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# Family Participation : Exploring the Role it Plays in Outcomes for Youth with Serious Emotional Disorders

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FAMILY PARTICIPATION: EXPLORING THE ROLE IT PLAYS IN  
OUTCOMES FOR YOUTH WITH SERIOUS EMOTIONAL DISORDERS

by

JODI LEE KERBS

A dissertation submitted in partial fulfillment of the  
requirements for the degree of

DOCTOR OF PHILOSOPHY  
in  
SOCIAL WORK AND SOCIAL RESEARCH

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2007

DISSERTATION APPROVAL


The abstract and dissertation of Jodi Lee Kerbs for the Doctor of Philosophy in Social Work were presented May 3, 2007, and accepted by the dissertation committee and the doctoral program.


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## ABSTRACT

An abstract of the dissertation of Jodi Lee Kerbs for the Doctor of Philosophy in Social Work and Social Research presented May 3, 2007

Title: Family Participation: Exploring the role it plays in outcomes for youth with serious emotional disorders

The participation of families of children with emotional or behavioral disorders is increasingly seen as an essential component of children's mental health services. Although it is frequently discussed in the literature, family participation has not been a major focus of most research surrounding youth with serious emotional disorders (SED). This gap in research is particularly evident in the literature related to those youth who are also in the juvenile justice system. This study explored the concept of family participation in the context of services for youth with SED and examined the relationship between family participation in treatment planning and child outcomes. Qualitative methods were used to examine, in depth, the participation of a subset of families with children involved in a mental health program within a juvenile department.

Secondary data analysis was performed on a data set collected from the evaluation of the System of Care initiative in Clark County, Washington

and from the Department of Juvenile Justice records. Qualitative data were collected using both focus group format and through individual interviews with families who are either employed by or enrolled in mental health services within the Juvenile Justice system.

This study supports existing research linking (a) child and family characteristics to child outcomes, (b) child and family characteristics to family participation, and (c) family participation to child outcomes. Results showed that overtime, older children had a decrease in problem behaviors and a decrease in criminal activity, and that a larger number of caregivers in the household was related to an increase in strengths and an increase in criminal activity. Additionally, higher income and higher child functioning were related to participation and participation was related to an increase in strengths and a decrease in criminal activity.

The qualitative results suggest that families experience participation in variety of ways and there are a number of steps that can be taken to facilitate participation. Families did not tie their participation to improved outcomes for their children, they did, however connect their participation to improvements in their own functioning and a lack of child progress to lack of child participation.

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## Chapter 1

### Introduction

This study explored the construct of family participation and examined the impact of family participation in treatment planning on child outcomes. Over the past several years, family participation has received increased attention in children's mental health and related fields. The extent to which families participate in services for their children is rapidly evolving, particularly in the context of services for youth with serious emotional disorders (SED) (Stroul, 1996). Youth with SED have multiple needs that tend to require services from multiple providers including education, child welfare, juvenile justice, health, mental health, and substance abuse agencies (Stroul, 1996; Stroul & Friedman, 1986a, 1986b). Youth and families seeking services related to emotional disorders have typically faced a fragmented system with little consistency regarding the extent to which families are involved in the treatment process (Lourie, 2003; Stroul & Friedman, 1986a).

Strong advocacy efforts coupled with federal initiatives aimed at improving services for youth with SED have been instrumental in advancing the role of families in mental health and related services for youth. A recent Surgeon General's report on mental health recognizes families as "essential partners" in the treatment process (U.S. Department of Health and Human Services, 1999). The U.S. Department of Education also included involving

families as part of the National Agenda for Achieving Better Results for Children and Youth with Serious Emotional Disturbance (U.S. Department of Education, 1994). Additionally, family participation was included as one of the core elements of the Child and Adolescent Services System Program (CASSP) that resulted in the development of systems of care that include family involvement as a central component (Stroul & Friedman, 1986a). The system of care philosophy emphasizes community based, culturally competent, integrated, and comprehensive services provided in the least restrictive environment and with the full participation of the child's family (Stroul & Friedman, 1986b).

Despite the growing emphasis on family participation as a core element of services for children and families, the research base regarding the implications of involving families remains underdeveloped (Friesen & Stephens, 1998). Although it is frequently discussed in the literature, family participation has not been a major focus of most research surrounding youth with SED. A number of questions related to family participation remain to be answered. For example, how do families participate, what child and family characteristics are related to participation, what facilitates their participation and what role does participation play in outcomes?

