented in chapter 4, bond with staff is presented in chapter 5 and collaboration on treatment goals and tasks is presented in chapter 6. All of these chapters of analysis follow a similar structure that is described below. Finally, a conclusion is provided in chapter 7.

The discussion of each component of caregiver engagement, including motivation and expectation about treatment, bond with staff and collaboration on treatment goals and tasks, lead with an overview of the qualitative analysis of the themes that have been identified in relation to that particular component of caregiver engagement. The themes used to represent caregivers’ motivation and expectation about treatment include their perceptions of or statements about the purpose of placement, agreement with placement, ability of RTC to help child, first impressions of agency and services, what led to placement, prior placement, youth’s history of getting in
trouble and frustration with the system. The themes used to represent caregivers’ bond with staff included first impression of staff, dissatisfaction with staff and communication with agency staff. The themes explored in relationship to caregivers’ behavior in treatment include treatment planning, feelings leading up to placement, caregiver’s personal expectations and barriers to participation. The component of engagement to which the themes relate were determined by identifying the commonly accepted measures of the individual components of engagement that have been used in previous research.

The qualitative analysis provided a wide overview of common caregiver perspectives at the outset of placement. Such an extensive overview serves to further understanding of the relationships between what the caregivers are experiencing and their ability to engage in treatment at the early stages of the process. The qualitative analysis addressed the first research question; what feelings and experiences related to residential placement do caregivers express during the early part of their child’s placement in an RTC. These findings have implications for treatment professionals and policy makers.

Next, the qualitative themes that were identified in the first phase of analysis were compared to quantitative measures of engagement, using both a measure of the applicable individual engagement component (e.g. motivation and expectation about treatment, bond with staff and collaboration on treatment goals and tasks) and a composite measure of engagement. This phase of analysis served to explore the relationships between the caregivers’ perspectives and engagement, thereby addressing the second research question focused on how the perspectives expressed by caregivers regarding the time leading up to their child’s placement relate to their engagement in the treatment process. For instance, can the perspectives expressed by the caregivers help to inform understanding of the individual components of engagement by
identifying themes that underlie either deficits or benefits in a particular component? While existing research has identified certain correlates of positive caregiver engagement, there has been little attention given to identifying the factors that underlie and influence those correlates. For example, caregiver bond with staff has been identified as a critical component of caregiver engagement, but what type of interactions with staff do caregivers describe as contributing to either a positive or negative bond with staff? Are there themes among the caregiver responses that uncover opportunities for agencies to make changes that promote greater caregiver engagement? Additionally, data limitations pertaining to sample size also highlight the ability of the qualitative data to facilitate a deeper examination of caregiver engagement in which information that can be used to inform the process might otherwise be missed if one were to rely on the quantitative construct alone.

**Summary**

This dissertation fully explored the early stages of caregiver engagement from the perspective of caregivers. No studies to date have explored the concept of caregiver engagement using in-depth interview data with as large of a sample as the one represented in this study (N=101). Other studies have relied on focus groups with smaller cohorts, or questionnaires with larger cohorts, but this study provides analyses of data generated during semi-structured interviews with caregivers of youth in residential placement, providing exploration of caregiver perspectives on a wide range of topics related to their child’s placement. This analysis provides valuable insight into the factors that are likely related to a caregiver’s ability to engage in their child’s treatment shortly after placement. This information from the caregiver perspective would be missed if relying on quantitative data alone, or data generated solely from the staff perspective.
Considering determinants of early engagement and effects of caregiver experiences and perspective on early engagement in youth treatment adds to the growing attention being given to the importance and value of caregiver engagement in youth treatment. No studies to date have given extensive consideration to how the caregivers’ perspectives may contribute to or detract from initial engagement. Further, this dissertation explores the issue from a well-rounded framework focused on the construct as a whole, as well as each of its individual components with a large sample (N=101). Therefore, this dissertation represents a comprehensive exploration of caregiver engagement.
Chapter 2: Literature Review

Recognition of the importance of caregiver engagement in youth residential placement began in the 1970s. Since then, there have been many studies that have explored the relationships between caregiver engagement and youth treatment outcomes. This chapter provides an overview of the paradigm shift from youth-centered to family-centered care including a discussion of the importance of caregiver engagement in relation to permanency planning, an underlying motivation for the paradigm shift.

Next, caregiver engagement in treatment is defined with a thorough explanation of each of the three components of engagement that have been articulated in prior research. Following a discussion of the definition and prior exploration of individual components of engagement, this chapter outlines some of the benefits of caregiver engagement and barriers to optimal engagement that have been identified in prior research. The literature review was used to inform the analyses presented in this dissertation by guiding the process of identifying themes that emerged during qualitative analysis of caregiver interviews to represent specific components of engagement. A thematic roadmap depicting the constructs that have been used in previous research to demonstrate motivation and expectation about treatment, bond with staff and collaboration on treatment goals and tasks was developed and is presented at the end of this chapter. The thematic roadmap will be revisited and expanded in chapter 3 to illustrate how the qualitative themes that emerged during analysis relate to the components of engagement.

Paradigm Shift: Youth-Centered to Family-Centered

From 1978 until 1997, there were a series of legislation that promoted family engagement in out-of-home placement. The Indian Child Welfare Act of 1978, the Adoption Assistance and Child Welfare Act of 1980 and the Adoption and Safe Families Act of 1997 all introduced...
safeguards to promote family preservation coupled with increased mandates on child welfare workers to seek reunification swiftly when a child is removed from the home. These Acts were passed with the underlying assumption that is the inherent right of a biological parent to raise his or her child and therefore the State should only intervene in extreme situations affecting child welfare. In consideration of this underlying tenet, even when a child is removed from the home, family reunification must remain the primary goal of the child welfare and juvenile justice systems (Wulczyn, 2004).

The Indian Child Welfare Act in 1978 strengthened the standards for removing a child from the home, placing a burden on the state to prove the need for temporary out-of-home care in a convincing manner. This Act also made it more difficult to terminate parental rights, applying the proof beyond a reasonable doubt standard to parental right termination hearings.

Later, in 1980, The Adoption Assistance and Child Welfare Act profoundly facilitated a shift in the juvenile residential treatment paradigm from a youth-centered approach toward a family-centered approach. The Act has multiple provisions to protect parental rights both prior to and during out-of-home placement. States must demonstrate reasonable efforts to leave a child in the home before a child can be removed from the home. The law also shortened the timeline to return a child to his or her home in the event that they are removed for safety concerns (Wulczyn, 2004). Further, there is a provision requiring states to establish procedural safeguards to protect parents’ right to visitation while their child is placed in a residential facility (Robinson et. al., 2005). Another concept introduced by the Act was permanency planning, or the need to establish a permanent plan for the youth upon discharge from a child welfare or juvenile justice agency. This translated to the recognition that the ultimate goal in youth residential treatment is
often family reunification (Demmitt & Joanning, 1988; Guerts, Boddy, Noom & Knorth, 2012; Jenson & Whittaker, 1987).

The third piece of legislation, the Adoption and Safe Families Act of 1997, furthered the rules pertaining to permanency planning and family reunification in a different way than the previous legislation had focused on the issue. This Act stated that child safety was the most pressing concern for child welfare. This Act required that child safety supersede the goal of family reunification by reducing the amount of time after a child was placed that an agency that would be required to file for the termination of parental rights (Dawson & Berry, 2002; Leathers, 2002). After 12 months of placement, there must be a permanency hearing to establish whether and when a child will return home or propose an alternative plan. Under this law, agencies gained the right to pursue adoption and termination of parental rights simultaneously. The state no longer had to wait until it had been legally established that a child would not be returning home to begin seeking an alternative plan. This law put greater pressure on agencies to establish caregiver engagement early in the treatment process, to ensure that family reunification remains the permanency goal above adoption or an alternative plan (Altman; 2008; Wulczyn, 2004). The residential treatment agency must partner with the caregiver early to work toward the goal of reunification. Otherwise, a safe and permanent alternative living situation for the youth must be established (Dawson & Berry, 2002; Nickerson et al., 2006). While there is a lack of standardized research on the effect of this law on caregiver engagement, there is reason to believe that caregiver engagement might be negatively affected when the caregiver knows that the worker is also pursuing an alternative plan while working with the family (Wulczyn, 2004).

**Family Reunification and Engagement**
At the core of the pieces of child welfare legislation that were passed in the second half of the 20th century, was the idea of family reunification, or that children who are removed from their home will return to the same home with the same family. Reports from the 2000s show that about half of the children in the child welfare system returned home to their birth family. Further, reunification is most often the central goal in permanency planning (US Department of Health and Human Services [DHHS], 2006; Wulczyn, 2004).

Family reunification serving as the primary permanency goal for children in out-of-home placements provides a strong rationale for caregiver engagement in treatment. It recognizes that the child is often going to be returning home to the same family-related difficulties that might have contributed to placement (Garfinkel, 2010; Griffith et al., 2009; Ryan & Yang, 2005). In fact, the idea that youth will return to the family environment has emerged as one of the main justifications for family-centered approaches to care (Garfinkel, 2010; Miller et al., 2016).

Over time, family reunification has begun to be recognized as a continuum where reunification does not have to be defined as a physical return to the family, but can also be viewed as a restoration of troubled family relationships (Robinson et al., 2005). Reunification should be viewed as a process and not a single event. Both a youth and his or her family are likely to undergo multiple changes during the time that the youth is in placement. Therefore, it is important to recognize how these changes can influence reunification (Wulczyn, 2004) and ensure that they are accounted for in the reintegration planning process.

Unfortunately, not all reunification is successful. Approximately 30% of children who are reunified with their primary caregiver will reenter the foster care system within 10 years of
discharge\textsuperscript{1}. Youth are slightly more likely to reenter the child welfare system after shorter placement versus longer placements. Wulczyn (2004) proposes that this is due, in part, to the reduced amount of time that a worker has to work with a family to address issues at home and successfully prepare the family for reintegration. Of those youth who return to foster care, they are at greatest risk for re-entry during the first year of discharge, often as a result of parental problems, such as substance use or deficient parenting skills.

While there is little research into the factors that contribute to positive reunification, a couple of studies have identified family factors to be important in the success of reunification and the agency worker’s decision to support reunification. Hess (1987) found that low family engagement, low family readiness, poor compliance with case plan and low involvement in post-discharge services were all predictors of failed reintegration. Another study that explored worker decision making to support reunification, found that workers considered caregiver engagement in terms of active participation in the treatment plan, as well as frequency of visitation when deciding whether a child should return home (Wulczyn, 2004).

While reunification is the most common permanency plan in child welfare, when the ultimate plan is not for the child to return home, there is evidence that maintaining contact with the caregiver during placement can still be beneficial. Engaging the parent and repairing relationship between parent and youth teaches the youth to form healthy attachments in the future (McWey, 2000; Robinson et al., 2005).

In addition to the empirical support for caregiver engagement in recognition of the reunification process, there is theoretical support in Bronfenbrenner’s Bioecological Theory of

\textsuperscript{1} The term foster care system includes youth who are placed in RTCs, such as those utilized in this dissertation. These RTCs are licensed by the state child welfare agency and therefore serve as a foster care placement for these youths.
Human Development. In his theory, which was continuously revised until his death in 2005, Bronfenbrenner proposed that human development is an interactional equation of Process-Person-Context-Time (PPCT). This model posits that, “human development takes place through processes of progressively more complex reciprocal interaction between an active, evolving biopsychological human organism and the person, objects, and symbols in the immediate external environment” (Bronfenbrenner & Morris, 1998, 996). These experiences of process will vary based on characteristics of both the individual experiencing the interaction and the context of the interaction. Each person possesses characteristics referred to as demand, resources and force that can influence interactions. Demand is characteristics that are easily apparent including age, gender, etc. Resources can be mental or emotional and include attributes such as intelligence or past experiences. Force is things like temperament, motivation and persistence (Tudge, Mokrova, Hatfield, & Karnik, 2009).

The context of interaction is also an important consideration. Bronfenbrenner proposed that there are four interrelated systems that comprise an individual’s context, or environment. The microsystem is any environment that an individual spends a lot of time in, such as school or home. The mesosystem is the interrelations between more than one microsystem. The exosystems are environments in which the individual does not directly spend time, but these systems still have an indirect influence on the individuals, such as a parent’s workplace. Finally, the macrosystem is any group whose individuals share common beliefs or values. This system is influenced by and influences all of the other systems. It is necessary for a particular value system to be experienced in more than one system for it to have an influence on an individual (Tudge et al., 2009).
The final model component, time, is critical to any theory of development. This theory considers subcategories of time. Microtime are events associated with a specific activity or event. Mesostime is the consistency of events or interactions in an individual environment. Macrot ime is the variation in developmental processes based on historical events and individual age. While this dissertation is not an empirical test of Bronfenbrenner’s theory, it does pull from some of the major tenets of Bioecological Theory of Human Development to frame and support this study.

In 1986, Bronfenbrenner published an article in *Developmental Psychology* that specifically sought to explore the effects of extrafamilial factors on intrafamilial processes. He delineated how three environmental systems, including the mesosystem, exosystem and chronosystem can influence the family. This discussion of the three systems are translated into a justification for caregiver engagement in youth residential treatment in the next three paragraphs.

First, the mesosystem acknowledges that the family is just one system among multiple that affects human development and that one system can influence another system. Applying this concept to the population of this dissertation, the RTC can be viewed as one system, or environment, and the family is a distinct system. Bronfenbrenner argues that what happens in the family system will influence what happens in the RTC system and vice versa. In this sense, the impact of the RTC on the youth will also have an effect on the family. In order for all parties to navigate the changes that occur for the youth during the residential treatment process, it is in the youth’s best interest for the caregiver to be involved during the treatment process, so that when the youth returns to the family system, both youth and caregiver can embrace and succeed in the reunification process. Alternatively, if the caregiver is not involved in the treatment process and the separation between the caregiver and the youth inhibits the youth’s ability to embrace and
engage in the treatment process, the efficacy of the youth’s time in treatment will be negatively affected. Beyond caregiver engagement specifically, the RTC should seek to address family issues that might have contributed to the youth’s placement or may arise during residence. The primary justification for this approach is the interaction between the two systems. For example, if the caregiver and youth experience conflicts while the youth is in placement and those issues are not addressed, it can affect the youth’s treatment trajectory. In his article, Bronfenbrenner uses school as an example, stating that events within the family at home can influence a child’s progress in school and vice versa. Within this context, engaging the caregiver in addressing the underlying conflicts would likely prove more effective than working with the youth alone. Further, the caregiver should be given a voice to identify and discuss issues that are affecting the family, so that they can be addressed to improve the transition between RTC and home.

The second system, or the exosystem, acknowledges that there are systems that affect a caregiver’s life without directly affecting a youth, however they still have a bearing on the youth’s life. For example, the caregiver’s workplace can influence a youth’s development, even if the youth does not spend time in that environment. If a mother works full-time, her work system can influence how often she is home and available to the youth, or how stressed she is when she is home with the child, therefore affecting her mood or behaviors toward the child. This particular system interaction is less central to the subject of this dissertation, however there is one possible way that it relates to this population. If we were to look at the home and RTC as two distinct environments, we would acknowledge that the youth being removed from the home environment for an extended period of time transforms the family home to an environment in which the caregiver spends a lot of time, but the youth spends limited time. The removal of the youth from the home is likely to spur changes in the home environment as far as how the
remaining family members function as a unit and how the family routine evolves during the absence of the youth. When the youth transitions in and out of the home for home visits, or ultimately returns to the home post-discharge, there will be challenges for both the youth and caregiver posed by the “new” home structure. Engaging the caregiver in the treatment process will theoretically improve communication and attachment between the youth and the caregiver which would help both to navigate reunification successfully. Further, the caregiver can provide some continuity for the youth if he or she is aware of the structure of the RTC and can reinforce the youth’s coping and social skills that have been addressed in the RTC.

The final system is the chronosystem, which considers how changes and continuities over time influence a person’s development. There are two types of transitions within the chronosystem that can influence development: normative and nonnormative. Normative transitions are the types of transitions that most, if not all, people will experience in their lifetime, such as puberty or entering school or the workforce. Nonnormative transitions are events that not all individuals will experience, such as parental or personal divorce, moving, or the death or illness of a family member. Life course studies are an example of exploring cumulative effects of developmental transition over time. In relation to this population, placement in an RTC represents a nonnormative transition, in that not all youth will experience this transition. Bronfenbrenner discussed an application of the theory that began to emerge in the 1970s, in which researchers consider changes over time within the person while also considering changes in the environment. Within this system lies additional support for caregiver engagement in youth residential treatment. This is the system that is focused on changes and continuities. First, the placement of a child in residential treatment is a large change for many families that is likely to illicit stress from both the caregiver and youth. However, engaging the caregiver in the
treatment process might serve as one strategy to reduce the distress felt within the youth and caregiver, therefore facilitating the treatment process. In his review of studies testing his theory, Bronfenbrenner cited a 1953 study by Prugh and colleagues in which children who had been admitted to a hospital for four months experienced less distress when they had unlimited contact with a parent in comparison to children who only had weekly contact with a parent (Bronfenbrenner, 1986 citing Prugh, Staub, Sands, Kirschbaum & Leninhan, 1953). Second, continuity among this population can be viewed as the continued application of the skills learned while in placement, even after the youth transitions back to the family environment. In order for the caregiver to be able to continue reinforcement of behaviors and skills gained during the treatment process, he or she must be privy to the types of interventions and skill that were used during the process. This can only be accomplished if the caregiver is engaged in the process. The continued application of the skills learned will reduce recidivism and improve family functioning as discussed later in this chapter. Relatedly, Tudge et al. (2009) discussed the importance of a particular value system being experienced in more than one system for it to have an influence on an individual. In this case, the value system would be the continuity of the skills and contexts of the treatment process after returning home and the two systems that would interplay would be the RTC and the family at home. Stability across both systems would reinforce the belief system of effective coping and social skills that has been introduced by the RTC.

**Caregiver Role in Youth Treatment**

In addition to the recognition that involving caregivers in the residential treatment process is important because the youth is often returning to the family environment, proponents have also recognized the positive contribution that caregivers can make to the treatment process, by being an expert in the youth’s behaviors. Garfinkel (2010) argues that, “the family is
potentially the most reliable source of information about their child’s strengths, needs and experiences (52).” Caregivers want the information they provide about youth behaviors and problems to be incorporated into the treatment plan (Iachini, Hock, Thomas & Clone, 2015). Further, caregivers can provide valuable insight that can be used to structure the treatment plan to address deficits or capitalize on strengths in family relationships, parental functioning or parenting style (Carlo, 1992). Finally, caregivers are a good source of information pertaining to the post-discharge environment, so that the treatment plan can be consistent with the post-discharge environment, maximizing the youth’s chance of success (Miller et al., 2016).

Since youth treatment has transitioned from youth-centered to family-centered, the role of the caregiver in treatment has been dramatically revised (Nickerson et al, 2004). Family-centered approaches to youth treatment require and encourage collaboration from the caregiver (Hornberger & Smith, 2011). Some of the basic assumptions of family-centered care include the beliefs that the child and the family are intricately interwoven, the participation of the caregiver will produce more powerful outcomes than focusing on the youth alone, and that professionals should incorporate family priorities into the treatment plan and goals (Bailey et al., 1992). According to Walter and Petr (2008), a family-centered program should, “maximize regular contacts between child and family, actively involve and support families in the treatment and provide ongoing support and aftercare once the child returns home” (p. 12). Discharge planning should include a provision for community based after-care services to aid in the transition of the youth from agency to home and to facilitate the retention of skills learned in treatment (French & Cameron, 2002).

Such changes to the guiding principles of youth care also place different demands on workers to collaborate with the families in ways that might have previously been considered
outside the scope of their work based on youth-centered approaches (Bailey et al., 1992; Brown, Barrett, Ireys, Allen, Pires & Blau, 2010; Garfinkel, 2010;). For many workers, the transition to viewing caregivers as a partner in treatment is difficult, at times burdensome, and requires additional training (Bailey et al., 2016; Brown et al., 2010; Carlo, 1992). Unfortunately, workers are often undertrained in family-driven principles of care (Brown et al., 2010)

**Engagement in Treatment**

As a result of the growing support for family-centered approaches to youth care, the emphasis on caregiver engagement in youth care has been increasing since the 1970s (Demmitt & Joanning, 1998). The belief that engagement is central to successful treatment intervention spans across multiple types of therapy (Cunningham et al., 2009; Yatchmenoff, 2005). Although, engagement lacks a singular definition (Cunningham et al., 2009; Platt, 2012), there is much overlap in the various definitions of the term. Cunningham et al. (2009) propose that all definitions of engagement tend to center around three components: (1) client’s motivation and expectation about treatment, (2) client’s relationship with therapist and (3) client’s behavior in therapy.

**Client’s motivation and expectation about treatment.**

The first component, client’s motivation and expectation about treatment, refers to the client’s attitude toward treatment and is sometimes conceptualized as readiness to change, perceived need for treatment, commitment to treatment and feelings about the potential effectiveness of treatment (Yatchmenoff, 2005). Recently, Platt (2012) proposed eliminating the term “readiness to change,” as it is hard to define and client behavior, such as cooperating with treatment conditions, could easily be confused as readiness to change. She proposes instead to view readiness to change factors as determinants of engagement.
There is believed to be a link between engagement and parental belief about treatment, such that those parents that do not perceive a need for treatment are less likely to be engaged (Morrissey-Kane & Prinz, 1999). Similarly, if a parent does not believe that their child’s problem behavior can be changed, he or she is less likely to engage in treatment (Morrissey-Kane & Prinz, 1999). Miller et al. (2016) have argued that motivation for change exists along a continuum of readiness. Clients will progress through stages of readiness, during which time it is not uncommon to experience setbacks that prevent progress toward the next stage of readiness.

Caregivers’ motivation and expectation for treatment are likely tied to a few factors related to parent and child functioning. For example, if a parent is unable to understand why their child needs treatment or agree with the idea of residential treatment, he or she will likely be less involved than if there was agreement with the need for treatment (Israel et al., 2006). Additionally, the severity of the child’s dysfunction can lower a caregiver’s expectation that their child can improve (Gladstone, Dumbrill, Leslie, Koster, Young & Ismaila., 2012; Nock & Kazdin 2001). Low expectation for treatment effectiveness decreases the likelihood of caregiver engagement and also increases the likelihood for early termination of services (Nock & Kazdin, 2001).

A specific challenge to caregiver motivation and expectation about treatment in youth residential placement is the fact that youth who are residentially placed are more likely to exhibit more complex symptoms than those who are treated in the community and they are also more likely to have failed in alternative programs (Garfinkel, 2010; French & Cameron, 2002; Miller et al., 2016). In the current child welfare climate, residential placement is typically seen as the intervention of last resort (French & Cameron, 2002; Walter & Petr, 2008). It is not uncommon for caregivers to feel depleted by the lengthy history with either or both the juvenile justice and
child welfare systems that typically precede residential placement, depending on the circumstances of the case. Many youths have experienced a prior placement and it is also common for a youth to enter residential placement from a setting other than the family home, suggesting a longer period of separation and possible detachment preceding placement (Griffith et al., 2009). These feelings of exhaustion and skepticism about any intervention to be effective for their child are a threat to motivation for treatment that must be addressed during the treatment process (Miller et al., 2016).

**Relationship between client and therapist.**

The second component to engagement is the relationship between the client and the therapist. This relationship has sometimes been referred to as the therapeutic alliance, ego alliance or working alliance. A better relationship between the caregiver and the therapist has been associated with greater family participation, as well as decreased treatment termination (Bordin, 1976; Israel et al., 2006; Morrisey-Kane & Prinz, 1999; Platt, 2012). Some have argued that the therapeutic alliance is the strongest predictor of treatment outcomes (Bordin, 1976; Karver, Handelsman, Field, & Brickman 2005). Caregivers and youth have identified the therapeutic alliance as one of the most important factors that contributes to engagement (Iachini, et al., 2015). The therapeutic alliance is being developed from the initial contact with the therapist, which is a pivotal moment in the treatment process (Saint-Jacques et al., 2006). Miller et al. (2016) have argued that the introduction between the caregiver and the treatment team sets the tone for the entire treatment process. Therefore, it is important to promote a positive rapport with the caregiver and promote an environment where the caregiver feels comfortable to express their needs. In a 2015 study by Iachini et al., caregivers identified a series of conditions that promote a positive relationship with worker including feeling care and concern from the worker,
feeling like the worker is actually listening to what the caregiver is saying, feeling that they are not being judged, and being valued for the information they can provide about the youth to guide the treatment process. An earlier study by Altman (2008) found similar qualities that were desired by caregivers to facilitate a relationship with the worker. In addition to the conditions set forth by the Iachini et al. (2015) study, caregivers wanted workers to be straightforward with them, even when this meant that the worker needed to exercise tough love, which workers agreed was often necessary with involuntary populations. Caregivers also wanted workers to follow through on things, such that if they said they were going to do something, they actually did it.

A positive therapeutic alliance with the caregiver is beneficial to the worker, as well as the family. For example, engaging the caregiver allows the worker to have a greater perspective on the family functioning and the conditions at home that may have contributed to the child’s problem behaviors (Carlo, 1992). In addition, when the caregiver is engaged, the worker also has the opportunity to educate the family members about the deeper causes of the problem behaviors, as well as how to sustain positive outcomes post-treatment (Hornberger & Smith, 2011). Practitioners and caregivers alike have acknowledged the important role of trust in developing a positive relationship between caregiver and worker (Saint-Jacques et al., 2006). A trusting relationship between the caregiver and workers is more likely to lead to a caregiver feeling hopeful toward the future (Gladstone et al., 2012). Caregivers were more likely to trust the worker when they perceived that the worker was competent and experienced (Gladstone et al., 2012). Workers begin to feel that the caregiver trusts them and is engaged in the treatment process when caregivers begin to demonstrate compliance with the treatment conditions (Altman, 2008).
Therapeutic alliance with caregivers is something that should be attempted as soon as the child arrives at the agency and maintained throughout the treatment process (Saint-Jacques, 2006). The degree of therapeutic alliance can be increased by workers who spend a lot of time in direct contact with the client (Dawson & Berry, 2002) and by allowing the caregiver to collaborate in the development and progression of the treatment plan (Iachini, 2015; Platt, 2012). Not only is the inclusion of caregivers in the development of treatment goals beneficial to the therapeutic alliance, but it is often highly desired by parents (Demmitt & Joanning, 1998). In a series of focus groups conducted by Demmitt and Joanning (1998), parents were able to acknowledge the importance of forming alliances with the staff, however they wished that staff would be more aware and sensitive to the difficulty in leaving your child in someone else’s care. This desire was echoed by caregivers in a study by Altman (2008), where caregivers voiced frustration with a perceived lack of urgency and action from the staff, making them feel as if the staff could not really understand or relate to the challenge of having a child placed outside of the home and that the staff were not focused on how to most effectively assist the caregiver with getting the child back home swiftly.

Practitioners, it has been argued, should not judge the caregiver and the family values system, if it is not endangering the child, and they should also incorporate caregivers into the process of developing treatment goals to address this concern and facilitate a stronger bond with the staff (Bordin, 1976; Iachini, 2015; Saint-Jacques, 2006). Bordin (1976) argues that the development of treatment goals that are mutually agreeable to client and practitioner is extremely central to the working alliance, as families are more likely to work toward a change if they can visualize the positive effect it would have on quality of life. Further, clients are more likely to
engage with the clinician when they feel that they are establishing a long term therapeutic relationship as opposed to a relationship for the brief treatment duration.

**Client’s behavior in therapy.**

The third component of engagement, client’s behavior in therapy, is most often concerned with the degree of collaboration, cooperation, agreement, participation and effort put forth by the client. Within the third component of engagement, client’s behavior in therapy, Littell and Tajima (2000) distinguished between two distinct levels of engagement: collaboration and compliance. Collaboration represents a deeper connection with the treatment process in which the caregiver participates in treatment planning and agrees with treatment goals, whereas compliance refers to keeping appointments, completing tasks and cooperating with workers. Some argue that collaboration is more central to treatment success than compliance (Cunningham et al., 2009; Dawson & Berry, 2002; Platt, 2012; Yatchmenoff 2005), especially in consideration of the fact that this population is a non-voluntary population. In a coerced or mandated treatment setting, attending meetings or completing tasks are not necessarily representative of engagement as these activities are often required and monitored by an outside government agency (i.e. court). Therefore, the coercive nature of a mandated treatment setting presents a unique challenge for attaining and measuring collaboration (Cunningham et al., 2009; Littell & Tajima, 2000; Osher & Huff, 2006; Platt, 2012). Further, the residential nature of the program presents a disruption to the natural bond between parent and child, which might facilitate a detachment process among caregivers (Blacher & Baker, 1994), or other negative consequences for the youth, such as reduced self-esteem, sense of identity and sense of safety (Jenson & Whittaker, 1987; McWey, 2000). Unfortunately, Yatchmenoff (2005) found that compliance is more likely than collaboration in a Child Protective Service (CPS) population.
Caregiver engagement and cooperation in service planning might be increased by utilizing the strengths of a widely defined family group, promoting decision making based on the family’s needs in addition to the child’s needs, and allowing cooperation between caregivers and workers in the planning process (Bordin, 1976; Dawson & Berry, 2002). Further, Platt (2012) argues that when a worker can create a less coercive environment by including the caregiver in the treatment planning, the feeling that the caregiver is under the power of an outside authority, such as the agency, will be reduced, therefore facilitating engagement. Littell and Tajima (2000) recommend that providing a wide range of concrete services to clients can increase collaboration from caregivers.

**Benefits of Caregiver Engagement**

The benefits of caregiver engagement in youth treatment are widespread, affecting both the youth and the family as a whole. Residential programs that have a family focus are more likely to produce significantly better long-term outcomes for youth than traditional residential care programs (Dawson & Berry, 2002; Garfinkel, 2010; Griffith et al., 2009), including shorter lengths of stay in treatment (McWey, 2000; Robinson et al., 2005), decreased misconduct while in placement (Borgman, 1985; McWey, 2000), lower levels of post-treatment problem behaviors, lower risk of recidivism (Lakin et al., 2004; Ryan & Yang, 2005), and successful family reunification (Carlo, 1992; McWey, 2000). The sum of these findings demonstrate the beneficial outcomes for youth in treatment when families are involved throughout the process, making a strong argument for family involvement in youth treatment.

Further, family therapy during residential treatment has not only been demonstrated as a service that is desired by caregivers (Demmit & Joanning, 1998), but has also been linked to positive discharge outcomes for youth. Stage (1999) found that the only significant predictor
regarding whether a youth was discharged to a less restrictive (as opposed to more restrictive) environment among 130 adolescent youths in residential treatment was whether the youth had received family therapy. If a youth received family therapy while in treatment, he was eight times more likely than a youth who had not received family therapy to be released to a group home or back to his own home than to move into a more restrictive setting. If a resident had received family therapy but was still released to a more restrictive environment, he was more likely to come from a violent home or a home where there was a history of substance abuse. These individuals were also more likely to be violent, have a criminal record and have their own history of substance abuse.

Youth who experience caregiver involvement and support during placement are more likely to experience successful reentry into the community (Jenson & Whittaker, 1987). In addition, Lakin et al. (2004) found that the families that had attended family therapy had higher family functioning, measured using the Family APGAR (adaptation, partnership, growth, affection, and resolve) scale, at the time of discharge than at intake, leading to a lower likelihood of recidivism for the youth.

**Barriers to Caregiver Engagement**

Despite the abundance of research that demonstrates the positive relationship between caregiver engagement and positive youth outcomes both during and after treatment, there are still challenges to caregiver involvement in treatment. There have been many case or family, worker, and system characteristics that have been linked to level of participation in the treatment process (Leathers, 2002; Littell & Tajima, 2000; Platt, 2012).

First, clients of the child welfare system are involuntary participants, which might make them harder to engage by nature (Littell & Tajima, 2000; Osher & Huff, 2006; Yatchmenoff,
The mandated nature of the program might make caregivers uneasy (Osher & Huff, 2006). Further, if there is a legal mandate by court to attend a meeting, keep appointments or participate in the treatment process, workers might witness more compliance than cooperation as a result of the legal demand. Compliance has been argued to be less central to engagement than collaboration (Yatchmenoff, 2005), although compliance is viewed by workers as an indicator that the family is ready to engage in the treatment process and is beginning to trust the worker.

Second, it is not uncommon for agency policy to restrict contact between the caregiver and the child, at least initially, to allow for a child to adjust to treatment (Borgman, 1985; Robinson et al., 2005). Many agencies also make subsequent visitation after the adjustment period contingent on the youth’s behavior (Borgman, 1985; Robinson et al., 2005). While agencies are moving away from restricting contact with caregiver as a component of the treatment process, a 2010 survey of 293 residential facilities found that ¼ of the agencies either had a waiting period for contact or restricted visitation as a form of punishment (Brown et al., 2010).

Third, residential placement is likely to disrupt the natural bond between a parent and a child by imparting distance and absence between them (Blacher & Baker, 1994; Jenson & Whittaker, 1987), eliciting feelings of distress, stress or anxiety (Harper & Russell, 2008; McWey, 2000; Robinson et al., 2005) and, thus, potentially making it difficult to constructively work with the caregivers (Guterman & Blythe, 1986). Simply put, residential placement is disruptive to the entire family unit; not only the youth who is residentially placed (French & Cameron, 2002; Jenson & Whittaker, 1987). It is not uncommon for a caregiver to have a sense of failure or guilt when a child is residentially placed (French & Cameron, 2002; Harper & Russell, 2008; Miller et al., 2016). Another common sentiment among caregivers of residentially
placed youth is frustration, which can negatively affect their willingness to be engaged in treatment (Altman, 2008). Workers often find that when a caregiver is frustrated with the events leading up to residential placement, or the conditions of treatment set forth by the system, they are less likely to engage in treatment. One strategy for overcoming this barrier is that the worker can validate their feelings and share in the frustration while motivating the parent to make changes that will facilitate reunification (Altman, 2008).

Demmitt and Joanning (1998) used focus groups with caregivers who have children in residential treatment programs to discover that caregivers wanted to be involved in the treatment process and desired high levels of contact with their child. Further, a study by Nickerson et al. (2006) found that caregivers appreciated that their children could receive required services, providing caregivers some sense of relief despite having some guilt and discomfort that they were involved with an external agency to assist with child-rearing.

Caregivers often have complex situations in their lives that can affect their ability to be engaged in the treatment process, even when they want to be committed to their child’s treatment (Garfinkel, 2010). Residentially placed children are more likely to come from single parent households, households suffering with chronic housing instability and difficult family relationships. These families typically demonstrate a history of impairment in caregiver function, such as substance use disorder, mental health issue and criminal justice involvement (French & Cameron, 2002; Miller et al., 2016). All of these conditions present additional barriers to engagement.

The Current Study

Parental engagement in youth treatment continues to be difficult in the child welfare and juvenile justice sectors, and workers would often like to see higher levels of caregiver
involvement in the treatment process (Bailey et al., 1992; Fanshel, 1975; Nickerson et al., 2006; Saint-Jacques et al., 2006). While some attention has been given to the complex situations and emotions that caregivers are dealing with immediately prior to and following placement, acknowledging that there are often things going on in a caregiver’s life that must be dealt with in addition to the residential placement of their child, more investigation is necessary to understand what caregivers experience and how their experiences relate to their level of early engagement in youth treatment.

