FAMILY INVOLVEMENT IN THREE UTAH ADOLESCENT
RESIDENTIAL TREATMENT CENTERS

by

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ABSTRACT

Family Involvement in Three Utah Adolescent Residential Treatment Centers

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Family participation in residential treatment for disturbed adolescents has increased over time. A general sense of this movement is that this is beneficial. However, there are no common descriptions of family involvement in residential treatment in the literature. In order to be able to better understand which components of family involvement are most beneficial, we need to first understand how residential treatment centers (RTCs) define and describe family involvement. This study compiled data from interviews with nine participants, one each from administration, therapy staff, and direct care staff level of three northern Utah RTCs that claimed family involvement in youth treatment at their centers. Results suggest that families are involved in their children's treatment both generally through letters, phone calls, and visits, and specifically through active participation in family therapy. Descriptions of family involvement are provided through thematic presentation with exemplar quotations from participants along with
their perspectives on advantages, disadvantages, restrictions, obstacles, and recommendations for enhanced family involvement in adolescent residential treatment. Participants uniformly agreed that family involvement both in general and in therapy is beneficial and that disadvantages are not sufficient to suggest that family involvement, in most cases, should cease. Implications include recommendations for increased resources to facilitate family involvement.
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Wesley W. Larson
## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>ii</td>
</tr>
<tr>
<td>ACKNOWLEDGMENTS</td>
<td>iv</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>vii</td>
</tr>
<tr>
<td><strong>CHAPTER</strong></td>
<td></td>
</tr>
<tr>
<td>I. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Costs</td>
<td>3</td>
</tr>
<tr>
<td>Need for Residential Treatment</td>
<td>4</td>
</tr>
<tr>
<td>Family Involvement</td>
<td>5</td>
</tr>
<tr>
<td>II. LITERATURE REVIEW</td>
<td>9</td>
</tr>
<tr>
<td>History of Adolescent Residential Treatment</td>
<td>9</td>
</tr>
<tr>
<td>Definition of Family Involvement</td>
<td>12</td>
</tr>
<tr>
<td>Current Trends in Residential Treatment</td>
<td>13</td>
</tr>
<tr>
<td>Family Involvement in Residential Treatment</td>
<td>14</td>
</tr>
<tr>
<td>Benefits of Family Involvement</td>
<td>16</td>
</tr>
<tr>
<td>Current Attitudes Toward Family Involvement</td>
<td>18</td>
</tr>
<tr>
<td>Summary</td>
<td>19</td>
</tr>
<tr>
<td>Purpose and Objectives</td>
<td>20</td>
</tr>
<tr>
<td>III. METHODS</td>
<td>22</td>
</tr>
<tr>
<td>Design</td>
<td>22</td>
</tr>
<tr>
<td>Sample and Procedure</td>
<td>23</td>
</tr>
<tr>
<td>Instrument</td>
<td>28</td>
</tr>
<tr>
<td>Analysis of Data</td>
<td>30</td>
</tr>
<tr>
<td>IV. RESULTS</td>
<td>32</td>
</tr>
<tr>
<td>Research Question 1: How Are Families Involved Generally in Treatment?</td>
<td>32</td>
</tr>
<tr>
<td>Research Question 2: How Are Families Involved in Therapy?</td>
<td>39</td>
</tr>
<tr>
<td>V. DISCUSSION</td>
<td>48</td>
</tr>
</tbody>
</table>
V. DISCUSSION...............................................................48

Research Question 1: How Are Families Involved Generally in Treatment? ..............................................48
Research Question 2: How Are Families Involved in Therapy? .................................................................50
Implications ...........................................................................54
Limitations ............................................................................58
Conclusion ............................................................................59

REFERENCES ........................................................................61

APPENDIX............................................................................68
<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>26</td>
</tr>
</tbody>
</table>

Sample Demographics
CHAPTER I
INTRODUCTION

In 1935, Sigmund Freud wrote the introduction to Augustus Aichorn’s book, *Wayward Youth*, saying that there are three impossible professions: governing, teaching, and healing (Aichorn, 1935). Residential treatment for troubled adolescents involves a complicated combination of all these. Children and youth who may be dangerous to themselves or to others or who display behaviors that families or communities cannot or will not tolerate are often served in residential treatment centers (RTC; Downs, Moore, McFadden, & Costin, 2000). Youth may be admitted due to homelessness, substance abuse concerns, criminal behaviors, and mild to moderate mental health issues. In the past, treatment consisted of behavior modification (most prevalent), psychoanalytic or psychodynamic therapy, peer culture, and psychoeducational programs (Whittaker, 1979), and usually focused on individual pathology (Cafferty & Leichtman, 2004). More recently, however, Garfat (1990) noted that involving family members in the treatment process helps signal that problems are family-based, and counteracts the message that the problem lies only in the young person. It also allows the treatment staff to see families in this new light.

Treatment of youth and families runs through a continuum of care. Communities provide different types of treatment programs and services for children and adolescents with mental illnesses. Not every community has every type of service or program on the continuum, which, according to the American Academy of Child and Adolescent Psychiatry (AACAP, 1997) includes a varied array of services. Depending on population
and demands, a community may offer services ranging from office visits or in-home interventions to possible hospitalization and residential placement. A residential treatment facility—midway on the continuum—offers services to seriously disturbed youth to receive intensive and comprehensive psychiatric treatment in a campus-like setting (AACAP). The AACAP defined the minimum psychiatric services that should be available in an RTC include therapy (individual, family, and group), educational availability, skills training, and collaboration with collateral agencies.

Residential treatment centers house youth between the ages of 12 and 18 years of age anywhere from 3 months to several years. The facilities are restrictive but not as much as psychiatric hospitals or secure facilities; admission can be court-ordered, referred by the family or guardian, or through a child welfare/social service system. There can be fewer than 10 or more than 400 youth residing in one facility. Placed youth are usually nonpsychotic, not actively suicidal nor overly aggressive, and, while in residential care, some form of therapeutic intervention is facilitated (Smollar & Condelli, 1990) with the ultimate purpose of returning the youth home or successfully into society (Tatana, 1993).

The Office of Juvenile Justice and Delinquency (OJJD, 2000) census identified more than 3,000 RTCs in the United States. Accurate figures for children and youth in residential treatment are difficult to obtain, with some estimating that approximately 20% of the 500,000 children served by the child welfare system are in some form of group facility, including residential treatment (Pecora, Whittaker, Maluccio, Barth, & Plotnick, 2000). It is difficult to know the exact number of RTCs in Utah, but there were 47
licensed facilities utilized by Juvenile Justice Services (JJS) in 2005 with an average daily population of 864 youth (Juvenile Justice System, 2005).

Costs

Next to secure care and psychiatric hospitals, RTCs are the most restrictive and most expensive settings for treating youth (Surgeon General’s Report on Mental Health, 1999). The Surgeon General’s report also showed that although used by a relatively small percentage of treated children nationally (8%), residential treatment facilities represent viable treatment alternatives for youth with serious emotional disturbances. According to the Utah Division of Juvenile Justice Services 2005 annual report, expenditures for community programs, including adolescent residential treatment centers, in Utah grew by 128% between FY 1996 ($14,344,039) and FY 2005 ($32,693,000). Over the same period, the overall Division budget grew by 132%.

In comparison, with an average length of stay of 172 days in an RTC, costs in Colorado for RTC care nearly doubled from $38 million in the late 1990s to an estimated $68 million during 2003-2004 (Colorado Office of the State Auditor, 2002). Factors that led to this increase include policy changes, most notably the full implementation of the Medicaid mental health capititated carve-out, which has been shown to increase RTC placements as a substitute for more expensive psychiatric inpatient stays (Libby, Cuellar, Snowden, & Horton, 2002).

In most cases, the family is burdened with the total cost of a private placement. If a family is fortunate enough, its insurance company may pay for aspects of placement
and treatment. When in state’s custody, payment is managed through a sliding scale depending on the family’s ability to pay. According to the State of Utah annual report (JJS, 2005), the average cost of placement ranges from $120.00 to $350.00 per day. In certain situations, religious organizations assist with placement costs. Residential treatment centers are the smallest percentage used in the continuum of care yet utilize the largest percentage of funds.

In addition to dollars spent, there are emotional costs. Parents feel guilty for having a special-needs child, siblings experience neglect as parents focus on the special-needs child, and disturbed children often feel alienated from peers and family as a result of their specific differences (National Advisory Mental Health Council [NAMHC], 1993).

Need for Residential Treatment

The challenges posed by children and youth who present multiple problems, including emotional disturbance, substance abuse, and a history of violence have worked together to maintain population levels and stimulate a renewed interest in residential care and treatment as a viable form of intervention for families and youth (Whittaker, 2000). Notwithstanding its high financial costs, residential treatment remains a necessary and widely used modality employed by both juvenile justice, family services, and psychiatric systems in the United States (Fonagy, Target, Cottrell, Phillips, & Kurtz, 2002).

Currently, residential treatment centers are experiencing scrutiny from many directions. A report from the U. S. General Accounting Office (1994) stated:
Not enough is known about residential care programs to provide a clear picture of which kinds of treatment approaches work best or about the effectiveness of the treatment over the long term. Further, no consensus exists on which youths are best served by residential care or how residential care should be combined with community-based care to best serve at-risk youths over time. (p. 4)

The report went on to say that one of the characteristics that appeared to be related to success was “family involvement” in the treatment process.