One of the issues facing researchers who are interested in family participation is the lack of a commonly accepted conceptual definition of family participation (Curtis & Singh, 1996). A number of terms such as

“involvement,” “participation,” “collaboration,” “empowerment,” and “family-centered services” have been used to describe the process or practice of involving families in services. Conceptually, some authors have positioned family participation as part of larger concepts of empowerment (Curtis & Singh, 1996; Koren, DeChillo, & Friesen, 1992) and parent-professional collaboration (DeChillo, Koren, & Schultze, 1994) or as a component of family-centered service (Hunter & Friesen, 1996) and wraparound (Epstein et al., 2003). Although these authors vary in their conceptualizations of family participation, they all suggest that involving families entails a collaborative partnership characterized by shared power and joint decision making.

Identifying a common definition for family participation is complicated by the fact that the meaning of “participation” tends to vary according to the context in which the participation occurs. Additionally, differences are likely to exist between actual participation and perceived participation. This study focuses on families’ perceptions of their participation in treatment planning and therefore, the following definition of family participation will be used:

Family involvement is the degree to which caregivers participate in the treatment planning process. This includes the extent to which they feel they have a voice and influence in decision making and the extent to which they feel supported and welcomed as partners in the planning process.

## Study Purpose and Research Questions

The aim of this study is to explore the construct of participation.

Through qualitative and quantitative methods, family participation will be examined based on family narratives, potential indicators of participation and the relationship between family participation in treatment planning and child outcomes.

The qualitative portion of this study is designed to gain information about participation through the experiences and perceptions of family members employed as program staff in a family-centered program as well as family members currently enrolled in the program. Data will increase understanding of how families experience participation in the process of treatment planning. Specifically, the qualitative portion of this study seeks to answer the following research questions:

- How do families experience their participation related to treatment planning?
- What facilitates their participation?
- How do families perceive their participation in relation to the outcomes experienced by their child?

An additional focus of this study involves the use of existing quantitative data to examine the relationships among (a) child and family characteristics, (b) family participation, and (c) child outcomes (i.e., functioning and criminal activity). Specifically, this part of the study is

designed to examine whether the relationships between child and family characteristics and child outcomes are mediated by family participation in treatment planning. Previous research has established a link between child and family characteristics and child outcomes; however, a possible mediating role of participation is less well understood. Testing participation as a mediator will add to the understanding of the mechanism through which child and family characteristics affect child outcomes. There are undoubtedly other factors that may contribute to the association between child and family characteristics and outcomes for youth. However, the study of family participation seems to have particular promise based on previous research and the current emphasis on involving families in services for youth with SED. The quantitative portion of this study seeks to answer the following research questions:

- How are the child characteristics of age, gender, CAFAS score, and offense history related to child outcomes?
- How are the family characteristics of income, number of caregivers and education related to child outcomes?
- How are child and family characteristics related to participation (ITC and FSQ scores)?
- To what extent is the relationship between child characteristics and child outcomes mediated by family participation in treatment planning?



- To what extent is the relationship between family characteristics and child outcomes mediated by family participation in treatment planning?

This study is distinguished from previous research regarding family involvement both conceptually and methodologically. First, this study employs qualitative methods to gain information about participation in treatment planning from the perspective of families who are either employed by or enrolled in a family centered program within a juvenile justice program. Additionally, this study focuses on family participation in relation to outcomes, specifically the possible mediating role of participation in treatment planning on child outcomes. The findings of this study will inform future practice and research related to family participation.

## Chapter 2

### Background and Significance

Traditionally, the role of families in children's services has been limited to either "informant" or "recipient of services" (Friesen & Koroloff, 1990), and their contributions have been primarily conceptualized and measured in terms of compliance. More recently, parent advocacy supported by policy mandates and funding requirements have moved the field of children's services to include parents as "full participants" allowing them to participate in the planning, implementation, and evaluation of services (Friesen & Koroloff, 1990; 2003; Osher & Hunt, 2002; Stroul, 1996).