In recognition of the well documented benefits of caregiver engagement in youth treatment in the engagement literature and the acknowledgement that caregivers deserve a voice in the conversation about caregiver engagement in youth treatment, this study examines the perspective of caregivers and how those perspectives relate to their level of early engagement in their child’s treatment process. Specifically, this dissertation addresses two research questions pertaining to caregiver engagement in youth treatment that emerged after reviewing the existing literature.

First, in response to the observation made by multiple scholars (Cunningham et al., 2009; Littell & Tajima, 2000; McWey, 2000; Yatchmenoff, 2005) that most studies assessing caregiver engagement in treatment have relied on the staff perspective, this dissertation explores caregiver perspectives related to residential placement that were expressed during the early part of their child’s placement in an RTC. While some previous studies have looked at caregiver engagement in youth treatment from the staff perspective or using data collected from small groups of caregivers during focus groups or interviews and others have looked at larger cohorts using questionnaires, this study represents the largest cohort of caregivers of residentially placed youths interviewed individually on a wide range of topics pertaining to youth behaviors and
family experiences prior to and immediately following a child’s residential placement. The first research question addresses an identified void in existing knowledge about caregiver engagement by considering the perspective of the caregiver.

Second, this dissertation assessed how the perspectives expressed by caregivers regarding the time leading up to and immediately following their child’s placement related to their engagement in their child’s treatment process. The perspectives provided by this cohort of caregivers further understanding of caregiver engagement by connecting their statements to components of caregiver engagement that were measured quantitatively, including their motivation and expectation about treatment, bond with staff and behavior relating to their child’s treatment plan. Specifically, the caregiver perspective provides a well-rounded understanding of what the family experiences leading up to a child’s residential placement, as well as their experiences dealing with the placement agency within the first few weeks of treatment and how that relates to their level of engagement. These analyses examined whether existing findings derived from the staff perspective are consistent with the findings produced from the caregiver perspective. It also considered whether there was additional information in the open-ended responses of the caregivers that enhanced interpretation of the fixed response questions.

Prior research has examined many factors related to engagement. These previous studies have assisted in establishing a definition of caregiver engagement, articulating three main components of engagement. Further, existing research has identified measures for exploring engagement, examining caregiver, agency and youth factors in relation to the three main components of engagement. This study used previous research findings as a roadmap (see Figure 1.1) for analyzing caregiver engagement in youth treatment from 101 semi-structured interviews with caregivers of youth 4-6 weeks into residential treatment.
The themes in the last column of Figure 1 demonstrate constructs that have been used in prior research to define or represent the corresponding component of engagement depicted in the middle column. Upon completion of analysis of the caregiver interviews (described in later chapters), the themes that emerged were related back to the caregiver engagement constructs that have been established in previous studies to enhance understanding of these measures. The qualitative themes were assigned to an individual component of engagement according to the similarity of the thematic category to other previously established constructs of that component. Specifically, caregiver perspectives were used to explore the relationship between their experiences and sentiments and their level of engagement. The themes that emerged in this analysis were then quantitatively compared to the individual component of engagement to which they most closely align, as well as a composite measure of engagement combining all three of the components.
Chapter 3: Methods

This study explores the relationship between caregiver perspectives pertaining to their child’s placement in an RTC and early engagement in their child’s treatment process. The analysis of these relationships was completed in two phases.

First, interviews with 101 caregivers of residentially placed youths were qualitatively analyzed using both inductive and deductive methods to provide a baseline understanding of caregivers’ experiences and sentiments relating to their child’s placement. Second, a subset of the qualitative themes that emerged during the first phase of analysis were explored in relationships to quantitative variables that measured each of three individual components of engagement, as well as a composite measure of engagement. The selection of qualitative themes to represent components of engagement was guided by the roadmap derived from the literature and described in Figure 1.1.

Prior to providing a detailed plan for these phases of analysis, this chapter will provide background information to understand the context of the study. Specifically, the setting where the data were collected, the design and implementation of the data collection process, the recruitment of study participants, the instruments used and the data limitations are outlined.

Data Collection Setting

This dissertation utilized data generated from the Service Outcomes Action Research (SOAR) Project, a practitioner-research partnership between researchers at the University at Albany Schools of Criminal Justice, Social Welfare and Public Health and two juvenile residential treatment centers (RTCs) in the surrounding community. The two facilities’ residential programs are gender specific, with one serving females and one serving males. For the purpose of anonymity, the agencies are referred to using the pseudonyms St. Mary’s (female
facility) and St. Thomas (male facility). The majority of the youth serviced by the RTCs have been adjudicated either persons-in-need-of-supervision (PINS) (55%) or juvenile delinquent (41%), while the remainder were referred for various reasons including cases of abuse or neglect (3%) or special educational needs (1%).

**SOAR Partnership**

The SOAR partnership is a research-practitioner partnership that has been ongoing since 2001 and was initiated to facilitate the integration of evidence-based practice into both agencies. The agencies first approached a faculty member at University at Albany School of Criminal Justice in 2001 to request assistance with determining which interventions worked best for their clients. In order to answer this question, the agencies were asked to articulate their program logic model depicting the services they delivered connected to their anticipated outcomes. A collaboration of faculty and doctoral students from School of Criminal Justice and administrative, supervisory, and line staff from the agencies then developed a pilot study to determine the best way to measure the agency services and client outcomes, collecting data from 2001-2005. The intention was to use the information collected during the pilot study to develop and implement a permanent and ongoing data collection effort at both agencies. This pilot study process also produced the data analyzed in this dissertation.

Currently, the project has fully implemented its continuous systematic data collection process and the data that is generated is being integrated into agency operations. The project continuously evolves to meet the needs of the RTCs, focusing on both macro level exploration of the data to understand the overall efficacy of the program model and individual level analysis to understand the progress of the residents and adjust treatment plans as necessary to facilitate
maximum progress. The data are also used for broad and specific understanding of the service population.

This SOAR partnership is quite unique in that it has fostered a steady flow of data and information from the agencies to the research team at the University over a long period of time. The open communication and level of trust between the two RTCs and the research team have facilitated a more in-depth exploration of the programs than might be possible with a larger study. The research team has an ongoing working relationship with administrators at the agencies that allows for a data analysis process that is fluid enough to regularly evolve over time.

The agencies are extremely accommodating when it comes to providing additional access to data or information to the research team for clarification or to facilitate a wider exploration of a topic. There have been many times that members of the research team have been able to approach staff at the agencies to enhance understanding of an issue or trend that is discovered during analysis. For example, the research team was able to conduct focus groups with frontline staff to understand why survey completion was so low when the process progressed from the pilot study to full implementation data collection. This information was important for understanding how to streamline the process and support staff in completing their assigned surveys to build a large and comprehensive dataset. On a larger scale, that endeavor was important to understand the challenges of implementing a systematic data collection process at a child welfare agency.

Members of the research team, including faculty investigators and undergraduate and graduate research assistants, are regularly invited to attend and participate in agency meetings with agency administrators and staff to better understand regular operations at the agencies. This also allows the agencies to demonstrate their specific analysis needs to the research team, so that
SOAR research staff can continuously assist the agencies with integrating their systematic data collection into regular operations.

While SOAR is an ongoing research-practice partnership to achieve the aforementioned goals, this dissertation employs data from the pilot study phase. The interviews conducted during the pilot study included open-ended questions as well as closed-ended questions. It is these qualitative data that permitted analysis to understand caregivers’ perspectives, in their own voice. The data currently collected through the partnership consist solely of quantitative data, precluding such an in-depth examination.

**Agency Policy on Caregiver Engagement**

One specific consideration for examining caregiver engagement is the role that agency policy can play in either facilitating or discouraging parental engagement. The literature has identified certain components of agency policy that influence engagement. In order to give context to the treatment setting and agency culture pertaining to caregiver and youth contact, as well as caregiver involvement in treatment, a summary of previous interviews with agency staff about the caregiver contact policy at the time of data collection is provided to demonstrate that there were no formal policies that would inhibit caregiver engagement.

In a prior study, Martin and Moriarty (2012) found that at the time of the pilot study, the agencies did not have very prescriptive written agency policies and further that most staff either were not aware that the agency had a policy manual or did not know where to access such a document. For that reason, I will not be examining the formal written policies at the agencies, but will instead be discussing comments from interviews with one administrator at the males’ facility, one administrator and one staff member at the females’ RTC. Respondents were selected because they were involved in the SOAR pilot study, therefore having intimate knowledge of the
project, and they were also very familiar with agency procedure regarding caregiver-child contact at the time of the pilot study. Interviews were guided by a protocol of eight questions that asked about some of the barriers that have commonly been identified in the literature. The questions that guided the interviews can be found in Appendix A.

Overall, both agencies were supportive of caregiver engagement in treatment and made accommodations to encourage continuous youth-caregiver communication while the youth was in placement. Neither agency had a probationary waiting period for youth to make calls home. The youth could begin calling home as soon as placement began and might be able to call more frequently in the initial week before a regular call schedule was set up for the youth. In some instances, these early calls home were seen as critical for facilitating the youth’s transition to residence.

Both agencies had provisions in place for youth to make weekly calls home. At the male facility, youth could call home twice a week and also receive calls from home twice a week. At the females’ facility, the youth were allowed two weekly calls with the caregiver; one outgoing and one incoming. At that time, the agencies utilized a phone schedule that assigned specific times for the youth to call home. At the males’ agency, the call schedule was tied to the treatment plan and was determined by the youth’s clinician as was deemed appropriate. At the females’ agency, the schedule was based on administrative factors. Specifically, they were focused on ensuring that each girl could have their allotted phone time during the week by implementing a specific call schedule. Both agencies accommodated instances where the youth was not actually able to make contact with their caregiver during their allotted time by allowing repeated attempts until contact occurred. The phones were available on the residential units, but the calls were routed through the front desk to ensure that the youth was calling an authorized phone number.
and was in fact calling their caregiver with their allotted time. If there were serious concerns about the youth talking to their caregiver, the phone calls at the females’ agency would be monitored by a staff member listening in on the call or calls occurred in the presence of the therapist at the males’ agency. Of course, there were some instances at both agencies where calls home were not possible due to legal factors such as orders of protection or a serious threat to youth safety.

Neither agency suspended phone privileges to call home as a punishment for youths’ poor behavior. In addition, both agencies permitted calls home during clinical sessions to address urgent and emergent treatment needs. This was at the discretion of the clinician and did not have to be previously scheduled.

Both agencies allowed caregivers to visit the campus. At the males’ agency, caregivers could visit weekly until the initial conference occurred where a visiting plan that was reflective of the current situation was developed. Caregivers also had the opportunity to visit on Sundays. The females’ agency had open campus visits available to caregivers Monday, Wednesday, Friday and on the weekend. Further, youth could eventually earn off-campus visits within the local community and home visits. These off-campus visits were tied to behavior, in that the youth could lose an off-campus or home visit for poor behavior because it was seen as a privilege to be able to leave campus. It is important to recognize that even when a youth could not leave campus for a visit based on poor behavior, the caregiver could still come to campus to visit the youth.

Finally, both agencies invited caregivers to partake in treatment plan reviews, which occurred on a quarterly basis. Caregivers were notified well in advance when the meeting would be held. In many instances, special accommodations were made for caregivers to participate in treatment meetings by offering transportation fare to and from the agency or in some instances
hotel accommodations based on the distance that the caregiver would have to travel. Caregivers were allowed to bring their other children to the meeting if they could not secure childcare. When it was impossible for a caregiver to attend in person, they were able to call in to the conference via the phone.

While both agencies recognize that at the time, the agency practices relating to caregiver-child contact might have created small barriers for participation, both agencies have made a concerted effort since then to loosen the rigidity of their procedures pertaining to youth-caregiver contact. For example, in 2001, the agencies favored limited disruptions to the youth’s routine over caregiver contact, whereas today, they make more accommodations for contact despite routine. Despite some slight barriers to contact created by agency practices, such as limited flexibility to working around the caregiver’s schedule when it required accommodations outside of normal business hours, both agencies clearly displayed a commitment to caregiver involvement in treatment. At the time of data collection for the pilot study, both agencies acknowledged the value of incorporating the caregiver in the treatment process.

Overall, both agencies demonstrated a clear commitment to caregiver engagement through both agency practices and culture. The policies in place were supportive of caregivers maintaining regular contact with their child and also being engaged in and informed about the treatment process and youth progress. While there still might have been factors that affected caregiver engagement (e.g. work schedule, distance from agency, etc.) there is no reason to believe that agency policies created additional barriers for caregiver engagement. In fact, whenever possible both agencies made every effort to alleviate some of the additional barriers affecting caregiver engagement that have been identified in previous literature. Therefore, the
agency’s commitment to and recognition of the importance of caregiver engagement at the time of pilot study development and implementation makes this dissertation study possible.

Data Collection

In the larger pilot study, data were collected from multiple sources, including the youth, the primary caregiver, agency staff and the youth’s file, for a sample of 130 youths admitted from October 2001 to April 2004. It was decided to collect data from multiple sources because the primary goal of the pilot study data collection effort was to determine the best source to provide information pertaining to a variety of measures during the later permanent data collection process. One consideration was who would be the best source for different types of data. If the data had triangulated, or been similar from all sources, then any of the three perspectives (staff, youth, caregiver) would have sufficed to use for permanent data collection. However, it was critical to not assume that the staff perspective would be representative or adequate to represent all of the measures, as has largely been presented in other studies. Ultimately, a rigorous process to compare data from all sources revealed that the sources were not equivalent (Service Outcomes Action Research, 2009), supporting the value of collecting data from multiple sources.

Sample Recruitment

Data collection was completed by the University research team instead of agency staff, to assist the agencies and also disseminate key findings, therefore requiring Institutional Review Board (IRB) approval and human subjects protections. However, all of the recruitment for the pilot study was done by intake staff at the agencies as a result of The Health Insurance Portability and Accountability Act (HIPAA) regulations that prevented the research team from knowing any information about the agencies’ clients prior to obtaining consent. If a caregiver
attended the intake meeting, he or she was given study information by the intake coordinator and asked to sign a consent form if willing to be involved in the study. If the caregiver did not attend the intake meeting, information about the study and a consent form was mailed to them in a packet with other forms required by the agency. This was often the case for a variety of reasons including a work conflict, the youths often came directly from another placement or the caregiver did not show up for a reason unknown to intake staff. Therefore, the pilot study was completely dependent on the agency workers to recruit participants. Workers stated that in some instances the caregiver was too emotional at intake to be able to discuss the study or that the caregivers might have declined the study because it was the only optional component of the intake process. If a caregiver signed a consent form, he or she was both agreeing to participate in the study him or herself and giving permission for their child to participate if the child decided to participate. The youth would be approached after receiving consent from the caregiver and he or she was given the opportunity to participate in the study if interested. The youth was free to decline participation. If the youth declined upon initial approach, they were approached again at a later time to see if they had changed their minds and would participate in the study. Once the youth reached the mid-point of their stay, no more requests were made to participate in the study because there were no baseline data.

During pilot study sample recruitment, caregiver refusal to participate when initially invited by agency staff to be involved in this study was not systematically collected by intake staff, nor was it systematically documented how many of the eligible caregivers were approached to participate in the pilot study. However, some information on refusal to participate is known and is presented in Table 3.1. It is estimated that the pilot study sample represents approximately
24% of eligible youths and their caregivers admitted to the agencies during the period of pilot study recruitment.

There were a total of 690 youth admitted to the two agencies from 2001-2004. Of the 690 youth, 551 were eligible to participate in the study (See Table 3.1). The eligibility criteria that were developed by the agency included admission to the general populations units rather than the critical care unit, being referred from one of sixteen counties in the State that most frequently refers to both agencies and having an identified caregiver at the time of admission since not all of the youth arrived to the agency in the custody of their caregiver. In addition to these criteria, some youth were deemed ineligible because they were Absent Without Leave (AWOL) or discharged before the caregiver could be approached for inclusion in the study, or they were admitted too close to the termination date for data collection. Agency intake staff at each agency approached about a third of caregivers who were eligible to participate at the time of their child’s placement. In addition to the reasons for not approaching a caregiver to participate in the study above, some additional circumstances for not inviting a caregiver to participate in the study included that there was a safety concern that prevented the caregiver from being involved in the youth’s treatment process, a caregiver was too agitated or overwhelmed at the time of intake to discuss the study, or a caregiver presented with an impairment that would have inhibited their ability to participate in the study.
Table 3.1: 2001-2004 SOAR Residential Pilot Study Sample Compared to Residential Populations

<table>
<thead>
<tr>
<th>Category</th>
<th>St. Thomas</th>
<th>St. Mary</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total non-duplicate Admissions Oct. 1, 2001 – April 30, 2004</td>
<td>308</td>
<td>382</td>
<td>690</td>
</tr>
<tr>
<td>Not eligible Total; (% of Admissions)</td>
<td>44 (14.3%)</td>
<td>95 (24.6%)</td>
<td>139 (20.1%)</td>
</tr>
<tr>
<td>Critical care (St. Mary decided not to include in study; no such unit at St. Thomas)</td>
<td>0</td>
<td>21 (5.5%/22.3%)</td>
<td>21 (3.0/15.1%)</td>
</tr>
<tr>
<td>Non-incl county (selected NYS 16 counties from which agencies got most clients)*</td>
<td>19 (6.2%/43.2%)</td>
<td>48 (12.6%/51%)</td>
<td>67 (9.7/48.2%)</td>
</tr>
<tr>
<td>No parent/guardian (and DSS would not consent)</td>
<td>2 (0.6/4.5%)</td>
<td>3 (0.8/3.2%)</td>
<td>5 (0.7/3.6%)</td>
</tr>
<tr>
<td>Youth AWOL then DIS before Caregiver could be approached</td>
<td>10 (3.2%/22.7%)</td>
<td>2 (0.5/2.1%)</td>
<td>12 (1.7/8.6%)</td>
</tr>
<tr>
<td>Youth discharged to other care before Caregiver could be approached</td>
<td>2 (0.6%/4.5%)</td>
<td>5 (1.3/5.3%)</td>
<td>7 (1.0/5.0%)</td>
</tr>
<tr>
<td>Admitted just before study end date, too soon for or missed approach**</td>
<td>11 (3.6%/25%)</td>
<td>16 (4.2%/16.8%)</td>
<td>27 (3.8/19.4%)</td>
</tr>
<tr>
<td>Total Eligible</td>
<td>264</td>
<td>287</td>
<td>551</td>
</tr>
<tr>
<td>Total Known Caregiver Responses; (% of Eligible)</td>
<td>89 (33.7%)</td>
<td>108 (37.6%)</td>
<td>197 (35.8%)</td>
</tr>
<tr>
<td>Caregiver Refusal (written, recorded on form); (% of Eligible)</td>
<td>7 (2.7/7.9%)</td>
<td>36 (12.5/33.3%)</td>
<td>43 (7.8/21.8%)</td>
</tr>
<tr>
<td>Caregiver Consent Total; (% of Eligible)</td>
<td>72 (25/66.7%)</td>
<td>154 (27.9/78.2%)</td>
<td></td>
</tr>
<tr>
<td>Youth Assent (In study); (% of Eligible/% of ParConsent)</td>
<td>82 (31.9/92%)</td>
<td>72 (25/66.7%)</td>
<td></td>
</tr>
<tr>
<td>Consent received too late to include in study (Not in study)</td>
<td>71 (26.9%/86.6%)</td>
<td>59 (20.6%/82%)</td>
<td>130 (23.6%/84%)</td>
</tr>
<tr>
<td>Youth Refusal (Not in study)</td>
<td>0</td>
<td>1 (0.3/1.4%)</td>
<td>1 (0.2/0.6%)</td>
</tr>
<tr>
<td>Youth in crisis, agency decided not to approach youth for assent (Not in study)</td>
<td>7 (2.7/8.5%)</td>
<td>8 (2.8/11%)</td>
<td>15 (2.7/9.7%)</td>
</tr>
<tr>
<td>Additional known info (% of Eligible)</td>
<td>4 (1.5/4.9%)</td>
<td>3 (1%/4.2%)</td>
<td>7 (1.3%/4.5%)</td>
</tr>
<tr>
<td>Caregiver given forms at intake, not returned***</td>
<td>29 (11%)</td>
<td>17 (5.9%)</td>
<td>46 (8.3%)</td>
</tr>
<tr>
<td>Caregiver not at intake, not return mailed forms</td>
<td>17 (6.4/58.6%)</td>
<td>9 (3.1/52.9%)</td>
<td>26 (4.7/56.5%)</td>
</tr>
<tr>
<td>Missed approaching caregiver (unknown why)</td>
<td>2 (0.8/6.9%)</td>
<td>8 (2.8/47%)</td>
<td>10 (1.8/21.7%)</td>
</tr>
<tr>
<td>Agency decided not to approach (St. Thomas – Juvenile Sexual Victim and Offender Program case)</td>
<td>9 (3.4/31%)</td>
<td>9 (1.6/19.6%)</td>
<td>16 (0.2/2.2%)</td>
</tr>
<tr>
<td>Unknown/No info</td>
<td>26 (4.7/56.5%)</td>
<td>10 (1.8/21.7%)</td>
<td>16 (0.2/2.2%)</td>
</tr>
</tbody>
</table>

Source: Table compiled by Dr. Dana Peterson, SOAR PI, University at Albany School of Criminal Justice
A total of 197 caregivers’ responses to the invitation to participate in the study were recorded by agency staff. Of these caregivers, 43 refused to participate in the study. A total of 154 agreed to participate when agency staff approached them about participating in the study. Of the 154 caregivers that agreed to participate in the study, 130 of their children provided assent to also participate in the study. Since both consent from the caregiver and assent from the youth were required to participate in the study, the total possible sample for the pilot study was 130 caregivers and their child (Table 3.1).

It is possible that this sample suffers from selection bias, such that those caregivers who are more likely to be engaged in their child’s treatment process would be more likely to volunteer to participate in this research study. As noted earlier, it can be difficult to elicit collaboration for caregivers who are mandated to participate in a program (Cunningham et al., 2009; Littell & Tajima, 2000; Osher & Huff, 2006; Platt, 2012), which would extend to this research study. Of all of the components of the RTC, participation in the research study was the only voluntary program component of which caregivers could expressly opt out in comparison to things such as completing necessary paperwork, participating in meetings, etc. Agency staff suspected that the voluntary nature of participation did dissuade some caregivers from participating. The difficulty of engaging treatment consumers in ongoing research has been documented. For example, in her attempt to use an empowerment evaluation model with a vulnerable population whereby she tried to engage consumers at a mental health drop-in clinic in an ongoing evaluation process, Sullins (2003) found that consumers had other stressors (e.g. financial and housing instability, family, physical and/or mental health concerns, etc.) that prevented them from being able to truly commit to involvement in the evaluation process. Many of the families involved with these two RTCs faced similar hardships that may have prevented
from committing to an ongoing research study that would require time and effort on their part. Generally speaking, this population might be challenging to engage in a research study, therefore producing a small response rate and increasing the likelihood of obtaining cooperation from those that are more highly engaged than those that are less engaged. Regardless of the potential for selection bias, there is no reason to believe that the perspectives and experiences of the caregivers expressed in this dissertation differ extremely from caregivers who might have been less engaged, as there are likely commonalities among their experiences preceding and immediately following their child’s placement. Further, the sample of 101 caregivers of youth in an RTC presented in this dissertation is a large sample compared to other studies that have explored this construct (see: Altman, 2008; Demmitt and Joanning, 1998; Harper & Russell, 2008; Nickerson et al., 2006) and provides valuable information that is currently missing in caregiver engagement literature.

To explore the extent of selection bias that was present in the pilot study sample, a comprehensive comparison was conducted by the SOAR research team, examining the youth that participated in this study and all youth discharged from the agencies during 2003, including 117 females and 84 males from their respective agencies. The two samples were examined by comparing the SOAR pilot study participants and the 2003 discharges on a variety of factors including demographics, psychiatric diagnoses, history of abuse, substance abuse history, prior placements, and program factors. Overall, the two cohorts were very similar on a multitude of factors, with few statistically significant differences between them (See Appendix B) Therefore, there is no reason to believe that the sample represented in this dissertation is not representative of the general populations of the RTCs.

**Data Collection Challenges**
Once the total initial sample was identified, there were additional challenges to obtain completed surveys from all 130 caregivers included in the study sample. Of the 130 caregivers, 18 did not participate in Wave 1 interviews for a variety of reasons. First, there were many instances where the caregiver provided contact information to the intake coordinator that would become invalid by the time the research team attempted to contact the caregiver. Some caregivers either moved or the phone number they provided was disconnected. If the contact information was not outdated, it was still challenging to actually make contact with the caregiver and schedule an interview at times. Sometimes the interviewer left multiple unreturned messages or left a message for the caregiver with a family member or someone else who did not relay the messages. Further, once an interview had been scheduled, there was no guarantee that the caregiver would show up for the interview. Sometimes he or she would know in advance that there would be something like a work or childcare conflict, but often he or she would forget or not show up without any explanation.

To address some of the challenges of doing interviews with a vulnerable population, several strategies were implemented. First, there was a designated toll-free number made available to caregivers, so that they would be able to contact the research team at any time regardless of any financial or technical situation. Second, interviewers would randomly stop by the participant’s last known address if feasible based on the distance that an interviewer would have to travel. Most often, an interviewer would make a cold call if the respondent lived in a local neighborhood, or if the interviewer was in the vicinity of the respondent because he or she had just completed another interview with another caregiver in the same area. Additionally, cards were mailed to the caregiver’s home to inform them that the research team was trying to contact them to schedule an interview. One motivation for this strategy was to see if the research team
would be able to obtain a forwarding address from the Post Office if the family had moved. Finally, when the caregivers agreed to participate in the study, they were asked to provide an alternate contact who would likely know how to reach them when the research team was attempting to schedule an interview in the future.

Out of the eighteen caregivers that did not complete a Wave 1 interview, twelve caregivers did not participate because the interviewer was unsuccessful at scheduling an interview with the caregiver. Even though these caregivers were unable to complete a W1 interview because of scheduling challenges, they were still invited to participate in a W4 interview when the time came to schedule W4 interviews, resulting in 5 caregivers completing W4 who had not completed Wave 1. Two caregivers refused when the research team contacted them to schedule an interview and one caregiver was hospitalized at the time of W1. There was no reason recorded for three caregivers who did not complete an interview. The total analysis sample for CW1 is 112.

Data Collection Strategy

The data were collected in four waves beginning four to six weeks after admission to the agency (Wave 1), at the approximate midpoint of the youth’s placement based on the court’s intended release date (Wave 2), within one week prior to discharge (Wave 3) and 3-6 months post discharge (Wave 4). Data collection was not initiated until four to six weeks into residence at the request of agency staff, who believed that it was important to allow the youth and caregiver a period of time to adjust to placement. The justification for collecting data at multiple time points was to unpack the black box of what happened in the treatment program. This would enable the analysis to capture what happens in the program as opposed to only examining what happens before and after treatment. This design would provide information, for example, on
youth who made improvements from baseline while in treatment, but ultimately declined in aftercare. A pre and post design would not be able to provide such valuable information about the youth’s progress while in treatment.

Although there were four waves of data collection, not all sources were tapped at all waves. Youth were interviewed at all four waves, while caregivers were interviewed at Waves 1 and 4 and staff completed surveys at Waves 2 and 3. The staff was surveyed at Waves 2 and 3 because the youth were in the midst of residence and it was believed that the staff would be a better source of information than caregivers of youth behavior at those points in time. At Wave 1 and Wave 4, it was believed that the caregiver would be the best source of information because the questions referred specifically to the time leading up to placement and the time since the youth had been discharged from the agency.

**Sources of Data for Current Study**

There were two sources of data from the pilot study that were incorporated into the analysis of this dissertation. Semi-structured interviews were conducted with caregivers 4-6 weeks after their child was admitted to the agencies. In addition to the semi-structured interviews, information was systematically collected form the youth’s file that was maintained while the youth was in residence. Each of the data sources will be discussed in greater detail in this section. Following the description of the types of data that were utilized in this dissertation, specific measures that were included in this analysis and the quality of the measures will be reviewed.

**Semi-structured Interviews**

Semi-structured interviews with caregivers 4-6 weeks after their child’s placement were analyzed in this dissertation study to better understand the determinants and effects of early
caregiver engagement by capturing caregivers’ thoughts, feelings and experiences at the outset of their child’s placement. This information enhances our understanding of caregiver engagement by considering their perspectives surrounding placement. The complex emotions and experiences that a caregiver faces during the placement of a child might either enhance or deter engagement.

Caregiver interviews were conducted by doctoral students and one faculty member on the research team. Interviewers were required to obtain human subjects protection certification, sign confidentiality statements and were trained in interview procedures including mock interviews with supervisors. The interviewers signed a total of three confidentiality statements. One was developed by SOAR investigators to ensure that interviewers understood the Federal regulations regarding confidentiality and human subjects protections, including the need to protect all information collected on this project. The other two statements were developed by each of the agencies and further required that interviewers would respect the confidentiality of the respondents and not share an individual’s information that was obtained during the data collection in such a way that could be traced back to the individual. The interviewers also underwent criminal and child abuse history background checks, including fingerprinting, at both agencies, due to direct contact with juveniles.

The caregiver interviews lasted from one hour to two and a half hours, depending on the level of detail in the responses provided by the caregivers. Respondents were allowed to choose the location of the interview (e.g., their home, a local restaurant) to ensure optimal comfort while answering the questions. This approach introduced a potential limitation, in that some of the interview locations presented challenges to conducting and recording the interview because of privacy, background noise and possible interruptions during the interview. The interviewers did all that they could to minimize these potential disturbances. The perceived benefit of increasing
comfort among respondents, therefore fostering a trusting and forthcoming relationship with the interviewer, was believed to outweigh the limitations. None of the interviews were lost in full due to issues such as background noise, although some were affected by certain sections of incoherence that could not be deciphered later. The occurrence of this was minimal and usually only affected a brief portion of the interview. As an additional safeguard, the interviewer took notes during the interview to be able to fill in any portions of the interview that may have been affected by technology issues or background noise. Upon completion of the interview, caregivers received a Walmart gift card valued at $35 as a reward for their participation.

In order to offset some of the risks to human subjects’ protections, a series of safeguards was implemented. The interviewers provided caregivers with an introduction prior to each interview that informed them about confidentiality, privacy and protections. They were informed that the research staff was separate from the agency and that none of the information divulged about their child during the interview would be reported back to the agency on an individual basis. The intent of the study was to provide information at the group level; not at the individual level. Further, the data would have no direct consequences to the youth’s treatment services. In order to protect the confidential information, the participants were assigned a random-generated 4 digit number so that their name was not associated with the interview data. Additionally, when the interviews were transcribed, any identifying information was replaced with XX’s or a non-identifying description (e.g. [son’s name]). The data were kept in locked filing cabinets in a locked office at the university and on a secure computer that required log on credentials.

The instruments were created to measure the concepts that were depicted in the program logic model that was developed in collaboration with agency staff. Scales were selected based on their fit to the logic model, meaning that they measured one of the key concepts identified in the
logic model and they were applicable to the population being served. Whenever possible, scales were drawn from other studies such as Rochester Youth Development Study (RYDS), where they had been validated. In some instances, measures were adapted, so that the language applied to an RTC population, or truncated to fit within the time constraints imparted by the agency to interview youth with minimal disruption to their daily routine. In the absence of existing scales to measure logic model concepts, measures were developed by the SOAR research team. Specific scales and their sources included in this study are described in greater detail at a later time in this chapter.

The caregiver wave 1 interview instrument was 34 pages long containing a mix of quantitative, or closed-ended, and qualitative, or open ended, questions. Some of the scales were aimed at measuring caregivers’ reports of their child’s characteristics, such as psychological symptoms, physical aggression, school attachment and achievement, engagement in risky behaviors, etc. Other measures pertained to family relationships such as caregiver attachment to youth, family trust, youth-caregiver communication, etc. Interviews were audio-recorded with the permission of the respondent, and then transcribed verbatim, whenever a recording of the interview was available, by members of the research team. If there was no recording available, either because the participant declined being recorded or the recording equipment malfunctioned, the interview was recreated using the interviewer’s notes.

Benefits of Interview Data

These data are ideal for this study for two main reasons. First, as noted by Littell and Tajima (2000), McWey (2000) and Yatchmenoff (2005), most studies examining components of caregiver participation in child welfare services have drawn exclusively on the perspective of the provider, either directly or by relying on records that are produced by the provider. These data
will allow an examination from the perspective of the caregiver, facilitating a direct
understanding of the factors that might either encourage or discourage the caregiver from
involvement in the treatment process. Further, these data will demonstrate the complex feelings
and sentiments surrounding residential placement on a wide variety of topics that were explored
through both open and closed ended questions, giving a voice to a population that has rarely had
a chance to express their perspectives or experiences. The instrument measures many constructs
pertaining to youth residential treatment, facilitating in depth analysis of many topics related to
residential treatment. In addition, the format of the interview, integrating both open and closed
ended questions allowed many topics to emerge about which the instrument might not have
specifically asked. The insight gained by considering information provided directly by the
caregiver can be used by child welfare agencies to foster and maintain engagement throughout
the treatment process.

Second, these data represent a large sample of caregivers in comparison to other studies
concerning caregiver engagement and the interviews covered a variety of topics that are central
to understanding caregivers’ experience with residential treatment centers. For instance, Harper
and Russell (2008) interviewed 14 families in their study, Demmitt and Joanning (1998)
conducted focus groups with a sample of 17 caregivers, Altman (2008) interviewed 16 caregivers
and Nickerson et al. (2006) conducted interviews with 21 parents of residentially placed youth.

File Data

Another source of data was information collected from the youth’s file at the agency. The
file information was meant to serve as a base of limited information that is routinely recorded for
youth at the agency. However, agency administration and staff felt that the youth’s file itself
would not provide sufficient information to fully measure the program logic model, which is
why the semi-structured interview instruments were developed. The specific components of the youth file that were coded by the research team for use in the pilot study included the youth’s intake assessment, service plan reviews when staff would reevaluate treatment goals and tasks, and critical incidents, such as behavior incidents or episodes of youth going absent without leave (AWOL).

A coding protocol for collecting file data to include in the pilot study was constructed. The protocol included information such as treatment goals and tasks, permanency plan, youth history, youth and caregiver demographics and behavior incidents. Detailed instructions for coding using the protocol were developed. A team of undergraduate research interns were trained in coding the file data. In order to measure interrater reliability, a subsample of cases were selected and three coders were assigned to code the same files to ensure coder agreement. Their coding was checked for error rates and additional training was provided to address the errors within coding. This process was repeated until coders achieved high reliability, measured by consistent coder agreement and low error rates.

This study incorporates some measures collected from the youth’s file including history of prior placements and youth permanency plan. Prior placements that the youth had experienced before arriving at the current agencies are included in this dissertation study to explore their relationship to caregiver motivation and expectation about treatment. Previous research has indicated that the longer the history of the youth’s involvement with the system and the amount of times that a youth has failed in other interventions can negatively affect caregiver engagement in treatment. The permanency plan for the youth included in this study will be broadly discussed to provide an overview of whether the youth was returned to their parents versus placed in an alternative environment. As documented previously, the majority of youth in residential
placement are expected to return to their parent’s custody, therefore justifying the need for caregiver engagement in the youth’s treatment.

**Measures**

This study utilizes a subset of the data that were collected during the SOAR pilot study, focusing on measures that facilitate exploration of the concept of caregiver engagement in youth treatment. A mix of open-ended, closed-ended, and file data are analyzed to explore the perspective of caregivers on a wide range of topics relating to their ability to engage in their youth’s treatment. Table 3.2 indicates the qualitative and quantitative measures that were included in this study. In addition to the variable name for quantitative measures, the source from which the measure was adapted is provided.