Family Involvement

There are numerous systems that have impact on human lives such as peers, schools, community, and work, to name a few. For the purpose of this study, the family system was chosen as a focus because families often are included in youth treatment and original peer groups are not. Although there has been a shift in thinking towards the inclusion of families in child welfare services over the past several years, Garfat and McElwee (2001) asserted that this ideology has not been translated into practice. Family systems theory has a basic premise that in order for an individual (in this case, a youth) to experience the effects of positive, long-lasting change, the individual’s family system must change also (Pitsch, Allerhand, & Blake, 1993). Ludwig von Bertalanffy is considered by most researchers to be the founder of systems theory in the early 1920s by advocating an organismic conception in biology that emphasizes the organism as a whole or system of interactions, rather than the individual parts of the system (von Bertalanffy, 1968). Bertalanffy believed that systems theory had broad potential in application to human systems (Broderick, 1990). Family systems theory suggests that changes made by members in the family system will affect and be affected by all members of the family
system in some way (Becvar & Becvar, 1999); as one part changes, other parts must change in response to that change. Another systems concept that applies to working with youth in residential treatment is that of homeostasis (system stability), in which a system—in this case, a family—is a self-regulating mechanism and will try to find a balance or equilibrium to keep functioning in a steady state (Koestler, 1967), often appearing to resist changes that the youth is making. This requires that as many members of the family system as possible be involved in treatment so that the family can adapt along with the youth and a new homeostasis can be developed. Otherwise, families may sabotage the youth's progress in order to reestablish the family's status quo. Fewster and Garfat (1993) offered the following as advantages in residential treatment according to the family systems model: "Practitioners acknowledge the complexity of human behavior as residents are not detached from the world of home, school, and community and they are not seen as the ultimate cause of the problem" (p. 40).

As far back as 1988, Dunst, Trivette, and Deal suggested that the role of residential treatment staff in empowering the family is rapidly emerging as a critical factor in promoting healthy functioning. Parents are regarded more as partners with professionals than as passive service recipients. Garfat (1990) noted that "including family members suggests to them that they have an important role to play in the helping process. Additionally, when involved in their child's treatment, the family may see themselves as resources rather than failures or causes of their child's problems" (p. 129). Barth (2002) presented compelling findings of fewer emotional/behavioral outbursts, increased family functioning, and greater permanency of outcomes for family-focused,
community-oriented residential programs that integrate aspects of family treatment interventions.

Families are being accepted for their knowledge and ideas about how to improve services to their children and how to strengthen the service delivery system (Osher, 2002). Osher also stated that growing numbers of participants in systems of care are viewing family-provider collaboration as a central component of relevant and respectful delivery of services.

For treatment to be successful, attention must be paid to the child’s context. In effect, the entire family has become the client in a very concrete way. Treatment centers are now often filled on a daily basis with visiting parents and siblings. Treatment must focus on both the overall family system as well as each individual in the system. Every family member’s beliefs, motivations, dreams, and aspirations are relevant to the treatment process (Goyette, Marr, & Lewicki, 1994).

Although family involvement is apparently valued, its meaning is unclear. There is little in the literature that describes what family involvement in treatment means and we do not know how much and in what ways families are involved. Because we know little about what family involvement in residential treatment looks like across various RTC programs and lack common definitions in the literature, it is difficult to measure its effectiveness. Before we can understand either the effectiveness of family involvement or which components of family involvement contribute to positive outcomes of treatment, we need to know how family involvement is defined and described. The current research
investigated definitions and components of family involvement in RTCs through interviews with staff of three RTCs in northern Utah.
CHAPTER II

LITERATURE REVIEW

Despite numerous advances in outpatient and home-based treatments for troubled youth with presenting problems that include serious emotional disturbances, substance abuse, and histories of violence, there is a renewed interest in residential care and treatment (Whittaker, 2000). This review of literature will discuss the history, definition, and current trends of residential care and specifically how families are included in treatment, including the benefits and barriers of involvement of families. At this time, there is little literature discussing how family involvement is incorporated in the many areas of residential treatment.

History of Adolescent Residential Treatment

The earliest interventions for youth-related problems took place during the scientific and industrial revolution, when society moved from simply survival mode to one of accumulation of possessions and wealth (Stone, 1979). This gave rise to the idea that the disturbing behavior of youth was a burden on society and their actions were labeled as “deranged” and “delinquent.” Institutions were created to isolate such youth from society and incorporated punitive and restrictive management measures (Stone).

Homelessness and abandonment of youth became another problem that came with industrialization and urbanization. Churches took the lead in providing care by funding orphanages, poor houses, group homes, and work farms. During this time, they operated from a strong hard work and piety ethic (Wilson & Lyman, 1983).
Beker and Maier (1981) noted that at the beginning of the 19th century, the notion of humane institutional care became an alternative to harsh punitive and restrictive attitudes, and a shift began from church-sponsored homes to privately funded ones. In France, the Villain’s progressive work house was founded and included treatment milieu (Redl, 1966). Milieu is defined as a type of treatment where the youth’s social environment is manipulated for his or her benefit. In residential placement, milieu is described as a highly structured therapeutic community (Trieschman, 1969), beneficial for people who display forms of disorders that hinder them from functioning in society. London opened the Philanthropic Society and in the United States, the Society of Relief of Poor Widows and Small Children was created (Zimmerman, 1990).

Children’s psychiatric units were created as a result of behavior disorders brought on by the encephalitis epidemic of 1919. Bellevue Hospital in New York, the Franklin School in Allentown, and Kings Park State Hospital in Philadelphia, Pennsylvania, opened in the 1920s, admitting youth with aggressive tendencies, but not displaying mental deficiency, brain damage, or psychotic behaviors (Zimmerman, 1990). In 1937, Bellevue Hospital was the first medically supervised unit exclusively for male and female adolescents (Curran, 1939). Most youth who were admitted to Bellevue were labeled delinquent and were referred by children’s court judges for truancy, stealing, fire starting, sexual offenses, and even murder (Zimmerman). Zimmerman also noted that housing at Bellevue was mixed-gender and offered group activities, psychodynamic services, and individual therapy to the residents. In spite of these services, the unit was fraught with problems of aggression and physical acting out by the residents and up until
1948, staff hid behind barred areas for their protection during riots. These dangerous
times did not lessen until the 1950s when young women were placed in their own units
(Zimmerman).

Through the early 1950s, most youth were incorporated into adult units although a
few institutions such as Bellevue cared solely for adolescents. In both England and the
United States, objections were raised about the suitability of housing adults and
adolescents together (Perry & Levy, 1950). Research by Beavers and Blumberg (1968)
began to show the efficacy of housing youth and adults separately. According to
Zimmerman (1990), all adolescent units, wards, and facilities were related to better long-
term treatment results. Durkin and Durkin (1975) noted that around 30 years ago, some
150,000 children and adolescents went to bed in approximately 2,500 child care
institutions in the United States including residential treatment facilities. A National
Institute of Mental Health (NIMH) survey found that in 1990, over 81,000 persons under
the age of 18 were admitted to residential treatment facilities (Zimmerman, 2001). In the
1990s, children and adolescents continued to be placed in RTCs in greater numbers and
more often than ever before (Perkins-Dock, 1990; Zimmerman). In 2000, the OJJDP
reported that 104,413 adolescents were housed in private and state licensed facilities.
Regardless of the fluctuation in the numbers over the years or the reasons, it is clear that
numerous children in this country reside outside the family home in RTCs.

Residential treatment facilities have been influenced by the social, economic, and
political contexts in which they operate (Yelton, 1993). In the 1960s and 70s, child abuse
reporting laws were deemed to be out of control, in part due to no overall national
standards. This confusion led to a large number of children being placed out of their homes, often inappropriately and for long periods of time. This alarmed the nation and in 1980, PL 96-272 was passed by Congress (Allen, Golubock, & Olson, 1987). Known as the Adoption Assistance and Child Welfare Act, this legislation provided sanctions for agencies that did not make “reasonable” efforts to keep families together and provide for timely judicial reviews of service plans. The act also stipulated consistency in the reunification of children with their families as soon as possible and termination of parental rights if children could not be returned home so that they could be eligible for adoption. In addition, Yelton of the American Association for Marriage and Family Therapy suggested that children should be safe and have permanent families and that community and state policies must reflect a family-centered philosophy.

Definition of Family Involvement

For this study, a family is defined as anyone who has a relationship with a child and is capable of caring for him or her (Fairhurst, 1996). There are alternative definitions of what constitutes a family; yet, for the purpose of this study, one that includes a child or children and that does not necessarily include biological relationships only will be used. Family participation gives the RTC a more complete picture of the youth and his or her family that can lead to an enhanced probability of the youth’s returning to his or her home with less time spent in the facility and a better chance of staying home (Johnson, 2000).
Current Trends in Residential Treatment

Mary Giliberti (2000) of the Bazelon Center for mental health law stated, "If you want mental health services for your child, you have to beat em up, lock em up, or give em up" (p. 30). Giliberti's study addressed how parents should never have to be asked to choose between getting mental health treatment for their child or to retain legal custody of the child. According to Giliberti's statement, for the last 20 years, families have been asked to do just that and despite the long history of this choice, the dilemma has received little attention.