Despite a growing emphasis on family participation in children's services, the research base remains undeveloped. Most of the research surrounding family participation has focused on developing conceptual understanding of participation (Coyne, 1996; Curtis & Singh, 1996; Friesen & Stephens, 1998; Koren et al., 1992) and identifying factors associated with the level and quality of participation (Baker, Blacher, & Pfeiffer, 1993; Baker & Blacher, 1993). The research regarding the role that family participation plays in treatment outcomes is limited.

#### *Conceptualization of Participation*

Participation is conceptualized differently across various settings. In the field of education, family participation has been defined to include a wide variety of activities including participation in after school activities, assisting in

homework, volunteering in the classroom, participating in the individual educational planning (IEP) process, and attending parent conferences (Mattingly, Prislín, McKenzie, Rodriguez, & Kayzar, 2002). In child welfare, family participation has been described as compliance with treatment or visitation schedules (Cantos & Gries, 1997). In the context of family preservation, participation has been described as involvement in developing plans, keeping scheduled appointments, completing assignments, and cooperating with services (Littell, 2001). In the context of out-of-home placements, family participation has been defined as involvement in the child's treatment including telephone calls, family visits, and participation in decision making and treatment team meetings (Baker et al., 1993; Baker, Heller, Blacher, & Pfeiffer, 1995). In children's mental health, family participation has been conceptualized as occurring across six broad roles, which include family members as context, as targets of change, as partners in the treatment process, as service providers, as policy makers, and as evaluators (Friesen & Stephens, 1998). This framework describes six different roles that denote various types of participation ranging from families as recipients of services to families as service providers. Currently, the families are seen less as targets of change and more as partners in the treatment and evaluation process. The Federation of Families has defined participation in the context of family-driven services in which family participation includes: "Choosing supports, services, and providers; setting

goals; designing and implementing programs; monitoring outcomes; partnering in funding decisions; and determining the effectiveness of all efforts to promote the mental health and well being of children and youth” (Federation of Families for Children’s Mental Health, 2007).

### *Predictors of Outcomes*

A number of child and family characteristics have been linked to differential treatment success for adolescents with emotional and behavioral problems. These factors include child age, gender and level of functioning at baseline, family structure and socioeconomic status.

In a study involving 4,434 youths between the ages of 7 and 17 years, Xue, Hodges & Wotring (2004), found that age was a significant predictor for outcomes in school. In this study, the authors found that older participants were less likely to achieve successful outcomes. Gender has also been identified as a predictor of treatment outcomes; however these results have been mixed. In the same study, Xue and colleagues (2004) found that gender was also a significant predictor of school outcomes. However, additional research focused on outcomes across settings, failed to find significant differences between females and males in either clinical or functional outcomes (Borduin et al., 1995; Freidman, Terras, & Kreisher, 1995).

Levels of functioning at intake have also been linked to outcomes for youth with SED. A study of 35 youths in a juvenile group home comparing

the CAFAS as a measure of functioning with a number of set factors associated with treatment outcomes (e.g., age, ethnicity, and gender and criminal history) found that lower levels of functioning at intake and previous involvement with the juvenile justice system were associated with reduced probability of successful outcomes for youth (Quist & Matshazi, 2000; Xue et al., 2004).

Family structure has also been linked to treatment outcomes. In a study of 59 adolescents involved in cognitive behavioral treatment for depression in an outpatient mental health setting, Clarke et al. (1992) found that living with parents or relatives at intake was significantly related to positive outcomes for youth. Similar results were found in a study for youth in an inpatient setting as well (Parmelee et al., 1995).

#### *Predictors of participation*

Studies have found that many of the same characteristics associated with outcomes are associated with family participation. In a study of three residential treatment centers in Arizona, California, and Florida, with a combined sample of 234 children with available family members, Baker and colleagues (1993) used regression analysis to determine the best set of predictor variables of family participation. The analysis included the following variables: distance, socioeconomic status, child's age, and level of child's behavioral problems. The results of this study found that participation was highest for caregivers whose children were younger and had fewer behavior

problems and when the family lived nearer the facility and had a higher socioeconomic status.

Additional studies of youth served in outpatient settings found that higher levels of participation were associated with higher family income, less severe problems, and custody status (Curtis & Singh, 1996; Robinson & Friesen, 2002). Curtis and Singh (1996) also found that among caregivers, females tended to have higher levels of participation than males.