**Table 3.2: Measures included in analysis**

<table>
<thead>
<tr>
<th>Qualitative measures</th>
<th>Quantitative measures</th>
<th>File Data</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interview Questions</strong></td>
<td><strong>Variable (Wave)</strong></td>
<td><strong>Source</strong></td>
</tr>
<tr>
<td>What do you see as the purpose of your child being at St. Mary’s/St. Thomas? (Is there any good reason for her/his being here?)</td>
<td>Caregiver engagement (CW1)</td>
<td>SOAR</td>
</tr>
<tr>
<td>Do you think St Mary’s/St Thomas will be able to help your child? (If so, how?)</td>
<td>Caregiver motivation and expectation about treatment (CW1)</td>
<td>University of Rhode Island Change Assessment (URICA) Scale</td>
</tr>
<tr>
<td>Is there anything that you personally expect or would like to get out of this experience with [agency]?</td>
<td>Caregiver bond with staff (CW1)</td>
<td>Horvath &amp; Greenberg (1986)</td>
</tr>
<tr>
<td>What were your first impressions of the agency &amp; its staff?</td>
<td>Caregiver-staff collaboration on goals and tasks (CW1)</td>
<td>Adapted from Horvath &amp; Greenberg (1986)</td>
</tr>
<tr>
<td>Question</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>the staff do? How did you feel about that?)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can you tell me what led up to your child being at St. Mary’s/ St. Thomas? (prompt for immediate conditions and some history of child’s / family’s problems.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is this the first time your child has been in trouble like this? If not, could you tell me when these problems first started to arise with your child?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Could you tell me about the days leading up to your child being admitted? What was that like for you?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The first column represents the open-ended questions that were included in the qualitative analysis of caregiver engagement in youth treatment. While these items represent all of the themes that were coded deductively, there are additional themes that will be discussed that emerged from inductive coding of the transcripts. These themes are not represented in this table because they did not result from a direct question that respondents were asked to answer. These data were analyzed for the first phase of analysis to address the first research question pertaining to caregiver experiences and perspectives related to their child being placed in an RTC.

The second column represents the quantitative measures that were used to explore the relationships between caregiver perspectives and engagement in youth treatment. Beside each measure is the source from which it was taken or adapted. With the exception of the caregiver W1 measure of engagement, all of the scales are previously validated measures. The construction of the caregiver W1 engagement measure by the SOAR research team is discussed in detail in a later section. This column represents the data that were incorporated into the second phase of
analysis in addition to the data generated during the first phase of analysis. These data were used to address the second research question focused on the relationships between caregiver experiences or perspectives and their level of engagement in their child’s treatment process.

The final column represents a limited number of file measures that were included in this analysis. The file measures were used to assess youth discharge location since a large justification for caregiver engagement is to facilitate family reunification and how many prior placements the youth experienced before arriving at the current agencies. The quantity of prior placements was included in the second phase of analysis.

Detailed information regarding the properties of the measures are discussed later in this chapter in relation to analysis strategy. Further, the complete quantitative measures including all scale questions are included in Appendix C.

Mixed Methods
This dissertation uses a mixed method approach to analysis, incorporating both qualitative and quantitative analyses. Mixed methods have been utilized in social science as early as 1959, when Campbell and Fiske argued that using multiple methods would increase confidence that the results are valid and not simply a result of the methodology (Jick, 1979). Mixed method studies use triangulation of methods, or they combine multiple methodologies to examine the same phenomenon. Triangulation can be used to ascertain a more holistic or complete understanding of the participants or phenomenon that are being studied. This method may capture some information that might have otherwise been missed if only a singular method were being used. Therefore, triangulation might enrich our understanding of trends by allowing a deeper exploration of subjects (Jick, 1979).

Qualitative methods are often used to enhance quantitative methods by supplying additional information to clarify or contextualize findings (Jick, 1979). However, the integration
of both qualitative and quantitative methodologies allows researchers to employ the appropriate method to explore different dimensions of the same phenomenon (Feilzer, 2010). Jick (1979) argues that multi-method approaches are beneficial regardless of convergence between the methods. When there is convergence, this methodology helps to bolster the confidence in the results. When there is a lack of congruity, a deeper explanation can be achieved by incorporating unpredicted and context-related findings. Triangulation can also be used to develop more creative ways of measuring themes.

Prior studies of engagement have mostly utilized quantitative measures. However, the utilization of both quantitative and qualitative measures in this study permits a more in-depth look at engagement than quantitative measures alone. The quantitative data that were used in this study are consistent with measures that have been utilized to represent caregiver engagement in previous studies, such as caregiver bond with staff and caregiver readiness to change. The incorporation of qualitative data provides an opportunity for a more detailed understanding of caregiver engagement by providing additional information that cannot be captured by numbers alone. For example, if a caregiver has a low score on the quantitative measure caregiver bond with staff, the narrative from the open-ended question pertaining to first impression of staff may provide more insight to the cause of the low score. For example, the caregiver may provide a detailed account of a negative interaction with a staff member that contributes to the understanding of the quantitative measure.

Data Limitations

These data are not exempt from limitations. First, there is the potential for selection bias, such that those who agreed to participate might be different from those who never responded to a request for participation or declined. It is not possible in this study to examine the differences
between those caregivers that agreed to participate and those that did not because HIPAA regulations prevented the research team from receiving any data on those who did not consent to the study. However, as discussed earlier in this chapter, a comprehensive comparison was conducted by the research team to examine the youth that participated in this study and all youth discharged from the agencies during 2003. Overall, the two cohorts were very similar on a multitude of factors. Therefore, there is no reason to believe that the sample represented in this dissertation is not representative of the general populations of the RTCs.

Second, this study utilized self-report data from caregivers and youth. One of the risks of self-report data are that respondents will not answer questions honestly, either inflating responses by embellishing the information they provide or withholding data by not reporting specific information. Also, despite being informed that the research team had no connection to the agency, the respondents might have still perceived a connection that would have caused them to provide inaccurate or dishonest responses. As previously discussed, the setting of interview could have also affected responses, such that the respondent might have been guarded in responses because of people who were close by during the interview. It is important to note that the interviewers felt that the caregivers were fairly straightforward and this threat to the data was minimal. At the end of each interview, interviewers were asked to complete a brief evaluation of the respondent and the interview conditions. They were asked to rate things such as participant’s level of comfort and interest during the interview, as well as frequency of interruption during the interview. Interviewers’ responses to these questions revealed that caregivers appeared to feel comfortable and forthcoming in their responses. Finally, some of the recordings of the interview were either lost or corrupted (N=10), or the respondent declined to be audio-recorded (N=2). In these instances, the interview transcripts needed to be recreated using the interviewers’ notes.
These interview transcripts were not verbatim and therefore contained less information than those that were able to be transcribed verbatim.

**Correction of Problematic Transcripts**

As discussed previously, there were a total of 112 Wave 1 caregiver transcripts available for inclusion in this analysis. All caregiver interview transcripts from Wave 1 were uploaded into NVivo 10, a qualitative software package, for analysis. Interviews had been previously transcribed by a group of SOAR undergraduate and graduate research interns. Upon beginning data analysis, I suspected that there might have been some errors made during transcription that would adversely affect the analysis. There were two main issues in the transcripts that were identified. The first issue was the presence of large strings of text that were marked “XXX,” indicating that the transcriber was unable to understand what the respondent was saying. While it is quite possible that the recordings were inaudible, I believed that a fresh approach to the recording might lend itself to understanding more than the original transcriber was able to understand. The second issue was that some of the transcripts were incoherent, suggesting that the transcriber had misunderstood what the respondent was saying. These issues are consistent with literature suggesting that there are many ways that transcription can be problematic to qualitative research (McLellan et al., 2003; Oliver et al, 2005). Altogether, 37 out of 112 transcripts were identified as questionable and deserving of another attempt at transcribing the interview to see if the quality of the transcript could be improved. When the original interview tapes and the technology with which to listen to them were available, I listened to the interview and corrected the transcript as I was able to understand more from the tapes. At the time of transcription correction, there was no mini tape transcription machine available. Therefore, six interviews that had been recorded on a mini tape were unable to be checked for accuracy. In
these instances, the transcripts were closely reviewed again to determine if there were enough
data to include the transcript in coding, or if too much of the transcript was incoherent to include
in analysis. Of the six interviews recorded on mini tapes, two transcriptions were deemed too
incoherent to analyze and were excluded from the analysis. Ultimately, eleven interviews were
excluded from this analysis. In addition to the two that were excluded because they had been
recorded on a mini tape and were incoherent, four standard sized interview tapes were unable to
be located in the SOAR research office and the transcripts were deemed too incoherent to be
coded and included in the analysis. Three interviews were excluded because they were only
partial interviews and most of the themes pertinent to my study were not discussed. One
interview was excluded because the youth was a precipitous discharge who had already run away
from the facility by the time the caregiver W1 interview was administered resulting in many
incomplete responses to questions. Finally, one interview was excluded because the transcript
was incoherent and the tape was inaudible. The total sample of caregiver interviews that were
included for analysis in this dissertation is 101 caregivers.

Analysis Strategy and Measures

The analysis was divided into two phases. In the first phase, qualitative methods were
used to explore caregiver perspectives related to their child’s placement in residential treatment.
The themes included information about youth behaviors prior to placement at the current agency,
as well as feelings and expectations at the time of and in the weeks immediately following
placement. The selection of themes to further explore after the initial coding of all interview
transcripts was guided by the thematic map of prior research depicted in Figure 1.1. This phase
of analysis addressed the first research question which sought to understand caregivers’
perspectives related to their child’s placement in an RTC. Specifically, this analysis explored
caregiver experiences and feelings in the period preceding and immediately following the placement of their child.

In the second phase of analysis, quantitative measures were compared to qualitative themes, to see if there is a relationship between the nature of caregivers’ perspectives and their level of early engagement. The discussion of perspectives in phase one served to provide additional insight into what factors influence a caregiver’s perspective and how that can further our understanding of caregiver engagement. This phase of analysis answered the second research question, exploring how the perspectives expressed by caregivers regarding the time leading up to their child’s placement related to their engagement in the treatment process.

**Qualitative Methods**

**Coding strategy.**

First, the interview transcripts were qualitatively coded using a mixed approach, including both inductive and deductive strategies. Deductive categories, or tree nodes in Nvivo terminology, were developed to correspond to the themes of the specific interview questions (described below). Responses specific to that theme were coded under that node regardless of whether they were a direct response to the question being asked or instead emerged elsewhere in the interview but pertained to that particular subject. For example, if a respondent made a statement pertaining to whether they believed that the agency could help their child, it was coded under the node, “Will RTC help.” It did not matter if the comment was directly related to the question, “Do you think the RTC will be able to help your son/daughter?” or if it was discussed elsewhere in the interview.

In addition, each interview was coded in its entirety and themes were allowed to emerge from anywhere in the transcript, whether or not the theme represented a particular question. These responses were coded as inductive categories, or free nodes. An example of a free node
that is examined is “prior placements.” This node captures any instance where a caregiver discussed a placement that occurred prior to the current placement. As part of the open-ended questions, caregivers were not specifically asked about any prior placement, but many chose to discuss their opinions of or their child’s experience with prior placements.

General thematic categories were developed based on caregivers’ responses. The general categories were further broken down to identify the central themes within each thematic category. Once this initial coding of all of the transcripts was completed, Figure 1 was revisited. The tree and free nodes that emerged during coding were examined to determine whether they closely related to one of the identified measures or definitions of engagement previously documented in the conceptual model. An additional column (far right) was added to Figure 1, which displays the themes that were identified in relationship to the individual components of engagement. This process led to the selection of 17 general thematic categories to be further analyzed by completing an additional level of coding.
In the first phase of analysis, the themes shown in the last column of Figure 2 were explored in detail. An overview of each theme and its relationship to caregiver engagement in youth treatment is provided.
**Qualitative exploration of motivation and expectation about treatment.**

In prior research, motivation and expectation has been linked to the need for treatment, the likelihood of the child changing, the severity of the child’s disorder and the child’s history of involvement with the system. There are eight qualitative themes that were explored in relation to these constructs.

Caregivers who perceive and understand the need for treatment are more likely to engage in the treatment process. There were two themes developed during coding that are used to represent this concept: purpose of placement and agreement with placement. Caregivers were asked “what do you see as the purpose of your (daughter/son) being at agency? (Is there any good reason for her/his being here?)” Their responses were coded into categories to better understand what the caregivers perceived as the reason for their child being placed at the agency. Caregivers were not directly asked during the interview whether or not they agreed with either their child’s placement in general, or more specifically if they agreed with placement at the present agencies. However, many discussed this topic, facilitating an exploration of what might lead a parent to agree or disagree with their child’s placement.

As identified in prior research, in order for caregivers to engage in treatment, they must believe that their child can change. There were two qualitative themes that emerged to represent this concept: whether the RTC will help and first impressions of the agency or services. Both of these themes were discussed as a result of direct interview questions regarding these subjects. Caregivers were asked, “do you think [the RTC] will be able to help your son/daughter?” and “what were your first impressions of the agency and its staff?” Their responses to these two questions were coded to explore how their perspectives related to caregiver’s motivation and expectation about treatment, as well as overall engagement.
Previous research has shown that the intensity of a child’s behavioral needs might affect caregiver engagement, such that the more intense the need is, the less likely a caregiver is to become engaged. One theme emerged in relationship to this construct: what led to placement. Caregivers were asked, “Can you tell me what led up to your son/daughter being at [the present agency]?” This theme was analyzed to facilitate understanding of the intensity of their child’s need and how it relates to engagement.

Finally, the child’s history of involvement with the juvenile justice or child welfare systems has been linked to caregiver engagement, such that the longer that the child has been involved in the system, the less likely a caregiver is to engage. There were three themes that were identified in relation to this topic: child’s prior placement, child’s history of getting in trouble and caregiver’s frustration with the system. Two of these themes emerged organically without caregivers being asked specific questions relating to them and one of them resulted from an interview question. Caregivers were asked, “Is this the first time that your son/daughter has been in trouble like this?” The response to this question provides insight into the youth’s history of problem behaviors. In many instances, without being prompted, a caregiver brought up a prior placement that a child had experienced. Within some of these discussions, they provided some detail about the placement, discussing an opinion or experience. This theme was used to further explore the relationship between prior placements and engagement, which is also explored quantitatively using file data. While the quantitative measure can provide a count of the number of prior placements, the qualitative node contributes to understanding the nature of the experiences with prior placements, providing a context for its relationship with engagement. Again, without being prompted, some voiced frustration or concerns with the system. This is
believed to be related to history of involvement with the system because caregivers often discuss frustration with the system based on their experiences of dealing with the system.

**Qualitative exploration of relationship between client and staff.**

In prior research, the nature of the relationship between client and staff has been linked to degree of comfort with staff, level of respect and understanding from staff, trust between caregiver and staff and inclusion of caregiver in developing treatment goals. There are three qualitative themes that were explored in relation to these constructs. Two of the themes emerged organically during the interview without specific probing by an interview question, while one related specifically to a question that had been asked.

Caregivers were asked, “What were your first impressions of the agency and its staff?” Any responses to this question that pertained to their first impression of the staff were explored in relationship to the bond between client and staff. This theme assists in understanding what sort of first impressions lead a caregiver to feel positive or negative about staff at the agency. The nature of their initial satisfaction and comfort with the staff is expected to contribute to their ability to bond with the staff.

Caregivers were not specifically asked about their communication with agency staff, but some discussed this topic during their interview focusing on either the frequency or nature of communication with staff. This theme provides additional understanding of how the frequency of communication or context of conversation with staff informs the caregiver’s opinion of staff and affect his or her willingness to bond with staff.

Caregivers were not asked about their satisfaction with the treatment goals and tasks during the open-ended portion of the interview. However, there was a quantitative measure pertaining to collaboration on treatment goals and tasks that was included in the quantitative
analysis. The few qualitative responses pertaining to this topic were coded to provide context around what leads a caregiver to feel either satisfied or dissatisfied with the treatment goals.

**Qualitative exploration of client’s behavior.**

In prior research, client’s behavior has been defined as including the caregiver in the development of treatment goals and tasks, caregiver agreement with treatment plan and caregiver participation in treatment. There are four qualitative themes that were explored in relation to these constructs. Two of the themes emerged organically during the interview without specific probing by an interview question, while two related specifically to a question that had been asked.

Caregivers were asked, “Could you tell me about the days leading up to your child being admitted? What was that like for you?” and “Is there anything that you personally expect or would like to get out of this experience with [agency]?” The responses to these questions, as well as unprovoked comments about barriers to involvement, are all believed to be related to caregiver participation in treatment. The analysis of the days and feelings lead up to placement provided a context for what the caregiver was dealing with immediately prior to placement and how those experiences relate to their ability to participate in treatment in the early days. A caregiver’s personal expectations for treatment was hypothesized to influence their level of participation, such that those with a personal expectation from treatment might be more vested in actively participating. Finally, the barriers that the caregivers identified during their interviews shed light on some of the challenges that might prevent a caregiver from participating in treatment.

There was one theme that emerged related to agreement with and participation in developing the treatment plan. This theme of “treatment planning” did not emerge related to a
specific question, but was a topic that some caregivers discussed. Understanding the caregiver’s relationship to treatment planning, such as whether they either participated in the development of the plan or if they agreed with it provided some context for understanding their behaviors related to treatment.

**Quantitative Methods**

The purpose of the quantitative analysis was to explore the relationships between the qualitative and quantitative themes. This analysis addressed the second research question: how do the perspectives expressed by caregivers regarding the time leading up to their child’s placement relate to their engagement in the treatment process? The purpose of this analysis was twofold. First, comparing the qualitative themes to the quantitative themes demonstrated if there is a link between the nature of the caregiver perspectives and their level of engagement, both overall and in relation to the component of engagement that is most closely related to the theme being compared. For example, does belief about whether RTC will help their child significantly relate to motivation and expectation about treatment and/or overall engagement? Second, if there were no significant relationships between the qualitative themes and quantitative variables, was there still pertinent information that can be gleaned from the qualitative analysis, therefore highlighting a limitation of relying on quantitative data alone? Regardless of the nature of the relationship (e.g. significant or not) between the qualitative and quantitative themes, the open-ended responses were used to provide additional insight into the caregiver perspective, therefore facilitating a more well-rounded exploration of the quantitative constructs. For example, if there is a significant relationship between belief about whether the RTC will help their child and motivation and expectation about treatment, which type of responses (e.g. affirmative, negative or ambivalent) has the greatest effect on motivation and expectation?
The quantitative analysis included many of the themes that were discussed during the qualitative analysis. Each of the qualitative themes were quantified using their general thematic coding categories. For example, pertaining to caregivers’ belief about whether the RTC would be able to help their child, three general categories emerged: (1) no, (2) yes and (3) skeptical. Each general theme was assigned a nominal categorical value (see Table 3.3) for exploration using the quantitative measures of the individual component of engagement under which the qualitative measure was considered most closely related and the composite measure of engagement. In the case of whether the RTC would help their child, responses were categorically coded as such: no=0, yes=1 and skeptical=2. Not all of the qualitative themes could be included in this phase of analysis because some had been discussed by too few caregivers to allow for statistical analysis. For the most part, the themes that emerged in response to a specific question had large enough response groups to allow for statistical inquiry. Therefore, based on that criterion, seven qualitative themes were included in this phase of analysis. One additional theme, prior placements was explored quantitatively, as well, by comparing the qualitative responses to the quantitative responses to see if the caregivers’ perspective adds additional insight into the quantitative findings.

**Table 3.3: Quantitative coding of qualitative themes**

<table>
<thead>
<tr>
<th>Qualitative Theme</th>
<th>Quantitative coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose of placement</td>
<td>1- Environmental</td>
</tr>
<tr>
<td></td>
<td>2- Formal sanction</td>
</tr>
<tr>
<td></td>
<td>3- Future orientation</td>
</tr>
<tr>
<td></td>
<td>4- Service</td>
</tr>
<tr>
<td></td>
<td>5- Skills</td>
</tr>
<tr>
<td></td>
<td>6- Multiple</td>
</tr>
<tr>
<td>Ability of RTC to help child</td>
<td>0- No</td>
</tr>
<tr>
<td></td>
<td>1- Skeptical</td>
</tr>
<tr>
<td></td>
<td>2- Yes</td>
</tr>
<tr>
<td>Overall first impression</td>
<td>1- Positive</td>
</tr>
<tr>
<td></td>
<td>2- Negative</td>
</tr>
<tr>
<td>What led to Placement</td>
<td>0- External source</td>
</tr>
<tr>
<td>-----------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>Prior placements (type)</td>
<td>1- Jail/detention</td>
</tr>
<tr>
<td>Prior placements (number)</td>
<td>0- No prior placements</td>
</tr>
<tr>
<td>First impression of staff</td>
<td>1- Negative</td>
</tr>
<tr>
<td>Feelings leading up to placement</td>
<td>0- Negative</td>
</tr>
<tr>
<td>Personal expectations for treatment</td>
<td>1- Expectations for child</td>
</tr>
</tbody>
</table>

All of the relationships were explored using the same process. First, the qualitative themes were assigned numeric values. Next, chi-square measure of association and Fisher’s Exact Test (F.E.T.) were calculated using crosstabulation analysis to determine if there were any significant relationships between the qualitative (in quantified form) and quantitative measures.

Unfortunately, due to the small sample size combined with the even smaller groupings that resulted from categorizing the themes, more sophisticated analysis was not possible. The sample within each category was too small to facilitate more sophisticated significance testing.

This strategy was selected because it allowed for an exploration of the relationships between the central themes of the qualitative analysis and the overall level of engagement, while also being able to hone in on the three specific components of engagement. Some of the themes are more closely related to one component of engagement than the sum of all three components. Instead of only looking at engagement as the sum of its parts, this dissertation was also able to
examine specific components and provide insight into the role of the caregivers’ perspectives in relation to a specific component of caregiver engagement.

**Quantitative measure of caregiver engagement.**

Each of the 8 qualitative measures (in quantified form) was explored in relationship to a composite measure of engagement using crosstab analysis. The caregiver engagement measure is a 14-item composite scale developed to coincide with a composite measure of youth engagement. The concept of treatment engagement was identified in collaboration with practitioners at the agency following the development of a Residential Program Logic Model (RLM). Through semi-structured interviews with staff during the process of developing the RLM, three concepts of client engagement became salient: motivation and expectation about treatment, bond and rapport with staff, and collaboration between client and staff on selecting treatment goals and carrying out treatment tasks.

The research team sought to find existing measures that captured these concepts identified by practitioners. The youth and caregiver engagement measures developed by the research team, consisted of a combination of measures from the URICA Scale from the Cancer Prevention Research Center (Cancer Prevention Research Center, University of Rhode Island, n.d.), the Working Alliance Inventory (Horvath & Greenberg, 1986, 1989), Hatcher and Barends (1996) and Simpson et. al. (1997). For the youth measure, individual items from these sources were adapted to provide a scale of items that both captured the key constructs articulated by the staff and that could be administered to students within the allotted time constraints. The measures were also adapted for appropriateness with the population; that is, the measures needed to be adapted to apply to a population in residential placement. In addition, the agency requested that interviews with youth not extend beyond one class period (approximately 45 minutes). The
youth measure was then adapted to develop the caregiver measure of engagement, retaining the three specific components, but appropriately worded toward caregivers than youth in residential treatment. Caregivers were instructed, “The next few questions ask how you feel about your involvement with [the agencies] so far. Please tell me how much do you agree or disagree with the following statements.” Responses were on a 7-point Likert scale from strongly disagree to strongly agree.

The statements center around three distinct, yet related concepts that are understood to demonstrate caregiver engagement in treatment. The first theme pertains to the caregiver’s acceptance of difficulties within the family and willingness to work on them (“expectation and motivation toward treatment”), such as “At times our problems are difficult, but we are working on them.” There are three items pertaining to this theme included in the composite measure. The second theme pertains to the relationship between the caregiver and the staff at the RTC (“bond with staff”), such as “I believe that the people who work here are genuinely concerned for my family’s well-being,” or “the people who work here speak in a way that I can understand.” There are eight items pertaining to this theme included in the composite measure. The final theme is focused on the idea of treatment collaboration between the caregiver and the staff at the agency (“collaboration on goals and tasks”), such as “I have established with the people who work here a good understanding of the kind of changes that would be good for my child.” There are three items pertaining to this theme included in the composite measure. Factor analysis of the caregiver engagement scale at Wave 1 yielded two factors explaining a total of 64.83% of the variance of the entire set of variables. The measure has a Cronbach’s alpha of .925, demonstrating excellent internal consistency. (See Appendix C for individual items included in
the scale measures, factor analysis and reliability analysis of all quantitative measures included in this study.)

Caregiver engagement was dichotomized for the analyses in this dissertation to allow for basic statistical exploration. Overall, there was little variation in engagement with most caregivers presenting as moderately to highly engaged. This could be an artifact of the fact that those who were more highly engaged would also be more likely to agree to participate in the pilot study. The average level of engagement was 58.89, with a standard deviation of 16.12. All caregivers that were one standard deviation or more below the mean level of caregiver engagement were categorized as “low engagement,” resulting in N=15, low engagement. The remainder of the caregivers were classified as “moderate to high engagement,” totaling N= 74 moderately to highly engaged caregivers.² Farrington and Loeber (2010) discussed the benefits of dichotomizing variables in psychiatric and criminological research highlighting that using dichotomized variables can produce findings that are as meaningful or more meaningful than findings produced using continuous variables. The findings can be easily interpreted by large audiences. As is the case in this dissertation, the use of dichotomization is sometimes more sensible than the use of a continuous variable because the relationship of interest is how one group differs from another group. In this dissertation, the exploratory focus was how caregivers with low engagement differ from all other caregivers. There are multiple accepted strategies for dichotomization of variables including the method employed in this dissertation.

² To test the robustness of the findings given the small sample size, the caregiver engagement measure was also dichotomized at the mean and median. First, all caregivers who had an engagement score below the average level of caregiver engagement of 58 and below were classified as low engagement, while those with a score of 59 or above were classified as average to high. The median for caregiver engagement at wave 1 was 63. Caregivers with a score of 62 or lower were classified as low engagement while those with a score of 63 or higher were classified as moderate to high engagement.
The dichotomized measure of caregiver engagement was used in the qualitative-quantitative analysis, where categorical variables representing the major qualitative themes were compared to this measure of caregiver engagement.

**Quantitative exploration of motivation and expectation about treatment.**

Motivation and expectation about treatment is a nine-item scale measure (Cancer Prevention Research Center, University of Rhode Island, n.d.) of caregiver’s acknowledgement that the family has things going on that can be positively addressed through treatment. The measure asked caregivers “Please tell me how much you agree or disagree with each statement.” The response options were a 7-point Likert scale ranging from strongly disagree to strongly agree. The Cronbach’s alpha for the scale is .716, suggesting acceptable, though low, internal reliability. Three items in the scale were reverse coded for consistency with other items: “I guess our family has faults, but there’s nothing that we really need to change,” “It doesn’t make much sense for my family to be involved with this program; we aren’t the ones with a problem,” and “My being involved in my child’s treatment is pretty much a waste of time because I don’t have any problems that need to be changed.”

Five qualitative themes were compared to caregiver expectation and motivation, using crosstab analysis. These themes included purpose of placement, whether RTC will help, changes in child’s behavior, first impression of the agency/services and what led to placement.

In addition to these relationships, the quantitative measure for prior placements was also examined in relation to motivation and expectation toward treatment. These analyses examined how perspectives expressed by caregivers in relationship to their child’s prior placement at another agency related to their engagement in the treatment process. Prior placements is a count of the number of placements (e.g. child welfare or juvenile justice) that the youth experienced.
prior to arriving at the current RTC. The number of prior placements was dichotomized into no prior placements and 1 or more prior placements, and also trichotomized into no prior placements, 1 prior placement and 2 or more prior placements. Both variables were used in this analysis because there is reason to believe that the more prior placements the youth has experienced, the more likely it will have a negative effect on caregiver engagement. Due to the size of the sample, however, using three response categories may have reduced the statistical power to detect significant effects.

Quantitative exploration of bond with staff.

The caregiver bond/rapport with staff scale (Horvath & Greenberg, 1986) pertains to the relationship between the caregiver and the agency staff and asks questions to assess the degree of trust, comfort and cohesion with the staff at the agency. It is a 10-item scale asking how much caregivers agree or disagree with questions such as “I feel that the staff care about my family even when we do things that they do not approve of,” and “I believe the staff members here are genuinely concerned for my family’s welfare.” Two items were reverse coded for consistency with other items: “Staff at (the agency) don’t seem to understand my situation and my problems,” “I don’t think that staff at (the agency) really like my family.” Responses were measured using a 7-point Likert scale ranging from strongly disagree to strongly agree. The scale has a Cronbach’s alpha of .927, demonstrating excellent internal consistency.

Caregiver bond with staff was dichotomized for analysis against qualitative themes. The measure was dichotomized on the mean with one standard deviation below the mean being used to represent caregivers with low bond with staff. The rest of the caregivers were classified as moderate to high bond with staff. One qualitative theme was compared to this quantitative measure: first impressions of staff. The quantitative analysis explored the relationship between
the direction of a caregiver’s first impression (e.g. positive, negative or neutral) with their dichotomized level of staff bonding.

**Quantitative analysis of client’s behavior.**

The quantitative measure used to represent client’s behavior is called collaboration on treatment goals and tasks. The collaboration on treatment goals and tasks scale (Horvath & Greenberg, 1986) pertains to the level of agreement the caregiver has with the established treatment plan, as well as their level of commitment to working towards those goals. It is a 5 item scale asking caregivers how much they agree or disagree with items such as, “Staff and I are working toward goals we agree on,” and “I am clear on what my responsibilities are with regard to my child’s placement and treatment at the agency.” Responses were measured using a 7-point Likert scale ranging from strongly disagree to strongly agree. Two items were reverse coded for consistency with other items: “I sometimes wish the staff could better clarify the purpose of the counseling sessions at agency,” and “Staff and I have different opinions about what’s important for our family to work on.” The scale has a Cronbach’s alpha of .808, demonstrating good internal consistency of the measures.

Caregiver motivation and expectation about treatment was dichotomized for analysis against qualitative themes. The measure was dichotomized on the mean with one standard deviation below the mean being used to represent caregivers with low collaboration on treatment goals and tasks. The rest of the caregivers were classified as exhibiting moderate to high collaboration on treatment goals and tasks. Two qualitative themes were compared to this variable: feelings leading up to placement and personal expectations about treatment. The nature of caregivers’ feelings leading up to placement (e.g. positive, negative, neutral) were compared using crosstabulation analysis to their collaboration on treatment goals and tasks because those
with negative or neutral feelings might report less collaboration. The caregiver’s personal expectations about treatment might relate to their collaboration by affecting their level of investment in treatment because they believe that something will be gained from treatment. Finally, the complexity of the events in the days leading up to placement may inhibit a caregiver from being able to initially collaborate in the treatment process because they are still processing all of the events leading up to the placement.

Sample Characteristics

Before discussing the characteristics of this sample, it is important to reiterate that the term “caregiver” is not necessarily synonymous with parent. This term refers to the individual who is designated at the time as intake as the legal guardian or primary caregiver of the child. The majority of identified caregivers that were interviewed were mothers (N=72, or 81%). Fathers (N= 12, or 13.5%) were the next most common respondents. One aunt (1%) completed the interview and the remainder of identified caregivers were grandparents (N=6, or 6.7%). In three instances, a mother and a father completed the interview together; twice, stepfathers completed the interview with the child’s mother; and once, a grandparent and a mother responded together. In addition, there were three times that the interviewer did not specify the relationship of the respondent to the child. Thirty-one (34.8%) caregivers identified as white, and 39 (43.8%) identified as a racial/ethnic minority with the majority of them being Black. The rest of the caregivers opted not to identify a race or ethnicity. A large group of respondents opted not to provide information pertaining to household income; however, many were willing to share whether or not anyone in the household received any sort of government assistance (i.e., food stamps, Medicaid, Section 8, SSI, etc.). Fifty caregivers (56%) responded that they lived in a household where at least one resident received some sort of government assistance, indicating a
less stable financial situation within the family. Twenty-eight (31%) caregivers stated that no one in their house received government assistance, and the remainder refused to answer this question. Consistent with national trends, the majority of the youth in this study were discharged from the agency to their parents’ custody (57%, N=56).

Table 3.4 provides descriptive information on the variables included in the quantitative analyses performed in this dissertation. The variable name is presented in the first column. All of the measures were collected from the caregiver at wave 1. The next column represents the number of respondents that completed the measure at each time point. Next, the mean, median, mode, standard deviation, variance and range of all variables are provided.

### Table 3.4 Sample Descriptives

<table>
<thead>
<tr>
<th>Dependent Variable</th>
<th>N</th>
<th>Mean</th>
<th>Median</th>
<th>Mode</th>
<th>Standard Deviation</th>
<th>Variance</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregiver engagement in treatment</td>
<td>89</td>
<td>58.89</td>
<td>63</td>
<td>70</td>
<td>16.11</td>
<td>259.46</td>
<td>76</td>
</tr>
<tr>
<td>Caregiver bond with staff</td>
<td>91</td>
<td>41.36</td>
<td>45</td>
<td>50</td>
<td>13.18</td>
<td>173.78</td>
<td>56</td>
</tr>
<tr>
<td>Caregiver motivation and expectation about treatment</td>
<td>92</td>
<td>42.80</td>
<td>43</td>
<td>45</td>
<td>6.42</td>
<td>41.23</td>
<td>30</td>
</tr>
<tr>
<td>Caregiver collaboration on treatment goals and tasks</td>
<td>94</td>
<td>20.94</td>
<td>22.5</td>
<td>25</td>
<td>6.49</td>
<td>42.10</td>
<td>28</td>
</tr>
</tbody>
</table>
Chapter 4: Motivation and expectation about treatment

Motivation and expectation about treatment has been identified as one of the central components of engagement, combined with bond with staff and client’s behavior. The focus of this study is caregiver engagement in youth residential treatment; therefore, this chapter will explore caregivers’ motivation to participate in their child’s treatment process and their expectations for outcomes related to either their child’s behavioral or family functioning improvement.

The construct of caregiver motivation and expectation about treatment was explored in the following way. A number of themes were identified from prior research in relation to motivation and expectation about treatment including the perceived need for treatment, the likelihood of the child changing, the severity of the child’s treatment needs and the child or family history of involvement with the system. The following themes emerged during qualitative analysis of interview transcripts and are discussed and analyzed in this chapter: the caregivers’ perception of the purpose of their child’s placement, caregivers’ agreement with their child’s placement, caregivers’ belief about whether the RTC will be able to help their child, caregivers’ first impressions of the agency and its services, caregivers perception of what led to the child being placed at the agency, prior placements that the youth has experienced, the youth’s history of getting in trouble and finally caregivers’ frustrations with the juvenile justice or child welfare systems (See Figure 4.1). These analyses answered the first research question of this dissertation aimed at understanding the perspective of the caregiver at the outset of their child’s placement in relation to the period leading up to and immediately following admission to the RTC.
Figure 4.1: Themes related to caregiver motivation and expectation about youth treatment

Figure 4.1 depicts the selection of themes that were explored with relation to motivation and expectation about treatment. The third column represents the themes that have been identified in previous literature to represent motivation and expectation about treatment. The fourth column illustrates the themes that emerged during qualitative analysis that were used to explore motivation and expectation about treatment and engagement in this sample of caregivers.