In 1997, Bates, English, and Koidou-Giles noted that at the time of publication, there were no standardized diagnostic tools used when making placement decisions. The State of Utah is currently undergoing a philosophical shift in the treatment of youth (JJS, 2005). In order to more effectively meet the needs of youth, a graduated-sanctions model is being adopted that essentially means specific treatments for specific needs. A risk assessment is conducted on all youth and their scores determine which kind of facility can best meet individual youth's needs. For example, low scoring youth no longer will be placed with a higher scoring population. Each RTC has informed the State of Utah as to what area of intervention they feel best at providing and the youth are then matched to that RTC whenever possible. This new direction is intended to have the youth return to the home and community sooner by addressing only the most recent incidents that brought him or her into custody.
Family Involvement in Residential Treatment

There was a time in RTC professional history when the family was not seen in a positive light. Indeed, in the early days of residential treatment, the family was considered irrelevant (Fewster & Garfat, 1993). Then, when families did become relevant, it was negatively so, in that the family was seen as a problem, the enemy, the cause of all this pain and suffering of the child (Garfat & McElwee, 2001). To make this statement is not a criticism of earlier programs or approaches. Those programs and approaches simply reflected the prevailing attitude of the times RTCs were operating in. RTCs have now, to a great extent, arrived at a place where they see the family as a partner, a solution, a way of helping the young person who remains our focus (Garfat & McElwee).

Family involvement may have a positive influence on outcomes from RTC placement through the way providers approach service delivery with youth and families (Dauber, 2004). Currently, families are seen as increasingly integral to effective service delivery (Duncan, 2000). Residential youth care workers can be seen as “systems interventionists” (Peterson, 1998, p. 37) by orchestrating the symphony of the youth’s social and treatment systems, creating new experiences in both the child’s ecological and family interactive domains. Families are experts regarding their children and can provide valuable insights on family and child strengths as well as cultural and protective factors that affect the youth (Villiotti, 1995). When a family presents for milieu treatment, it is assumed that their present situation represents the culmination of a widely diverse number of factors that have melded together in a unique manner. Therefore, it is
imperative to fully explore the family's history, including the family's reaction to life events.

Thirteen years ago, Villioti (1995) noted that family participation in residential treatment was a relatively new concept. It is a philosophy of service that places family at the center of the service focus and decision-making, and considers the family as the "client." Villioti also contended that the family is the customer for change and that family treatment is based on beliefs that families are doing the best they can and that their resources can be built upon to bring about change. He also stated that most families are capable if given support and that it is their right to have a say in what happens with their children. Accordingly, Villioti suggested that honesty, give and take or two-way communication, and constructive feedback from all parties can lead to a greater collaboration in treatment. As Dunst et al. (1988) noted, the role of residential treatment staff in empowering the family is rapidly emerging as a critical factor in promoting healthy functioning. Parents are regarded more as partners with professionals than as passive service recipients.

Using Villioti's (1995) model, every family is encouraged to share its unique story. Parents are seen not as "bad" or "inadequate," but as individuals who have tried their best to deal with difficult situations. Parents are seen as doing the best they can with the personal resources that they currently have. There is no "good guy" or "bad guy." Instead, there are individuals who can be helped to develop the resources they need to be responsible for themselves and their roles in their families (Ainsworth, 1991).

Families can be an integral part of the treatment setting and plan. Durrant (1993)
argued for placing the whole experience of residential treatment within a different frame, one that would maximize the possibility of clients’ experiencing themselves as competent and successful, which may be the current task of RTCs. This situation is a constant struggle for RTCs, families, and youth who are housed in the facilities (Durrant). Durrant also noted that residential placement is often a “last resort.” As long as residential placement occurs within a context built upon ideas of parental failure and/or child pathology, even successful treatment will be made sense of in a way that will tend to reinforce those pre-existing beliefs (Durrant). The context of placement involves the way the adolescent and other family members view themselves in this situation (e.g., “we have failed,” “he/she is disturbed,” or “I am bad”) and the way residential staff view themselves and their roles in the treatment process.

Benefits of Family Involvement

The child welfare field has seen a shift toward an emphasis on family welfare rather than only on child welfare. This shift has resulted in greater recognition of the importance of biological parents to children in out-of-home care (Ainsworth, 1991). No literature was found regarding the similar importance of adoptive families. Approximately 66% of youth being released from RTCs return to the family home (Tatana, 1993). According to Landsman, Groza, Tyler, and Malone (2001), youth in family-centered care had shorter lengths of stay, were more likely to return home at discharge, and had better long-term stability than did youth without family involvement. Mann-Feder (1996) found that residents who ran away or sought early dropout had
considerably less family contact compared to non-dropouts, suggesting that families may have a positive effect on sustaining treatment.

Henggler and Borduin (1995) reported that long-term success for mental health, growth, and psychosocial development of children is intricately linked with family and social environments as well as with families who will manage and care for the children after treatment (Hartman & Laird, 1983). Additionally, the study found effectiveness in approaches that employ direct and indirect client and community services, and tend to be action oriented, multifaceted, preventive and remedial, culturally sensitive, systemic in nature, and comprehensive.

Garfat (1990) noted that families have years of previous experience with their children and can help child and youth care professionals understand what does or does not work. Their insights about needs, behaviors, and psychodynamics can be extremely helpful. Taylor and Alpert (1973) noted that family support emerges as a significant factor in determining post-discharge adaptation. Rzepnicki (1987) noted that parental commitment towards treatment goals and motivation to work over the course of treatment increased as family involvement in treatment increased. Additionally, Rzepnicki determined that caseworkers offered more appropriate and relevant services to families that participated in case planning. Incorporation leads the family to feel empowered, according to Worthington, Hernandez, Friedman, and Uzzell (2001). When parents are encouraged to retain, exercise, and fulfill their responsibilities while their child is in care, their role has not been usurped and motivation for reunification is increased (Tam & Ho, 1996).
Current Attitudes Toward Family Involvement

Much residential work has reflected ideas of child and family pathology or of parents’ being incompetent or deficient (Durrant, 1993). Durrant argued that operating from this viewpoint leads to staff seeing themselves as experts who operate upon the clients in order to fix or cure something. By not being involved in the process, families may leave treatment with the feeling of the immediate problem being solved but with their status as failures confirmed. Families have usually been well-schooled in notions of their own failure, incompetence, or pathology. This may lead them to look at the current placement as being simply more of the same and not really believe anything will be different. Durrant went on to note that this in turn creates the “self-fulfilling prophecy” for the family that they are failures and for the RTC staff that the family is unmotivated.

In an address to the National Council on Children and Charities, the Reverend Hastings Hart, a child welfare reformer of the early twentieth century, noted that “institutional life is contrary to child nature” (as cited in Whittaker, 2000). Whittaker also commented that over the years, residential treatment has been viewed as part of the problem instead of the solution regarding child and family problems. Child welfare’s challenge is to become family-centered, which includes assessment and adaptation of all the environments involving the family (Friesen, 1993). If the RTC is to be seen as a temporary support for families in crisis rather than as a substitute for families that have failed, it must engage families as full and equal partners in the helping process (Whittaker & Maluccio, 1989).

The paradigm shift toward family inclusion is showing signs of incorporation
into RTC programming and is the focus of this study. RTCs remain a prominent option for treatment of troubled youth. Many residential treatment facilities profess to utilize the family and incorporate them into the treatment process; however, time constraints, economic resources, and facility/staff attitudes are all variables that can inhibit family participation. Selected RTCs in northern Utah were used to seek better understanding of the extent of family participation in the treatment of adolescents.

Summary

Disturbing youth usually are referred to RTCs after community-based treatments such as outpatient care and out-of-home placement have failed (DeLeon, 2001). Residential placement provides for more intensive observation of behavior and functioning than is possible in outpatient settings, potentially leading to a better diagnosis and more appropriate treatment planning (Billick, 2004). However, RTC involvement often comes with a large financial and emotional cost to the family and society (NAMHC, 1993).

Although most RTCs offer group and individual therapy, family members have traditionally not been included in activities in many residential programs, and at times were specifically excluded (Rose, Duby, Olenick, & Weston, 1996). The OJJDP (2000) noted that care and treatment while in the RTC are focused on changing the residents’ perceptions of family coping but often without the involvement of other family members. A Surgeon General’s Report on Mental Health (1999) suggested that family participation is beneficial to obtaining and maintaining positive results and without family
participation during treatment, reintegration to the home often fails. An additional study noted that including the family into the treatment process appears to reduce the length of stay in residential treatment (Tam & Ho, 1996). Research and best practice (Gordon, Graves, & Arbuthnot, 1995; Kaplan & Sadock, 1991; Pfeiffer & Strzelecki, 1990) demonstrate the importance of family involvement in the treatment process for children and the positive effect on outcomes while in residential treatment.

**Purpose and Objectives**

Although literature suggests the importance of family involvement is in RTCs, we have no common definitions or descriptions of involvement, which are needed to better understand what components, if any, of family involvement are most beneficial to treatment of youth in RTCs. Family involvement could include time during initial assessments, phone contact, letters, occasional visits both on and off campus, and/or involvement in therapeutic treatment. It appears that each RTC defines family involvement on its own. In order to further study the effects of family involvement in residential care, we first need to better understand how RTCs are defining and describing family involvement, and how they are incorporating it into their treatment programs.

At present, no clear consensus from the perspectives of staff exists in the field with respect to the locus of family engagement (in-home, agency-based, community-based); the focus of the engagement (family visits and other contact, family treatment, counseling, education); the format (telephone contact, face-to-face visits, face-to-face or phone therapy); the knowledge and skills required of the family worker; or the
sequencing of interventions (Whittaker & Savas, 1999). The purpose of this study was to learn to what degree and how the RTCs in the study involve families in youth treatment. The objectives included learning the degree to which staff (administrators, therapists, and direct care staff) from three residential treatment centers in northern Utah incorporate families in the treatment process of served youth and how different levels of personnel view family participation in their centers by interviewing participants from each of those levels.