Caregiver education has also been associated with levels of participation, however findings have been mixed. In a study focused on outpatient mental health services, Curtis and Singh (1996), found that less education predicted higher levels of participation among families of youth receiving services. However the authors noted the possibility that higher education might equate with higher expectations regarding participation. Another study found that caregivers with higher levels of education were more likely to initiate services for their children (Elliott, Koroloff, Koren, & Friesen, 1996).

In addition to what is known about the influence of child and family characteristics on outcomes for youth with SED, there is also a small body of research available that deals specifically with family participation as a component of care and examines the relationships between family participation and outcomes (Aeby, Manning, Thyer, & Carpenter-Aeby, 1999; Grolnick & Slowiaczek, 1994; Jones, 1994).

### *Participation as a predictor of outcomes*

In the field of education, Aeby and colleagues (1999) conducted a comparative evaluation of the effectiveness of an alternative school program offered with and without intensive family involvement. Family involvement included participating in the intake process, identifying interventions, and participating in treatment through family therapy, family meetings, and family-teacher conferences. Families also participated in the ongoing evaluation of progress and in planning for transition back to the student's home school. The researchers compared outcomes of youth and families involved in the standard alternative school during the year prior to implementation, with outcomes of a similar group in year 2 when family involvement was added to the program. The researchers measured psychosocial functioning (self-esteem, depression, locus of control), academic performance (grades and truancy), and rates of drop out. The results of this study showed significant between-group differences. The youth whose program included intensive family involvement had higher grade point averages, increased attendance, and lower drop out rates.

Research on out-of-home placements has also shown positive outcomes related to family participation. Although rigorous methodology was not employed, Bylan (1990) evaluated outcomes from an adolescent psychiatric hospital program designed to promote family participation and

found that the length of stay for adolescents could be reduced by more than half when parents were involved in the process of services.

Shorter lengths of stays were also linked to parental involvement for children in foster care. Benedict and White (1991) examined social service records from the state of Maryland on 689 children placed in foster care. The majority of children in this study were placed due to abuse or neglect, and most were noted to have some behavioral problems. Although the researchers noted the possibility that parental visiting was a proxy indicator for more complex relationships between families and providers, the researchers found parental visiting to be among the factors associated with shorter lengths of stay. Parental visiting has also been linked to the well-being of youth in foster care.

Cantos and Gries (1997) examined the effects of parental visiting on the emotional and behavioral adjustment of children in foster care. The sample consisted of 49 children in foster care who were referred for therapy for behavioral problems by their foster parents, teachers, or caseworkers and 19 children in foster care who had not been referred to therapy since their initial placement. The researchers compared the relationship between parental involvement (visiting) and behavioral/emotional adjustment (CBCL scores) and parental involvement and educational functioning (WRAT-R scores). The researchers used an ANCOVA to compare groups in order to control statistically for the level of adjustment that the child had made relative



to his or her placement. The researchers found children who experienced regularly scheduled visits with their families had fewer externalizing problem behaviors regardless of their level of adjustment. In addition, the children in the referred group who were visited regularly exhibited fewer internalizing behavior problems compared to those that did not experience regular visiting, yet the reverse was true for the non-referred group. The authors suggested that for the children in this study, the problems experienced by some children might be obscured by the benefits of visiting experienced by most children. Although these results add support to the research regarding the benefits of participation in the form of parental visiting for youth in placement, they also suggest that there are additional complexities associated with family participation in out-of-home care.

Noser and Bickman (2000), conducted a secondary data analysis of the Ft. Bragg Demonstration Project, which provided mental health services to child and adolescent clients and their families in the Fort Bragg (Fayetteville, North Carolina) area through an innovative approach to a continuum of care service system. This study was designed to assess the relationship between standards of quality care including caregiver involvement in treatment planning and youth mental health outcomes. The results indicated a very small, but significant effect that suggests a positive relationship between participation and outcomes.

In mental health, one of the more promising approaches that facilitates the full participation of families in the process of treatment planning is wraparound (Goldman, 1999). Wraparound has been defined as both a service philosophy and a planning process. One of the key tenets of this approach is an emphasis on family participation in service planning. This approach to service delivery differs from traditional services in a number of ways. A primary difference is the extent to which families participate in decision making. Wraparound involves a planning process that includes the child and family in collaboration with other stakeholders in the child's life to identify the outcomes desired and the appropriate supports and interventions needed to achieve them (Goldman, 1999).