In addition to the discussion of qualitative analysis, a subsample of themes will be explored quantitatively to address the second research question of this dissertation; how do the caregivers’ perspectives on themes related to their motivation and expectation about treatment affect their level of motivation and expectation about treatment or overall engagement. Themes were selected for quantitative analysis based on the number of caregivers that discussed the theme, therefore creating a large enough sample of responses for quantitative exploration. The following themes are explored quantitatively, in relation to the quantitative scale of treatment motivation and expectation: caregivers’ perception of the purpose of the child’s placement, caregivers’ belief about whether
the RTC will be able to help their child, caregivers' first impressions of the agency and its services, caregivers’ perception of what led to the child being placed at the agency, and prior placements that the youth has experienced.

This chapter concludes with a discussion of major findings related to caregiver motivation for and expectations from treatment. Additionally, the implications of the findings for practitioners and policy makers will be discussed.

**Purpose of Placement**

*Qualitative exploration of purpose of placement.*

Caregivers were asked “What do you see as the purpose of your child being at [the agency]?” They were prompted to think about “Is there any good reason for her/ him being here?” Eighty-four caregivers discussed this topic during their interview. There was a wide range of responses and over one third of caregivers who discussed this topic (N=33) cited multiple purposes for their child’s placement, feeling that their child needed to get more than one thing out of their experience at the agency.

There were five generalized purposes that caregivers reported. Within four of these general categories, there were additional themes identified (Table 4.1).

**Table 4.1: Caregiver’s perception of the purpose of their child’s placement**

<table>
<thead>
<tr>
<th>General purposes of placement</th>
<th>N</th>
<th>Specific purposes of placement</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services</td>
<td>40</td>
<td>Academic</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Counseling</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Anger management</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Substance use treatment</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medication management</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Social and emotional functioning</td>
<td>15</td>
</tr>
</tbody>
</table>
## Services.

Nearly half of the caregivers (N=40) who discussed the purpose of their child’s placement discussed a specific service that their child needed to receive from the agency. Within this group of caregivers, many discussed more than one type of service that their child needed.

The most common response was that the child needed academic support services. This could include help to “get up and go to school,” “renew interest in school,” and/or “grades.” The responses varied based on what the particular need of the resident was. For some, it is simply to be forced to go to school, as many of the residents are placed for issues related to truancy. For others, the caregiver discussed a deeper need of not only attending school, but understanding the importance of education. And finally, some thought their child needed help with academic achievement, improving grades or addressing a specific deficit, such as reading level.

Many (N=12) discussed the need for counseling or therapeutic services to assist the youth in getting “better,” with little expansion on what the youth’s problems were exactly. In some instances, there seemed to be a diagnosable disorder that needed to be addressed through behavioral services, such as “She has very up and down, up and down behavior.” Others talk

<table>
<thead>
<tr>
<th>Skill acquisition</th>
<th>Accountability for actions</th>
<th>13</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Learn respect</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Learn responsibility</td>
<td>7</td>
</tr>
<tr>
<td>Environment</td>
<td>Structure</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Disrupt environment</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Safety</td>
<td>6</td>
</tr>
<tr>
<td>Future orientation</td>
<td>Change direction</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Goals for future</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Self-exploration or improvement</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>1</td>
</tr>
<tr>
<td>Formal Sanction/None</td>
<td></td>
<td>8</td>
</tr>
</tbody>
</table>
about their child needing “help.” One mother, who completed the interview with the youth’s father, explains, “The things that he was involved with needed to stop. And he needed to learn stuff about himself and stuff about the problems.” During their interview, the mother and father both discuss a history of psychiatric hospitalization in their own pasts, stemming in part from the father’s history with alcohol.

There were two specific types of therapeutic services that emerged: anger management (N=9) and substance use treatment (N=7). In addition, three caregivers specifically discussed the youth’s needs in relation to the family and permanency planning. All of these caregivers noted that whatever the youth was working on while at the facility should have a component geared toward the youth returning home to the family. For example, one caregiver hoped that her son was going, “to work towards getting back into the family.” Finally, one caregiver discussed that her child needed medication management, or to ensure that her son’s medications were regulated. She does not share what type of medications he is prescribed, but does discuss a history of emotional issues likely related to physical abuse by his father.

**Skills acquisition.**

The next most common theme was that the caregivers (N=35) hoped that their child would develop a particular set of skills while at the agency. There were four types of skillsets discussed: social and emotional functioning, accountability for actions, learning respect for others and/or their property and learning responsibility.

Fifteen caregivers hoped that their child would develop some social and/or emotional functioning skills. Comments pertaining to social functioning typically discussed the youth developing an ability to fit into and be a productive member of society. One mom explains,
That he’ll be able to fit into society without being a loner. I mean, I don’t know how else to put it (laughs). And I don’t wanna see him in prison or one of those people that walk the streets with their little shopping cart or you know on drugs and alcohol.

Emotional functioning skills pertained to coping skills and changing perspective to be able to act more appropriately in a situation. For example, one mom hopes that her son will “learn that life isn’t as hopeless as he seems… as he seems to think it is. He just feels that he’s hopeless and nobody can help him.” This mother had been trying to get help for her son for years before he was placed at this agency. He has a long history of aggressive and anti-social behaviors. Other caregivers seeking emotional functioning skills for their children discussed things like self-control, self-confidence and communication skills.

Thirteen caregivers were hoping that their child would learn accountability for their actions, while seven wanted their child to learn responsibility. The caregivers who discussed accountability talked specifically about their child learning about consequences for their behavior or for the youth to reflect on the mistakes that he or she has made that have gotten him/her to this point. For example, “make her see that she has to follow the rules and if she doesn’t there are consequences,” or “so that she can see what…her mistakes in life.” Whereas, the seven caregivers who discussed learning responsibility did not connect their statement to learning to take responsibility for actions. Any statements pertaining to taking responsibility for behaviors were coded as accountability. In this sense, responsibility referred to being able to be responsible or fulfill responsibilities in life. For example, “To try to help him to, get a grasp on what he needs to do in his life,” or “follow through with chores and stuff that he’s supposed to get done.”

The final skill that was discussed was learning to be respectful. Twelve caregivers discussed respect in terms of respect towards others, respect towards others’ property or respect for
authority. One mother recounts how, “Well, we were leaning towards him going someplace where he could get some help before it ended up with him having a record…. It was like he had no fear of consequences, no fear of any authority. He was just totally out of control.” In this instance, she is referring to her son needing to have respect for authority and rules. Many of the caregivers in this category discussed how their child needed to learn to respect either authority figures, whether the parent themselves or an external authority figure, or how to obey the rules. Others in this category discussed more of a need to show respect towards others and their belongings. For example, “It’s understanding and hearing and feeling other people.”

**Environment.**

Twenty-two caregivers discussed an environmental component to the purpose of their child’s placement. Three themes emerged pertaining to youth’s environment: structure, disruption of environment and safety.

Eleven caregivers discussed the topic of structure. All responses pertaining to structure discussed that either the youth needed more structure in his or her life, such as “he needed to get structure back in his life,” or that the agency provided more structure than the youth had while in the community, such as “there’s more structure there.” Two of these caregivers also talked about the agency being able to provide positive role models for their child.

The theme disruption of environment was discussed by six caregivers and is meant to represent statements focused on removing the youth from his or her environment in an attempt to interrupt patterns of problem behaviors or isolate the youth from his or her peer group. This mother, who felt that her daughter’s attitude and behaviors prevented her from being able to parent her daughter prior to being placed at the agency, believed that the time at the agency was an opportunity for her daughter to reflect and take, “some time away from her environment to
see from an outward perspective. Because it seemed like she was just looking from inward, just not really able to see what was actually going on.” Another mother, who was happy that her son was placed at this agency felt, “While on the streets doing what he was doing, he needed to get away from the people he was hanging around with, and I’m glad he did.”

Finally, within the topic of environment, six caregivers discussed safety, feeling that the purpose of the placement was to remove the youth from the streets and unconventional behaviors for a safe alternative environment. One mother explains, “Well, basically, cause she needed to realize that she just can’t be on the streets and do the things that she’s doing. She’s either going to end up hurt, or, you know, something bad’s going to happen to her.” Many caregivers highlighted the safety of the youth’s environment at the agency versus the unsafe and unpredictable environment of the streets prior to placement.

**Sense of purpose and future orientation.**

Many caregivers discussed the purpose of their child’s placement with a focus on allowing for self-reflection or achieving long-term goals to expand future opportunities for their child. Specifically, they saw the purpose of placement as an opportunity for their child to change direction, set goals for the future or explore or improve oneself. A couple of caregivers in this response category did not fit within the subthemes.

The node “change directions” was discussed by seven caregivers and is meant to encompass comments about the youth needing to “straighten up” or turn their life around. A few parents shared the view of this mother, “To help him straighten up, kinda help straighten his life out a little bit. Help him out a little bit.” Others spoke more specifically about turning their life around or changing from unhealthy to healthy. “To really take a look at himself. And, um, get all the help that he can get. To take a chance to turn his life around.”
The next set of caregivers discussed the need for their child to get serious about their future, appreciating life and setting some long-term goals for their future. “It’s important for her to value what the future holds for her,” explains one mother, who described feeling burnt out prior to her daughter’s placement for hanging out with the wrong kids, not taking school seriously and inciting conflict at home.

Four caregivers hoped that their child would be able to explore themselves, becoming more comfortable with who they are or developing new interests. One father, whose son had been expelled from school and fell in with the wrong crowd, felt the purpose of placement was to, “find and understand himself and to see what he needs out of life, you know, to become a better person.”

One caregiver expressed sentiments that did not quite fit into any of the other categories. She really just hoped that her daughter would get more out of being at this facility than she had at another facility, where she was placed three times. This mother was hoping that her daughter would retain benefits from this agency for longer than she had in her previous placement.

**Formal sanction.**

There were a few caregivers who felt that the purpose of their child’s placement was as a punishment or a formal sanction for the child imparted by the justice system. One single mother, who felt that her separation from her husband contributed to her son’s problem behaviors, explains, “He’s there because he has to be there. He was court ordered to be there. So, that’s his basic reason for being there.” Two other caregivers gave similar responses related to the purpose of their child’s placement.

Half of the caregivers in this category appear to be against the placement of their child at these agencies, because they either see no purpose for the placement other than it being court
ordered, or they explicitly state that they would like their child to come back home with them immediately. One mother, who cites her children as her source of resilience, the driving force that pushes her to keep going through the challenging times such as when she is experiencing anxiety or depression, explains, “No (purpose for placement) because everything that they’re doing pretty much there, my husband and I could do, probably better.”

Finally, one caregiver in this category discusses the purpose of placement in the more broad sense of the juvenile justice system. She explains, “As to why she’s up there… how they put it to me is… they’re warehousing here, through the court system til she’s 18, so she can be safe.” While she discusses the issue of her daughter’s safety, she discusses it in the context of the formal or informal processes at play in the juvenile justice system.

**Quantitative exploration of purpose of placement.**

Prior research has found that caregivers are less likely to engage in their child’s treatment if they do not perceive a need for the treatment (Morrissey-Kane & Prinz, 1999). The following analyses explore if there is a relationship between what the caregivers view as the purpose of their child’s placement and their motivation and expectation for treatment, as well as their overall engagement. Specifically, are caregivers who cited a specific purpose for their child’s placement during their interview more likely to be motivated or engaged than caregivers who cited a different type of purpose?

To explore this relationship, the major categories of caregivers’ perception of the purpose of their child’s placement were quantitatively compared to their level of engagement and their motivation for and expectations from their child’s treatment (see Table 4.2). There were six categorical perceptions included in the analysis: environmental, formal sanction, future orientation, service, skills and multiple purposes. The last category, multiple, encompasses
caregivers that discussed more than one purpose category. Chi square analysis was used to investigate if caregivers who identified a particular category were more or less likely to be motivated or engaged in their child’s treatment than caregivers who identified another purpose.

Table 4.2: Caregiver perception of purpose of placement and engagement

<table>
<thead>
<tr>
<th>Caregiver Motivation &amp; expectation+</th>
<th>Count</th>
<th>Services</th>
<th>Skills</th>
<th>Environment</th>
<th>Future orientation</th>
<th>Formal Sanction</th>
<th>Multiple</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>20 (26.3%)</td>
<td>6 (7.9%)</td>
<td>7 (9.2%)</td>
<td>6 (7.9%)</td>
<td>6 (7.9%)</td>
<td>31 (40.8%)</td>
<td>76 (100%)</td>
</tr>
<tr>
<td>Moderate to high</td>
<td>29 (39.7%)</td>
<td>5 (6.8%)</td>
<td>7 (9.6%)</td>
<td>6 (8.2%)</td>
<td>6 (8.2%)</td>
<td>29 (39.7%)</td>
<td>73 (100%)</td>
</tr>
<tr>
<td>Total</td>
<td>59 (100%)</td>
<td>11 (100%)</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

+ p=.123, chi-square measure of association; p=.143, F.E.T.
++ p=.118, chi-square measure of association; p=.120, F.E.T.

3 To test the robustness of these findings given the small sample size, engagement was dichotomized at both the mean and median for comparison to perception of purpose of placement. The trends in the data remained consistent and the relationships were not statistically significant (p=.234, F.E.T.=.214 and p=.352, F.E.T. =.368, respectively).
There was no statistically significant relationship between the caregiver perception of the purpose of their child’s placement and their motivation and expectation for youth treatment and no obvious trends emerged from the data. However, half of the cells did not meet the minimum threshold of five during chi square analysis. Likewise, there were no statistically significant relationships between caregiver perception of the purpose of their child’s placement and their overall engagement. Over half of the cells (58.3%) did not meet the minimum threshold of five for chi square analysis. The data were scattered with no obvious trends.

As a result of the low cell counts during chi square analysis, data were condensed for further analysis. Three categories were created to represent caregivers who identified a single purpose for their child’s placement, multiple purposes for their child’s placement and no purpose (other than a formal sanction) for their child’s placement (Table 4.3). This analysis also examined a slightly different line of inquiry. In Table 4.2, the relationship of interest was whether there was a particular type of purpose that facilitated greater motivation or engagement. In Table 4.3, the relationship of interest is whether the number of purposes that a caregiver envisions for treatment has an effect on their engagement and motivation. Specifically, is a caregiver who feels that there is no purpose for their child’s placement less likely to be motivated and/or engaged than a caregiver who feels that there is a purpose? Likewise, is a caregiver feels that there are multiple purposes for their child’s placement more likely to be motivated and/or engaged than a caregiver that only sees a single purpose?
Table 4.3: Caregiver engagement and condensed purpose of placement

<table>
<thead>
<tr>
<th></th>
<th>One purpose</th>
<th>Multiple purposes</th>
<th>No purpose</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Caregiver Motivation &amp; expectation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>3 (27.3%)</td>
<td>5 (45.5%)</td>
<td>3 (27.3%)</td>
<td>11 (100%)</td>
</tr>
<tr>
<td>Moderate to high</td>
<td>36 (55.4%)</td>
<td>26 (40.0%)</td>
<td>3 (4.6%)</td>
<td>65 (100%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>39 (51.3%)</td>
<td>31 (40.8%)</td>
<td>6 (7.9%)</td>
<td>76 (100%)</td>
</tr>
</tbody>
</table>

| **Caregiver engagement** |             |                   |            |       |
| Low                      | 5 (45.5%)   | 3 (27.3%)         | 3 (27.3%)  | 11 (100%) |
| Moderate to high         | 33 (53.2%)  | 26 (41.9%)        | 3 (4.8%)   | 62 (100%) |
| **Total**                | 38 (52.1%)  | 29 (39.7%)        | 6 (8.2%)   | 73 (100%) |

* p<.05, chi-square measure of association; p=.038, F.E.T.
** p<.05, chi-square measure of association; p=.084, F.E.T.

When purpose of placement response categories were condensed, the number of cells with less than an expected count of five was reduced to two (33.3%) for both variables. Caregivers who believed there was a single purpose for their child’s placement were most likely to exhibit moderate to high motivation and expectations, p<.05, .038 F.E.T. Those who perceived no purpose for their child’s placement were evenly divided between both low and moderate to high expectations or engagement.

*To test the robustness of these findings given the small sample size, engagement was dichotomized at both the mean and median for comparison to caregivers’ perceptions of the number of purposes for their child’s placement. The trends in the data were slightly different using these cut points and the relationships were not statistically significant using chi-square measure of association like they had been when the measures were dichotomized using the standard deviation, although they were approaching significance (p=.070, F.E.T.=.067 and p=.108, F.E.T. =.119, respectively).*
Agreement with Placement

Qualitative exploration of agreement with placement.

Caregiver agreement with residential treatment has previously been linked to motivation and expectation for treatment, such that those who agree with treatment are more likely to be motivated and engaged in treatment (Israel, et al., 2006); therefore it is important to understand what factors caregivers consider when it comes to agreeing or disagreeing with their child’s placement in an RTC. Caregivers in the current study were not directly asked if they agreed with their child being placed or not. However, they were asked questions that provided an opportunity to discuss whether they agreed or disagreed with placement, such as “Could you tell me about the days leading up to your child being admitted? What was that like for you?” or “Is this the first time your son or daughter has been in trouble like this?” Since there was no direct question relating to this topic, too few caregivers discussed the topic to facilitate quantitative analysis of their responses. Despite the inability to perform statistical analyses examining the relationships between agreement with placement and motivation and expectation toward treatment or caregiver engagement, the qualitative exploration of this construct provided insight into the themes that underlie a caregiver’s level of agreement or disagreement with their child’s placement. Forty-five caregivers discussed their opinions of their child being placed, speaking generally to whether they agreed or disagreed with placement. Within the categories of agree or disagree, some specific clusters of responses emerged that are discussed below (Table 4.4).

Table 4.4: Caregiver agreement or disagreement with placement

<table>
<thead>
<tr>
<th>Theme</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agreement with placement</td>
<td>29</td>
</tr>
<tr>
<td>Caregiver asked for placement</td>
<td>23</td>
</tr>
<tr>
<td>Caregiver or youth selected agency</td>
<td>6</td>
</tr>
<tr>
<td>Disagreement with placement</td>
<td>14</td>
</tr>
</tbody>
</table>
Twenty-nine caregivers were in agreement with their child’s placement. Many of these caregivers describe reaching a point of frustration with their child’s behaviors and feeling that they needed external help to address their child’s needs. This mother, whose son had been in the day services program at the male agency at the time of his residential placement explains, “We went to court…. And they said they were going to send them home and I said, ‘no.’ I told them to take him. I told the state to take over.” By that point, her son was already on probation and in the day program at the agency, but neither served as a deterrent from drinking, doing drugs and engaging in delinquent behaviors including burglarizing a bowling alley, where he and three friends stole two to six cases of wine.

Among the 29 caregivers that agreed with placement, 23 asked for their child to be placed, like the mother above, and six either selected the present agency themselves or their child selected the RTC. The caregiver or youth’s preference for the current agency was honored by the court, who ultimately decides where the youth is placed. One mother explains how she chose this agency because the other agency that was offered as an option,

would take kids that [present agency] couldn’t handle, so I’m thinking she is gonna be in with the rougher crowd of kids [if she went to the other agency]. And [this agency] was offering the services that I thought [my daughter] needed.

Another mother describes how her daughter picked the current agency. She describes how, “she [her daughter] knew she had to be placed,” because the judge had made it clear to the youth that placement was imminent based on her behaviors. This youth was able to learn about a couple of RTCs that were available to her, “…and St. Mary’s was one of them and out of the two that she checked out, St. Mary was the one that she chose, herself to go to.”
Fourteen caregivers disagreed with their child’s placement. All of the caregivers that disagreed with their child’s placement fell within one of two subcategories. Either, they disagreed with their child being placed at all (N=9), or they were in disagreement with this specific agency as the placement location (N=5). Some caregivers shared similar sentiments as this father, who felt that maybe their child was placed too soon without exploring alternative situations, “I don’t think that he should’ve been placed. There are steps in between that we never explored prior to placement.” Others who disagreed with placement felt that their child’s behaviors were not severe enough to warrant residential placement, “I just thought it was wrong. I’m like this is his first time ever in court and, there’s kids that been there fifty times and they’re still out here…” The five caregivers that disagreed with the specific placement felt that their child needed a different type of environment or a specific type of programming that they would not get at either of the agencies. For example, “I think they should have put her in secure like I told them to. I told them not to put her in no regular place where she could run away.” Other caregivers in this category did not feel that that the program was right for their child, with one favoring the idea of a boot camp structure and another criticizing the fact that it’s a single campus for all things including school and living, allowing her daughter no diversity to her day and potentially exposing her to girls with worse problems.

**Ability of RTC to Help Youth**

**Qualitative exploration of ability of RTC to help youth.**

Morrisey-Kane and Prinz (1999) found that caregivers needed to believe that their child’s behavior could be changed through the treatment intervention if they were going to engage in the treatment process. To explore this concept, caregivers were asked, “‘Do you think [the RTC] will be able to help your son/daughter?’” This topic pertains to perceptions about the likelihood of
the child changing as a result of the intervention and its effect on a caregiver’s motivation and expectation about treatment. The purpose of the qualitative exploration is to see how many caregivers believe that the program either will or will not help their child, while also exploring the perspectives and/or experiences that underlie their belief. Altogether, 76 caregivers discussed their belief about treatment effectiveness during their interviews (see Table 4.5).

Table 4.5: Belief about treatment effectiveness

<table>
<thead>
<tr>
<th>Do you think the RTC will be able to help your son/daughter?</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>37</td>
</tr>
<tr>
<td>No</td>
<td>8</td>
</tr>
<tr>
<td>Skeptical</td>
<td>31</td>
</tr>
<tr>
<td>Total</td>
<td>76</td>
</tr>
</tbody>
</table>

Nearly half of the caregivers (N=37) who reflected upon this topic felt that the agency could help their child. Many of the caregivers in this category gave vague affirmative statements, such as “Yes,” or “Mmmhmm.” A few caregivers provided more detail including this mother who explained, “I think it’s a better chance for him to learn from St. Thomas because they do offer a better program than the [public school] would offer;” and another mother who responded, “Yeah. I truly believe that if the family is not involved that it’s not going to work. I believe that.” This mother did not provide any additional detail to support her statement, however one could interpret this statement to mean that she appreciates the family-centered approach of the agency because she believes that the agency will help her son and she only believes that this is possible when the family is involved in the process.
The most common trend among caregivers who provided more detail than just saying a variation of “yes,” such as “mmhmm,” “yeah,” etc., was to provide evidence of observing a change within their child that allowed them to believe that the youth would be helped by the RTC. There was a cohort of 14 caregivers within this response category that were more descriptive and explicitly expressed that they believed that the RTC would be able to help their child because they had already seen evidence of successful change in their child. One mother who had requested placement for her son because she felt that he was, “out of control…you know…very disrespectful at home…wouldn’t listen to my orders,” commented, “I have to admit, [agency] has done wonders for him.” She went on to describe some of the changes in behavior that she has noticed in her son such as opening up more about what is going on in his life and how he is feeling. She observes that he is happy, lovable, carefree and cares about himself since going into residence. She goes as far as to say that she feels like she has gotten her son back.

Another mother responded, “Oh yeah. I’ve already seen it.” She goes on to describe how her daughter is, “very non-combative when she’s at home compared to what she was before she left,” and “She has a very good concept of the rules and she’ll follow them.” When asked if she had any idea what is responsible for these changes in her daughter, she explains, “I think there’s something there [at the agency] that is making her feel very good about herself.”

Only eight caregivers felt passionately that the RTC would not be able to help their child. There was a wide range of comments in this category. Half of the eight responses were vague without further explanation as to why the caregiver did not believe the agency would help their child. The remainder of the caregivers gave supporting evidence about why they did not believe the agency would help their child. In one instance, a mother and stepfather, who later indicated that they did not want their daughter placed at this particular agency because the agency had
failed to help a member of their extended family, felt that the agency, “ain’t done nothing for anybody I know that’s been in there. They ain’t doing nothing for my daughter now.” This excerpt demonstrates that some caregivers come into the process with a closed mind regarding the ability of the treatment center to help for many reasons and thus are potentially less likely to engage in the treatment process, since attitude toward treatment is one of the components of engagement. In the last example, these parents made a decision based on their knowledge of other youth who had been placed at the agency before their daughter was placed there. Even before their first interaction with anyone from the agency, they had made their minds up about the agency based on external influences. The mother does go on to say that her daughter’s grades are up since being at the agency, but is still adamant that the agency does not do anything to help any of its clients.

Another mother of a 16-year-old girl explained, “Well she’s gone through every single program imaginable in this area. She’s been in every single program and it has been unsuccessful. So, I don’t see this program helping her either.” Her daughter had been accessing services and programs since the age of three to address her diagnosis of ADD. At the age of 11, her daughter’s behaviors started to escalate and she entered her first placement at age 12, where she resided for 2 years. It is not uncommon for the youth placed in either of these facilities to have experienced multiple programs and placements before arriving at the agency. For most, placement at the RTC is an act of last resort. This mother’s sentiments are an example of the toll multiple previous placements can take on a caregiver’s belief that the agency will be able to help their child. Based on her daughter’s experiences with other services and RTCs, this mother presents as somebody who has already lost hope that her daughter will improve by the time she entered this RTC.
A stepfather reported,

Actually, I hate to say it but they’ve done more harm than good right now. Because she’s learned some street skills from some of the other people in that facilities. You know some more hard-core kids. That she’s gotten colder to the family in a way. You know, just because of some of, she’s picked up some of the attitudes.

His stepdaughter had struggled with self-harming behaviors, including alcohol/substance abuse and self-mutilation after being raped at the age of 12. Both her stepfather and mother clearly articulated their belief that her acting out behaviors were specifically related to the trauma of the sexual assault. In an effort to help her daughter desist from negative coping skills, this mother took out a PINS petition against her daughter. Despite initiating the PINS, she was surprised to learn that her daughter would be removed from the home and placed in a facility in lieu of receiving treatment close to home while still attending the school in which she was enrolled.

For many of the caregivers (N=31) the issue of the ability of the agency to help their child was not clearly dichotomized between yes and no. Many came into the process with an amount of skepticism. These caregivers did not expressly say that the agency would definitely be able to help their child or not. They clustered somewhere in the middle demonstrating either hope or doubt without making an absolute determination. A couple simply stated, “I don’t know.” One mother whose daughter had gone AWOL from a previous RTC stated, “Nobody has so far.” While this sentiment has an air of skepticism to it, she does not outright say that she does not believe the current agency will be able to help her child.

Despite being skeptical, 17 of these 31 caregivers felt hopeful or optimistic about the ability of the agency to help their child without stating an explicit affirmative belief, “You know, I hope [agency] does it for him,” or “I’m optimistic about it.” A caregiver explains that she believes that the program will work if her son invests himself into it, “A lot of it is up to (my son). Everything is in place, if (my son) just opens up.”
A few caregivers were uncertain about how they felt as a result of the involuntary nature of the program or the fact that it was a controlled environment that did not mirror the community environment to which the youth would return, “I’d like to see it work for him but…[my son’s] ultimate goal is to get out of there. So, he’s gonna do whatever he’s got to do to get out of there,” or “They help her in that environment, but in our environment, I doubt it.” These caregivers fear that their children would never fully engage in treatment but instead just go through the motions, commonly referred to as “fake it to make it.” When a youth is faking it, there is reason to believe that no measurable improvements will be maintained over time.

**Quantitative exploration of ability of RTC to help youth.**

The next phase of analysis focused on the relationship between a caregiver’s belief about the ability of the RTC to help their child and their level of motivation and expectation or overall engagement. Specifically, were caregivers who believed the agency would be able to help their child more likely to exhibit high motivation and engagement than those that did not believe the agency would be able to help their child? The qualitative response categories of “no,” “skeptical” and “yes” were categorically coded for exploration against quantitative measures of caregiver engagement including overall engagement (N=67) and motivation and expectation about treatment (N=70; See Table 4.6). Some of the 76 caregivers that were included in the qualitative analysis were excluded from the quantitative analysis because six were missing a measure for motivation and expectation about treatment, resulting in a total sample of 70 caregivers. An additional three caregivers were missing another measure that comprises the engagement composite scale, resulting in a total sample of 67 caregivers for caregiver engagement. The relationships were analyzed using chi-square analysis. Fisher’s Exact Test was selected due to low expected counts in at least half of the cells based on cross tabulation results.
There is a statistically significant relationship between the caregiver’s belief about treatment effectiveness and their motivation and expectation about treatment, as well as their overall engagement. Caregivers that believed that the agency would definitely be able to help their child were most likely to have moderate to high motivation (91.2%), while those who did not believe that the agency would be able to help their child were most likely to have low motivation (57.1%), p=.012, F.E.T. Among caregivers who were skeptical about the ability of the agency to help their child, they were more likely to exhibit moderate to high engagement (96.4%) than low engagement (3.6%). Caregivers who believed that the agency would be able to help their child were most likely to have moderate to high engagement (93.8%), while caregivers that did not believe the agency would be able to help their child were most likely to have low engagement.

Table 4.6: Caregiver engagement and belief about treatment effectiveness

<table>
<thead>
<tr>
<th>Caregiver engagement**</th>
<th>Low</th>
<th>Count</th>
<th>No</th>
<th>Skeptical</th>
<th>Yes</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Motivation &amp; expectation</strong></td>
<td>Moderate to high</td>
<td>Count</td>
<td>3 (5.0%)</td>
<td>26 (43.3%)</td>
<td>31 (51.7%)</td>
<td>60 (100%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>Count</td>
<td>7 (10.0%)</td>
<td>29 (41.4%)</td>
<td>34 (48.6%)</td>
<td>70 (100%)</td>
<td>100%</td>
</tr>
</tbody>
</table>

**p<.01; chi-square measure of association; p=.012, F.E.T.

***p<.001; chi-square measure of association; p=.000, F.E.T.

---

5 To test the robustness of these findings given the small sample size, engagement was dichotomized at both the mean and median for comparison to belief about ability of RTC to help youth. The trends in the data remained consistent and the relationship retained statistical significance (p<.001, F.E.T.=.000 and p<.01, F.E.T. =.005, respectively).
Further caregivers who were skeptical were more likely to exhibit moderate to high engagement (93.8%) than low engagement (6.3%).

First Impression of Agency/Service

Qualitative exploration. Throughout the interviews, caregivers discussed their first impressions of the agency, the services the agencies offered, and the staff that worked at the agency. In addition to the comments that emerged organically relating to this topic during the caregiver’s interview, caregivers were specifically asked, “What were your first impressions of the agency and its staff?” The findings related to this subject are presented in two different chapters. This chapter will provide a general overview of the responses, including the overall direction of comments: negative, positive, neutral or mixed. In addition to this broad analysis of comments, individual comments related to one of the specific components of the agency including the agency itself, the services offered by the agency and the staff at the agency were also analyzed. This discussion in this chapter will focus on the specific comments pertaining to first impressions of agency and services offered because these impressions are proposed to relate to the content of this chapter, caregiver’s motivation and expectation about treatment. The specific findings related to caregivers’ first impressions of staff will be presented in the next chapter (Chapter 5), as they are expected to relate to bond with staff, a distinct component of engagement.

The effect of a caregiver’s first impressions of the agency and the programs offered have not previously been studied in relationship to their engagement or motivation and expectation for treatment. This dissertation hypothesizes that a caregiver’s first impressions of the agency can inform their motivation and expectation about treatment, such that those with a positive first
impression will be more motivated to be engaged in the treatment process and those with a negative first impression will exhibit lower motivation and overall engagement.

Impressions of these components of the agency will facilitate an understanding of caregiver involvement in the treatment process; for example, those with positive impressions would be expected to be more involved in the treatment process than those with negative impressions. Positive impressions of the agency and services offered are likely increase a caregiver’s comfort with the agency, improving their engagement through a better attitude toward treatment. Additionally, the negative impressions of the agencies that caregivers discuss might provide important information for the agencies to consider for ensuring optimal caregiver engagement, as well as providing insight into what caregivers are most concerned with at the outset of treatment.

The findings for the general first impressions theme are divided into two tables. The first (Table 4.7) depicts the four general categories of impressions: positive, negative, neutral and mixed. There were ninety-one caregivers who discussed their general impressions, which represents 2 instances where multiple caregivers completed the interview together and disagreed on their impressions. After initially coding the interviews for general first impression, more specific impressions emerged centering around the agency and the services offered at the agency (Table 10). There were 27 caregivers with mixed first impressions meaning that they made both positive and negative statements. For example, one caregiver who stated, “well the people seem nice,” also said that “the place seemed dirty, un-taken care of kinda, run-down.” These caregivers typically had a positive impression of one area, such as the facility, the staff or the services that the agency offered while having a negative first impression in another area. For example, they might like the staff, but feel that the facility was unimpressive or vice versa. There were three caregivers that made neutral comments, meaning it was hard to discern if they viewed
the particular aspect they were talking about as good or bad. For example, one caregiver said that she felt that, “it’s just another school,” and another stated that she had no thoughts about the agency.

**Table 4.7: General first impressions of the agency, staff and services offered**

<table>
<thead>
<tr>
<th>Positive</th>
<th>Negative</th>
<th>Neutral</th>
<th>Mixed</th>
</tr>
</thead>
<tbody>
<tr>
<td>57</td>
<td>4</td>
<td>3</td>
<td>27</td>
</tr>
</tbody>
</table>

The most common general first impression among the caregivers was positive (N=57) while only four caregivers expressed solely negative feelings. It was more common for those with a negative first impression of a particular component (e.g. agency, staff or services) to have a positive first impression of another component, and they were therefore coded as mixed. In terms of general first impression, each caregiver was only coded into one category.

While the caregivers’ responses could only be coded into one category of general first impressions, their specific first impressions of the agency or services offered (Table 4.8) could be coded into multiple categories. In Table 4.7, the sum of their statements was coded and those that stated something both negative and positive were coded into the “mixed” category. In the following table (Table 4.8) there was no mixed category, and the individual statements were coded as either positive or negative to get a better understanding of the particular themes within each category that were causing caregivers to view something within the RTC as positive or negative. Therefore, a caregiver could be coded as having both a negative and positive first impression in Table 4.8 if for example, they felt that the agency was clean, but they also stated that they observed inadequate supervision. In this analysis, caregivers could be coded into multiple categories based on the individual statements they made.

**Table 4.8: Specific first impressions of agency and services offered**
First impressions of agency

Positive first impressions (N=30) of the agency were more common among caregivers than negative (N=9) (see Table 4.8). The responses were either something about the agency that stood out to them, such as it being a nice place or being clean, or that the agency instilled comfort within them. Many who reported positive first impressions made very generic comments without going into much, if any, detail about why they had a positive impression of the agency (N=24). For example, one caregiver states, “I thought it was a very nice place,” while another states, “I got a good impression.” Neither caregiver provided any additional information about why they thought it was a nice place or what contributed to their good impression. Conversely, in some instances the caregiver provided more detail about a specific component of the agency that caused them to have a positive first impression.

Ten caregivers appreciated the cleanliness of the facility, “The facilities seemed clean, neat, orderly.” A grandmother who was unhappy with her granddaughter’s community based school remembers, “The school was really nice. The location, the setting, you know, the way it looked. It was clean.”
Eleven caregivers focused on the fact that something about the agency made the caregiver feel comfortable with their child being placed in that facility. A mother, who expressed a strong desire that her daughter be placed in more a structured program than her daughter’s prior placements explains, “We came home that night and we felt very comfortable that she was there.” Another caregiver described, “I was a little concerned because it was old, but… when I left there, I felt like she was in good hands.” It appears that something transpired during her visit to the facility to instill a greater level of comfort than she had upon initially arriving at the agency.