Specific questions for this study include:

1. How are families involved generally in residential treatment?

2. How are families involved in therapy?
CHAPTER III

METHODS

Design

This study used qualitative data to understand the extent of family involvement in RTCs. According to Trochim (2005), qualitative research seeks understanding by using the study’s participants’ points of view as the context and is developed through concepts, insights, and understanding from patterns in the data, rather than analyzing data through preconceived hypotheses or theories. The current research is exploratory in nature and addresses perspectives on family involvement from workers in the field of residential treatment. Data were gathered through interviews of RTC staff (administrators, therapists, and direct care staff) about their perceptions regarding the definition of family participation in youth treatment at their facilities to expand the researcher’s perspectives and understanding of this participation.

I have been working in the field of Juvenile Justice Services for over 15 years in capacities of secure care, detention, shelter care, observation and assessment, and currently, case management. This time included several years with the Department of Child and Family Services in youth services and family preservation. The years of personal experience with youth and families has led, in part, to the interest in this study. Family inclusion and participation has been integral in my involvement and my curiosity was to explore how staff in RTCs viewed the situation.
Sample and Procedure

Residential treatment centers typically include three levels of staff. Administration guides the philosophy and often mandates the atmosphere and direction of the facility along with expectations of the employees. Depending on the facility size, there may be one or several therapists on staff with each being responsible for a number of youth. Direct care staff are the day-to-day, shift-to-shift employees who have constant and direct contact with the housed youth. Participation from each level of staff was recruited to gather an overall picture of perspectives regarding family participation in treatment for youth in RTCs.

A convenience sample of three RTCs in a close geographic area in northern Utah was selected to participate in this exploratory study. The chief criterion for inclusion in this study was a statement from the director of any degree of “family involvement.” Interviews included one person from each job title in each RTC; that is, one administrator, one therapist, and one member from the direct care staff from each RTC were interviewed to provide perspectives from all levels of staff. Direct contact was made with the directors of a male substance abuse program, a male sex offender program, and a conduct disorder program for females. Contact resulted in agreement for administration, therapists, and direct care staff to participate and support the study.

The three facilities all house youth for different reasons and do so in different locales within the state of Utah. They all present with physical similarities in structure. As each facility is entered, there is a day/family room where the youth can visit, read, watch TV, interact with other youth by playing games, and hold group meetings. The
bedrooms generally have at least two to four beds and each resident has a personal storage place. There is a communal kitchen and dining area and the youth are encouraged to assist in the cooking and cleaning. The facilities vary in size and one program has separate educational classrooms while the other two hold class in an area adjacent to the day room. All three programs try to display a family-style atmosphere. Many RTC staff say that all the youths’ needs are met, but not all their wants.

Each participating RTC was supplied with enough packets for all staff in all categories. Packets were coded by RTC and the list connecting codes and RTCS was destroyed after the interviews. Packets included a cover letter explaining the study and each packet contained a form for potential interview participants to return to the researcher with contact information, which indicated their willingness to participate in an interview. The request was for participants to meet with the researcher and discuss their attitudes, beliefs, and insights about involvement of families in the RTC. An explanation of what to expect along with the informed consent and contact phone numbers for questions or concerns included in the packets (see Appendix for materials in the information packet).

The first person to respond from each level from each treatment center was interviewed for the study. I gained a sense that each wanted to promote personal beliefs of how to enhance the RTC process. These nine workers displayed passion for what they do on a daily basis and, referring back to Freud (Aichorn, 1935), they fall into the categories of governing, teaching, and healing. The sample consisted of an administrator, therapist, and direct care staff person from each center. All nine requests for participation
were responded to positively and all surveys were completed, both demographics and questions. Two male and one female administrator, two male and one female therapist, and two female and one male direct care staff participated in the interviews.

Interviews were conducted face-to-face. To address the schedule and comfort of the participants, they were offered the choice of near or on the respective facility. All chose to participate in interviews away from their facilities. The researcher answered questions about the study and participants signed informed consent forms. For their time, participants were offered $5.00 vouchers for redemption at a local restaurant. Of note, no participant accepted the money, stating they were happy to provide information about their facility and business. Facility administrators ranged in age from 29 to 36 years with 2 to 14 years of experience in the field (see Table 1 for sample demographic information). All were Caucasian and grew up in the western United States. Two had graduate degrees and one a bachelor’s degree in human services-related fields. Each administrator was directly involved with families in some form: gathering information, answering questions, arbitrating grievances, or clarifying situations, and all were available to parents through office and cell phones or e-mail.

The participating therapists ranged in age from 26 through 48 years with 5 to 10 years in the field. Each held a graduate degree in social work or mental health. Two of the three therapists had children and all had grown up in Utah and Southern Idaho. Time spent actually working with families averaged seven hours per week either in face-to-face sessions or conference calls over the phone.
Table 1

Sample Demographics

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<tr>
<th>Variable</th>
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<th></th>
<th></th>
<th>FCD</th>
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<tr>
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<td>DCS</td>
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<td>Erik</td>
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<td>Jason</td>
<td>Julie</td>
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<td>UT</td>
<td>UT</td>
<td>UT</td>
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<td>6, 9</td>
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<td>2, 4</td>
<td>18, 20</td>
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(table continues)
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<th>Variable</th>
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<th>DCS Becca</th>
<th>Admin Marie</th>
<th>Therapist Erik</th>
<th>DCS Jared</th>
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<td>After school</td>
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<td>Resource ed., research in behavioral pharmacology</td>
<td>Speech therapy with youth</td>
<td>Hospital psych unit, school counselor, university counselor</td>
<td>Motherhood</td>
<td>Unit supervisor Benchmark hospital</td>
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<td>N</td>
<td>Y</td>
<td>N</td>
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</tr>
<tr>
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<td>N</td>
<td>N</td>
<td>Y</td>
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<td>Y</td>
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</tr>
<tr>
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<td>40+</td>
<td>40</td>
<td>40</td>
<td>30</td>
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</table>

*Note. MCD = Male Substance Abuse; FCD = Female Conduct Disorder; MSO = Female Sex Offender*
Direct care staff ranged in age from 23 to 25 years and were born either in California or Utah. One held a bachelor’s degree, one was attending college and working toward a bachelor’s degree, and one held a high school diploma. The DCS participants had been working in the field from seven months to two years. Each participating administrator, therapist, and DCS was involved in ongoing training but none specifically in family relations.

Face-to-face interviews were audio recorded and transcribed by this researcher, and the informed consent forms were kept separate from the data. All tapes were destroyed after transcripts were verified. Transcripts and informed consent forms are kept in locked storage at the Family Life Center at USU. Exemplar reports do not include identifying information.

For each facility, administrators, therapists, and direct care staff participated in individual and private explorations through questions regarding family participation in the overall routine of the center. They also answered questions pertaining to the therapeutic involvement of families. All USU Internal Review Board mandates and regulations were maintained. The IRB of USU reviewed and approved this proposal.

Instrument

Qualitative research uses the researcher and other people as the “data gathering instruments” and, therefore, bias-free inquiry and observation do not exist because of the personal values of the researcher that are present and that guide and influence the data collection and analysis (Denzin & Lincoln, 1994). Thus, the researcher must be candid
about personal values, biases, and judgments (Creswell, 1994) and must state how he or she influences the process.

In my current capacity working in the field of Juvenile Justice Services and an employment history with the Division of Child and Family Services in Utah, I have developed a personal view of youth and family interventions. At present, I work a great deal with youth who have been placed in RTCs and their families and as such, have a curiosity about how and the extent to which families are involved in the process of residential treatment. I have been trained as a marriage and family therapist and believe that frequent therapeutic involvement and collaboration with families is beneficial for positive outcome of youth in residential care and I am curious about the perspectives of those who work in the RTCs.

An interesting and important task of this study was to remind myself that I am gathering data for understanding and not attempting to influence anyone in the field. I provided information to participants about myself and emphasized that I was truly interested and curious in their experiences. A semistructured interview allowed each participant to share experiences, insights, and thoughts from their own perspective. The time for the interviews averaged 35 minutes. The demographic portion of the interview provided information about factors that may have influenced perspectives such as education, gender, having children, and how long the interviewee had been working in the field. To gain information related to the research questions, open-ended questions were generated (see Appendix) by this researcher. During the interview, clarifying, probing, and additional questions were asked to provide sufficient data to answer the
research questions. It is notable that all participants believed that it is important for families to be integral in the treatment process through visits, phone conversations, or letters, and especially in family therapy sessions. None of the demographic variables appeared to provide any difference in the family participation philosophy.

For uniformity, the interview structure was the same for participants in each category (administrator, clinician, or direct care staff). A practice interview with a coworker who was not employed in an RTC provided information regarding the length of time potentially necessary for the interviews as well as ideas for refining the interview questions and format. The study searched for personal descriptions and clarifications of family participation in the field of adolescent residential treatment. Additionally, personal views of treatment and suggestions for improved family involvement were sought from each participant.