Although research is emerging, there are a few studies that examine the effectiveness of wraparound (Bickman, Smith, Lambert, & Andrade, 2003). There have been at least two studies that used randomized trials to evaluate wraparound as a type of case management (Clark, Lee, Prange, & McDonald, 1996; Evans, Armstrong, & Kuppinger, 1996). Evans et al. (1996) conducted a study involving 42 children referred to out-of-home placements who were randomly assigned to either treatment foster care or family-centered intensive case management (FCICM), which entailed keeping children at home with an array of individualized services. The FCICM model employed most of the elements of the wraparound process. The results showed that compared to youth in treatment foster care, children who

received FCICM had a greater decline in client reports of behavioral symptoms, fewer externalizing problems measured by the Child Behavioral Checklist (CBCL), and lower overall impairment measured by the Child and Adolescent Functional Assessment Scale (CAFAS).

In a second randomized study, Clark, et al. (1996) compared outcomes for children in foster care. Children were randomly assigned to either standard foster care services or the Fostering Individualized Assistance Program (FIAP). Both groups received standardized foster care services. The children in the FIAP program also received specialized services such as flexible funds and case management using a wraparound model. Data were collected at six-month intervals for three and a half years. While both groups showed some improvements, the FIAP group had fewer placement changes and missed fewer days of school compared to those who received standard foster care services. The boys in the FIAP group also showed reduced delinquency rates.

A number of promising findings have come out of evaluations of programs such as Wraparound Milwaukee. Wraparound Milwaukee is a program that coordinates the needs of youth involved in multiple service systems through a public managed care organization. Youth and families are enrolled in a health maintenance organization (HMO) with a benefit plan that offers a comprehensive array of services that can be individualized for the unique needs of each participant.

Evaluations of this program have shown decreased utilization of residential and inpatient psychiatric placements as well as improved clinical outcomes (Kamradt, 2000). Comparisons of pretest and posttest assessments of child functioning were made using the CAFAS. The 300 delinquent youth enrolled in the program showed improved functioning at six months on the CAFAS with continued improvement at one year follow up.

Additional evaluation of Wraparound Milwaukee has shown marked reduction in recidivism rates for delinquent youth. A comparison of court records on 134 youth for one year prior to enrollment and one year following enrollment showed significant reductions in re-offending patterns following youth involvement in the wraparound program (Kamradt, 2000).

Another model that incorporates family participation as a central component is Family Group Conferencing (FGC). FGC originated as a solution to the lack of culturally appropriate services for indigenous groups in New Zealand and has since expanded to several countries including the United States (Merkel-Holguin, 2000). In this model, family members play a key role in decision making regarding treatment. Central to this approach is the idea that families are capable of making good decisions and they are able to develop useful plans given the support of professionals (Moore & McDonald, 2000).

The FGC process begins with a meeting of family members and professionals where the professionals describe their concerns and family

members have an opportunity to ask questions. The intent of this phase of the process is to present a holistic view of the family and provide enough information for the family to make decisions. During the second part of the meeting, the professionals leave and family members consider the issues and create a plan that they then present to the professionals for implementation (Moore & McDonald, 2000).

To date, most of the literature on FGC has focused on defining the practice model and measuring fidelity (Merkel-Holguin, Nixon, & Burford, 2003). There are a few implementation evaluations that focus on outcomes of FGC such as child and family safety, child permanency, family functioning, and child well-being.

An evaluation of a FGC initiative in Washington State examined outcomes of 70 FGC's related to the well-being of 138 children who were referred through Child Welfare. Cases with comprehensive records at least six months post FGC were included in the analysis. Findings showed an increase in the percentage of children living with their parents (20% prior to the start of FGC compared with 43% following the FGC) and overall stability of placements over time - only 10% of cases experienced difficulty with initial plans (Gunderson, Cahn, & Wirth, 2003).