Conversely, the majority of those caregivers that had negative first impressions walked away with complaints about the facility itself (N=7), such as this mother who felt after visiting the facility for her daughter’s interview that the facility was “Just very institutional. As you go through even the residence halls, it’s a very institutional setting,” and also felt, “It seemed very stark, very cold.” Six caregivers were unimpressed with the level of supervision or the staffing of the agency. This mother, who felt that there wasn’t enough communication between the agency and herself, stated that, “My main impression was that it wasn’t, it wasn’t um, strong enough supervision.” Another mother, who had some clear frustrations with the staff, stated that

Um, another thing, when we’re in that room, you know, the cafeteria, I feel that there should be a staff member at there at all times. It shouldn’t be just us parents and, um, children. I feel the room should be supervised because how do we know those people are really who they say they are. Like the first time I went up in there, this girl was doing this guy’s hair and she gave me the impression he wasn’t family, he was like a boyfriend or something. And these children in there are very young.

*First impressions of services offered*

First impressions of the services offered by the agencies were discussed by far fewer caregivers than first impressions of the agency itself (see Table 4.8). Of the 16 caregivers that made comments about the services offered by the agencies, 14 had positive comments while two
had negative comments. At the most basic level, some caregivers with a positive impression made comments consistent with this mother’s sentiments, “I was very impressed with the services they were going to offer.” Others provided a more detailed analysis of the program, such as

well when we had the evaluation we spoke on a lot of things and they hit everything right on the head. Like therapy for anger management, family therapy and therapy alone for herself. I like the setting like it’s only 6 students in the class so they’re able to give her more attention.

Some even highlighted appreciation for specific programs such as anger management, vocational skills or school, “It seemed like a place that offered a lot of different activities in terms of cooking and shop or arts and crafts. And a lot of different areas.”

The negative comments about the programs were that one mother felt “their presentation is misleading… in their programs” mainly because she felt that prior to her son’s placement the agency made it seem as though there would be a greater deal of parent-child contact throughout placement. The same caregiver also stated that she felt “things are too rush rush at [agency].” Another mother “was hoping for much more of the therapist to be involved. One hour a week… I mean what, what can they do in one hour in a week?”

First Impressions of Agency, Staff or Services Offered

Quantitative exploration of first impressions of agency, staff or services offered.

The focus of this chapter is exploration of factors that might influence a caregiver’s motivation and expectations about their child’s treatment and their overall engagement, including first impressions of agencies and services. The next chapter will focus on bond with staff and overall engagement. Therefore, their first impressions of the staff specifically will be discussed in greater detail in the next chapter, whereas their first impressions of the agency and services are discussed in this chapter. As a result of the coding strategy that was used to categorize the
direction of the caregiver’s overall impression of the agency, its staff and services, it is not possible to separate out responses based on their relation to a particular component of engagement. Many caregivers had mixed general first impressions (N=23), meaning that they discussed a negative or positive comment about the staff and a negative or positive comment about one of the other aspects of the agency, such as the services or agency itself. The sum of their statements and their overall direction will be explored in this chapter, even though some of their general impressions might include perspectives related to bond with staff. In the following analyses, the question of interest is how does the overarching direction of their impression (e.g. positive, negative, neutral or mixed) relate to their level of engagement (See Table 4.9)? Are caregivers with a positive first impression more likely to be motivated and engaged than caregivers with a negative impression? This relationship was explored using chi-square, however five cells had an expected count below five, so Fisher’s Exact Test was utilized.

**Table 4.9: Relationship between the general direction of a caregiver’s first impression and their engagement in their child’s treatment**

<table>
<thead>
<tr>
<th>Caregiver motivation &amp; expectation* &amp; **</th>
<th>Low Count</th>
<th>Negative</th>
<th>Positive</th>
<th>Neutral</th>
<th>Mixed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>3 (21.4%)</td>
<td>4 (28.6%)</td>
<td>2 (14.3%)</td>
<td>5 (35.7%)</td>
<td>14 (100%)</td>
<td></td>
</tr>
<tr>
<td>Moderate to high</td>
<td>1 (1.4%)</td>
<td>49 (71.0%)</td>
<td>1 (1.4%)</td>
<td>18 (26.1%)</td>
<td>69 (100%)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>4 (4.8%)</td>
<td>53 (63.9%)</td>
<td>3 (3.6%)</td>
<td>23 (27.7%)</td>
<td>83 (100%)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Caregiver engagement*</th>
<th>Low Count</th>
<th>Negative</th>
<th>Positive</th>
<th>Neutral</th>
<th>Mixed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>3 (20.0%)</td>
<td>6 (40.0%)</td>
<td>0 (0.0%)</td>
<td>6 (40.0%)</td>
<td>15 (100%)</td>
<td></td>
</tr>
<tr>
<td>Moderate to high</td>
<td>1 (1.5%)</td>
<td>44 (67.7%)</td>
<td>3 (4.6%)</td>
<td>17 (26.2%)</td>
<td>65 (100%)</td>
<td></td>
</tr>
</tbody>
</table>

6 To test the robustness of these findings given the small sample size, engagement was dichotomized at both the mean and median for comparison to the general direction of the caregiver’s first impression of the agency. The trends in the data remained consistent and the relationship retained statistical significance (p<.001, F.E.T.=.001 and p<.01, F.E.T. =.006, respectively).
<table>
<thead>
<tr>
<th>Total</th>
<th>Count</th>
<th>4 (5.0%)</th>
<th>50 (62.5%)</th>
<th>3 (3.8%)</th>
<th>23 (28.8%)</th>
<th>80 (100%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

***p<.001, chi-square measure of association; p=.001, F.E.T.
*p<01, chi-square measure of association; p=.021, F.E.T.

There was a statistically significant relationship between the overall direction of the caregiver’s first impression and their motivation and expectation about their child’s treatment (F.E.T.=.001). The caregivers who had a positive first impression were substantially more likely to exhibit moderate to high motivation and expectation than low motivation or expectation. Further, those with a negative first impression were most likely to exhibit low motivation and expectation toward their child’s treatment. Those who reported mixed first impressions were more likely to exhibit moderate to high motivation and expectation than low motivation and expectation. This might suggest that the positive portion of their comments outweighs the negative portion of their comment, therefore decreasing the effect of their negative impressions of a certain program aspect on their overall impression of the agency.

There was also a statistically significant relationship between the overall direction of the caregiver’s first impression and their level of engagement (F.E.T.=.021). Similar to motivation and expectation, those caregivers who reported a positive overall first impression were much more likely to report moderate to high engagement than low engagement. The nature of the rest of the relationships follow the same trends as motivation and expectation about treatment. However, none of the caregivers with a neutral first impression also reported low engagement.

What Led to Placement

Qualitative exploration of what led to youth’s placement.

Prior research has documented that there are ultimately many paths that can result in a child being placed in an RTC. (Garfinkel, 2010; French & Cameron, 2002; Miller et al., 2016). The caregivers interviewed in this study were asked, “can you tell me what led up to your...
daughter/son being placed at [agency]?” Caregivers who responded to this question categorized the reason for their child’s placement into two main categories (Table 4.10). Caregivers who discussed this topic (N=99) either felt that their child’s placement was directly related to the child’s behavior, or resulted from an external source’s behavior. External sources could be a peer influence, the school, the court, etc. This section discusses who the caregivers ultimately view as responsible for the child needing to be placed in an RTC; the child or an external source. The qualitative analysis of this question assessed caregivers’ perceptions of the cause of their child’s placement and what factors led a caregiver to believe that the child directly caused the placement versus believing that the placement is more strongly the result of an external influence, such as a school. The relationships between the primary influence and the caregiver’s motivation and expectation about treatment, as well as overall engagement were analyzed quantitatively. The quantitative analysis explored how caregivers’ opinions of who primarily led to the child being placed out of the home influenced their motivation and expectation toward treatment and overall engagement. The hypothesis for these analyses was that caregivers who primarily viewed their child as the cause of placement, instead of blaming an external source (e.g. school, probation, a peer), were more likely to exhibit moderate to high motivation and engagement.

Table 4.10: Primary influence leading to child’s placement

<table>
<thead>
<tr>
<th>Reason for child’s placement</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child’s behavior</td>
<td>76</td>
</tr>
<tr>
<td>Influence of an external source</td>
<td>23</td>
</tr>
</tbody>
</table>
Child

Most caregivers (N=76) identified the child and his or her behavior in the time leading up to placement as the primary influence that led to the placement. A father of a youth that was experiencing his first placement out of the home when he was sent to the agency recounts, “His behavior in school and the community. He was getting into trouble at school and in the community. Then he pretty much violated his PINS petition, didn’t follow the judge’s instructions so he was placed.” Sometimes, the history of behaviors that precipitated placement appear to be simplistic, such as “She wasn’t going to school and that was basically it.” Generally, if the caregiver focused on one singular cause of placement, it was the child’s truancy. In this category, caregivers framed their responses such that they recognized the role of their child’s decision making in actively choosing not to go to school.

Most of the caregivers in this category generally provided a long list of problem behaviors in which the youth was engaged that ultimately led to placement. In many instances, the issues that precipitated placement had been ongoing for years. For example, one mother who had two other children in the house for whom she was responsible, recalls her son “threatening to kill his sister, destroying our house, cutting the couch, he would get mad at me take a knife and cut them. He cut his bed sheets, cut my couch, cut my counter top, put holes in doors, punch holes in the wall.” The presence of other children in the house and nature of her son’s behavior created heightened concerns for safety that required CPS involvement. Reflecting historically on the problem behaviors of her son, she says, “[Youth’s] had problems, I mean he got kicked out of regular school when he was in fourth grade for setting fires.”

External Source
Of the caregivers who believed that an external source led to the placement of their child (N=23), they appeared to apply less culpability to their child in precipitating the placement. Some placed blame on the school for precipitating youth’s placement. For example, one father discusses, “A lot or part of this he was having difficulty with a teacher, an assistant principal. He was being constantly accused of being a, a, like a bully, and everything that happens in the class also they would always be blaming him, you know, because he was a tall big kid, they said that he’s intimidating.” As the conversation continues, the father also divulges that the son threatened to bring a gun to school and shoot up the place. Despite the severity of the statement that the youth made, the father seems to diminish the seriousness of the situation. This became evident later in the interview when he is asked if it is the first time his son has been in trouble like this and he responds, “Is that considered trouble?”

Other caregivers discussed the youth’s peer group and how his or her peers got her in trouble. Another father discusses an incident where his daughter was an accessory to a crime in which her friend broke into a woman’s house by smashing the window with a rock. “And the little girl picked up a rock and told (my daughter), ‘here, break the window.’ And (my daughter) said… she said the ‘f’ word and she told her ‘no.’” Upon breaking the window his daughter’s friend entered the house, stealing a bag full of items including an envelope of money. The father says that his daughter ran off at this point, but that did not prevent the police from pursuing her for this incident. He concludes with, “Because the first girl [referring to the friend who broke into the house after smashing the window with a rock] got her in trouble. That’s why she’s at [agency].” In addition to describing this incident and placing blame exclusively on the friend who was responsible for the burglary, he states, “She likes to help people out, that’s why sometimes she got in trouble at school.” He describes incidents where he feels that peers have
been able to manipulate his daughter into doing the wrong things. One example is a peer that told his daughter that she was pregnant, so his daughter skipped school to go to Planned Parenthood with her friend. Once again, he places the blame on the youth’s peer for influencing her daughter to behave inappropriately.

**Quantitative exploration of what led to placement.**

One hypothesis that emerged based on the existing literature relating to caregiver engagement is that the source of the caregivers’ blame, whether the child or an external source will affect caregiver motivation and expectation, or engagement (Table 4.11). Specifically, this analysis explores if a caregiver who blames an external source for their child being placed in an RTC is less likely to engage in the treatment process than a caregiver who believes their child is primarily responsible for his or her placement. The relationship was explored using chi-square analysis. One cell (25%) had an expected count less than five in each model of crosstabulation, and therefore, Fisher’s Exact Test was used.

<table>
<thead>
<tr>
<th>Table 4.11: What led to placement and engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregiver Motivation &amp; expectation+</td>
</tr>
<tr>
<td>Low Count</td>
</tr>
<tr>
<td>Count 23.8%</td>
</tr>
<tr>
<td>Moderate to high Count</td>
</tr>
<tr>
<td>Count 76.2%</td>
</tr>
<tr>
<td>Total Count</td>
</tr>
<tr>
<td>100%</td>
</tr>
<tr>
<td>Caregiver engagement++</td>
</tr>
<tr>
<td>Low Count</td>
</tr>
<tr>
<td>Count 19.0%</td>
</tr>
<tr>
<td>Moderate to high Count</td>
</tr>
<tr>
<td>Count 81.0%</td>
</tr>
<tr>
<td>Total Count</td>
</tr>
</tbody>
</table>

7 To test the robustness of the findings given the small sample size, engagement was dichotomized at both the mean and median for comparison to who the caregiver perceived to be the primary influence that resulted in the youth being placed in residence. The trends in the data remained consistent and the relationships were not statistically significant when the data were split at either of these points (F.E.T.=.779 and p<.01, F.E.T. =1.00, respectively).
There were no statistically significant relationships between who the caregiver viewed as the primary influence responsible for their child’s placement and their motivation and expectation about treatment or overall engagement. There were also no apparent trends in the findings. Therefore, whether the caregiver blames the youth or an external source does not appear to influence their motivation and expectations about treatment, or their overall engagement.

**Prior Placements**

**Qualitative exploration of prior placements.**

As mentioned previously, it is not uncommon for the youth who are placed in either agency to have a history of placement in other agencies before arriving at this RTC. In many instances, the youth has failed in alternative interventions, necessitating the need for residential placement; and at times, the youth is placed directly from an alternative program, and therefore there has already been a period of separation between the caregiver and the youth by the time the child is placed. Many scholars (Garfinkel, 2010; Griffith et al., 2009; French & Cameron, 2002; Miller et al., 2016) have argued that prior placements negatively affect caregivers’ motivation and expectation for treatment, as well as overall engagement.

There were both quantitative data and qualitative data available for prior placements. The quantitative data were used to explore relationships between the quantity or type of placement (e.g. residential, hospital, jail, etc.) and motivation, expectation and engagement. For example, as in prior research, are caregivers of youth who have experienced multiple prior placements less likely to be motivated and engaged in treatment? Prior research has not considered the effect that the type of previous placement could have on motivation or engagement. However, theoretically,
it is plausible that different types of placement might have different effects on these constructs. For example, if the prior placement is a treatment based placement, such as a substance use facility or another RTC, does that have a greater effect on motivation or engagement than a non-treatment oriented placement, such as jail? In a treatment-oriented environment, a caregiver will have greater exposure to failed interventions than in a non-treatment oriented environment. If the mechanism of decreasing engagement is observing failures in prior interventions, one might expect a greater effect for an environment where a youth was actively being treated versus strictly incapacitated or held until the youth could be placed in a suitable program. The qualitative data were used for two purposes. The first was to gain a better understanding of the caregiver’s perspective regarding the youth’s prior placements, if the caregiver discussed any details about prior placements. The second purpose was to identify additional prior placements that the youth experienced, which were not quantitatively coded.

The quantitative data were taken from the youth’s file at the agency, while the qualitative data were discussed by caregivers during their interview. After the interviews were qualitatively coded, the qualitative and quantitative data on prior placements were combined, because the interviews identified additional youth who had experienced a prior placement than had been recorded in the file data.

Quantitative data on youths’ prior placement were taken from their file at the agency. Information on prior placements was available from 91 youths’ files (Information not provided in the table). As discussed in Chapter 3, the file information was collected by a team of student research interns, who systematically reviewed the youth’s intake assessment from their case file for information pertaining to previous placement, paying particular attention to the type of placement. Based on the information drawn from the file alone (before integrating qualitative
data), on average youths had experienced 1.3 placements prior to arriving at the current agency. According to their file data exclusively, the majority of youth (N=55, 60%) had previously experienced one or more placement versus no prior placements (N=36, 40%).

While caregivers were not explicitly asked to expand upon their experiences with prior placements during their open-ended interview, many (N=47) divulged information about a previous placement that their child had experienced, discussing either the length of placement, the type of placement, or their experiences with the prior agency throughout the course of the interview. There were no open-ended questions asking specifically if their child had been previously placed or asking caregivers to expand upon their experiences and/or feelings related to prior placements if one had occurred. This topic most frequently came up during questions pertaining to the period leading up to placement or if their son/daughter had been in trouble before being placed at these agencies, which are questions that were directly asked during the interview.

Both the qualitative and quantitative measures of prior placements are included below. Not all caregivers discussed a prior placement in their open-ended interview; therefore, the number of youth who experienced a prior placement as originally identified in the case file (quantitative; N=55) was higher than the number of prior placements that were identified in the interviews (qualitative; N=47). However, upon further investigation, not all previous placements had been recorded in the youth’s intake file, as determined by youth who did not have a prior placement listed in the quantitative data despite their caregiver discussing a prior placement during their open-ended interviews. A thorough comparison of the qualitative and quantitative data revealed 19 additional youth who had a prior placement that had been quantitatively coded as either not having a prior placement or missing data on prior placements. As a result, a new measure of
prior placement was created by combining qualitative/quantitative information for prior placements. This increased the initial sample from 91 to 97 youth, while also decreasing the number of youth identified as having no prior placements. Once data sources were combined, the average number of placements grew to 1.5 and 77% of youth had experienced one or more prior placements, while only 23% had no prior placements.

Qualitative responses are summarized to explore how experiences with prior placements might affect caregiver engagement in the current treatment process (See Table 4.12). This discussion is followed by a quantitative exploration of the relationships between the prior placements and the caregiver’s motivation and expectations about treatment, as well as overall engagement. Quantitative analysis will utilize the combined variable that was determined by integrating both qualitative and quantitative data on prior placements.

Table 4.12: Youths’ prior placements

<table>
<thead>
<tr>
<th>Average number of prior placements</th>
<th>Mean</th>
<th>SD</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.5</td>
<td>1.4</td>
<td>97</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total number of prior placements</th>
<th>Type of placement</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Detention center or jail</td>
<td>16</td>
</tr>
<tr>
<td>1</td>
<td>Residential treatment center</td>
<td>15</td>
</tr>
<tr>
<td>2 or more</td>
<td>Substance use treatment</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Hospital (mental health)</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Multiple types</td>
<td>7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Types of prior placements (Qualitative)</th>
<th>Type of placement</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>Jail</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>RTC</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Substance use treatment</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Hospital</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Foster care</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Types of prior placement (Quantitative)</th>
<th>Type of placement</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>91</td>
<td>None</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>Jail/detention</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>RTC</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Substance use</td>
<td>4</td>
</tr>
</tbody>
</table>
Forty-eight caregivers mentioned another placement by specific name or category (e.g. hospital) during their open-ended interviews that allowed the responses to be categorized into 5 types. The specific types of qualitative placements include jail, RTC, multiple types of placements, substance use treatment and hospital for mental health services. The descriptions of youth behaviors in prior placement, caregivers’ feelings about prior placements and discussions relating to the length of time the youth was previously placed that are provided below are specific to the forty-seven caregivers that discussed a type of placement that was qualitatively coded.

The most common prior placement according to caregivers in their interviews was in a detention center or jail (N= 16). Typically, youth who had been placed in this type of facility prior to being sent to the current agency were transferred directly from custody and did not return home between placement in detention or jail and the present facility. The next most common prior placement was in another residential treatment center. Seven caregivers discussed multiple previous placements preceding the current placement. In most instances, these youths had been placed in another residential setting and had engaged in behaviors like running away or
continuously acting up that led to them being transferred to a detention center before arriving at the present agency. In a couple of cases, the youth had been moved from a secure detention setting to another residential program before ultimately ending up at the current agency or had been to multiple residential settings before the court decided upon the present agency for longer term care. In one instance, a youth had been hospitalized and then transferred to a substance abuse program before arriving at the agency. The remainder of the youth had either previously been in an inpatient substance use program or hospitalized for mental health services in response to self-harming behaviors.

Nineteen caregivers discussed their child’s behavior in the previous placements. Many of the youth had run away or gone AWOL (absent without leave) from the other agencies where they were placed. Sometimes the youth had run away multiple times, like this girl who joined a gang at 14 years old, “She’s been placed and run from just about every place she’s been placed. Every chance she gets, she’s just been taking off.” Each time that this girl ran away from a placement, she picked up additional charges for her delinquent behaviors. In fact, it was not uncommon for the youth who ran away from their previous placements to be arrested or receive additional charges while AWOL from their placement. Another common reason for being moved to the current agency was continued problematic behaviors while in previous placement that led to the youth needing to be moved to another placement. These are typically behaviors that defy the code of conduct at the agencies such as fighting, disobeying the rules and truancy. In one instance, it was not clear exactly what the youth was doing, but her mother and stepfather recount,

That was a 30 day…uh…trial thing there…to…um…to see if she would…uh…straighten up her behavior or whatever and that didn’t work. So then she went to…um…[another facility] which was another thing to see if she would straighten up in there to come home. And she didn’t.
One set of parents felt that their son’s behavior in his prior placement did not precipitate his need to come to the current agency, “He did very well there. He did excellent.” Rather, his behaviors upon returning home from the placement, such as refusing to go to school, led to his placement at the present agency.

Nine caregivers discussed particular feelings about a previous placement. Three of these caregivers were in disagreement about the placement or the selection of the facility. For example, this mother felt,

I told them that I thought she needed a structured placement and they placed her in the first place only because it was close to home and they knew I didn’t have a car. Instead of taking into consideration what she needed.

One father, with a thick accent from his country of origin, felt that out-of-home placement altogether was inappropriate for his son and upon reflecting on his son’s previous placement in a detention center while awaiting permanent placement in the current agency, he stated, “The only reason they send him here is because he was late. I didn’t say cut class, no. Late for classes three times. And you end up sending him to a place like that?”

Three of the nine caregivers were dissatisfied with the previous placement. These caregivers gave a concrete reason for being unhappy with something specific about the agency. For example, this mother recalls,

I mean when he was in [agency], it was in a bad neighborhood, the place wasn’t as clean as it should be, not that I’m a spotless house but it’s like ok, some of these places, am I leaving my kid there?

Three of the nine caregivers talked about stressful situations surrounding their child’s previous placement. In one instance, a mother remembers that when her son was hospitalized for alcohol poisoning after being arrested multiple times, “like they were gonna arrest me for that.” This mother had not been home, supervising her son at the time of his alcohol poisoning and the
police tried to place blame on her for not supervising, thus allowing her son to drink to the point of alcohol poisoning. Another mother discussed how her daughter made molestation accusations against her brothers, precipitating her removal from the home. The accusations were later determined to be unfounded. The final mother in this category talked about how stressful it was that her daughter’s initial placement coincided with the death of her husband, making her emotionally unable to support her daughter being placed. This category of caregivers who discussed stress, exemplify the fact that the removal of their child from the home can sometimes be sandwiched in between a period of other high stress situations. These external factors might be in competition for the caregivers’ ability to be initially engaged in the treatment process.

Ten caregivers discussed the length of time that their child had been in a previous placement. This category was not coded into subcategories because the specific amount of time that a youth had been engaged in prior placements was not as important as what the responses in this category represent. First, the responses of the caregivers, whether discussing a temporary situation of residing elsewhere for days or months until the youth could secure a longer-term placement at the present facility or talking about a child being in and out of drug treatment programs for four years before the current placement, demonstrate the fact that the youth are usually involved with the child welfare or juvenile justice system for a period of time before arriving at the current agencies. The time spent in between placements or trying multiple things to figure out what will work best can be extremely stressful for these caregivers, possibly affecting their motivation by the time the youth is placed in the present agency. Second, in almost all of these instances, the youth spent a period of time somewhere else before being transferred directly to the present agency. Therefore, by the time the youth arrives at either of the current agencies, it can be months since he or she has lived at home and had daily interaction
with his or her caregiver. This extended period of separation prior to arrival at the current agency can possibly have a negative effect on family relationships even before the youth arrives at the longer-term facility. The amount of time spent searching for the best treatment option for their child and the amount of time spent separated before arriving at the agency are both important factors to consider when thinking about caregiver engagement because they can both have an effect on a caregiver’s motivation and expectations for treatment.

**Quantitative exploration of prior placements.**

Within the youth’s file, there was no systematic data available to determine how long the youth had been living elsewhere from the caregiver by the time he or she was admitted to the agency. However, there was a record of how many prior placements a youth had experienced before arriving at the current agency. The qualitative data was used to identify more caregivers of youth who had experienced a prior placement than had been identified in the file data alone. The relationship between the number of prior placements and caregiver engagement is described below (see Table 4.13). These relationships were explored using chi-square analysis. None of the relationships presented are statistically significant at the 95% confidence interval. There were two cells (33.3%) with an expected cell count less than five in crosstabulation. It is possible that the trends observed below might become statistically significant if the sample were larger and therefore more conducive to significance testing.
<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>0 (21.4%)</th>
<th>1 (35.7%)</th>
<th>2 or more (42.9%)</th>
<th>Total (100%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregiver Motivation &amp;</td>
<td>15.0%</td>
<td>13.5%</td>
<td>17.1%</td>
<td>15.2%</td>
<td></td>
</tr>
<tr>
<td>expectation+</td>
<td>Moderate to</td>
<td>17 (21.8%)</td>
<td>32 (41.0%)</td>
<td>29 (37.2%)</td>
<td>78 (100%)</td>
</tr>
<tr>
<td></td>
<td>high</td>
<td>85.0%</td>
<td>86.5%</td>
<td>82.9%</td>
<td>84.8%</td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
<td>20 (21.7%)</td>
<td>37 (40.2%)</td>
<td>35 (38.0%)</td>
<td>92 (100%)</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Caregiver engagement++</td>
<td>Low</td>
<td>3 (20.0%)</td>
<td>6 (40.0%)</td>
<td>6 (40.0%)</td>
<td>15 (100%)</td>
</tr>
<tr>
<td></td>
<td>15.8%</td>
<td>16.2%</td>
<td>18.2%</td>
<td>16.9%</td>
<td></td>
</tr>
<tr>
<td>Moderate to high</td>
<td>Count</td>
<td>16 (21.6%)</td>
<td>31 (41.9%)</td>
<td>27 (36.5%)</td>
<td>74 (100%)</td>
</tr>
<tr>
<td></td>
<td>84.2%</td>
<td>83.8%</td>
<td>81.8%</td>
<td>83.1%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
<td>19 (21.3%)</td>
<td>37 (41.6%)</td>
<td>33 (37.1%)</td>
<td>89 (100%)</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

+p=.912, chi-square measure of association; p=.932, F.E.T.
+++.967, chi-square measure of association; p= 1.00, F.E.T.

There were no significant differences based on whether the youth had experienced no, one, or more than one previous placement on caregiver’s motivation and expectation about treatment and their overall engagement. Due to the small sample, after considering three categories of placement including none, one and two or more, the responses were condensed into two categories of prior placement. A dichotomous variable of prior placement, such that youth had no prior placement or youth experienced any prior placement, was created. The relationships between never having experienced a placement prior to this one or experiencing at least one prior placement and caregiver motivation and expectation about treatment or engagement were

---

8 To test the robustness of the findings given the small sample size, engagement was dichotomized at both the mean and median for comparison to the number of prior placements that the youth had experienced. Using chi-square analysis with the engagement variable at both cut points, the number of cells with a count below five was reduced from two per table to none per table. The distribution of the data at both cut points was such that cases were added to all of the categories of low engagement and reduced in all of the categories of moderate to high engagement. The relationship between number of prior placement and caregiver engagement dichotomized on the median rose to near statistical significance, p=.067, while the relationship with engagement dichotomized on the mean was not statistically significant p=.601.
analyzed using chi-square. There were no statistically significant relationships between prior placements and either motivation and expectation or engagement using two categories of responses, either.

One interpretation of this finding is that dealing with prior placements does little to deter caregivers from committing to work on issues that might have contributed to the youth’s problem behaviors. Further, prior placements that the youth has experienced does not seem to influence caregiver’s overall engagement in treatment. However, in a larger sample, one might expect to see a significant relationship between prior placements and readiness to change or engagement, as has been found in prior research.

In an effort to further explore why these relationships were not significant in this sample, the type of placement was examined for a relationship to motivation and expectation, as well as overall engagement (see Table 4.14). The purpose of exploring this relationship was to see if there were any significant differences in caregiver motivation and expectation about treatment or engagement based on whether their child had experienced a previous placement in a treatment oriented environment, such as an RTC or substance use treatment facility, versus a facility that is unlikely to be providing intensive therapeutic treatment, such as jail. The relationships were explored using chi square analysis; however, half of the cells (50%) in crosstabulation had an expected value of less than five. In consideration of the low cell counts, Fisher’s Exact Test was used to examine these relationships.
<table>
<thead>
<tr>
<th>Caregiver motivation &amp; engagement</th>
<th>Jail</th>
<th>RTC</th>
<th>UDs</th>
<th>Other</th>
<th>Multiple</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Count</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 (27.3%)</td>
<td>2 (18.2%)</td>
<td>0 (0.0%)</td>
<td>2 (18.2%)</td>
<td>4 (36.4%)</td>
</tr>
<tr>
<td></td>
<td>15.8%</td>
<td>20.0%</td>
<td>0.0%</td>
<td>20.0%</td>
<td>18.2%</td>
</tr>
<tr>
<td>Moderate to high</td>
<td>Count</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>16 (27.6%)</td>
<td>8 (13.8%)</td>
<td>8 (13.8%)</td>
<td>8 (13.8%)</td>
<td>18 (31.0%)</td>
</tr>
<tr>
<td></td>
<td>84.2%</td>
<td>80.0%</td>
<td>80.0%</td>
<td>80.0%</td>
<td>81.8%</td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>19 (27.5%)</td>
<td>10 (14.5%)</td>
<td>8 (11.6%)</td>
<td>10 (14.5%)</td>
<td>22 (31.9%)</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Caregiver engagement++</th>
<th>Jail</th>
<th>RTC</th>
<th>UDs</th>
<th>Other</th>
<th>Multiple</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Count</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 (27.3%)</td>
<td>2 (18.2%)</td>
<td>0 (0.0%)</td>
<td>1 (9.1%)</td>
<td>5 (45.5%)</td>
</tr>
<tr>
<td></td>
<td>16.7%</td>
<td>20.0%</td>
<td>0.0%</td>
<td>10.0%</td>
<td>23.8%</td>
</tr>
<tr>
<td>Moderate to high</td>
<td>Count</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>15 (26.8%)</td>
<td>8 (14.3%)</td>
<td>8 (14.3%)</td>
<td>9 (16.1%)</td>
<td>16 (28.6%)</td>
</tr>
<tr>
<td></td>
<td>83.3%</td>
<td>80.0%</td>
<td>100%</td>
<td>90.0%</td>
<td>76.2%</td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>18 (26.9%)</td>
<td>10 (14.9%)</td>
<td>8 (11.9%)</td>
<td>10 (14.9%)</td>
<td>21 (31.3%)</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

There were no significant relationships between the type of youth’s previous placement and a caregiver’s motivation and expectation or engagement in treatment. The most common types of prior placement were multiple types of placement or jail. Caregivers who reported that their child had only had a prior hospitalization for mental health or substance use treatment, all exhibited moderate to high motivation and overall engagement, with none reporting low engagement. Despite the lack of statistical significance, this is an interesting trend to explore in future research with a larger sample.
To further explore the relationship between treatment-oriented placements versus jail, the categories of prior placement types were condensed into three types including jail, treatment and multiple (not presented in table form). Multiple encompasses youth who experienced a placement in both jail and a treatment setting. “Other” was excluded from this analysis. There were no statistically significant relationships between the orientation of the treatment, whether treatment, punitive or multiple and either caregiver motivation and expectation about treatment (p=.546, chi-square measure of association; .539, F.E.T.) or caregiver engagement (p=.964, chi-square measure of association; 1.00, F.E.T.).

**History of Getting in Trouble**

**Qualitative exploration of youth’s history of getting in trouble**

As previously noted, caregivers are more likely to be engaged in treatment when they believe that their child can be helped by the intervention. Further, the severity of a youth’s needs can lower caregiver engagement (Gladstone et al., 2012; Nock & Kazdin 2001). In order to get a sense of the history of the caregiver’s exposure to the youth’s problem behavior, caregivers were asked, “Is this the first time that your son or daughter has been in trouble like this?” The responses were analyzed to provide insight into the longevity and severity of the youth’s problem behaviors. Was there anything within the context of the interview to indicate that the caregiver might be less likely to be motivated in their child’s treatment, have lower expectations for their child’s treatment, or be less engaged because of the amount of time that the issues had been ongoing, or how severe they viewed the problem? These relationships could not be explored quantitatively because only 38 caregivers discussed this theme, therefore inhibiting statistical analyses. Regardless of the ability to examine these relationships quantitatively, the qualitative responses provided interesting insight into how a caregiver determined whether this was the first
time their child got in trouble and also gave an overview of the trajectory to out-of-home placement for many of these youths.

Thirty-eight caregivers responded to this question. The majority (N=25) stated that it was the first time their child had been in trouble, while twelve said that it was not the first time their child had been in trouble. One caregiver gave a neutral comment, “Is that considered trouble?” because he felt that his son did not belong in the system since he perceived that the school had targeted him unfairly. However, further investigation of the responses from caregivers coded as “yes, this is the first time in trouble” and “no, not the first time in trouble” reveal that the two groups are not very distinct in terms of their description of their child’s history. The similarities between the groups begs the question of how they interpreted the idea of their child being in “trouble like this.”

There were 25 caregivers who said that it was the first time that their child had been in trouble. One mom recounts how her son stopped going to school, which prompted the school and her to file PINS petitions against her son. She recounts, “They [the school] were calling me and I was calling them [the school]. I couldn’t get him, he would not get up out of that bed no matter what I did.” She describes how her son went to court five times and this continued for a year before being placed. Each time, the judge gave her son a chance to start going to school, but he still refused. Her son’s failure to go to school resulted in a 30-day placement in a diagnostic facility to be assessed for an appropriate placement, at which time he was transferred to the current agency. This mom discusses how the youth had no other issues besides truancy. Based on her statements, despite the issue being ongoing for a year, she views this as the first time her son is in trouble because it was a singular behavior that persisted, thus resulting in placement. Another mother describes a similar perspective about how her daughter’s truancy was the only
reason underlying her daughter’s placement, therefore she believed it was the first time her
dayughter had been in trouble. “She wasn’t going to school and that was basically it.” A different
mother in this category describes a much swifter trajectory to placement for her son, which she
attributes to her family moving to a different town. “Yes, he never got in trouble anywhere we
lived before this… [This town] is rough.” She recounts how Child Protective Service (CPS)
became involved and placed her son on probation. “…then he stole the Slim Jims. When he went
to court, they put him away.”

Interestingly, among the twenty-five caregivers that said it was their child’s first time in
trouble, about half or 12, discuss years of problem behaviors leading up to their child’s current
placement. One mom recounts a steady escalation of her son’s behavior that prompted the school
and her to both seek PINS petitions for him. When asked to think about what might have been
going on to cause the problem behaviors, she reflects, “There had been problems in the past…
stemming from his father, who’s had drug and alcohol problems.” A grandmother who stated this
was her granddaughter’s first time in trouble shared, “I mean she had been having problems in
school for the past three years, but we could deal with that.” Her granddaughter had been placed
in an alternative school program three years prior and was struggling with a learning disability
that caused her to fall behind and prompted her to act out and display aggression. The
grandmother recounts that she could deal with that because, “…I always knew where she was
and I could deal with that, but I couldn’t deal with her sneaking out. Getting up in the middle of
the night and sneaking out of the house.” Despite admitting to ongoing challenges that spanned
multiple years, the grandmother still considered this the first time that her granddaughter was in
trouble because she was more upset by her granddaughter’s recent behaviors outside of school.
Two of these caregivers also discuss prior placements that their child had experienced.
Ultimately, the caregivers in both subsets of this “first time in trouble” group seem to describe similar patterns of behaviors and experiences prior to the child’s current placement.