Analysis of Data

The interview process gathered data to help the researcher better understand the participants' experiences. In an effort to create a picture of what family participation in RTCs looks like to participants, steps described by Biklen and Bogdan (1982) were used. Interview transcripts were read twice by the researcher. The first reading was for general content and an overall sense of the data; the second reading allowed the researcher to begin to identify themes from the data. First, general categories were generated. From these categories, evaluation of patterns and connections among the categories were sought.
A chart (see Appendix) was developed for coding the data. Verbatim quotes from the interviews were placed in the first column and primary codes according to interview questions were placed in the second column. A third column allowed the data to be coded for a research question that did not directly fit the interview question. The researcher's major advisor reviewed transcripts and the coding table and independently developed codes. The researcher and advisor met to discuss and resolve discrepancies, check for reliability, plausibility, cohesiveness, and internal consistency. Data are reported by research questions; categories, connections, and exemplar quotations are provided.
CHAPTER IV
RESULTS

This chapter presents the results of data analysis for the research questions. A summary of the analyses of qualitative data and response examples are presented. Nine participants from three residential treatment centers in northern Utah were interviewed regarding family participation in treatment and how that participation was viewed by the participants. Participants are identified through pseudonyms.

Research Question 1: How Are Families Involved Generally in Residential Treatment?

The question of how families generally are involved in residential treatment explored the degree to which participants reported that residential treatment centers in northern Utah incorporate families in the day-to-day lives of resident youth, and formulated definitions of family participation in the field. All respondents acknowledged that family participation and involvement in the respective centers was observed, supported, and practiced. More specific responses fell into categories related to (a) the kind of involvement, (b) the frequency of contact, (c) the kind of people who had contact, (d) the kind of restrictions to contact, (e) obstacles to family involvement, (f) the participants’ general thoughts about family involvement, (g) the advantages and disadvantages that participants perceived, and (h) participants’ suggestions for enhancing family involvement.
Kind of Contact

Every respondent reported that youth had contact with families through letters, phone, face-to-face visits (on and off campus), family therapy (in person and over the phone), and overnight home visits. Drew commented, "We attempt to point out the importance of the family [involvement] even when their child is out of the home, and ask them to be supportive." Other reported contact consists of meetings at the time the child enters the center and quarterly team meetings with therapists and case managers.

Frequency of Contact

The frequency of contact varied among the programs. One program had no time constraints and wanted to start family participation right after the resident arrived, barring safety concerns such as violence or drug-abusing parents. Another program prohibited contact for two weeks after the youth was admitted to the center. The third program had a 21-day waiting period for family visits, but families were encouraged to make contact over the phone and through letters. Participants from every program stated that they made modifications to these policies for emergency situations and special circumstances.

Once the contact criteria for each facility were met by the residents, unlimited letter writing was encouraged. Letters could be read by therapists for any suspected safety or therapeutic concerns. Phone contact could be monitored for the same reasons and ranged from bi-weekly to weekly; family visits were available on a weekly basis. As youth moved through the levels of advancement in the program, family time could increase both on and off campus.
Who Participates?

Participants from each program reported a range of answers about who was considered "family." All reported that immediate and extended family were considered with parents being most prevalent followed by grandparents and siblings, then aunts, uncles, and cousins. Religious leaders, neighbors, and former or future proctor/foster parents were mentioned, also. The creativity and willingness of every program is evident by Marie's statement: "We will use just about anyone who cares about the youth and is willing [to be involved and participate]."

Restrictions to Family Contact and Involvement

Safety. Participants in all three agencies commented on safety issues and concerns as paramount and that these could lead to restrictions to family involvement. This included safety to self, family members, other residents, and staff. Safety also involved risks of running from the program or from home while on a visit, damaging property, sneaking contraband, and use of illegal substances. Alcohol consumption by family members or dangerous situations in the family were also viewed as restrictive to family contact.

Progress level and time. Even though literature about including families in residential treatment does not advocate restricting visits and communication, all of the study participants reported that the residents' individual levels of progress in treatment indicated the level of family visits. The rationale for this was to maintain "program integrity" where all the youth are treated the same for understanding how personal accountability fits into the guidelines of the program. Youth who were in higher levels,
which usually indicating compliance with treatment and better behavior were generally
allowed more family contact, particularly onsite and home visits. Youth who broke rules
of the facility were typically placed in lower levels and often lost family contact
privileges. Each program varied in how strict it was with these restrictions, yet all
participants expressed some ability to be flexible. Family emergencies, unforeseen
developments, or resident illness where pointed out as examples of exceptions to the level
restriction. Time was another factor. That is, family involvement was reported to be more
restricted during the early weeks of a youth’s stay in the facility.

Obstacles

Each variable described above was viewed as impacting whether and how often a
family could visit and participate in onsite therapy sessions. After safety, progress level,
and time, nearly all participants spoke of the family’s distance from the facility as an
inherent difficulty for family visits. Finances were also reported as an obstacle and
included time lost from work, childcare costs, and travel expenses. Other factors that
served as obstacles to family involvement as reported by study participants included
desire for contact (both families’ and youths’), the family’s attitude in terms of desire to
be helpful, family members’ health, youths’ acting-out behaviors, court orders,
incarceration of parents, and restrictions placed by case managers. Nick summed up his
program’s attitude regarding obstacles this way: “We want the participation and we know
our business well enough to know these situations often come up. With time,
communication, and usually a lot of work by the therapist and staff, contact gets started
up again.”
Participants’ General Thoughts about Family Contact

Participants agreed that family contact was important. Erik summed up the predominant views with the comment, “I don’t think that there is ever just the child as the issue. There is a whole system at home. I think there is a whole system problem that needs to be resolved.” Every participant from direct care staff to administrators was generally supportive and positive toward involving families in the youths’ treatment. A “sub” question or prompt was, “Do you ask the family to participate?” Becca commented, “Yes we do; you can’t get what you don’t ask for.”

Participants’ Views on Advantages to Family Involvement

Responses from participants about advantages to family involvement included the youths’ knowing there is love waiting at home and that the family is trying to make modifications so things will be different in the future. Direct statements included, “There is no replacing support and encouragement from a family member” (Jen), “The family benefits so much if they participate” (Julie), “I think overall it helps when the family does their part and supports the youth and the program” (Jason), and,

They need the information on how to deal because a part of it is, for some of them, to admit, or even accept and cope with the fact they were in or are a part of the problem that the kids get into. (Drew)

These types of comments came from participants from all three programs and all levels regarding advantages to family involvement.

All direct care staff commented that managing youth was easier when contact with families was positive in nature. Watching families interact helped staff understand a
youth’s family context: “Family contact provides the ability to assess the influence of the family on the youth” (Jared).

Participants’ Views on Disadvantages to Family Involvement

The comments and views of participants regarding disadvantages to family involvement varied by how long they had been in the residential care business and whether they had experience working in the “trenches” with youth. Direct care staff, those most closely involved with residents and who spend the most time with them, often voiced more disadvantages than did administrators or therapists, who had less sustained day-to-day contact with the youth and who did not have to deal with acting-out behavior as much. Julie said, “Some days, the visit or therapy session doesn’t go well and it ruins [the youth’s] whole day. They can lose a level and struggle in therapy. Whatever happens, direct care staff are the ones left to manage the fallout.” Participants noted that parents or other family members were part of the conditions that brought the youth into custody and because they are not “in a program,” the youth feel angry and hurt. Participants noted that youth were often depressed and homesick and that those conditions impacted other youth in the program. Direct care staff observed that if family members and the youth were angry at one another, family involvement could be counterproductive in their view.

Therapists, who had less contact with youth than direct care staff, did not mention youth behavior as something that was a disadvantage to family involvement and contact. All three therapists commented that they could attempt to work through any issue and
viewed obstacles as opportunities. Administrators admitted disadvantages, though fewer than direct care staff. Nick said, "Participation can be difficult at times, but even with the down sides, we feel family contact has many more positives than not."

*Suggestions for Family Involvement and Contact*

Participants had several suggestions for improving family involvement in residential youth treatment. Marie stated that she seeks out new options and alternate ways of doing her job based on the current literature, and provides trainings for all staff members. Additionally, she seeks input from other programs regarding how diverging ideas and concepts are working for them.

Participants across different levels of staff had many suggestions that ranged from ideas for working with the youth to more staff training and administration involvement, and, at the same time, encouraging and helping families be involved with their children. Some DCS suggested that more communication between the program and the families would be helpful. For example, Jared stated, "There could still be a lot more communication from administration to the family; I think that is a weak spot."

Encouraging families to see the benefits of their involvement in treatment and frequent communication with the youth were seen as important by all participants.

Other participants focused on communication between the youth and their families. Jason offered the following observation: "[Youth go] off of behavior, so help . . . [them] see sooner that better behavior results in more contact." Erik noted, "The family needs to make a more concerted effort to visit. Some families are really good at it and
others just make up excuses and they don’t show up as often as they could.” Some participants had specific suggestions such as, “Help the family maintain communication with the boys and have [the boys] call home when they are ready or encourage them when they may not be ready,” and, “Encourage [the families] to write and call as often as possible (Julie).” As Becca suggested, “Tell the youth how so and so is doing, tell [them] what’s going on at home, and tell [them] how [their] brother is doing in school.”

Many participants encouraged understanding of the difficulties and dilemmas that youth in residential care and their families face. Jen commented, “When the family visits, they get to see the progression, see how things are going, [but] it is stressful for the family to have their child here,” and Jason noted, “The child is gone for such a long time, I can’t imagine how hard it would be—it would be hard” and “I think it is important that we create a family-style atmosphere.” Encouraging positive attitudes was seen as important. Jason suggested, “Try to help [the youth] keep a positive outlook—let them know it’s a good family unit that is waiting for them. Try to find the motivators and keep them positive.” Jen said, “I would say, ‘be supportive,’ as it helps them with the treatment they are doing and the program they’re in, and keep an open mind.”