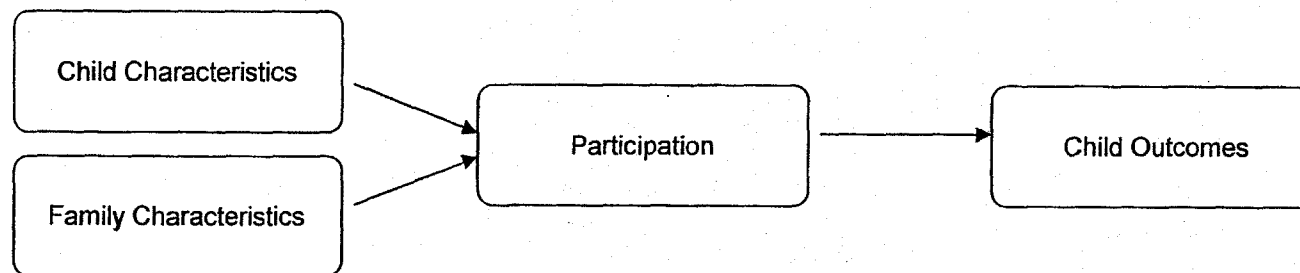
The evaluation of a similar initiative in California examined outcomes for 271 youth and 137 families. This study compared findings for some of the youth to a similar group who were not referred to FGC and found that 97% of

children involved in FGC were able to maintain residence with their families compared to 84% of children in the comparison group. Additionally 44% of youth involved in FGC who were placed with relatives exited care within one year of removal, compared to 24% in the comparison group (Wheeler & Johnsen, 2003).

Taken together, the literature related to family participation and outcomes suggests the need to further explore the concept of participation and the role that family participation plays in relation to outcomes for children. This study seeks to address the need for additional exploration of family participation through both qualitative and quantitative methods.

This study uses both primary and secondary data both of which will come from a program developed within the context of a System of Care (SOC) Initiative. Family participation is a key component of SOC initiative making it an ideal setting for an exploration of family participation. The conceptual model for this study is depicted in Figure 1. Information regarding the context of this study is discussed in the next chapter.

Figure 1  
Conceptual model



To what extent is the relationship between child characteristics and child outcomes mediated by family participation in treatment planning?

To what extent is the relationship between family characteristics and child outcomes mediated by family participation in treatment planning?

How are child characteristics related to participation?  
How are family characteristics related to participation?

What is family participation?  
How do families experience participation in treatment planning?  
What role does family participation play in treatment outcomes?

How are child characteristics related to child outcomes?  
How are family characteristics related to child outcomes?

## Chapter 3

### Context of Study

#### *System of Care*

System of Care (SOC) is both a concept and philosophy that has provided the framework for most of the reform efforts in the children's mental health arena since the mid-1980s. System of Care has been defined as "A comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with serious emotional disturbances and their families" (Stroul & Friedman, 1986a). The system of care represents a philosophy about the way in which services for children and families should be delivered. Inherent in this philosophy are three core values that guide service delivery: systems of care should be: 1) child centered and family focused, 2) community based, and 3) culturally competent (Stroul, 2003).

Since 1984, the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (SAMSHA), has funded a number of initiatives across the country to develop systems of care for children and youth with severe emotional disturbances. In 1998, Clark County, Washington received an \$8 million grant from SAMSHA, entitled the Comprehensive Community Mental Health Services for Children and Their Families Initiative.



### *Clark County SOC*

The Clark County initiative, named The Community of Care, was designed to support the development of a comprehensive system of care for children and families. As part of the Clark County initiative, the Regional Research Institute for Human Services at Portland State University (RRI) conducted an evaluation to assess the system of care effort in Clark County. The evaluation was designed to describe the youth and families receiving services, the services they received, and related outcomes. Caregivers and youth were interviewed at baseline (within two months after intake into a mental health center or the Juvenile Justice Connections program), and every six months for up to 36 months.

Upon intake by a mental health provider, caregivers and youth were asked to sign a consent form releasing the child's diagnosis information and granting permission to the evaluation team to contact them. Families automatically qualified for the study if they were receiving intensive services, which in Clark County were provided through Connections or Catholic Community Services, and almost all of these families were invited to participate in the study. Families from other providers qualified for the study if their child: 1) had a mental health diagnosis or was diagnosable, 2) had an Axis V Global Assessment of Functioning, (GAF) or Children's Global Assessment Scale (CGAS) score of 50 or below, 3) had a disorder that had lasted for one year or was expected to last for one year, 4) was receiving

services or needed services from multiple child and family serving agencies, and 5) was between 5 and 17.5 years old. All families that were qualified to participate completed a brief "Descriptive Information Questionnaire," upon intake into the agency or during a telephone call soon after intake. Most families were selected to participate in the evaluation, however, periodically their interviewers, Family Information Specialists (FIS), were too busy. At these times, a portion of families were randomly selected to participate.