Twelve caregivers stated it is not the first time their child has been in trouble and all of them describe issues that have been going on for years by the time the youth is placed at the current agency. This is not dissimilar from the caregivers that stated it was the first time their child had been in trouble. One father, whose daughter was seventeen years old at the time of his interview, recounts when asked to discuss when the problem behaviors started, “About the age of eleven. She’s had problems all of her life since the age of three.” He explains that his daughter is diagnosed with Attention Deficit Disorder (ADD) and from the time of her diagnosis, she tried multiple local programs to “get her straightened out.” Her behaviors began escalating to verbal abuse and defiance at the age of eleven. A mother who was interviewed in 2003, recalls that her daughter “…started acting up after I came home in 2000 and really acting out in 2001.” This mother came home from a six-month inpatient drug rehabilitation (rehab) program in 2000 and feels that her daughter struggled to transition back to living with her instead of her father, who had cared for the children while she was in rehab. Two of these caregivers discuss prior placements that their child has experienced. For example, “Well no, no because she’s been in group homes before.”

Frustration with the Systems

Qualitative exploration of frustration with the systems.

Caregivers were not expressly asked to discuss their frustrations with the child welfare or juvenile justice system, however some did discuss different issues that they experienced while interacting with different parts of the systems during their interview. This construct was analyzed to understand the things that cause caregivers to become frustrated with the juvenile justice
and/or child welfare systems. Frustration with the system could contribute decreased motivation to be engaged in the treatment process. Unfortunately, the relationship between frustrations with the systems and caregiver motivation and expectation about treatment or engagement could not be analyzed because only 12 caregivers discussed this topic. Therefore, the sample was too small to perform statistical analyses. However, the qualitative analysis provided valuable information into what causes frustration among caregivers who have a child involved in either the child welfare or juvenile justice systems.

Twelve caregivers discussed frustrations they felt while interacting with the service systems. There were three themes that emerged: the amount of time it took for youth to be placed, lack of consideration of the caregiver’s desires or recommendations in decision making and lack of community resources to support caregiver and youth prior to placement.

Many caregivers discussed frustration with the amount of time invested in the court process before a decision was made on the long-term plan for the youth. There seemed to be two causes of frustration related to time. The first cause of frustration was the amount of time it took for a child to actually be placed in a facility. This was frustrating to caregivers because they perceived that waiting so long to place the child in a residential center gave the child more time to act out and get in trouble, while delaying the inevitable. “He had to get in some legal trouble and that’s why the system with our children, they wait for them to get, you know they use all these other obstacles before when they should place them.”

The other comments related to frustration with time describe how much stress it puts on the caregivers to be attending multiple court hearings and to feel caught in between the bureaucratic uncertainty of the system, unsure when they will learn the fate of their child. One father recounts
an eight-month period of going back and forth to court and doing a lot of work between court visits to get his son situated. He recalls feeling,

a little discouraged with the judge because when we went to court we went on June 2\textsuperscript{nd} or 3\textsuperscript{rd} I think was our court date and the judge has asked us to have all these evaluations done by the school district and letters and this that and the other thing. And...uh...we did everything on our end... And then when we got to court...the judge was like...um...you know...I haven’t really had a chance to go through everything so we’re going to postpone this to February. Yes. So now he was home for another month and you can imagine our frustration at that point because we had brought in...um...what was it the November or December court day?

Another source of frustration for caregivers related to the decision-making process preceding their child’s placement and the feeling that their opinions and perspectives were not considered by the court. For example, one mom did not want her daughter placed in a specific facility because she thought she would have behavior problems in that particular setting. Another mother discusses how mitigating factors in her son’s case were not introduced. Her son was charged with breaking into a house, however it was his grandmother’s house and the court was never informed that it was his grandma’s house, where he spends a lot of his time normally.

Finally, some caregivers discussed frustration with the lack of resources that were available to support their child while he or she was still in the community prior to placement. These resources were not specifically juvenile justice or child welfare resources, but they are community based resources that could have treated what the caregivers perceived to be the underlying causes of their child’s problem behaviors. One mother explains how there are no pediatric brain injury support services in her area. Her daughter sustained a traumatic brain injury at the age of six. When this mother found a school that could support her daughter, the district refused to pay for her daughter to attend. One of the leading causes of her daughter’s
placement was truancy. Another caregiver describes how her insurance company was not willing to pay for her daughter to complete a substance use program.

**Discussion**

Many themes were explored using a mix of qualitative and quantitative methods in an effort to understand the determinants of caregiver motivation and expectations about their child’s treatment and their overall engagement in their child’s treatment process. It is clear from this analysis that the experiences of the caregivers are complex and their perspectives are important for understanding their motivation and engagement.

**Purpose of Placement**

Overall, most caregivers were able to articulate a purpose for their child being placed in an RTC. Very few (N=8) could not visualize any purpose for their child’s placement, other than to serve as a form of punishment or a formal sanction. Further, those who saw the purpose of placement as solely a court-sanctioned punishment and also had a measure for caregiver motivation and expectation about youth’s treatment and caregiver engagement at W1 (N=6), were evenly divided between low and moderate to high engagement, suggesting that this perception of the purpose of treatment did not directly increase the likelihood of low engagement. The remainder of the caregivers believed that the placement offered an opportunity for the youth to be exposed to a beneficial environment, to receive a specific service, acquire a specific skill or improve the youth’s future orientation.

There was a statistically significant relationship between caregiver’s perception of purpose of placement and motivation and expectation for treatment. This finding suggests that there is a relationship between a caregivers’ recognition that their child needs a specific type of service, such as drug treatment or anger management, and their level of engagement. Further, those
caregivers who exhibited low engagement were most likely to perceive multiple purposes of placement. It is possible that the caregivers who perceived multiple purposes of placement might feel like their child’s needs are too complex to be addressed through treatment, as discussed in prior research. Practitioners should consider helping caregivers to visualize and understand a specific purpose for their child’s placement at the outset of placement to increase caregiver motivation. Perhaps if practitioners are able to assist caregivers with attaching a specific desirable outcome with their child’s placement, caregivers’ motivation and expectation for treatment could increase. Additionally, if they help caregivers to sift through multiple purposes and focus on a specific purpose tied to a specific outcome, the occurrence of low motivation could decrease. It is possible that the agency will provide a range of services that will address the underlying issue, but the focal purpose of placement should be identified and integrated into the treatment plan. This process is similar to Littell and Tajima’s (2000) recommendation to increase engagement by providing caregivers with a range of concrete services. If caregivers are concerned that treatment will not help their child because of diverse and intense needs, helping them to focus on a particular need in connection to a strategy for addressing that need, might improve belief about the ability of the program to assist the youth.

**Agreement with Placement**

More caregivers discussed agreeing with their child’s placement in an RTC than disagreeing with their child’s placement. Among those that agreed with placement, most had actually asked for the placement themselves. They describe feeling like they needed help from an external source because of being stressed out by their child’s behavior for a long period of time. Some felt that placement was the only option to prevent their child from engaging in risky or delinquent behaviors and turn their lives around. Some described feeling helpless and unable to continue
dealing with their child’s behaviors on a daily basis. Among those that disagreed with their child’s placement, about a third discussed disagreeing with the placement facility and not necessarily disagreeing with their child being placed at all. Those that disapproved of the placement felt that their child needed something different than the agency could offer, such as more secure detention or a particular service.

Due to the small number of caregivers that discussed this topic, future research should quantitatively explore the relationship between the caregiver’s level of agreement with placement and their motivation or expectations for treatment and their overall engagement with a larger sample. Of specific interest is whether caregivers who asked for their child to be residentially placed differ from those who either did not expressly ask for placement or who disagree with placement. Related, many of the caregivers in this study initiated a PINS petition against their child in an attempt to address their child’s problematic behaviors and receive assistance from the courts in dealing with their child. Is there a difference in the level of motivation or engagement among caregivers who initiated the PINS themselves versus caregivers of youth who had a PINS initiated by an external source, such as the school or probation? One might expect to find higher engagement from caregivers who initiated the PINS petition than caregivers who might have been forced into court supervision by an external source that initiated the PINS petition.

**Ability of RTC to Help Youth**

Few caregivers believed that the RTC would not be able to help their child, while the majority believed that either the agency would be able to help their child, or they were unsure that the agency would be able to help, but leaned towards feeling hopeful that the agency could help their child. Within the cohort of caregivers that were certain that the agency would be able
to help their child, over a third arrived at this conclusion based on an observation of improvement within their child between the time of his or her arrival at the agency and the time of the caregiver’s interview. This suggests that caregivers’ initial beliefs can be influenced by their perception of improvement in their child. Therefore, belief about ability of the RTC to help their child is likely to change over time for caregivers based on their perception of their child’s behavior. When caregivers are provided with opportunities to see changes in their child, either through continuous contact or home visits, they are more likely to believe that the RTC will help and will exhibit higher motivation and engagement in their child’s treatment. Agencies should provide ample opportunity for caregivers to observe changes in their child as a result of being residentially placed.

Caregivers who did not believe that the agency would be able to help their child were most likely to exhibit low motivation and engagement. However, not believing the agency could help their child did not guarantee that a caregiver would have low motivation or engagement. Despite the fact that caregivers might initially doubt the ability of the agency to help their child, agencies should continue to expose caregivers to changes in their child while in residence in an effort to increase caregiver motivation and expectation about treatment.

Many of the caregivers in this sample fell somewhere in between believing that the agency would or would not be able to help their child. They discussed feelings of skepticism based on things such as youth’s experiences in previous placements, concerns about the youth applying skills learned while in residence to their lives in the community and other concerns. Agency staff should recognize that most of these caregivers have been dealing with the youth’s problem behaviors for a long period of time prior to placement and therefore might be less likely to believe that their child can change. However, this skepticism does not appear to threaten a
caregivers’ willingness to be engaged in treatment or motivated to participate in their youth’s treatment. While these caregivers might present as less likely to engage based on their opinions and attitudes, staff should actively work to engage them as they are more likely to be moderately to highly engaged than not engaged in their child’s treatment.

**First Impressions of Agency and Services**

Caregivers were most likely to report a positive overall impression of the agency. Few reported an overall negative impression of the agency. Many reported mixed first impressions. A mixed first impression generally indicated a positive impression of one aspect of the agency (e.g. facility, staff or services) and a negative or neutral impression of another aspect of the agency. At the time of interview, four to six weeks into placement, caregivers placed a lot more emphasis on impressions of the agency than on impressions of the services offered. When forming an opinion of the agency, they considered the cleanliness of the facility and how comfortable they felt with leaving their child at the agency. These types of factors contributed to both positive and negative impressions of the agency. Agency practitioners should be aware that these are the types of things that caregivers are considering when forming an initial opinion of the agency and should work to increase positive impressions by maintaining a clean and comfortable environment at the facility.

While few caregivers discussed their impressions of the services, it is possible that this was less common because by the time of the interview, the caregivers seemed to know little about the programs. Those who did discuss programs were more likely to discuss them in a positive manner. It is possible that caregivers need more information on the specific programs offered by the agency and the programs that will be a part of their child’s treatment plan earlier into their child’s residence. It is also possible that this early into residence, the caregivers place greater
emphasis on knowing that their child will be residing in a clean and comfortable environment, thus increasing their level of comfort with leaving their child in the care of the RTC, than knowing which services will be provided to their child.

Alternatively, caregivers might have focused on the agency itself over the services offered because of the way the question was asked. They were asked, “What were your first impression of the agency and its staff?” The framing of the question might have prompted them to focus more on the physical aspects of the agency than the service aspect.

**What Led to Placement**

Among caregivers who discussed what led to their child’s placement, they were more likely to attribute the placement directly to the youth’s behavior than an external source, such as the school or youth’s peer group. These caregivers tended to hold their child more responsible for the part that their child played in precipitating their placement than to place greater blame on an external source.

There were no statistically significant relationships between where the caregiver placed responsibility for placement, whether the youth or an external source, and either their motivation and expectation about treatment or their overall engagement. Therefore, this analysis did not find evidence that caregivers who view their child as responsible for their own placement are more likely to exhibit moderate to high motivation or engagement in comparison to those who think that an external source, such as the youth’s peer group or the school, led to the youth being placed.

**Prior Placements**

Parents who discussed prior placements provided valuable insights into the history of their child’s involvement in the juvenile justice and child welfare systems. Both qualitative and
quantitative methods revealed that most (almost 80%) of the youth in this sample had experienced a prior placement. While quantitative analysis of the effects of prior placements on caregiver motivation and expectation about treatment, as well as overall engagement, did not yield statistically significant results, qualitative analysis provided valuable information that would have been missed through reliance on quantitative analysis alone.

Caregivers discussed three specific themes that are important for consideration by practitioners and policy makers. First, not only have youth experienced prior placements, but they have often “failed” in prior placements, meaning that they have continued to exhibit problem behaviors that have necessitated the need for subsequent placement. Youth in prior placements engaged in running away, aggressive behaviors and truancy. Although the quantitative data demonstrated that the youth had experienced multiple placements, implying that there was some type of failure in the prior placement, it did not provide information about what was happening with the youth to necessitate subsequent placement. While placement itself can be very stressful for caregivers, the stress must be exacerbated when it feels like the intervention is not working and the youth continues to act out. Therefore, practitioners could expect a reduction in engagement from caregivers on the heels of a previous unsuccessful placement.

While the quantitative analysis did not reveal a significant reduction in caregiver engagement for those whose child experienced a previous placement, the staff perspective might not be consistent with the caregiver perception. The data that were analyzed were based exclusively on the caregiver perspective, and caregivers at the point of their child’s placement perceive themselves to be engaged with minimal effect of prior placements on their degree of engagement. However, staff might disagree with the caregivers’ perception of their own engagement and not see the level of engagement they desire from caregivers. Previous studies;
that have found a relationship between the two variables are capturing the staff’s perception of caregiver engagement (Griffith et al., 2009), or are considering a different construct to exemplify engagement that is more consistent with involvement or contact between caregiver and youth (Walter & Petr, 2008.) From the outside looking in, staff might observe a negative effect of prior placements on caregiver engagement or contact with youth that the caregiver does not perceive exists. The caregiver may be unable to objectively see that their engagement has been affected as a result of the additional stress introduced by previous placements. Future research should be done to investigate how similar the staff and caregiver perspective of early engagement is. Caregivers might not be able to see if and how prior placements are negatively affecting their engagement and it is also possible that staff could learn a lot from the caregiver perspective concerning their experiences with prior placements.

Second, the caregivers described a long period of interaction with the child welfare and juvenile justice systems, or long periods of problem behavior. Many discussed years of challenging behaviors before the youth initially came into contact with either system. Further, even after the point of initial contact with the system, for many there were months or years leading to the point of placement. The length of time that a youth has been exhibiting problem behaviors or has been involved with the system poses a threat to caregiver engagement by increasing caregiver frustration and burn out.

Finally, caregivers described periods of intense stress in their lives surrounding prior and present placements. Caregivers are often dealing with other stressful events, or compounded life stress, in the time precipitating youth’s placement. The placement of their child is only one stressful event in their lives, while other stressors continue to affect their lives. Therefore, caregivers are likely to be overwhelmed and possibly burnt out by the time the youth is placed at
the agency, especially in consideration of the fact that many youths have previously experienced unsuccessful placements. Practitioners should validate and recognize these experiences to promote caregiver engagement. One strategy for practitioners is to frame the youth’s placement as an opportunity to alleviate some of the stress the youth’s behavior has created in their lives and work toward strategies for reducing the stress of the placement on the caregiver.

**History of Getting in Trouble**

Many parents felt that this is the first time their child had been in “trouble like this.” While 24 believed that it is the youth’s first time in trouble and 12 did not recognize this as the first time the youth had been in trouble, the responses between the groups were similar. Regardless of which group the caregiver fell into, most of them describe years of behavioral problems leading up to the placement of their child. Some even discuss previous experiences of placement elsewhere before coming to the current agencies. While it is difficult to discern the context that caregivers applied to the timeframe “like this” as asked in the question, it is clear that for most respondents the problems have been ongoing for years. This is consistent with our current child welfare paradigm of demonstrating long term attempts to keep the child at home instead of placing the child in a residential facility. Further, it provides a framework for child welfare practitioners to understand the families that they serve. These are families that have been dealing with a prolonged history of problematic behaviors exhibited by their child and therefore may have been in crisis or under extreme stress for a long period of time when the youth arrives at the agency. Despite the fact that this analysis did not find a statistically significant relationship between prior placements and engagement, prior studies have identified that youths’ history of getting in trouble can contribute to caregiver burn out and decrease likelihood of early engagement.
Frustration with Systems

One theme that became pervasive across topics, including frustration with the system was time. Caregivers throughout this chapter discussed the role that time played in the placement of their child. It was a source of frustration, feeling like too much time elapsed between initial court involvement and the actual placement event, or that too much time was invested in attending court hearings and appointments. Caregivers also discussed frustration when they felt that their perspective were not considered in the decision-making process by major players prior to and during placement proceedings. In order to alleviate some of these frustrations that might threaten caregiver engagement, key players should be mindful of the amount of time and energy caregivers have invested in the process by the time youth are residentially placed. Caregivers’ perspectives and experiences should be integrated into decision making at each step of the juvenile justice or child welfare processes.

Conclusion

Quantitative analysis of themes potentially underlying caregiver motivation and expectation about their child’s treatment and overall engagement revealed many interesting trends, albeit many insignificant findings. It is possible that some of these findings were not statistically significant as a result of the small sample size. While Fisher’s Exact Test was used to account for the small sample size, many of the crosstabulations still did not meet the minimum threshold of expected cell count of five per cell. As a result, the relationships between this component of engagement and the primary source to which the caregiver attributes placement, the youth’s number and type of prior placement and what the caregiver views as the purpose of placement should be examined using a larger sample. Further, the majority of this sample presents as moderate to highly engaged, therefore limiting the amount of variation on both the engagement
and motivation and expectations toward youth’s treatment measures. Many of statistical analyses that were performed did not meet a meet a minimum threshold of 80% power. This issue will be discussed further in Chapter 8.

This study did not find significant relationships between engagement and many factors that have previously been identified as contributing to engagement, such as prior placements. An additional limitation of these data that must be considered is the fact that this is a measure of caregiver engagement four to six weeks into placement from the caregiver perspective. Many previous studies have considered engagement from the staff perspective and have focused on different points in time, such as further into placement than 4-6 weeks. Most studies do not explicitly state when their data were collected in relation to the child’s placement in an RTC, but a couple of focused on data collected prior to 4-6 weeks (Blacher & Baker, 1994; Griffith et al., 2009). It is possible that if these relationships were examined using a measure of caregiver engagement from the staff perspective, some of these relationships would have looked different. Therefore, future research is needed to explore the similarities and differences between staff and caregiver perspective at the same time point. Perhaps caregivers report higher engagement within themselves than staff feel that they outwardly exhibit at the initial stages of residential treatment. If so, what is necessary to converge the two perspectives? Part of the answer to this question might lie in the qualitative data that were discussed in this chapter. Learning about the caregivers’ experiences leading up to their child’s placement provides valuable context for practitioners to understand the determinants of a caregiver’s engagement. It is possible that practitioners need to adjust their expectations for early engagement based on the experiences and sentiments of caregivers prior to and immediately following their child’s placements. It is also possible that practitioners can help caregivers to provide a more realistic assessment of
engagement by educating them about some of the components of engagement and how they apply to the caregivers’ current presentation toward agency staff.

Ultimately, the mixed methods employed in this chapter bolstered the importance of using qualitative methods to expand our understanding of caregiver motivation and expectation about youth treatment and overall engagement. Caregivers provided a lot of insight into the things that they consider important in relationship to themes that have previously been identified as central to motivation and expectation for youth treatment and engagement. For example, this study allowed an examination of what factors form the basis of a first impression or how caregivers assign culpability for their child’s placement in an RTC. When agencies are able to consider this information and understand the caregiver’s perspectives and experiences better, they are also able to target their engagement strategies to better address caregivers’ concerns surrounding their child’s residential placement.

By the time a youth reaches an RTC, many caregivers have invested a lot of time and energy into trying to address the needs of their child. It is essential to caregiver engagement that these efforts and experiences be recognized and validated by members of the juvenile justice and child welfare service sectors.
Chapter 5: Bond with Staff

Bond with staff has been identified as one of the central components of engagement, combined with motivation and expectation about treatment and client’s behavior. The focus of this study is caregiver engagement in youth residential treatment, and this chapter explores factors that are believed to affect caregivers’ bond with staff and their relationship to overall caregiver engagement. In contrast to the previous chapter on motivation and expectation about treatment, there were fewer themes that were identified during analysis to correspond with bond with staff, therefore the exploration of this engagement component is briefer.

The construct of bond with staff was explored in the following way. A number of themes were selected to be explored in relation to caregiver bond with staff and engagement after qualitatively coding all interview transcripts. The selection of themes to explore in relationship to bond with staff was guided by a thematic map (Figure 5.1) that depicts constructs that have been identified in previous research as related to a caregiver’s bond with agency staff. Others have characterized components of a relationship between client and staff as relationship with staff, respect and understanding from staff, trust between client and staff and inclusion of client in treatment planning. The themes that emerged from analysis that appear to be most aligned with these concepts are the caregivers’ first impressions of staff, caregiver communication with agency staff, and caregiver dissatisfaction with agency staff. The qualitative findings for these three themes are presented in this chapter.

Caregivers’ first impressions of staff, which is a theme that was introduced in the previous chapter, emerged in response to an open-ended question that respondents were asked. Therefore, this theme will be explored both qualitatively and quantitatively since there were enough respondents to allow quantitative analysis. To explore the theme quantitatively, the major
themes identified in the qualitative analysis were assigned numeric values (as discussed in Chapter 3) that were compared to the quantitative measures of bond with staff and caregiver engagement.

Caregiver communication with agency staff and satisfaction with staff were not explicitly asked during the interview, but emerged as common discussion points from some caregivers. These themes will only be discussed qualitatively to provide insight into interactions with staff that could enhance or threaten a caregiver’s bond with staff.

**Figure 5.1: Themes related to caregiver motivation and expectation about youth treatment**

This chapter concludes with a discussion of major findings related to caregiver bond with staff. Additionally, the implications of the findings for practitioners and policy makers are discussed.

**Bond with Staff**

**Qualitative exploration of bond with staff.**

Caregiver bond with staff has been identified as the most important factor that underlies engagement in treatment by scholars (Bordin, 1976; Gladstone et al., 2012; Karver et al., 2005) and treatment participants (Iachini et al., 2015) alike. Kruzich et al. (2003) found that caregivers identified a negative impression of staff as a barrier to their involvement in their child’s treatment. Caregivers have identified a variety of factors that promote bond with staff including feeling valued by the worker and not judged, trusting that the worker is being honest with them, believing the worker cares about them and is listening to what they say and being included in the treatment planning process. Caregivers were asked, “What were your first impressions of the
agency and its staff?” They were also asked, “How did you get those impressions?” As an additional prompt, caregivers were asked to expand upon what staff did to give them that impression, or if there was a particular staff member that stood out for any reason. The responses to these questions were analyzed to see if this cohort of caregivers agreed with the constructs that had been identified by prior research and if they discussed any additional themes that can contribute to or inhibit bond with staff.

The responses relating to first impression of staff were coded on an individual level, meaning that the focus of the analysis was on each individual statement and not each caregiver who discussed this topic. Therefore, it is possible for a caregiver to be coded into multiple nodes and multiple subcategories. For example, a caregiver could have voiced both a positive and a negative statement regarding staff and these statements were coded in their appropriate category. There were seven caregivers who made mixed statements indicating both negative and positive statements. Further, a caregiver could have arrived at a positive first impression after considering both staff demeanor and staff treatment and therefore their statements would have been coded into different subcategories.

Caregivers’ first impressions of the staff at the agency, whether positive (N=62) or negative (N=17), were based on two main things: staff demeanor and staff’s treatment of caregiver and/or their child. In addition, some of those who developed negative first impressions arrived at such feelings as a result of internal biases (N=4) that staff action did not necessarily precipitate, such as this mother who stated, “I don’t trust anybody with my kids.” Through her dialogue with the interviewer this mother made it clear that she was generally distrustful of outside agencies. For example, she felt that her son had been placed because Child Protective Services (CPS) targeted him. It would be difficult, though not impossible, for an agency to offset the hesitations of this
caregiver. Her initial sentiment toward the staff is closed-minded, but not because of anything in particular that they have done. While it is conceivable that the staff would earn her trust, this sentiment appears to have developed over a long period of time and many adverse experiences with the system.

Table 5.1: First impression of agency staff

<table>
<thead>
<tr>
<th>First impressions of agency staff</th>
<th>Positive (N=62)</th>
<th>Negative (N=17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme</td>
<td>N</td>
<td>Theme</td>
</tr>
<tr>
<td>Based on demeanor</td>
<td>44</td>
<td>Based on treatment by staff</td>
</tr>
<tr>
<td>Based on treatment by staff</td>
<td>32</td>
<td>Based on demeanor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Personal reasons</td>
</tr>
</tbody>
</table>

There were 62 caregivers who initially had positive impressions of agency staff (see Table 5.1). Forty-four caregivers arrived at this conclusion, at least in part, based on staff demeanor. These caregivers used positive adjectives to describe the staff such as “She was really nice. Um, very pleasant. Very helpful,” or “They were kind…professional.” These descriptions of the staff are very general but demonstrate a common appreciation among caregivers for staff that are nice, professional and helpful. These excerpts also represent the most commonly cited adjectives to describe staff positively. Thirty-two caregivers based their positive first impression of staff, at least partially, on how either they or their child were treated by the staff. This evaluation of staff occurred at a somewhat deeper level than those parents who made decisions about staff based on their demeanor. These caregivers tended to be deeply impressed with a particular action of the staff or a feeling invoked within them following an interaction with a staff member. For example, one mother, who had taken out a PINS petition on her son after realizing he would need help to stop his problem behaviors, described how one of the workers, “listened to my husband and I and he really listened. I tell ya they really listen.”
Some of the things that made caregivers view the staff favorably included staff members being honest with caregivers, really listening to caregivers and understanding where they were coming from without passing judgment, and creating a sense within the caregiver that the staff genuinely cared for their child and his or her ability to succeed through the program. One father described, “I felt they were honest about my son and about what they would do, uh could do,” while a mother discusses appreciation for a staff member who acknowledged “ok…we understand that you’re a mom that has your child here…and…um…you know…we’re not condemning you or anything like that but we’re…we’re…we’re here to help.” Another mother who articulated during her interview that she felt like the parents should always be involved in their child’s treatment process valued her son’s therapist because “She listens. She don’t try to be above because maybe she has a degree in counseling, but I think that what makes a really good counselor is someone who can listen to both sides and really try to say ‘okay, I’m listening to what you’re saying.’” As a parent who valued participation in her son’s treatment, the therapist treating her as an equal, rather than inferior, went very far to instill comfort and trust with the therapist, ensuring active participation and engagement.

There were 17 caregivers who formed negative impressions of the staff initially. As discussed earlier, four of these caregivers arrived at this conclusion based on internal biases that would be difficult for the staff to prevent since the sentiments were preexisting at the time of placement. Of the remaining caregivers, eight felt negatively toward the staff, at least in part, based on their demeanor and 10 felt negatively toward the staff, at least partially based on how they were treated by staff during interactions. Some of the parents felt that the staff were “not very polite,” or that “the staff is immature, underqualified.” Other caregivers who did not
appreciate the demeanor of the staff discussed feeling like the staff “don’t care” or that “it’s just a job to them.

The remainder of the caregivers arrived at their negative impressions based on how the staff treated either themselves or the youth, with slightly higher attention given to how the residents were treated. An example of a mother being displeased with how the staff interacted with her is exemplified by this mother who discusses the process for having her daughter placed, “I took her up there for a visit. They accepted her. They took her there a couple days after that, dropped her off. I didn’t hear from anybody up there for probably three weeks.” This particular mother discussed an ongoing issue with communication between the agency and herself, as well as opportunities to talk to her daughter.

One mother, who was displeased with the way the staff interacted with the residents stated Some of the staff I didn’t like right off the bat because of the way they talked to all the kids in general... They were picking on them. Sitting there telling them your momma doesn’t like you, this and that. That’s not right.

In this example, it does not sound like she was discussing her child specifically. Rather she was interpreting the overall environment and staff interaction with other residents.

Quantitative exploration of bond with staff.

The relationships between the direction of a caregiver’s impression, whether positive or negative and their bond with staff and overall engagement were explored. Based on prior research, the expectation was that those with a negative first impression would exhibit lower bond with staff and lower engagement than those with a positive first impression. Qualitative responses pertaining to the caregiver’s first impressions of staff were quantitatively coded into negative=1 or positive=2. There were seven caregivers who had mixed first impressions of the staff, stating one positive and one negative thing about the staff. These caregivers were excluded from analysis because the relationship of interest was the overall direction of their first
impressions, whether negative or positive, and their bond with staff or overall engagement. The relationships between first impression of staff and caregiver bond with staff or caregiver engagement were analyzed using chi square analysis (see Table 5.2). One cell in each table had an anticipated count of less than five, therefore Fisher’s Exact Test was used.

<table>
<thead>
<tr>
<th>Table 5.2: First impression of staff and caregiver engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregiver bond with staff***</td>
</tr>
<tr>
<td>Low Count</td>
</tr>
<tr>
<td>Moderate to high Count</td>
</tr>
<tr>
<td>Total Count</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Caregiver engagement*</th>
<th>Low Count</th>
<th>Moderate to high Count</th>
<th>Total Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count</td>
<td>4 (44.4%)</td>
<td>4 (8.3%)</td>
<td>8 (14.0%)</td>
</tr>
<tr>
<td>Total Count</td>
<td>5 (56.6%)</td>
<td>44 (91.7%)</td>
<td>49 (86.0%)</td>
</tr>
</tbody>
</table>

***p<.001, chi-square measure of association; p=.001, F.E.T.
*p<.05, chi-square measure of association; p=.016, F.E.T.

Caregivers with a positive first impression were significantly more likely to have a moderate to high bond with staff than a low bond with staff, while those with a negative first impression were significantly more likely to have a low bond with staff than a moderate to high bond.

---

9 When the mixed first impression category was included in the chi-square analysis, there was still a statistically significant relationship between caregiver’s first impression of staff and overall engagement (p=.001, F.E.T.=.002), however the interpretation of these results were less intuitive than only considering positive or negative first impressions.

10 To test the robustness of these findings given the small sample size, engagement was dichotomized at both the mean and median for comparison to the general direction of the caregiver’s first impression of the staff. The trends in the data remained consistent and the relationship retained statistical significance when the variable was dichotomized on the mean (p<.01, F.E.T.=.004). When the data were dichotomized on the median, two cells had an expected cell count of less than 5 and the trends were similar, but the findings were not statistically significant (p=.091, F.E.T.=.132).
bond with staff, F.E.T.=.001. Further, caregivers with a positive first impression of staff were significantly more likely to exhibit moderate to high engagement than low engagement, F.E.T.=.016.

**Qualitative Exploration of Dissatisfaction with Staff**

Caregivers were asked about their first impressions of the staff, but they were not explicitly asked about their ongoing interactions or opinions of the staff. Some caregivers (N=11) discussed interfaces with the staff that informed their level of satisfaction with agency staff (see Table 5.3). This code was analyzed to gain insight into the specific actions of staff that caregivers cite as causing them to feel dissatisfied or satisfied with the staff. Those who are satisfied with the staff should exhibit higher bond and engagement. The number of caregivers who discussed this was too small to allow for quantitative analysis to test the effect of satisfaction on engagement or bond, but the qualitative data provided insight into staff behaviors that are valued by caregivers.

**Table 5.3: Level of satisfaction with staff**

<table>
<thead>
<tr>
<th>Dissatisfaction with staff (N=9)</th>
<th>Satisfaction with staff (N=2)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cause</strong></td>
<td><strong>Cause</strong></td>
</tr>
<tr>
<td>Lack of supervision or rule enforcement</td>
<td>Commitment to child</td>
</tr>
<tr>
<td>Inconsistent information</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

The majority of caregivers who spoke about interactions with staff that contributed to their level of satisfaction with the staff described feeling dissatisfied (N=9). The main cause of dissatisfaction with the staff stemmed from feeling like the staff did not provide enough supervision, or were not strict enough when it came to enforcing the agency rules for youth behavior.
One mother describes her frustration and disbelief about her son continuing to go AWOL from the agency, “…he can just up and walk out the door and nobody stops him. That…that baffles me…you know. I mean they’re there to supervise the kids.” She is concerned that her son is not learning that he has to abide by rules because he continues to get away with leaving the campus. (It should be noted that it is not uncommon for youth at either agency to go AWOL, as both campuses are open (non-secure) campuses that are embedded in community locations.)

Another mother voiced frustration toward the staff for not strictly enforcing rules despite her repeated requests,

when I told staff that [my son] was breaking rules they didn’t do anything about it. They said they would crack down and [he] still kept doing what he wanted to do. There was no change. Eventually I stopped saying anything. Staff sometimes even condoned it.

Other caregivers felt that the staff provided inconsistent information. In one example, the mother describes how the staff provide inconsistent messages to her daughter, “Yeah, I don’t think they’re consistent, I think like one person’s telling her something and another person’s telling her something else because she gets her hopes up high and then, I don’t know if they’re honest with her.” The other caregiver discusses how she is provided with mixed messages from the staff, “…the staff that’s on his floor, in the division, they’re the ones – that don’t stick by what they say, what they tell me, which I don’t understand.”

Two caregivers discuss being satisfied with the staff. In both instances, the caregiver discusses the staff’s commitment to the child or the caregiver. The first mother describes how the agency staff responded to her concerns in a manner that increased her comfort, “I felt that they were sincere with it. Um…and when I expressed my concerns about the locality of the, place, uh they told me that they would you know would keep an eye on things.” The second mother appreciated how the staff committed to her son and were able to get him to improve his
behaviors, “Yea they worked with him, they all love [my son]. [He] stopped running away after he went to [unit].”

**Qualitative Exploration of Communication with Agency Staff**

The only open-ended question pertaining to staff that caregivers were directly asked referred to their first impression of the staff. One of the prompts available to the interviewers was, “what did the staff do (to make you form that impression)?” While not asked directly, some caregivers (N=13) discussed complaints about communication with staff (see Table 5.4). Overwhelmingly, those who criticized communication with staff, had complaints about the lack of communication (N=11). The analysis of communication with staff provides information about the things that caregivers value in terms of quality communication with staff. When these communication needs are not met, caregivers could be less likely to form a strong bond with staff or engage in the treatment process. It was beyond the scope of this analysis to quantitatively test this relationship, based on the low response rate.

**Table 5.4: Caregiver complaints about communication with staff**

<table>
<thead>
<tr>
<th>Lack of communication (N=11)</th>
<th>Communication about home visits (N=2)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of communication</strong></td>
<td><strong>N</strong></td>
</tr>
<tr>
<td>Lack of contact</td>
<td>9</td>
</tr>
<tr>
<td>Lack of information about child</td>
<td>3</td>
</tr>
</tbody>
</table>

There were two types of complaints about the amount of communication between the caregiver and the agency. The first is that the agency either did not initiate contact with the caregiver enough or respond to the caregiver’s attempts to contact the agency (N=9). The second type of complaint is that the agency does not disclose enough information with the caregiver about issues that their child has while in residence (N=3). Parents are not always involved in the
decision-making process, or are not informed if their child has been hospitalized. In the latter group of caregivers, they are describing a lack of information about a specific incident, whereas the nine caregivers who complained about the level of contact with the agency make broader statements about an overall lack of information or communication with staff.