Research Question 2: How Are Families Involved in Therapy?

This question moved from family participation overall in the centers and focused on philosophies and concepts revolving around the therapeutic process in particular. Responses fell into areas related to family (a) participation in decision-making about the youths’ treatment, (b) participants’ perceptions related to helpfulness of family involvement in treatment, (c) restrictions to family participation in treatment, (d)
advantages of and obstacles to family participation in treatment, and (e) suggestions that
participants had for enhancing family participation in youth treatment.

*Family Participation in Treatment*

*Decisions*

Participants were asked, “Do you involve family members in decisions about
treatment?” Nick replied:

Absolutely we do. In our facility, family contact is made from one of our
therapists shortly after the youth’s arrival to ask for information and input that
could be beneficial. From an administrative viewpoint, the family generally has
some sound advice.

All three therapists in the study talked about obtaining information about the family
history, medical needs and requirements, friends and associates the youth is involved
with, school performance and attitude towards education, and what the family feels helps
the most. All therapists responded by commenting that families need to be “listened to
and heard.” The belief is that not all ideas can or will be followed, but being part of the
process helps resolve confusion or differences between everyone. A direct care staff
participant made the point: “Let the family give input because that can bring everybody
together sooner.” As Erik observed, “We want them to work with us and not against us
and parents are no different than anyone else: they want to be heard.”

*Family Participation in Treatment*

According to Jason, “From [my] experience, I can think of very few situations
where not participating benefits anyone.” The predominant view from the participants
was that families should attend as many therapy sessions as possible. Julie commented,
“Well it only makes sense because these kids are leaving us and going to the same place they came from.”

*Are families asked?* Every participant reported that families are invited to participate in youth treatment. “An effort from the family is encouraged from this program,” stated Drew. Administrators and therapists were most emphatic, with responses including, “Absolutely, yes, of course they are” (Drew), and “Without question, they are asked” (Erik). Direct care staff were nearly equally enthusiastic by stating, for example, “I’m sure they are” (Jared) and “They are” (Becca).

*How do families participate?* When asked how families participate in youth treatment, Erik responded, “Hopefully, and for the most part, in-person sessions on a weekly basis if not more often.” From therapists’ perspective, important aspects of family involvement in treatment included taking ownership of everyone’s part of the situation, showing a willingness to support both the youth and the program, assignments, honest expressions and openness to each other, participating in team meetings, and maintaining contact if they physically could not attend sessions. Conferences calls and letter writing were often mentioned for times the family could not be present in sessions or to enhance treatment between sessions.

*What happens during the treatment participation?* What occurs during therapy tended to vary depending on numerous variables. A summary would include learning new and different ways of managing the areas that brought the youth into the program. Families and youth learned about communication techniques, social skills enhancement, educational efforts, knowledge about family rules and rituals, how to view situations
differently, self-knowledge, and empathy towards others as main goals that therapists
tioned. Erik said, “If we can make a small change in one area, it often opens
windows and doors to make changes in other areas, too.” “Gaining trust is one of our first
jobs,” commented Drew. When prompted, every participant stated that there needs to be
trust, and Drew noted, “Without trust, we don’t have much.”

Restrictions to Family Participation
in Treatment

Most direct care staff were uncertain as to what might be obstacles in therapy
sessions yet did mention safety concerns for everyone involved. Safety and security are
always of utmost importance in the field and can outweigh hoped-for involvement in
treatment and program participation. The level system can be both a benefit and a
detriment in the process. There are times when a youth and their families need to be held
accountable for certain behaviors and involvement in therapy. Some participants talked
about whether it is best to withhold therapy until level criteria are reached or to involve
families to help the process proceed more quickly. Again, flexibility and guidelines were
viewed more important than strict rules. Distance, money, jobs, other children, court
orders, and health were issues that could restrict contact in general and participants
commented that efforts should be explored to accommodate them. Administrators were
supportive of the therapists’ judgments as to what might restrict involvement in therapy
and all made comments such as Drew’s: “[They can] just let me know or keep me up to
date regarding the positives versus the negatives and I will provide support where I can.”
Advantages to Family Participation in Treatment

Advantages to family participation in treatment were presented in three sub areas: for (a) the youth, (b) the families, and (c) the staff and center.

For the youth. Therapists commented that family participation in treatment helped youth gain knowledge about themselves and to view their situations differently. "We are not born with an empathy gene, so helping the youth gain that is a big part of what I try to get across to the youth," commented Erik. A typical comment from administrators' viewpoints was, "[We try] to help them gain the strength to return home" (Jason). Direct care staff made comments such as, "We try to help the youth stay on track with the gains made in therapy" (Becca).

For the family. Julie noted that the "family gets to see the gains and progress made by their child; the family can see we are doing the best we can so they can try as well" through participation in therapy. Administrators noted that the more the family can work together, the sooner they can be reunited and get on with their lives "without us in it." Erik spoke of changing "how the family system" works and finding positives in the home instead of seeing only negatives as a plus to the treatment process.

For the staff and center. This question brought about numerous responses from all three levels of RTC care. Administration saw "learning, passing along information to all areas to keep everyone informed and knowledgeable." All therapists wanted information and insights from direct care staff and that seemed to have the effect of inclusion and involvement that benefitted the whole program. In every program, direct care staff commented that their information and insights were sought and that administrators and
therapists valued them and what they had to offer. All three direct care staff commented they felt more a part of the program when asked for input and given direction by the therapists regarding youth and family treatment. If a youth was given an assignment or staff were given information regarding the family, staff could follow through with the assignment and with knowledge.

Obstacles to Family Participation in Treatment

Responses to this portion of the interview are divided into four areas. These include obstacles as they affect (a) youth, (b) families, and (c) staff and centers.

For youth. Staff thought that there were disadvantages to family participation in treatment “when the youth is just not on board with what we are trying to do” (Julie). Marie noted, “Sometimes, the youth blames the family and works against anything offered in therapy.” Safety was mentioned by every administrator as a potential negative for the youth, the family, and for the staff and center. All therapists commented that they were willing to work through just about every scenario and had the insight to “shut down” or lessen family participation if warranted. Direct care staff all noted they could tell when a session did not go well and knew the youth would need enhanced observation and possibly intervention to “get through the feelings.” It appears that all levels of study participants were reluctant to label difficulties as disadvantages. Rather, they seemed to be seen as opportunities or challenges.

For the families. Obstacles towards participation in treatment for families included distance, money, time, embarrassment, lack of willingness, family issues, health, and job
restrictions. Court orders and case manager concerns were also noted as barriers. These are similar concerns that participants mentioned in terms of family contact in general.

*For the staff and centers.* Direct care staff, administrators, and therapists all agreed that volatility, negativity, hurt, anger, disappointment, and frustrations are inherent in any center and yet could be reframed and viewed as challenges to work through. Participants at all three levels commented that tempers and behaviors could be better managed in therapy sessions than having direct care staff try to manage the situations as well as other activities during a visit to the program.

*Helpfulness of Family Participation in Treatment*

All participants commented that family participation in treatment, in general, is helpful to the youths’ progress. Participants were prompted, “Even with all the barriers and concerns we have spoken about, you still feel family involvement in treatment is worth it?” Not one participant felt family involvement in therapy should be removed from programs. Participants from all three programs expressed an endorsement of involving and including the family in all phases of the youths’ placement. Administrators such as Drew, in support of family involvement in treatment, commented, “Overall, it helps [toward meeting goals] when the family does their part and supports the youth and the program.” Several direct care staff noted that family involvement seemed to enhance self-confidence on the part of the youth and greater honesty regarding issues that brought them into placement, which also helped them meet their treatment goals.
Suggestions About Family Participation in Treatment

Participants' enthusiasm for family participation in the treatment of youth was evident in their comments. They suggested finding ways to help the family participate more often either through technology or, possibly, meeting "half way." Two of the three therapists (Erik and Jason) suggested more time with families, smaller case loads, and family weekends "to help families see they are not alone in this experience." Jason made suggestions for therapeutic components of the program such as, "more individual sessions provided at an earlier stage" and "Include the family sooner and provide more sessions." Jen suggested, "Provide family systems theory training for administration and staff and more training for staff on interacting and/or diffusing certain situations."

Participants also suggested enhanced communication from the program to the family through newsletters, internet availability, and therapy using technology such as cameras if security concerns could be taken care of, and having the ability for therapists to visit family homes. Jason commented, "The possibilities are endless for family inclusion and participation [in therapy], but money and all the other variables that go along with our society tend to get in the way." Becca said that it is important for families and youth to keep writing letters: "If they can't drive from Logan or Ogden or other faraway places, let the girls know you love them and that they are doing well."

From the demographical data about the participants, it appears there were no differences among participants with respect to experience, age, or education that impacted the overall attitudes toward family participation. Additionally, unexpected findings that came out in the interviews included the utilization of new technologies and
concern for the environment. Video conferencing and program contact through the internet could be incorporated and confidentiality precautions would be met through passwords or other enhancements that come along. Julie noted that technology could save everyone a lot of time and money and that it would be "environmentally" sound as well.
CHAPTER V
DISCUSSION

This research project elicited comments from administrators, therapists, and direct care staff in residential treatment centers about their opinions related to family involvement in the care of resident youth. Overall, participants from all three centers expressed active attempts and positive feelings regarding family participation in both center activities and therapy. Only the direct care staff from the RTCs reported any negative thoughts regarding family participation. Overall, every participant stated that family involvement in the program and therapy was more positive and beneficial to treatment outcomes than not. Participants provided suggestions for improving family involvement in the overall treatment of youth.

Research Question 1: How Are Families Involved

Generally in Residential Treatment?

Participants noted that involving families in residential treatment was promoted and supported in all of their programs. Family participation, according to all participants, included letters as the most used form of contact. Through letter writing, families could stay involved with youth between visits or phone therapy sessions. Many times, families cannot visit in person and all participants suggested that letters could be bridges to maintain a sense of connection. Phone contact was the second most mentioned form of contact, yet restrictions, such as monitoring, were generally placed on the usage. The current level of the youth, youth and family attitude, and the need to monitor calls needed
to be taken into consideration. Family therapy sessions, both onsite and over the phone, were also promoted.

The level system subscribed to by all participating programs regulated the frequency of contact between youth and families. Of note is that participants from every program viewed restrictions as guidelines, not strict rules, and stated that restrictions were modified as best as possible to fit situations. The goal is family reunification and it participants suggested that guidelines, not rules, best serve that purpose. To substantiate the guideline approach, each program was flexible in terms of who they considered family. Parents, grandparents, and siblings were obvious participants; yet, to meet the youths’ needs and best interests, just about anyone who was a positive person in a particular youth’s life and was available could be involved and participate. Keeping the family connected during out-of-home placements was seen as an integral part of the treatment process by each program.

While maintaining awareness of the importance and benefits of continuous family involvement, participants did mention times when restrictions for involvement were put in place. Safety concerns were noted by all, and included the youth, family members, and staff. Participants also noted that the treatment level of the youth impacted the amount, the time, and the kind of participation they had with their families. All commented on the benefits of participation and mentioned that maintaining program integrity with family participation in treatment was worth the extra efforts involved.

Every participant interviewed saw family participation as enhancing the eventual return of the youth to their homes and stated empathy towards all parties. This
understanding was a factor in creating an atmosphere where family participation was encouraged. Very few negatives were seen as insurmountable. Safety was the major concern for everyone, yet all participants commented that when safety concerns were resolved, involvement could recommence.

A study by Jansen, Schuller, Oud, and Arends in 1996 found that involving the family was beneficial to successful outcomes in RTCs and the comments and insights gathered from the participants of this study seem to be in line with the current literature. Family reunification studies conducted by Mech (1985) and Tam and Ho (1996) showed a strong correlation with family inclusion in the process as well. The Adoption Assistance Act of 1980 emphasized the continuity of child-parent relationships and thus the use of visitation as a permanency intervention increased after the Act's passage (Hess, 2005).

My personal views regarding family involvement are very much biased towards inclusion as well; therefore, these findings were reassuring and optimistic to me. My history of employment with the Department of Child and Family Services, Juvenile Justice Services, and life experience have led me to a strong belief in the influence and importance of family in youth treatment. Additionally, my recent participation in a marriage and family therapy graduate program has strengthened and solidified family concepts that were reported by participants in all three programs.

Research Question 2: How Are Families Involved in Therapy?

Participants observed and commented that hopes for family reunification are greater when families are involved in the treatment process. Asking for the family to
participate was reported by participants from all facilities along with wanting families to be involved in decisions about treatment. The number and kinds of treatment decisions that participants reported families were included in varied, yet all participants wanted families to feel important and involved in the process. All participating therapists viewed family involvement as helping toward faster progress toward therapeutic goals.

Therapy involvement included both phone and face-to-face sessions for family therapy; all participants reported that face-to-face meetings were generally optimal and should be facilitated whenever possible. Participants stated that twice weekly was the ideal, yet occasional sessions were reported as better than none at all. Of interest was the insight by two therapists that phone conference calling was better than no therapy and even observed that it could oftentimes be more productive than face-to-face sessions.

Family participation in therapy has many of the same limitations regarding distance from the program, finances, court orders, family situation, and so forth, as did general participation in the program. Safety was mentioned as the major concern for therapy, yet all three therapists reported that flexibility in a therapeutic environment lessened the concern.

Every study participant said that the advantages of family therapy to the youth, family, and program offset the perceived problems and barriers. In addition, family therapy was promoted by administration in each of the programs. As with general participation, the therapeutic involvement was viewed with few negatives. Direct care staff spoke of the fallout from difficult sessions that they were left to manage, yet still looked at these times as opportunities to work with and assist all parties.
Suggestions from study participants included internet video sessions with adequate confidentiality security. This suggestion moves into the technology realm and shows promise. Even knowing the difficulties involved, this was the number one suggestion for family involvement in therapy for youth. Financial assistance for the families with travel, housing, and structured activities when visiting their children was a common suggestion from both administrators and therapists, showing there are alternatives to standard practice being sought.

All that has been gathered from the literature and through the information-gathering process for this study has solidified and reinforced my personal thoughts regarding including the family in the process of residential placement and therapy. I worked at the beginning of my human services career in a secure juvenile facility and almost every employee there commented that the “kids do great here and now we send them back to the same environment without any changes.” It could be frustrating; yet, that was all we, as an agency, knew at the time. We believed that things would be better for the youth if their families were involved in their treatment and made changes also.

My experience with family preservation while with the Division of Child and Family Services was a great influence on me as well. The state of Utah and DCFS were involved in a law suit at the time and vast changes were ongoing within the agency. There were numerous trainings for division staff regarding family inclusion during the time of out-of-home placement of a child, whether RTC or foster care. The trainings stressed the importance of working with the entire family and how each family member played a role in resolving problems, explored the everyday workings of the family, and
emphasized treating all with respect and dignity. This philosophy produced what I felt were noticeably enhanced outcomes for family reunification if a child had been out of the home.

I have held several positions within the human services field and with each position and from my perspective, including the family in the treatment process appears to have benefits surpassing noninclusion. I had believed that RTCs do not encourage family involvement in general or in therapy. I currently oversee youth in out-of-home care and am, again, personally encouraged to see that programs ranging from proctor care, residential treatment, wrap-around aftercare services, and secure facilities include families in the treatment process. I agree with this synopsis: For treatment to be successful, attention must be paid to the child's context, particularly his or her family. In effect, the entire family becomes the client and the focus must be on both the overall family system and each individual in the system. Every family member's beliefs, motivations, dreams, and aspirations are relevant to the treatment process (Goyette et al. 1994). Strengthened families are thus more able to help youth with other aspects of their lives, including peers and school.

Family inclusion is not a new concept yet has been re instituted in the field of residential placement and treatment. In his first speech as the Director of the Child Welfare League of America, Carl Carstens noted:

If family ties are to be conserved and family responsibilities insisted upon, systemic attention is needed in dealing with the families of children for whom we are caring. . . . When the child comes into care, the family comes with it. . . . By such means reconstructive and recreative work with families becomes possible, the child does not stay away from his home any longer than is necessary, and there is ample time for his adjustment and follow-up. (Carstens, as cited in
Daniels & Tucker, 1989, p. 184)

What was once old is now new again (unknown). The results of this study validate these impressions. It is gratifying to see that RTCs do as much as they do to include families in youth treatment.

Implications

Implications for Family Therapy

It may be beneficial to marriage and family therapy graduate programs to include introductive insights about residential placement and treatment for youth because utilization of RTCs continues to be an option for families and communities in crisis (Yelton, 1993). Specific training of MFTs for residential settings in graduate curricula could enhance both students' understanding of treatment in residential care and treatment effectiveness as well as preparing them as therapists for residential treatment. MFTs could benefit from knowledge of the workings, practices, and philosophy of RTCs when providing therapy to a family that has or has had a child in an RTC placement. It could also be beneficial for therapists to have knowledge of particular programs for times when families suggest them as treatment options. Knowing more about how families are involved in particular RTC care could help families and therapists make decisions about youth care.

Because there was no consensus in this study about definitions of family involvement in residential care, it is important for therapists not to make assumptions
when a family or center says that families are “involved.” Rather, it is important that therapists inquire of families and the centers what involvement actually looks like.

Earlier outcome studies (e.g., Hess, 2003; Mech, 1985; Tam & Ho, 1996) concluded that including families in decision-making, visiting, and as part of treatment teams enhanced the success of reunification. Data from the participants of the current study suggest that personnel in the three surveyed treatment programs would agree with Tam and Ho’s conclusion. In the Tam and Ho study, participation also enhanced the youths’ completing their programs sooner and returning to their communities with less risk of returning to treatment. All three centers in the current study appear to embrace that philosophy. At the same time, participants in the current study suggested that frequent family contact outside of or in addition to formal family therapy is beneficial to youth and their outcomes. Therapists could work more to communicate with center staff, which might enhance the therapy and the youths’ nontherapy experiences while in care and in aftercare.

*Implications for Policy*

Further work is needed that focuses specifically on the involvement of parents and extended family that incorporates insight related to ethnic, cultural, and gender differences for families’ involvement in residential placement. It appears evident that the definition of “traditional” family may need to be extended to include others in youths’ lives. From the interviews, it seems appropriate to utilize caring individuals in treatment to enhance the RTC process and reunification of the youth into the community.
Hess (2003) stated that states should develop comprehensive visitation guidelines that include the following: (a) the purpose of the visit, (b) written plans for the visit, (c) who may participate in visits, (d) the frequency of visitation, (e) responsibilities of each party, (f) families’ rights to contact, (g) when and where visits may occur, (h) whether visits are supervised and by whom, (i) visiting activities and durations, and (j) guidelines for situations such as parental incarceration, violence, or abuse. Additionally, the idea of reducing or disallowing family contact as punishment should be addressed on a case-by-case basis as potentially more harmful than helpful to treatment. It appears that the benefits of family involvement may be viewed as positive and to all parties within the RTC field and that philosophy is growing. The State of Utah is actively engaged at present in family participation and inclusion in an attempt to reduce recidivism and cost rates. To this end, funding should include money to facilitate family involvement.