Some caregivers describe a general lack of communication with the staff. One mother explains, “The only problem I really have with them is, they don’t call me.” Another mother complains, “nobody ever gets a hold of me, or nothing. I haven’t had a meeting up there yet, and it’s been, what, three months or more?”

One father recounts how the amount of contact with the agency changed once his son was moved to his permanent unit. It was normal procedure for the male facility to admit all residents to an “intake” unit, where they would remain for a period of time before being assigned to a permanent unit. This father describes this process, noting that while his son was on the “intake” unit, staff “…initiated contact with us on a regular basis.” It is unclear exactly how much time the youth was on the intake unit before being transferred to his new unit, but based on the nature of this father’s comments, it seems that he was unclear about the process, which might have resulted from a lack of communication from the agency to clarify the process. After moving units, the father explains, “Since he’s gone to the permanent unit, it’s been a complete turnaround. It’s like pulling teeth to find anything out.”

A smaller group of respondents (N=3) had complaints about the failure of the agency to communicate with them about a particular event or issues. For example, one mother elaborated on a closed-ended question asking how often the staff let her know how the youth is doing with the description of a specific incident. “He was brought to the hospital and I was upset that no one told me…nobody told me- why didn’t they tell me?”
Another father, who completed an interview with the mother of the youth, described both categories of frustration. Regarding the amount of contact with the agency, he states, “We only hear from them when we call first.” His wife follows up his statement with, “When we call them, and then we have to call like three or four times.” In terms of feeling that the agency is not communicating enough with the parents about decisions that are being made while their child is in residence, he explains, “They changed her medications. They changed her medications without even contacting us.” The mother goes on to describe that they found out about the medication change from their daughter. She criticizes the level of internal communication at the agency as well, describing how she could not get an immediate answer from staff about her daughter’s medication change because the staff member had to consult with another staff member to determine what happened.

In addition to the caregivers who complained about the amount of communication with the agency, two caregivers were displeased with communication concerning their child’s home visits. In one instance, the caregiver felt that the staff gave inconsistent information to both her and her daughter about when she could go home, “… telling her and me that she would be able to go home for the weekend and then she turns back and takes it away saying it’s another two weeks.” The other caregiver describes not having enough notice that her son was coming home for a visit, “I had his last social worker call me the day of his visit to tell me the time the bus was arriving and I didn’t even know he had a visit. I had plans for the weekend, so it was hard.”

**Summary**

Overall, positive first impressions of staff were much more common than negative first impressions of staff. Regardless of the nature of the first impression, caregivers valued the way that the staff treated either themselves or their child and the staffs’ demeanor. The common
phrases that came up to describe staff demeanor that elicited a positive first impression were nice, helpful and professional. The common sentiments about staff demeanor that contributed to a negative first impression were that the staff were impolite or unprofessional. Caregivers who formed a positive first impression felt that staff treated them with respect and were honest with them. Those who formed a negative opinion based on treatment by the staff were more concerned about how the staff treated the youth, specifically focusing on whether they treated the youth with respect or provided enough supervision for the residents.

A positive first impression of the staff significantly increased the likelihood that caregivers would form a moderate to high bond with staff than a low bond with staff. Those with a positive first impression were also more likely to exhibit moderate to high engagement than low engagement. Therefore, a negative first impression of staff is likely to lead to a lesser bond with staff and engagement in treatment.

Staff should be cognizant of the fact that caregivers are forming opinions of the staff at the agency with each interaction and that this process is ongoing. They are measuring the quality of interaction based on how helpful and respectful they perceive the staff to be. These interactions can be face to face or over the phone. When caregivers call the agency, they prefer to be treated with respect, and they gauge the competency of the staff based on their ability to answer questions about their child’s treatment without having to speak to someone else to find out the answer to a caregiver’s question. Caregivers also place a lot of value on how the staff interact with the youth who are in placement and can be positively affected when they perceive respectful treatment from staff toward residents. They also form positive opinions of staff when they feel that they are providing enough supervision, enforcing the rules, or giving consistent information to the youth. Even when staff are not interacting with the caregiver directly, a
caregiver’s observation of their demeanor toward or treatment of others can positively or negatively affect his or her bond with staff and engagement in their child’s treatment.

While caregivers were not explicitly asked to describe their communication with staff, some had criticisms about the amount and quality of communication. Approximately 13% of the sample discussed this topic during their interview. Their main concerns pertained to the lack of communication with the staff in general, or in relationship to a particular event or component of the youth’s treatment. Frustration created by inadequate communication between agency staff and caregivers threatens caregiver engagement by decreasing a caregiver’s bond with staff. Failure to communicate with the caregiver also strips them of the opportunity to inform the treatment plan and witness positive changes in their child as a result of placement. Both of these activities have been correlated to increased caregiver engagement in youth treatment.

Conclusion

This chapter explored the experiences and sentiments of caregivers that could influence their bond with staff, one of the central components of engagement. There was a significant relationship between the nature of a caregiver’s first impression of staff and their bond with staff, as well as overall engagement. While there were few additional themes relating to bond with staff discovered during analysis, the themes that were discussed in the chapter offer important insight into how caregivers’ interactions with staff shape their opinions and contribute to frustrations. The small number of caregivers that discussed communication and satisfaction offered common themes underlying these constructs. Future research should explore these concepts with a larger sample. Agencies can use the information provided by the caregivers to increase bond with staff and decrease frustrations among caregivers.
Chapter 6: Client’s behavior in treatment

Client’s behavior in treatment has been identified as one of the central components of engagement, combined with motivation and expectation about treatment and bond with staff. The focus of this study is caregiver engagement in youth residential treatment, and this chapter explores factors that are believed to affect a caregivers’ behavior in relationship to their child’s treatment (as opposed to a client’s behavior in his or her own treatment) and their relationship to overall caregiver engagement.

The construct of client’s behavior in treatment was explored in the following way. A number of themes were selected to be examined in relation to client’s behavior in treatment and engagement after qualitatively coding all interview transcripts. The selection of themes to explore was guided by a thematic map (Figure 6.1) that depicts constructs that have been identified in previous research in relation to client’s behavior in treatment. Others have characterized components of this construct as engaging the caregiver in developing treatment goals and tasks, caregiver’s agreement with treatment plan and caregiver participation in treatment. The themes that emerged from analysis that are most aligned with these concepts are treatment planning, feelings leading up to placement, personal expectations, and barriers to involvement. Qualitative findings for these four themes are presented in this chapter.

Figure 6.1: Themes related to client’s behavior in treatment
The themes relating to caregivers’ involvement in treatment planning and barriers to caregiver involvement did not emerge in response to a specific open-ended question that respondents were asked, but rather emerged organically in some but not all respondents’ interviews. Responses were too few in number to be able to conduct quantitative analyses of these two themes. Accordingly, these themes were only explored qualitatively to provide additional insight into caregivers’ perceptions of these topics and how they could affect behavior in treatment.

The caregiver’s feelings leading up to placement and their personal expectations for treatment were discussed in response to specific open-ended questions asked of all caregivers. These two themes are explored both qualitatively and quantitatively, since there were enough respondents to allow quantitative analysis. As described in Chapter 3, the major categories of responses from the qualitative analysis were assigned numeric values. Crosstabulation was used to explore the relationships between the major response categories and caregiver’s collaboration on treatment goals and tasks, as well as their overall engagement.

This chapter concludes with a discussion of major findings related to caregivers’ behavior in treatment. Additionally, the implications of the findings for practitioners and policy makers are discussed.

**Treatment Planning**

**Qualitative exploration of treatment planning.**

Participating in treatment planning is one of the markers of collaboration, which is a common construct used to represent caregiver engagement in their child’s treatment process (Littell & Tajima, 2000). A caregiver’s behavior in their child’s treatment process at an RTC has been identified as difficult to measure because of both the mandated nature of the program
(Cunningham et al., 2009; Littell & Tajima, 2000; Osher & Huff, 2006; Platt, 2012) and the separation between the youth and the caregiver (Blacher & Baker, 1994). However, Platt (2012) argued that including the caregiver in the treatment planning process is a strategy to reduce the coerciveness of the environment, therefore increasing collaboration. Caregivers were not directly asked to comment on their participation in treatment planning through an open-ended question. However, a small sample of caregivers (N=10) discussed a component of treatment planning during their interviews. The responses are summarized below (in narrative; not table form) and provide insight into what they appreciate and/or do not appreciate during the treatment planning process.

Four caregivers discuss being invited to participate in the treatment planning process and being kept informed about the treatment plan. In two instances, the comments were vague focusing on the process of generally developing goals, “…we talked about a lot of things and they told me things that would be going on and if I agreed or disagreed with them.” In the other two examples, the caregivers discussed a specific focus, such as the use of pharmaceutical drugs to treat behavioral issues, “it was a big dilemma if we were going to do the pharmaceutical route or look for an alternative…and he went to a psychiatrist and he explained how the medication works…” or what specific behaviors to outline in the behavior contract for the youth, “because he’s not allowed to really hang out with any of the kids in town… because they’re basically part of the reason he was in there.”

Three caregivers discuss being excluded from the treatment planning process. These caregivers discussed how they are not informed about the goals or the processes in place to assist the youth in attaining the goals, “we didn’t discuss goals, or how to work toward them. He’s supposed to be ‘there’ by the end of his stay, but there are no suggestions about how to get
there.” Two out of these three caregivers also complained about the lack of communication from the agency, as discussed in the previous chapter.

Three parents disagreed with the treatment plan. One mother disagreed with the agency about her daughter needing drug and alcohol services, even though her daughter failed a drug test. She feels that her daughter, “tried it….she experimented with it just like any kid would. And I think the difference between [my daughter] and anybody else is that she got caught.” Therefore, she shared that, “I don’t think that [my daughter] is an addict. I think she tested positive and yeah… she did it a few times, but maybe the alcohol might have been a problem.” Another mother was in disagreement with the frequency with which her son received substance use treatment, “I think he’s been to two or three NA meetings. That just really is not very impressive.” Finally, a mother disagreed with the agency’s plan to allow her son to see his father. She referred to it as “little differences of opinion.”

Caregivers’ Feelings Leading up to Placement

Qualitative exploration of caregivers’ feelings leading up to placement.

Understanding the feelings that primary caregivers are experiencing immediately prior to and after placement of their child could provide insight into their behavior regarding their child’s treatment, especially in the initial stages of engagement, which is the focus of this analysis. Prior studies have not explored caregiver’s feelings leading up to placement in the context of understanding behaviors in their child’s treatment. However, if behaviors are defined as participation and effort put forth by the caregivers, there is reason to believe that their feelings and experiences leading up to their child’s placement will directly affect the degree to which they are interested or available to be part of the treatment process. Caregivers were asked, “Can you tell me what led up to your son/daughter being at St. Mary’s/St. Thomas?” Interviewers
were provided with the additional guidance to “prompt for immediate conditions and some history of youth’s/family’s problems.” These feelings could also dictate their behavior in treatment during the initial stages of treatment. Qualitative analysis revealed that this is a complicated time for many caregivers, rife with complex emotions. Therefore, it is conceivable that the feelings that a caregiver experiences immediately preceding placement might interfere with their initial engagement and behavior in their child’s treatment process. For those whose interviews touched upon this topic (N=80), caregivers’ feelings leading up to placement fell within three main categories of feelings (see Table 6.1): negative (N=46), positive (N=13), or conflicted (N=21). Caregivers were coded such that they could express multiple specific feelings under one general category but could not be coded into multiple general categories. Those that expressed both negative and positive general feelings were coded as conflicted, thus creating three mutually exclusive categories.

Table 6.1: Caregivers’ feelings leading up to placement

<table>
<thead>
<tr>
<th>General feelings leading up to placement</th>
<th>Specific feelings leading up to placement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative (N=46)</td>
<td>Emotionally trying (N=25)</td>
</tr>
<tr>
<td></td>
<td>Stressed/Worried (N=19)</td>
</tr>
<tr>
<td></td>
<td>Hard to adjust (N=18)</td>
</tr>
<tr>
<td></td>
<td>Frustrated/Angry (N=10)</td>
</tr>
<tr>
<td></td>
<td>Powerless (N=3)</td>
</tr>
<tr>
<td>Positive (N=14)</td>
<td>Hopeful/Open to treatment (N=9)</td>
</tr>
<tr>
<td></td>
<td>Relieved (N=9)</td>
</tr>
<tr>
<td>Conflicted (N=21)</td>
<td>Both positive and negative feelings (N=21)</td>
</tr>
</tbody>
</table>

As shown in Table 6.1, there were five main subcategories that emerged in the negative responses. The most prominent response among caregivers with negative feelings is that they found placement to be emotionally trying (N=25), in that placement led to feelings of depression,
loneliness, or heartbreak. One mother, a former victim of domestic violence and a recovering alcoholic who was attending AA meetings twice weekly at the time of the interview, explained that, “it was very difficult because I wanted to pick up the drink again.” A few of the caregivers share the sentiment of this mother who described, “Oh my God, it was heartbreaking… absolutely heartbreaking.” Others described the time period immediately leading to placement as challenging: “It was hard because I never went through nothing like this.”

The next most prominent feeling was that the caregiver felt stressed or worried. Interestingly, those caregivers classified as stressed or worried (N=19) were not worried for themselves, but instead were worried for their child. A mother, who was remarried to a very active stepparent, remembered, “I really just worried about how she must have felt.”

Some caregivers described the period leading up to and immediately following placement as hard to adjust (N=18) to placement. These caregivers struggled with the fact that their child was going to be placed out of the home and that they were going to be living apart from their child. Many of these caregivers described feelings somewhat indicative of guilt or disbelief that it had come to placement, such as one caregiver who described, “it’s very hard when you get to the point that it’s… it’s… like…uh….um…you’ve done everything that you can and there really seems like there should be more that you can do and there’s not.” A father that felt his son’s placement was based solely on truancy and therefore unnecessary, explains, “I cried a lot, you know that he’s got a whole new address.”

Frustration and anger were described by 10 caregivers including this mother who admits that she had heard stories about the agency prior to her daughter’s placement that made her feel, “angry when she got there. I was mad, and upset, and didn’t want to talk to anyone.” This mother did not provide any details about the stories she had heard about the agency that caused her to
feel this way. Another mother recounts the time leading up to placement as, “Frustrating. Very frustrating.” She discusses how her daughter adopted an “I don’t care’ attitude. I don’t care what happens to me. I don’t care if I get in trouble. I don’t care if I go to school. She never used to be that way so mostly frustrating.” This mother explains that she had tried to avoid placement for her daughter, hoping to work things out at home, but eventually the stress of her daughter’s behavior became too much for her to avoid formal intervention.

Three caregivers cited powerlessness, “I didn’t have…basically I had to go with the flow. These were none of my choices. These were choices that were brought in by other people. So there was no option.” This mother felt that her son was placed because the school staff had grown tired of dealing with him. Another mother describes, “I didn’t want him to go in as a JD [juvenile delinquent]. I wanted him to go in under me, so I would have more say in his placement and what goes on with him.” This mother goes on to explain that she works in the child welfare field and that it was, “…really tough. To have a child in placement and I work in the field…I mean where I work…it’s like where I can help them, but I can’t help my own son.” This mother does not discuss taking a PINS petition for her son, but she does talk about asking the judge to place her son sooner than he was placed in order to get him off of the streets. Instead, the judge ordered probation and the youth remained at home until violating his probation. This mother feels that the juvenile justice system is ineffective because they wait too long to place children, allowing them multiple failures before being sent to an RTC. She is in favor of earlier intervention, believing that children would not get so “out of control,” if they were placed sooner upon coming into contact with the law.

There were two central types of positive feelings including hopefulness that treatment would be able to help their child or, at the very least, an openness to the idea that treatment was going to
be a positive thing (N=9), or feeling relieved (N=9). For example, one grandmother, whose granddaughter had been rejected from multiple child welfare settings prior to this placement, described, “I really, I just wanted it to work.” Another mother, who had another daughter placed in a rehab setting out of state, explained that it was hard but she knew “…that I made the right decision when I agreed with you know everyone who got together.” Other caregivers described being relieved by placement, in large part because they would feel a comfort in knowing that their child is safe at all times, which was not felt while their child was living at home:

I would rather know that he’s placed somewhere and getting help than not knowing where he’s at and having this child running around not knowing, thinking that he knows what he’s doing, but I know as a parent that he don’t know what he’s doing.

Some of the caregivers who were relieved also described being glad that the child was in placement:

I was glad that he was in detention because he wasn’t running the streets. And I was glad when the day came for him to go [to the agency]. And when I found out that he actually got on the plane and he couldn’t make a pit stop or jump out and he didn’t have a pair of shoes, I was happy.

Those caregivers that gave conflicted responses (N=21) all described feelings of not wanting their children to be placed but also knowing that it was best for them,

It was kind of mixed. In a way I couldn’t wait for him to get out and have it be over, because it was very stressful. I knew it was coming, and he knew it was coming, but in a way then I didn’t want it to come either, because I didn’t want to see him go.

This is distinct from feelings of “hard to adjust” (which occurred post-placement) because these conflicted caregivers explicitly describe struggling prior to placement with coming to terms with the fact that placement was necessary for their child. One mother, who believed her son was bipolar or suffering from some form of mental illness remembered,

I really didn’t know what to expect. I was scared. And you know handing… um control over to… somebody that I didn’t really even know and felt comfortable with was hard. But
at the same time...I also knew that things could not continue because they were getting worse. I needed help.

By contrast, caregivers that were coded in the “hard to adjust” category struggled more in the immediate aftermath of placement with the physical absence of their child from the home.

**Quantitative exploration of caregiver’s feelings leading up to placement.**

Are caregivers who report negative feelings leading up to placement less likely to collaborate and engage in treatment? Conversely, are caregivers who report positive feelings more likely to exhibit moderate to high collaboration and engagement? To explore the relationships between a caregiver’s feelings leading up to the placement and their level of collaboration and engagement, qualitative responses pertaining to caregivers’ feeling leading up to placement were quantitatively coded as negative= 0, conflicted= 1 and positive= 2. The relationships between caregivers’ feelings leading up to placement and their collaboration on treatment goals and tasks (the quantitative scale of client’s behavior in youth’s treatment.), as well as their engagement were analyzed using chi-square analysis (Table 6.2). Three cells in the collaboration on treatment goals and tasks table and two cells in the caregiver engagement table had an anticipated count of less than five, therefore Fisher’s Exact Test was used.
Table 6.2: Relationship between caregivers’ feelings leading up to placement and engagement

<table>
<thead>
<tr>
<th></th>
<th>Negative</th>
<th>Conflicted</th>
<th>Positive</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregiver</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>collaboration on</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>treatment goals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Count</td>
<td>5 (55.6%)</td>
<td>4 (44.4%)</td>
<td>0 (0.0%)</td>
<td>9 (100%)</td>
</tr>
<tr>
<td></td>
<td>12.2%</td>
<td>20.0%</td>
<td>0.0%</td>
<td>12.2%</td>
</tr>
<tr>
<td>Moderate to high</td>
<td>36 (55.4%)</td>
<td>16 (24.6%)</td>
<td>13 (20.0%)</td>
<td>65 (100%)</td>
</tr>
<tr>
<td></td>
<td>87.8%</td>
<td>80.0%</td>
<td>100%</td>
<td>87.8%</td>
</tr>
<tr>
<td>Total</td>
<td>41 (55.4%)</td>
<td>20 (27.0%)</td>
<td>13 (17.6%)</td>
<td>74 (100%)</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

|                  |          |            |          |       |
| Caregiver        |          |            |          |       |
| engagement++     |          |            |          |       |
| Low Count        | 7 (63.6%)| 3 (27.9%)  | 1 (9.1%) | 11 (100%) |
|                  | 17.5%    | 15.8%      | 10.0%    | 15.9% |
| Moderate to high | 33 (56.9%)| 16 (27.6%)| 9 (15.5%)| 58 (100%) |
|                  | 82.5%    | 84.2%      | 90.0%    | 84.1% |
| Total            | 40 (58.0%)| 19 (27.5%)| 10 (14.5%)| 69 (100%) |
|                  | 100%     | 100%       | 100%     | 100% |

+p=.229 chi-square measure of association; p=.2.33, F.E.T.  
++ p=.845 chi-square measure of association; p=.1.00, F.E.T.

There were no statistically significant relationships between the overall direction of a caregiver’s feelings leading up to placement, whether negative, conflicted or positive, and either their collaboration on treatment goals and tasks, or their overall level of engagement. There were interesting, albeit insignificant observations between positive feelings leading up to placement and both collaboration and engagement. None of the caregivers with positive feelings leading up to placement exhibited a low level of collaboration on treatment goals and tasks and only one caregiver with positive feelings demonstrated low engagement.

11 For the purpose of exploratory analysis, the relationships between feelings leading up to placement and collaboration on treatment goals or tasks and caregiver engagement were examined after excluding the conflicted category of responses. The conflicted category demonstrated a negative and positive sentiment, and therefore might have presented as a confounding variable. There were no statistically significant relationships after omitting conflicted responses. To test the robustness of these findings given the small sample size, engagement was dichotomized at both the mean and median for comparison to caregivers’ feelings leading up to placement. The trends in the data remained consistent and the relationships were not statistically significant (p=.862, F.E.T.=.933 and p=.981,, F.E.T. =1.00, respectively).
Caregivers’ Personal Expectations

Qualitative exploration of caregivers’ personal expectations.

Two recommendations to increase caregiver collaboration, and therefore engagement, are to promote decision making based on the family’s needs, instead of only focusing on the youth’s needs (Dawson and Berry, 2002) and to provide a wide range of concrete services (Littell and Tajima, 2000). One way to integrate these strategies into practice is to determine any personal expectations that the caregiver has to ensure that they are integrated into the treatment process. Caregivers were asked, “Is there anything that you personally expect, or would like to get out of the experience with [the agency]?” This theme has not been explored in previous research, but represents an important consideration for increasing collaboration from caregivers. Eighty-eight caregivers responded to this question, with twelve stating that they had no personal expectations, or were not hoping for anything specific from the agency (Table 6.3).

Table 6.3: Caregivers’ personal expectations for treatment

<table>
<thead>
<tr>
<th>Personal Expectation</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expectations for child</td>
<td>39</td>
</tr>
<tr>
<td>Improvement in family relationships</td>
<td>30</td>
</tr>
<tr>
<td>No expectations</td>
<td>12</td>
</tr>
<tr>
<td>Improvement in parenting skills</td>
<td>7</td>
</tr>
</tbody>
</table>

Interestingly, the majority of caregivers that responded to this question (N=39) did not actually discuss an expectation or direct benefit for themselves, but rather focused on an expectation for their child. Some of these caregivers focused on a specific skill that their child could develop or a service that they could benefit from, such as “I’m just glad he is back in school, that’s all,” or “No, I just basically want [my son] to be able to control himself and
basically get an education.” Education was a common topic among these caregivers. Other caregivers took a broader stance on expectations for their child, generally hoping “I would personally like to see my son benefit from this experience in a positive way.” While, they did not discuss a direct benefit to themselves, it is arguable that the improvement of their child could lead to reduced stress for the caregiver, therefore indirectly benefiting them.

The next most common response (N=30) was that caregivers were hoping to experience an improvement in family relationships. The largest subset of responses pertained to the desire to improve family communication. One mother, who had quit her job to be able to supervise her daughter more once she started acting out, said, “I’d like to learn how to communicate better with her, so that things don’t turn into a screaming argument.” A grandmother, who described a very tense environment prior to placement in which, “…I knew that if he kept, if he stayed and kept being more and more abusive verbally, I was probably going to have to hit him,” expressed the desire to, “learn how to communicate more with him… on a verbal basis.” This grandmother explains that she did not want things to escalate to a physical level with her grandson prior to his placement, but she felt that it was inevitable if things did not change between them.

The other common desire to improve family relationships focused on better understanding the youth when he or she returned home. In many instances, caregivers expressed a feeling that if they could better understand the child, they could reduce tensions between caregiver and child and offer greater support. For example, a mother who has a daughter that sustained a traumatic brain injury (TBI) after being hit by a car explains, “I’m learning how I can help her with her mood swings. That’s the biggest problem we have when she is home. She’ll be happy one minute and nasty the next.” Some of these caregivers specifically discussed the role that family counseling could play in improving family relationships, “I’m hoping it will work.
The counseling will help with our family problems that we had before [my daughter] had her problems.”

One mother, who admitted that she and her daughter both tended to be sarcastic, exhibited both types of desires to improve family relationships. She stated, “I want to learn more about her and I would like to be able to talk to my daughter and understand her kind of thinking without arguing.” On one hand, she is discussing understanding her daughter better, while on the other hand she is discussing healthier communication between the two of them.

Finally, a small cohort of caregivers (N=7) discussed a desire to learn or improve parenting skills for when the youth returned home. A mother, who completed her interview with the youth’s father, desired to gain insight into, “If there’s anything that we have done, or anything we could do to help her function better, we would gladly do it.” Their daughter had struggled with chronic self-mutilation before being placed at the agency. Another mother who completed her interview with the youth’s father explained how she was hoping for, “some counseling for us on parenting, in terms of being able to discipline effectively.”

Quantitative exploration of caregivers’ personal expectations.

The four qualitative codes that were identified during analysis of caregivers’ personal expectations were quantified, such that 1= expectations for child, 2= improvement in family relationships, 3= no personal desires and 4= parental skills. For the purposes of quantitative exploration, there was a specific relationship that emerged as intuitive for analysis. How does whether the caregiver has personal expectations for the youth only, the family as a unit and no expectations affect caregiver collaboration on treatment goals and tasks and overall caregiver engagement (see Table 6.4)? Therefore, the category of parenting skills was excluded from this
analysis. Both crosstabulations had two cells with an expected cell count less than five. Therefore, Fisher’s Exact Test is reported.

Table 6.4: Caregivers’ personal expectation for treatment and engagement in treatment

<table>
<thead>
<tr>
<th></th>
<th>Improvement</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Expectations for child</td>
<td>in family relationships</td>
<td>None</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>Caregiver collaboration on treatment goals and tasks+</td>
<td>Low Count</td>
<td>5 (45.5%)</td>
<td>2 (18.2%)</td>
<td>4 (36.4%)</td>
<td>11 (100%)</td>
</tr>
<tr>
<td></td>
<td>Moderate to high Count</td>
<td>30 (46.9%)</td>
<td>27 (42.2%)</td>
<td>7 (10.9%)</td>
<td>64 (100%)</td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
<td>35 (46.7%)</td>
<td>29 (38.7%)</td>
<td>11 (14.7%)</td>
<td>75 (100%)</td>
</tr>
</tbody>
</table>

|                      | Low Count | 7 (53.8%) | 1 (7.7%) | 5 (38.5%) | 13 (100%) | 17.8% |
|                      | Moderate to high Count | 28 (46.7%) | 26 (43.3%) | 6 (10.0%) | 60 (100%) | 82.2% |
| Total                | Count | 35 (47.9%) | 27 (37.0%) | 11 (15.1%) | 73 (100%) | 100% |

+ p=.063, chi-square measure of association; p=.072, F.E.T.
** p<.01, chi-square measure of association; p=.009, F.E.T.

There was a relationship approaching significance between the nature of the caregiver’s personal expectations for treatment and their collaboration on treatment goals and tasks. Those who hoped for family improvement, an outcome that would directly include the caregiver, were less likely than those who had no expectations or only expectations for the child to exhibit low collaboration and more likely to exhibit moderate to high collaboration (p=.063, .072, F.E.T.).

12 Crosstabulation was also conducted using the four distinct categories of caregivers’ personal expectations created during qualitative coding. Ultimately, the category of parenting skills was excluded from analysis presented within the body of the manuscript because the research question of interest was the relationship between a caregiver having desires exclusively for their child, for their family (the relationship between caregiver and youth), or no expectations. There was a statistically significant relationship between the four categories of expectations and overall engagement (p<.05; .016, F.E.T.). Caregivers with expectations related to family relationships or parenting skills, outcomes that would directly involve them versus only relating to their child, almost exclusively exhibited moderate to high engagement, with the exception of one caregiver in each response category. There was no statistically significant relationship between the four categories of expectations and caregivers’ collaboration on treatment goals and tasks (P=.125; .130, F.E.T.).
There was a statistically significant relationship between the nature of a caregiver’s expectation for treatment and their level of engagement. All but one of the caregivers who cited expectations for improvement in family relationships, an outcome that directly involved the caregiver, demonstrated moderate to high engagement, (p<.01, .009, F.E.T.).

**Barriers to Caregiver Engagement**

**Qualitative exploration of barriers to treatment involvement.**

Caregivers were not directly asked if there were any barriers that prevented them from being involved in their child’s treatment process. However, common barriers have been identified in prior research on caregiver engagement and many of those themes became salient in the analysis of interviews with this cohort of caregivers. As presented earlier, both agencies made many accommodations to promote caregiver participation in the treatment process. For example, when a caregiver lived far and did not have the means to travel to the agency, the agency would provide a bus or train ticket for the caregiver to attend the youth’s treatment meeting at the agency. Contact between youth and caregiver was not suspended as a form of punishment or to facilitate treatment adjustment; however, the number of calls between youth and caregiver were restricted to four per week, unless an emergent situation arose.

There were five types of barriers that were discussed by caregivers (see Table 6.5), though some barriers were much more common across caregivers than other barriers. The caregivers were not coded exclusively to one category of barrier, meaning that the same caregiver could be coded into multiple types of barrier. The N column represents the total number of caregivers that discussed that particular barrier. The purpose of this analysis is to gain a better understanding of what caregivers perceive to impede their involvement in their child’s
treatment process. Are there factors that they identify which can be addressed by the agency, and are there any additional factors that emerge beyond what has been reported in previous research?

**Table 6.5: Barriers to parental involvement in treatment**

<table>
<thead>
<tr>
<th>Barrier</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency policy or procedures</td>
<td>20</td>
</tr>
<tr>
<td>Ideas about parental involvement</td>
<td>14</td>
</tr>
<tr>
<td>Travel restrictions</td>
<td>10</td>
</tr>
<tr>
<td>Work</td>
<td>3</td>
</tr>
<tr>
<td>Financial</td>
<td>2</td>
</tr>
</tbody>
</table>

The most commonly cited barrier to caregiver engagement in their child’s treatment was agency policy or procedures (N=20). Most of the caregivers in this category discussed issues with the system for making phone calls to their child and the visitation policies of the agencies, highlighting challenges for the caregiver and youth to communicate regularly. One mother details her frustration with the phone call system,

...the phone. They have a phone problem up there. It’s like they tell you, you can call anytime, but you can never get through. I start at 8 o’clock, I don’t get through until 9:30, and then when I do get through, they say, well, he’s in bed, and I say, you mean to tell me I sat her for an hour and a half trying to get through to my son and I finally get through and now I can’t talk to him.

Another mother discusses why she has not visited her child, yet,

And I haven’t been, ‘cause you’re supposed to set up visits up there so um, I haven’t even been up there. I can’t get a hold of anyone so I know my social worker down here is gonna, look into it for me.

Some caregivers discussed their thoughts about the appropriate level of involvement for the family (N=14). Within this category, there were caregivers who felt that caregivers should not have a lot of involvement, while others felt that family involvement was important. One father explains,
I think my son’s the one with the problem, you know. He, you know, decided to take on a lifestyle that is not appropriate, breaks the social contract and although I don’t believe that there is a remedy, I’m looking on the bright side that he’ll change for the better.

In contrast, a mother explains, “I don’t know if every parent feels the way I do, but I want to be involved. I want to know.”

Within the category of responses relating to caregivers’ ideas about appropriate parental involvement, there were common sentiments that the level of communication with agency staff created a barrier to being involved with the treatment process. While most of these caregivers felt that it was important to involve caregivers in the treatment process, they did not always feel that the agency prioritized this objective. One mother, whose daughter had experienced multiple placements to address self-harming and acting out behaviors prior to arriving at the agency, explains,

I thought that it was going to be a lot like [other programs youth has been in]. That they were going to keep in contact with us, and work with us, because we stressed the point that just because [youth] does not live with us, does not mean that we are not part of her life. She is my daughter and she is still a part of our family and we want to be involved with her. And I think if we are not, then it’s gonna hurt our relationship…I would expect them to contact us at least once if not twice a week. To keep us up to date….I get the impression from [agency] that they’re used to dealing with kids that have parents that don’t want to be involved.

Despite the accommodations that the agency made to facilitate caregiver travel to the agency for meetings, some caregivers (N=10) still cited travel as a barrier to involvement. Most of these caregivers highlight how far the agency is from their home, making travel a hardship. One mother explains, “Um, she suggested for me to, to go once or twice for a meeting they were having; a meeting about, discussions about my daughter. Uh, I couldn’t come, it was too far for a half an hour meeting.” Of the caregivers who did not expressly discuss how far the agency is from their house, they discussed issues of unreliable transportation, “I’ve only been there one time, and I talk to staff on the phone a bit, but I can’t take part in meetings because of my
financial situation and car problems. It’s hard for me to get up there.” Another caregiver stated that she does not drive.

The least common barriers cited by caregivers were work (N=3) and financial strains (N=2). The combination of the travel distance and inflexible work schedules made attending meetings a hardship for some caregivers, while others believe that a visit to the agency is financially unobtainable.

**Summary**

The majority of caregivers expressed negative feelings in the days leading up to or immediately following their child’s placement. Despite the overall direction of their comments (e.g. negative versus positive), many caregivers still clearly show that they feel love and concern for their child and their child’s wellbeing. This is demonstrated by various caregivers who stated that they felt worried for their child or that they found it hard to adjust to their child living elsewhere. Further, the fact that many caregivers struggled with depression, loneliness or heartbreak demonstrates that they care deeply for their child, making this process difficult. Further examination of the statements made by caregivers demonstrated that a caregiver who described negative feelings prior to their child’s placement should not be expected to be less engaged than a caregiver who described positive feelings in the days leading up to placement.

While there were no statistically significant relationships between the direction of a caregiver’s feelings leading up to placement and his or her collaboration on treatment goals and tasks, or overall engagement, it is likely that this is a result of the nature of the caregiver’s comments. These quantitative codes were likely not intuitive for the purposes of this analysis. On a superficial level, one might expect to find a relationship between negative feelings leading up to placement and low collaboration or engagement. However, when the nature of the negative
comments are taken into consideration, demonstrating a strong bond to and deep concern for the child, there is no reason to believe that these comments will negatively affect collaboration or engagement.

When caregivers were given an opportunity to articulate their personal expectations about treatment and whether they had any needs that they were hoping to have addressed by the agency, most caregivers focused on benefits for their child. They expressed desires that their children would make educational gains, improve behaviors to become more manageable upon returning home and become a healthier and happier person through their time at the agency.

Another large group of caregivers was hoping for improvements in family functioning, mainly improved communication with their child and increased ability to understand and relate to their child. Caregivers who cited improved family relationships were least likely to exhibit low collaboration on treatment goals and tasks or low engagement. Improvements in family relationships typically represented a more direct outcome for the caregiver than the other categories of expectations. In this category, the caregiver stood to gain some additional skills, such as communication or understanding their child, while the youth would simultaneously develop these types of skills to improve the overall function and cohesiveness of the family. In order to reduce the likelihood of low engagement or collaboration on treatment goals and tasks, staff should include family goals in the treatment planning process. Caregivers are hoping to be able to better understand and communicate with their children through the treatment process and beyond. Caregivers should be engaged in interventions to teach healthy communication and attachment between youth and caregiver.

Despite the agencies’ attempts to foster an environment of parent-child contact and parental involvement in treatment planning, many caregivers discussed that they felt limited in these
capacities. Common sentiments were that the agency practices made it difficult for caregivers to communicate with their children over the phone because it was too difficult to get through due to the phone line being busy, or that staff did not keep the caregivers informed of what was happening with their child while in residence. Other caregivers felt that the distance between home and the agency was too great for them to regularly be able to participate in meetings. Even though the agency offered travel funds, there were still a lot of logistics involved that presented obstacles for caregivers, such as travel time in relation to meeting time (e.g. 90 minutes for a 30-minute meeting) and juggling work schedules.

While both agencies discussed in this dissertation have made revisions to their phone call policies to increase the amount of contact between youth and caregiver by lifting restrictions on frequencies of incoming and outgoing calls, it is important for other agencies to consider how their phone call polices might negatively affect caregiver engagement. Many caregivers discussed social, not therapeutic calls, with their child; however, chapter 4 discussed how important it was for caregivers to witness positive change in their children to increase motivation toward treatment. These phone calls are important because they allow caregivers opportunities to observe behavioral change in their children through interactions between youth and caregiver. Further, when caregivers experience frustration associated with a lack of contact with their child, or a lack of clear and consistent information about their child’s progress, it threatens caregiver bond with staff by increasing frustration toward staff.
Chapter 7: Conclusion

Support for caregiver engagement in youth residential treatment is widespread and growing. The paradigm shift from youth-centered care to family-centered care, coupled with the abundance of empirical and theoretical support for caregiver engagement in youth treatment has effectively justified and supported the need for caregiver engagement in youth treatment.

Study Overview

Some of the major justifications for caregiver engagement in youth treatment that have been cited include protecting the rights of the parents in the face of out-of-home placement (Altman; 2008; Wulczyn, 2004), facilitating a successful transition from residential treatment back to the community because the majority of children in out-of-home placement will return to their family home (Demmitt & Joanning, 1988; Guerts et al., 2012; Jenson & Whittaker, 1987; Wulczyn, 2004), improving treatment and post-discharge outcomes for youth (Dawson & Berry, 2002; Garfinkel, 2010; Griffith et al., 2009; Lakin et al., 2004; Ryan & Yang, 2005) and utilizing the caregiver as a source of information on the youth’s problematic behaviors to inform the treatment process (Carlo, 1992; Garfinkel, 2010; Iachini et al., 2015; Miller et al., 2016). Many studies have confirmed the benefits of caregiver engagement in youth treatment (Dawson & Berry, 2002; Garfinkel, 2010; Griffith et al., 2009).

In addition to empirical support, Bronfenbrenner’s Bioecological Theory of Human Development lends theoretical support for caregiver engagement in youth treatment by recognizing the family as one of the systems with a large influence on youth development (Bronfenbrenner, 1986; Tudge et al., 2009). In this context, the family can be influential to the youth’s experiences while in residential treatment because if there are issues within the family during the residential stay that are not being addressed, the youth may not be able to focus on
and engage in other components of the therapeutic process. Further, if the family is engaged in the treatment process, it can offer continuity of the skills learned during placement once the youth returns home. According to this theory, a belief system must be present in more than one system for a youth to adopt the values. For youth in residential treatment, the values learned in the RTC should be reinforced in the family home to increase the likelihood of the youth continuing to subscribe to them. This can only be accomplished if the family has been engaged in the treatment process and know which values have been focused on in treatment and how they can be best reinforced.

Building upon the existing theoretical, legislative and empirical support, this dissertation sought to explore the construct of caregiver engagement from the perspective of the caregiver approximately four to six weeks into their child’s placement in an RTC. Caregiver engagement in this dissertation is defined as caregiver motivation and expectations for treatment, bond with staff and collaboration on treatment goals and tasks (Cunningham et al., 2009). Specifically, the first research question addressed was what feelings and experiences do caregivers express during the early part of their child’s placement related to the period leading up to and immediately following placement? By examining the caregivers’ perspective, this dissertation gave voice to a population that is largely overlooked in existing research; the caregiver. Most studies that have explored caregiver engagement have relied exclusively or heavily on the perspective of agency staff (Cunningham et al., 2009; Littell & Tajima, 2000; McWey, 2000; Yatchmenoff, 2005). Further, by focusing attention on the early part of the treatment process, within the first six weeks of placement, this study explored how experiences preceding and immediately following placement influenced caregiver engagement in the treatment process.
The first research question was examined using both inductive and deductive strategies for qualitatively analyzing 101 interviews conducted with caregivers who recently had a child placed in an RTC. The interviews were conducted as part of the Service Outcomes Action Research (SOAR) project, a research-practitioner partnership between two Schools within the University at Albany and two local RTCs. The purpose of the partnership was to help agencies implement a continuous data collection process to inform and improve practice. As part of the pilot study to prepare for full implementation of the continuous data collection process, interviews including both open-ended and fixed response questions, were conducted with 130 youth admitted from 2003-2005, their caregiver and agency staff. In addition, data were collected from the youth’s file to better understand the treatment process and the outcomes produced through involvement with the RTCs. Official report of arrest and subsequent placement were also provided for this cohort of youth from State agencies.

Upon qualitatively coding 101 interviews in their entirety, a thematic map of terms that have been used to represent motivation and expectation about treatment, bond with staff and readiness to change in prior research was utilized to guide the selection of themes that emerged during coding to be used in this analysis. Analysis of caregiver perspectives on a range of topics relating to the three central components of engagement were discussed in chapters four, five and six.

The results from the qualitative analysis of the interviews were used to inform the next phase of analysis, therefore addressing the second research question; how do the perspectives expressed by caregivers regarding the time leading up to their child’s placement relate to their engagement in the treatment process? To answer this question, the major themes that emerged during qualitative analysis were quantified using nominal categorical variables to compare to
quantitative measures of caregiver engagement, including individual measures of motivation and expectation about treatment, bond with staff and collaboration on treatment goals and tasks, as well as a 14-item composite measure of engagement combining several items from the individual measures. The constructs to represent engagement including motivation and expectation about treatment, bond with staff and collaboration on treatment goals and tasks were identified in collaboration with agency staff, who articulated a research logic model and participated in interviews where the three individual themes became salient. The SOAR research team then sought existing measures that assessed these themes and could be adapted to fit the needs of the RTCs. The caregiver engagement measure consisted of a combination of measures from the URICA Scale from the Cancer Prevention Research Center (Cancer Prevention Research Center, University of Rhode Island, n.d.), the Working Alliance Inventory (Horvath & Greenberg, 1986, 1989), Hatcher and Barends (1996) and Simpson et. al. (1997). The quantitative measures of engagement, including individual and the composite measure, were dichotomized using one standard deviation below the mean to denote a low level of the engagement component or overall engagement. The rest of the caregivers were coded as moderately to highly engaged in the treatment process. The relationships between the qualitative response categories and the level of engagement were explored using chi-square analysis. The inclusion of individual component measures in addition to the composite measure allowed caregiver perspectives to be compared to the most closely related component of engagement, as well as overall engagement. This was strategic because there is theoretical justification to believe that certain themes would most closely relate to one component of engagement instead of relating to all components of engagement. For example, first impressions of staff should most closely relate to bond with staff. There was a statistically significant relationship between caregivers’ first impressions of staff
and bond with staff, as well as overall engagement as was anticipated. Additionally, the qualitative analysis of first impressions of staff provided valuable information to understand what factors contribute to a caregiver developing a positive or negative first impression of staff. These factors should be used to inform agency policies to promote bond with staff.

The purpose of this phase of analysis was two-fold. The first objective was to determine if the themes that have been established as relevant to caregiver engagement in existing research were consistent among this cohort of caregivers. This objective was important to determine if findings derived from the staff perspective of engagement are consistent with findings derived from the caregiver perspective. Second, regardless of the nature of the relationship between the qualitative and quantitative measure of engagement, was there additional information in the qualitative responses that provided a context to deepen understanding of caregiver engagement in such a way that would be missed if relying on quantitative data exclusively?

A summary of findings related to the two research questions are provided below. The discussion of findings is structured based on the components of engagement, beginning with motivation and expectation about treatment (chapter 4), followed bond with staff (chapter 5) and finally, collaboration on treatment goals and tasks (chapter 6). Finally, data limitations and directions for future research are discussed.

**Motivation and Expectation about Treatment**

Belief about treatment effectiveness, agreement with treatment, complexity of child’s needs and history of involvement with the juvenile justice or child welfare system have all been connected to motivation and expectation about treatment in prior research (French & Cameron, 2002; Garfinkel, 2010; Gladstone et al., 2012; Israel et al., 2006; Miller et al., 2016; Morrissey-Kane & Prinz, 1999; Nock & Kazdin 2001). Most caregivers in this study believed that the
agency would be able to help their child. A portion of these caregivers believed it to be so because they had already witnessed changes in their child as a result of RTC intervention by the time of the interview. Another large portion of caregivers were skeptical about the ability of the RTC to help their child, though many tended toward optimistic. Some of the caregivers who were skeptical feared that the RTC might help their child in the treatment environment, but not once they returned to their own environment. The small number of caregivers that felt the RTC would not help their child provided no further details about how they arrived at this belief, discussed disagreement with the placement or talked about the failure of other interventions.

Caregivers that believed the agency would be able to help their child were significantly more likely to exhibit moderate to high motivation and expectation than low motivation or expectation, as well as moderate to high engagement than low engagement. Those who did not believe that the agency would help their child were significantly more likely to exhibit low motivation or expectation than moderate to high expectation. These findings are consistent with prior research.

The fact that many caregivers were able to believe that the agency would be able to help their child because they saw signs of change within their child highlights the need for treatment agencies to allow caregivers a chance to observe changes within their child while the child is in residence. This can be accomplished by inclusive contact policies, where caregivers and youth are permitted regular phone calls, frequent home or agency visits and regular involvement of caregivers in treatment meetings.

Many caregivers believed there was a purpose for their child being placed in the RTC. The purposes that they articulated included that their child needed specific services, such as academic support or anger management, needed help to acquire a certain skillset, such as being accountable for behaviors, environmental change, meaning a disruption of the peer group or
environmental components that might have contributed to problem behavior and to assist with future orientation, or setting goals for the future. There was no statistically significant relationship between the type of purpose and motivation and expectation about treatment, but there was a statistically significant relationship between quantity of purposes and motivation and expectation about treatment. Caregivers who identified a singular purpose for their child’s placement were significantly more likely to exhibit moderate to high engagement than low engagement. This finding is consistent with prior research, which recommends connecting concrete services to outcomes as a strategy for increasing caregiver engagement (Littell & Tajima, 2000). Initially, agency staff should find out from caregivers the types of behaviors that they hope to address within their child. Then, staff should help caregivers to understand the services that the agency offers and how they will directly relate to the caregiver’s desired treatment outcome.

More caregivers in this sample had a positive first impression of the agency and its services than a negative first impression. In terms of the agency, caregivers valued the cleanliness and the degree of comfort they experienced when it came to leaving their child at the agency. There was a statistically significant relationship between forming a positive first impression of the agency and motivation and expectation about treatment, such that those with a positive impression exhibited higher motivation and engagement. Fewer caregivers focused on their first impressions of the services offered than on their first impressions of the agency overall. This could be due in part to being so early into the treatment process and not fully understanding the services that the youth was receiving at the time of the interview. Also, the framing of the question asked to caregivers, “What were your first impressions of the agency and its staff?” placed greater emphasis on their first impression of the agency and its staff than the services
offered, which might have caused caregivers to discuss these components more heavily than the services offered.

Caregivers were asked to articulate what they believed led to their child’s placement in the agency. Generally speaking, there were two types of responses. Most caregivers believed that their child caused their own placement. Another subset of caregivers believed that placement was the result of an external influence, more so than the child’s behavior directly. For example, these caregivers blamed the school or the youth’s peer group for placement. There were no statistically significant relationships between who the caregiver held responsible for placement and level of engagement, or motivation and expectation about treatment.

There was a series of themes that were interrelated in relation to motivation and expectations about treatment: prior placements, history of getting in trouble and frustration with the systems. While there was no statistically significant relationship between prior placements and caregiver motivation and expectation about treatment, or engagement in this cohort of caregivers, there were consistent perspectives across this theme that provide valuable insight into the caregiver’s experiences prior to placement. Across these three themes, most caregivers discussed long term problem behaviors, often snowballing or escalating over time. The majority of the youth in this sample had experienced at least one prior placement before arriving at the current agencies. Many of these caregivers have been dealing with either the juvenile justice or child welfare system for years prior to their child’s current placement. These types of experiences introduce the potential for frustration with the system, which was discussed by some caregivers, or possible burnout in terms of dealing with the child and his or her problem behaviors. This idea was introduced by some caregivers when they discussed whether or not they agreed with their child’s placement. Many of the caregivers who discussed this topic agreed with
their child’s placement at the current agencies. A subset of these caregivers even discussed
asking for the placement or taking steps to initiate the process of out-of-home placement, such as
taking out a PINS petition for their child. They describe the feeling of needing help to address
their child’s behavioral needs after long periods of problematic and escalating behaviors. It is
plausible that at the time of the interviews, because the youth had been placed so recently, the
caregiver might not have recognized signs of burnout and therefore might not have realized that
their motivation and expectation or engagement were being affected. Since caregiver
engagement was measured from the caregivers’ perspective in lieu of the staff perspective, there
may not have been statistically significant relationships between prior placements and
engagement because the caregiver does not recognize the influence of prior placements or
burnout on their motivation and expectation. Further, many of these themes were discussed by
too few caregivers to explore the relationships quantitatively. Future research should explore the
relationships between frustration with the system, caregiver agreement with placement and
youth’s history of getting in trouble with a larger sample. Despite the inability to quantitatively
explore these relationships in this sample, there is valuable insight to be gained by listening to
the caregiver’s descriptions and perspectives of the period leading up to the youth’s placement.

Bond with staff

Bond with staff, often referred to as therapeutic alliance, has been identified as one of the
leading contributing factors to caregiver engagement in treatment (Bordin, 1976; Karver et al.,
2005). A greater number of caregivers in this sample discussed positive first impressions of staff
than negative first impression of staff. Caregivers valued staff that were nice, helpful and
professional, whereas they did not appreciate impolite or unprofessional staff. Caregivers with
negative first impressions placed greater emphasis on staff treatment of youth in residence than
on how they themselves were treated. Caregivers with a positive first impression were significantly more likely to report a moderate to high bond with staff and moderate to high engagement than low bond with staff or engagement. Consistent with findings in prior research, staff should be aware that every interaction with caregivers is an opportunity to promote a positive impression of staff, leading to a stronger bond between caregiver and staff.

A small subsample of caregivers discussed feeling dissatisfied with staff. The behaviors that made them feel dissatisfied included feeling that the staff did not provide enough supervision, adequately enforce agency rules or provide consistent information to the caregiver about the youth while in residence. Another small group of caregivers discussed their dissatisfaction with the level of communication with agency staff. Most of the caregivers who discussed this theme were critical of the frequency of contact with staff, feeling that communication with agency staff was too infrequent. Others were dissatisfied with the level of information provided about their child during interactions. It is important for agencies to recognize these are the types of behaviors that caregivers value from staff. When caregivers feel confident in the level of supervision and believe there is adequate communication with agency staff in terms of frequency and quality, they will likely form a more positive bond with staff, thereby increasing engagement.

**Client behavior in treatment**

Client behavior in therapy, sometimes viewed as collaboration on treatment goals and tasks, is the final component of caregiver engagement that was examined in this dissertation. Caregivers describe complex feelings surrounding their child’s placement in an RTC. Many struggle with adjusting to their child going into placement. Simultaneously, many feel relieved or glad because they know that their child is safe and will be getting necessary treatment to address
problem behaviors that have been going on for a while and in many cases, escalating. There is reason to believe that the variety of emotions that caregivers experience surrounding their child’s placement influences their ability to engage in treatment during the early part of the process. Staff at agencies should validate the caregivers’ feelings and expectation, while still encouraging them to be involved in the process of treatment planning. Including the caregivers in the treatment process is one strategy that will allow caregivers to still feel connected to their child, despite the physical separation.

When asked to articulate any personal expectations that the caregivers had for themselves during the treatment process, most focused on expectations for their child, such as educational gains or improved behaviors. Another large category of responses referred to family outcomes, such as improved family communication. Caregivers who articulated a desire for improvement on family measures were more likely to exhibit moderate to high engagement than low engagement. Agency staff should incorporate specific family goals into the youth’s treatment plan to encourage caregiver engagement.

As discussed by scholars previously, there are a number of barriers that caregivers identify that prevent them from being involved in the treatment process (Altman, 2008; Bordin, 1976; Borgman, 1985; Garfinkel, 2010; Karver et al., 2005 & Robinson et al., 2005). Among this cohort of caregivers, the main barriers that they identified were agency policy, contact with agency staff, travel restrictions, or work and financial burdens. Agencies should consider the effects of these barriers on a caregiver’s ability to be present for the treatment process and develop policies to help offset some of these barriers. For example, phone calls and meetings could be held outside of normal business hours to accommodate working caregivers. In this age of technology, tele-meetings over a virtual platform would allow the caregiver to still be
present in the room and participate in conversations about their child without having to travel to the agency.

**Data Limitations**

This study was framed on the theoretical foundations of Bronfenbrenner’s Ecological Theory of Human Development and existing empirical findings relating to caregiver engagement in youth treatment. Some of the themes that have already been established as pertinent to caregiver engagement in youth treatment were found to be statistically significant in this analysis as well (e.g. belief about ability of RTC to help and purpose of placement) while others were not statistically significant (e.g. prior placements) and some had not been explored in prior research (e.g. first impression of agency and staff, caregiver’s feelings leading up to placement and caregiver’s personal expectations). There are a number of potential reasons that the results of this analysis differed from prior studies.

First, the information source in this dissertation was the caregiver, which differs from most prior studies that have used the staff perspective (Fanshel, 1975; Lakin et al., 2004; Leathers, 2004). Staff and caregiver perception of caregiver engagement could differ greatly, causing different results when relationships are tested.

Second, this analysis focused on caregiver engagement approximately 4-6 weeks after the youth had been placed, however, caregiver engagement should exist along a continuum and should change over the course of treatment (Cunningham et al., 2009; Miller et al., 2016; Yatchmenoff, 2005). A complete measure of caregiver engagement consisting of all three subthemes from the caregivers’ perspective was only available at Wave 1 in this dataset, which was collected 4-6 weeks after arriving at the agency. It is plausible that a measure of engagement
collected closer to the measurement of post-discharge outcomes would produce different results, including significant relationships between engagement and post-discharge outcomes.

Third, there is no standard definition of caregiver engagement (Cunningham et al., 2009; Yatchmenoff, 2005). In fact, it can be challenging to distinguish caregiver engagement from caregiver cooperation in a mandated treatment setting. Therefore, many prior studies exploring caregiver engagement have actually focused on a different interpretation of engagement, more consistent with cooperation, such as attending treatment meetings or maintaining contact with youth (see: Borgman, 1985; Israel et al., 2006; Lakin et al., 2004; Morrisey-Kane & Prinz, 1999).

Finally, this analysis represents a small total quantitative sample (N=101), while still representing a sizeable qualitative sample. The resulting sample is smaller than most of the samples that have been utilized in other quantitative studies to explore caregiver engagement (see: Fanshel, 1975; Griffith et al., 2009; Nock & Kazdin 2001 & Yatchmenoff, 2005). The size of the sample decreased the statistical power of these analyses in comparison to analysis with a larger sample, therefore failing to replicate statistically significant relationships that have been found in other studies using larger quantitative samples. A retrospective power analysis indicated that many of the analyses presented were low in statistical power. In many models, the achieved statistical power was less than .80, the threshold for adequate statistical power. One risk of analyses with low statistical power is increased likelihood of a Type II error, or failure to reject a false null hypothesis, thereby failing to identify a real effect (Cohen, 1992). Therefore, the interpretation of quantitative results should be cautiously considered and future research should examine these relationships with a larger sample.

In addition to the limitations that prevented the replication of findings in prior studies, selection bias is another concern within this cohort. Participation in the research study was
voluntary and the caregivers who consented to participate may have been more highly engaged in the treatment process than those that refused participation. Demographically, those who consented and refused participation were comparable, but there was no way to ascertain if those who consented were more likely to be engaged than those who declined based on available data for comparison.

**Conclusion**

This dissertation represents a well-rounded exploration of early caregiver engagement in youth residential treatment with a large sample of caregivers. The utilization of mixed methods to examine the construct of caregiver engagement using both open-ended and fixed-response interview questions of constructs relating to the experience of having a child residually placed facilitated a deeper understanding of the contexts surrounding early caregiver engagement than has been obtained by prior research. Further, this dissertation is one of the largest studies of caregiver engagement in youth residential treatment using qualitative data from the caregiver perspective that has ever been conducted. Most existing research on caregiver engagement has relied exclusively or in large part on the staff perspective, in lieu of the caregiver perspective (Cunningham et al., 2009; Littell & Tajima, 2000; McWey, 2000; Yatchmenoff, 2005). Conversely, other studies have conducted research using smaller cohorts of caregivers or relying on questionnaires that did not give caregivers the opportunity to voice their perspectives beyond the specific questions included in the surveys Fanshel, 1975; Lakin et al., 2004 and Leathers, 2004).

The benefits of the study design in this dissertation are two-fold. First, this dissertation provided caregivers an opportunity to inform a construct that exclusively pertains to them, their level of engagement in their child’s treatment process, which has traditionally been informed by
the staff perspective. While staff perspective is valuable, staff would never be able to provide as much detail and context pertaining to what the caregivers have experienced in relation to their child’s placement, both prior to and immediately following placement. Second, the inclusion of open-ended discussions of caregivers’ perspectives relating to their child’s placement provides much more information and insight into how the caregivers’ experiences contribute to or detract from engagement than could be understood relying on only questionnaires or surveys. This was demonstrated through the constructs that did not produce statistically significant quantitative results, however still provided valuable qualitative results to understand how agencies can better encourage caregiver engagement based on the perspectives provided by caregivers. For example, there was no statistically significant relationship between caregiver engagement at wave 1 and prior placements experienced by the youth. Despite the lack of significance, the comments that caregivers made about their child’s prior placements provided examples of topics such as why a child failed in a previous intervention (e.g. running away), the longevity of interactions with the child welfare or juvenile justice systems (e.g. years of challenging behaviors, multiple court appearances before a youth is placed, etc.) and how the caregiver felt about the prior placement (e.g. disagreed with placement, dissatisfied with placement or stressed out by the placement). All of the factors that were discussed by caregivers in relation to prior placements demonstrate how their child’s experience in a previous placement threatens their expectations for treatment in the current setting. If this study had relied solely on the quantitative data, a lot of valuable and dense information pertaining to caregiver engagement, including the example using prior placements above, would have been missed. The context provided by the caregiver should be used to inform agency policies and procedures aimed at increasing and maintaining caregiver engagement in youth treatment.
Future research should examine the effect of caregiver engagement on post-discharge family and delinquency outcomes. Specifically, more research looking at changes in family relationships during and after RTC is important because of the important role that family plays in youth development. Further, additional research should be conducted to see how caregiver engagement changes over the course of their child’s placement and if this has any differential effects on the variables of interest in this dissertation. Engagement should be an ongoing process and it is important to understand what factors associated with the RTC lead to changes in caregivers’ perspectives and how that relates to their engagement over time.
References


Cancer Prevention Research Center, University of Rhode Island. (n.d.). Smoking: URICA (Long Form).


McLellan, E., MacQueen, K.M. & Neidig, J.L. (2003). Beyond the Qualitative Interview: Data Preparation and Transcription. *Field Methods, 15*(1), 63-84


Appendix A

Interview protocol for agency culture regarding caregiver contact

1) What opportunities did youth and caregiver have for contact? How often were youth allowed to call home? What was the process (e.g. phone location, ask permission, etc.)?

2) Were phone privileges restricted for youth to adjust to the program? If so, how long would youth have to wait before they could call home?

3) Were phone privileges ever restricted as a form of punishment for poor behavior? If so, how long would phone privileges be restricted? Was this specific to individual behavior or could it be a group punishment (e.g. a unit on lockdown)?

4) How often were caregivers invited to participate in treatment meetings? How far in advance were they notified of treatment meetings?

5) Were any special accommodations made for caregivers to participate in meetings (e.g. childcare, transportation, phone conferencing)?

6) Is there anything about the agency policy that might have created a barrier for caregiver involvement?

7) What types of opportunity did caregivers have to visit with youth at the agency?
8) Is there anyone else who was employed at the agency at the time of data collection that you believe would be able to provide additional insight regarding these topics?
Appendix B

Sample characteristics at Wave 1 (n = 126), with comparison to Discharge Cohort

<table>
<thead>
<tr>
<th></th>
<th>Study Sample N= 126</th>
<th>2003 Discharge Cohort (n=201)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at Admission, mean in years</td>
<td>14.98</td>
<td>14.67</td>
</tr>
<tr>
<td>Length of Stay, mean in months</td>
<td>9.6</td>
<td>11.5</td>
</tr>
<tr>
<td>Referral Reason</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PINS (person in need of supervision)</td>
<td>56%</td>
<td>57%</td>
</tr>
<tr>
<td>Juvenile delinquency</td>
<td>40%</td>
<td>30%</td>
</tr>
<tr>
<td>All other</td>
<td>4%</td>
<td>12%</td>
</tr>
<tr>
<td>Unknown/ Missing</td>
<td>2%</td>
<td>6%</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>48%</td>
<td>50%</td>
</tr>
<tr>
<td>Black</td>
<td>40%</td>
<td>33%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>7%</td>
<td>9%</td>
</tr>
<tr>
<td>All others</td>
<td>6%</td>
<td>9%</td>
</tr>
<tr>
<td>Known Alcohol Use (Ever)</td>
<td>74%</td>
<td>64%</td>
</tr>
<tr>
<td>Known Drug Use (Ever)</td>
<td>83%</td>
<td>64%</td>
</tr>
<tr>
<td>Prior Placements (Any)*</td>
<td>62%</td>
<td>72%</td>
</tr>
<tr>
<td>UCR Risk Assessment Scalesa</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caretaker (CT) abused as child</td>
<td>.28</td>
<td>.42</td>
</tr>
<tr>
<td>CT alcohol/drug use</td>
<td>1.21</td>
<td>1.25</td>
</tr>
<tr>
<td>CT expectations of child</td>
<td>.87</td>
<td>1.24</td>
</tr>
<tr>
<td>CT acceptance of child</td>
<td>.33</td>
<td>.70</td>
</tr>
<tr>
<td>CT physical/mental capacity to care for child</td>
<td>.50 / .41</td>
<td>.41 / .62</td>
</tr>
<tr>
<td>Child’s vulnerability</td>
<td>.91</td>
<td>.94</td>
</tr>
<tr>
<td>Child’s response to caretaker</td>
<td>.75</td>
<td>1.02</td>
</tr>
<tr>
<td>Child’s behavior problems</td>
<td>2.55</td>
<td>2.74</td>
</tr>
<tr>
<td>Child’s mental/ physical health and development</td>
<td>.90 / .08</td>
<td>1.15 / .22</td>
</tr>
<tr>
<td>Family domestic violence</td>
<td>1.07</td>
<td>1.14</td>
</tr>
<tr>
<td>Family ability to cope with stress</td>
<td>1.67</td>
<td>1.96</td>
</tr>
<tr>
<td>Family availability of social supports</td>
<td>.95</td>
<td>1.11</td>
</tr>
<tr>
<td>Family living conditions</td>
<td>.07</td>
<td>.32</td>
</tr>
<tr>
<td>Family interactions</td>
<td>.99</td>
<td>1.22</td>
</tr>
<tr>
<td>CT motivation to meet child’s needs***</td>
<td>.60</td>
<td>1.10</td>
</tr>
<tr>
<td>CT cooperation with intervention</td>
<td>.59</td>
<td>1.11</td>
</tr>
<tr>
<td>Behavioral Incidents in RTC, mean per year</td>
<td>41</td>
<td>54</td>
</tr>
<tr>
<td>Home Visits, mean per year**</td>
<td>17.8</td>
<td>12.9</td>
</tr>
<tr>
<td>AWOLs, mean per year</td>
<td>3.71</td>
<td>3.48</td>
</tr>
<tr>
<td>Discharge to Parents</td>
<td>70%</td>
<td>52%</td>
</tr>
</tbody>
</table>

*a New York State’s Uniform Case Reporting risk assessment scales range from 0 (best)-4(worst)

*p<.05 Chi-square measure of association

***p<.001 Chi-square measure of association
Appendix C

Caregiver Measures

Caregiver engagement (CW1). To what extent do you disagree or agree with the following statements? (7-point scale from strongly disagree to strongly agree)

1. People in my family are really working hard to change

2. At times, our problems are difficult, but we are working on them.

3. In my family, we are finally working on our problems

4. I feel that staff at (the agency) care about my family even when we do things that they do not approve of

5. Staff at (the agency) don’t seem to understand my situation and my problems.

(recoded)

6. I feel that staff members at (the agency) appreciate us. ("get" us, whatever it is about us that is special).

7. I believe that staff members here are genuinely concerned for my family’s welfare.

8. Staff here speak in a way that I can understand.

9. The staff helps me view problems realistically.

10. I’m not sure if I can really trust the staff here. (recoded)

11. The staff helps me focus my thinking and planning.

12. Staff and I are working towards goals we agree on

13. Staff and I have different opinions about what’s important for our family to work on

(recoded)

14. I have established a good understanding with the staff here of changes that would be good for my child
Caregiver motivation and expectation (CW1). To what extent do you disagree or agree with the following statements? (7-point scale from strongly disagree to strongly agree)

1. It doesn’t make much sense for my family to be involved with this program; we aren’t the ones with a problem. (recoded)

2. I guess our family has faults, but there’s nothing that we really need to change. (recoded)

3. My being involved in my child’s treatment is pretty much a waste of time because I don’t have any problems that need to be changed. (recoded)

4. Maybe this place will be able to help my family.

5. Our family has some problems and I really think we should work at them.

6. I hope that someone at (the agency) will have some good advice for our family.

7. In my family, we are finally working on our problems.
8. People in my family are really working hard to change.

9. At times, our problems are difficult, but we are working on them.

<table>
<thead>
<tr>
<th>Items</th>
<th>Factor Matrix without Rotation</th>
<th>Reliability Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F(1)</td>
<td>F(2)</td>
</tr>
<tr>
<td>#1</td>
<td>.419</td>
<td>.551</td>
</tr>
<tr>
<td>#2</td>
<td>.510</td>
<td>.601</td>
</tr>
<tr>
<td>#3</td>
<td>.363</td>
<td>.485</td>
</tr>
<tr>
<td>#4</td>
<td>.696</td>
<td>-.170</td>
</tr>
<tr>
<td>#5</td>
<td>.539</td>
<td>.345</td>
</tr>
<tr>
<td>#6</td>
<td>.728</td>
<td>.087</td>
</tr>
<tr>
<td>#7</td>
<td>.596</td>
<td>-.479</td>
</tr>
<tr>
<td>#8</td>
<td>.550</td>
<td>-.618</td>
</tr>
<tr>
<td>#9</td>
<td>.591</td>
<td>-.370</td>
</tr>
<tr>
<td>Eigenvalue</td>
<td>2.880</td>
<td>1.804</td>
</tr>
<tr>
<td>% variance explained</td>
<td>32.005</td>
<td>20.042</td>
</tr>
</tbody>
</table>

### Caregiver bond/rapport with staff (CW1)

*Please tell me how much you agree or disagree with the following statements: (7-point scale from strongly disagree to strongly agree)*

1. I feel that staff at (the agency) care about my family even when we do things that they do not approve of.

2. Staff at (the agency) don’t seem to understand my situation and my problems. (recoded)

3. I feel that staff members at (the agency) appreciate us. ("get" us, whatever it is about us that is special).

4. I believe that staff members here are genuinely concerned for my family’s welfare.

5. I don’t think that staff at (the agency) really like my family. (recoded)

6. Sometimes staff members here are not easy to talk to. (recoded)

7. Staff here speak in a way that I can understand.

8. The staff helps me view problems realistically.

9. I’m not sure if I can really trust the staff here. (recoded)
10. The staff helps me focus my thinking and planning.

<table>
<thead>
<tr>
<th>Items</th>
<th>Factor Matrix without Rotation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F(1)</td>
</tr>
<tr>
<td>#1</td>
<td>.798</td>
</tr>
<tr>
<td>#2</td>
<td>.739</td>
</tr>
<tr>
<td>#3</td>
<td>.840</td>
</tr>
<tr>
<td>#4</td>
<td>.883</td>
</tr>
<tr>
<td>#5</td>
<td>.591</td>
</tr>
<tr>
<td>#6</td>
<td>.770</td>
</tr>
<tr>
<td>#7</td>
<td>.780</td>
</tr>
<tr>
<td>#8</td>
<td>.836</td>
</tr>
<tr>
<td>#9</td>
<td>.724</td>
</tr>
<tr>
<td>#10</td>
<td>.847</td>
</tr>
<tr>
<td>Eigenvalue</td>
<td>6.518</td>
</tr>
<tr>
<td>% variance explained</td>
<td>61.584</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Items</th>
<th>Reliability Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Item-total correlation</td>
</tr>
<tr>
<td>#1</td>
<td>.743</td>
</tr>
<tr>
<td>#2</td>
<td>.680</td>
</tr>
<tr>
<td>#3</td>
<td>.787</td>
</tr>
<tr>
<td>#4</td>
<td>.840</td>
</tr>
<tr>
<td>#5</td>
<td>.519</td>
</tr>
<tr>
<td>#6</td>
<td>.708</td>
</tr>
<tr>
<td>#7</td>
<td>.718</td>
</tr>
<tr>
<td>#8</td>
<td>.782</td>
</tr>
<tr>
<td>#9</td>
<td>.661</td>
</tr>
<tr>
<td>#10</td>
<td>.802</td>
</tr>
</tbody>
</table>

**Collaboration on goals & tasks (CW1).** How much do you agree or disagree with the following statements?

1. Staff and I are working towards goals we agree on.

2. I sometimes wish that staff could better clarify the purpose of the counseling sessions at (the agency) (recoded)

3. Staff and I have different opinions about what’s important for our family to work on (recoded)

4. I have established a good understanding with the staff here of the kind of changes that would be good for my child.

5. I am clear on what my responsibilities are with regard to my child’s placement and treatment at (the agency).
<table>
<thead>
<tr>
<th>Items</th>
<th>Factor Matrix without Rotation</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F(1)</td>
<td>F(2)</td>
<td>F(3)</td>
<td></td>
</tr>
<tr>
<td>#1</td>
<td>.875</td>
<td>n/a</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>#2</td>
<td>.634</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>#3</td>
<td>.742</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>#4</td>
<td>.898</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>#5</td>
<td>.620</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eigenvalue</td>
<td>2.910</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% variance explained</td>
<td>58.191</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Items</th>
<th>Reliability Analysis</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Items</td>
<td>Item-total correlation</td>
<td>Alpha if item deleted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#1</td>
<td>.735</td>
<td>.730</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#2</td>
<td>.476</td>
<td>.811</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#3</td>
<td>.597</td>
<td>.770</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#4</td>
<td>.776</td>
<td>.713</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#5</td>
<td>.430</td>
<td>.814</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Alpha = .808  
N = 102  
(listwise deletion)