Implications for Research

Reviews of the literature on outcomes of residential treatment suggest a need for ongoing and rigorous study of residential treatment programs. Although numerous outcome studies of residential treatment programs as well as reviews of literature have been conducted (e.g., Bums & Friedman, 1990; Curry, 1991; Pecora et al., 2000; Pfeiffer & Strzelecki, 1990; Whittaker & Pfeiffer, 1994) few firm conclusions can be drawn. Evidence suggests that parental involvement during treatment is associated with more successful outcomes (Jansen et al., 1996). The results of the current study portray an active attempt to explore whether and how families are included in the overall RTC process in youth treatment based on data from all levels of staff of the three participating
programs. This information may assist studies on outcomes by delineating different ideas about what family involvement means. Clearly, there is no single variable and various definitions must be included in studies.

Because the staff at the three participating programs suggested that family involvement in care and therapy enhances youths’ progress toward treatment goals and family reunification, it would be interesting to explore the effectiveness of family involvement in residential care, both for general contact and family therapy. It also would be interesting to explore how the types of problem (sex offenders, conduct disorder, incorrigibility, depression, eating disorders) that require residential treatment are affected by family involvement. Which kinds of problems are best treated by a combination of family treatment and residential care? When is the best time for family involvement or family therapy?

With more study, we could learn more about how the different components of residential care interact to produce the best outcomes for youth and their families. What are the best ways for administrators, therapists, direct care staff, youth, and families to interact to help these young people leave residential care and lead productive lives?

Although participants all mentioned family therapy as advantageous to youth treatment in residential care, this study did not explore descriptions of family therapy. Further research is needed to determine the best approaches to family therapy for different goals, including family reunification, reduced recidivism, and changes in family systems.
There were numerous comments regarding obstacles to family participation in youth treatment. These included distance, finances, health, child care, and so forth. Research of the effectiveness and confidentiality of video conferencing could provide benefits to all involved in the RTC placement process. These insights from participants gave rise to possibilities involving technology that could open many doors for family inclusion and program enhancement.

Study participants mentioned a few negative consequences to family involvement in treatment. Well-designed studies could help to identify these further and find ways of ameliorating these consequences. Similarly, studies could be conducted to assist in finding ways of overcoming obstacles to family involvement.

Limitations

The current study was exploratory and used only three RTCs in one geographic area, with a total of nine individual participants, each selected on a first-come, first-interviewed basis. Such a low sample size and restricted geography is an obvious limitation to the study and results should not be considered representative of RTCs across the nation or even in Utah.

Our society is currently motivated to facilitate family participation in the RTC process (Tam & Ho, 1996) and it is possible that this philosophy or industry pressure influenced participants’ responses and their desire to either look good or to appear to be “on board” with this philosophy. No attempt was made to actually observe family involvement in the treatment centers. Further, it is possible that staff at all levels in these
or other RTCs did not share the views of this sample, suggesting a potential bias in results through participant self selection.

Other limitations can be attributed to the interviewer or the interview questions. I attempted to limit my biases by checking myself after each interview through review of the interview data and my field notes. However, my bias toward family involvement in treatment and particularly toward family therapy as an important component for residential treatment likely influenced the way I asked questions and, therefore, the responses I received from participants. Although I was seeking information about the participants’ thoughts about family involvement in residential care and in family therapy, the questions I asked may not have elicited the most helpful information, affecting the validity of the results. Similarly, these biases likely affected data analysis and the development of categories and themes.

Finally, although random transcripts were analyzed by both my major professor and me, it is possible that our biases did not allow us to recognize potential results that might run counter to these biases. This could have affected the reliability of the findings.

Conclusion

The purpose of this study was to investigate how RTCs in northern Utah promote family participation in overall program functions including therapy, and what is viewed by them as family involvement. No conclusions were drawn regarding outcomes. Interviews suggested that frequent family involvement in the programs and in therapy were desired and promoted in all participating facilities. As noted earlier, there are a few
studies that suggest that family involvement and participation in youth treatment are beneficial to successful outcomes regarding shorter lengths of stay, program completion, and family reunification. It appears that each participating program in this study currently agrees with and adheres to that philosophy through their promotion of family involvement. Residential treatment staff can play a critical role in facilitating the child's transition from residential care back to the community and in empowering families throughout the process. The attitudes and roles of residential staff in empowering families is fast emerging as a critical factor in promoting healthy functioning, with parents regarded more as partners with professionals rather than as passive service recipients (Dunst et al., 1988). It is clear that the participants in this study shared this view and promoted it. The results of the study suggest that it is possible that family involvement in RTC treatment is more pervasive than this researcher originally thought.
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INFORMED CONSENT

Family Involvement in Residential Treatment Centers

Professor Thorana Nelson and Wes Larson in the Department of Family, Consumer, and Human Development at Utah State University are conducting a study to find out more about participants' views about family involvement in residential treatment centers. You have been asked to take part because you work in an RTC and have valuable insights pertaining to the study.

The service you provide is important. I understand your work because I have been working in the field of Juvenile Justice Services in the State of Utah for over fifteen years. In my current capacity, I am involved with numerous youth in placement within the State of Utah. My experience and curiosity provided much of the impetus for this research project to better understand the incorporation of families in the treatment process. I know your time is of great value in your RTC, a summary of the research findings will be available upon request. Thank you in advance for your assistance and support.

If you agree to be in this research study, I will interview you for about 30 minutes in a location and at a time of your choosing. I will ask questions about individual demographics and your views about family involvement in your RTC. The conversations will be audio taped during the interview. The tapes will be transcribed and then destroyed. Your signed informed consent will be kept separate from the interview transcripts and all tapes and transcripts will be coded and will contain no identifying information.

Although I am involved in your field and know people who work at your center, I will not tell anyone at your center that you are participating in this project nor will I tell anyone at the center about your views. Your answers will in no way be directly associated with your facility or used for any purpose other than this research project. No participant from any facility will see another's responses unless you decide to reveal the information yourself. All data will be presented in aggregate form only with no identifying information.

Perceived risks or discomforts may include personal time taken to participate or discomfort of expressing personal views and or insights regarding family involvement. There will be no direct benefit to you from these procedures. The investigator, however, may learn more about what family involvement looks like in northern Utah RTCs, possible new directions for the field, and possible new insights for future research.

Your participation in this research is entirely voluntary. You may refuse to participate or withdraw at any time. If you decide to participate in this study, you will receive a $5.00 voucher for a local restaurant. You will receive no other compensation for participation in the study.

Family, Consumer & Human Development Department • College of Education
Telephone: (435) 797-7430 • Facsimile: (435) 797-7432
INFORMED CONSENT
Family Involvement in Residential Treatment Centers

If you have questions or research-related problems, you may reach Professor Nelson at 435-797-7431 or Wes Larson at 435-752-8694.

The Institutional Review Board for the protection of human participants at USU has approved this research study. If you have any questions or concerns about your rights, you may contact the IRB at (435) 797-1821.

You have been given two copies of this Informed Consent. Please sign both copies and retain one copy for your files.

"I certify that the research study has been explained to the individual, by me or my research staff, and that the individual understands the nature and purpose, the possible risks and benefits associated with taking part in this research study. Any questions that have been raised have been answered."

_________________________  ________________________
Thorana Nelson Ph. D          Wes Larson
Principal Investigator        Student Researcher
(435) 797-7431                (435) 752-8694
thorana.nelson@usu.edu        wlarson@usu.edu

Wes Larson has explained this research study to me and answered my questions.

_________________________  ________________
Participant’s signature       Date

If you would like to receive results of this study, please provide contact information below:

Name ________________________________

Address ______________________________

____________________________________
Email address:

Family, Consumers, & Human Development Department  College of Education
Telephone: (435) 797-7430  Facsimile: (435) 797-7432
Respondent Demographics

ID _____ Age: _____

Sex:  M  F

Marital status:

_____ Single (never married)

_____ Married or residing with partner

_____ Divorced

_____ Other

Do you have children? _____ Yes _____ No

What is your highest level of education? __________________________

Advanced degree? _____ Yes _____ No

Currently attending school? _____ Yes _____ No

Ethnicity (optional)

Years worked in human services? _____

Years worked in current facility? _____

Your job title __________________________

Prior to your current employment, was there any educational/training history
regarding working with families? __________

Are you engaged in any ongoing training regarding family
involvement/intervention? _____

How many hours per week are you involved in working with families? ________
Interview Questions

(Questions followed with thought of probing thoughts)

Family contact with youth:
1. What kind of contact of family members have with youth?
2. Who participates (who do you consider family)?
3. Are there any restrictions or obstacles to family contact with youth?
4. What are your personal thoughts about family contact?
5. What suggestions do you have about family contact?

Family involvement in treatment:
1. Do family members participate in decisions about youth treatment? In what way? In which decisions?
2. What is considered family involvement in treatment?
3. Are there any restrictions or obstacles to family participation in youth treatment?
4. What prevents family participation?
5. Do you think there are advantages or disadvantages?
6. Do you believe that family participation is helpful for youth outcomes?
7. What suggestions do you have about family participation in treatment?
## Coding Chart

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