The evaluation continually accepted new enrollees from December 1999 until July 2004. Families went through a baseline interview within two months of service intake and had a follow-up interview every 6 months thereafter for up to 36 months. At each interview time point, caregivers and youth completed an informed consent process. The caregiver interview took one to two hours to complete, and caregivers were given a \$20 gift certificate to local department stores. Youth interviews were completed with youth age 11 and older; they took approximately 45 minutes to complete, and youth were compensated with a \$10 gift certificate. Approximately 60% of the families had youth old enough to be interviewed. In the rest of the families only a caregiver completed the interview.

### *Connections*

The Connections program was implemented in October of 2001. Funded in part by the system of care grant, and nested within the system of care principles, the Connections program was developed as a specialized

program within Clark County's Department of Juvenile Justice. As one of the primary service providers for youth with SED, the Department of Juvenile Justice designed the Connections program to integrate services and coordinate resources to meet the needs of youth and families involved in the juvenile justice system who also had mental health needs. The program represented a partnership between the juvenile court and the mental health community that was designed to enhance services through stronger community connections.

Connections continues to serve youth and families with SED. Using a Wraparound/individualized and Tailored Care model, Connections employs a strength-based approach to link youth and families to local resources to meet their individualized needs. To this end, families are full partners in developing, delivering, and implementing interventions.

The project began with four teams that each worked with 25-30 families at a time. During the first year of the program 164 youth were served. Prior to the implementation of the program, staff received a three-day training with several nationally recognized wraparound trainers (Miles, 2000). Training included an overview of the wraparound philosophy and individualized strengths-based planning, and reviewed the process of developing creative, needs-driven plans with families. Connections staff continue to receive follow-up trainings and consultation as needed.

The teams consist of a mental health professional serving as a care coordinator, a family assistance specialist, a probation counselor, and a juvenile services associate. The mental health care coordinator facilitates wraparound team meetings with youth, family, and team members to identify strengths, determine needs, and locate or create services and supports. The family assistance specialist positions are each staffed by a caregiver of a child who has been in the juvenile justice and/or mental health system. They provide emotional and practical support, often helping the family prepare for meetings or accompanying them through court proceedings. They also help families connect with natural support systems. The family assistance specialist and the mental health care coordinator positions are both available 24 hours a day, seven days a week.

The probation counselor's primary responsibility is to ensure that services promote community safety, and she or he is responsible for ongoing supervision of court orders. The juvenile services associates work closely with youth to assist in completing requirements of the treatment plan. They also work as mentors, often accompanying youth in the community to activities. A staff clinical psychologist provides 20 hours per week to the program, performing psychological evaluations, staffing cases, and counseling youth. Connections contracts out for psychiatric services including medication management.

Youth are referred to the Connections program by any juvenile justice staff. Criteria for admission include having six months or more probation time remaining, having a diagnosed or diagnosable behavioral health disorder, receiving services in more than one system, and being assessed as having a moderate to high risk to re-offend as determined by their score on the Washington State Juvenile Court Assessment (WSIPP, 2004). Following an initial review by the Connections program manager, all referrals are considered by the care coordinators and the clinical psychologist to ensure the youth meets criteria, the family is interested in participating in the program, and that there are no extenuating circumstances that would make them unfit for the program (such as being in an extreme psychiatric crisis). An initial wraparound team meeting occurs within 30 days of intake.

The child and family teams meet at least once a month or as often as necessary depending on the needs and circumstances of the youth and family. In order to access an array of individualized services, each child and family team may request flexible funds. Flexible funds are issued when a purchase cannot be made with established county funds and when all other possible funding sources are exhausted. These funds are used for non-traditional services such as GED testing, respite care, clothing, or transportation. Youth are generally discharged from Connections when their probationary period is completed. Transition out of Connections begins three

months prior to discharge to ensure youth and families are connected with community service providers and other resources.

## Chapter 4

### Methodology

This study employed both qualitative and quantitative methods of analysis using several sources of data to explore the concept of family participation and the relationship between family participation in treatment planning for youths with SED and youth outcomes. The qualitative analysis involved data collected through in-person interviews and a focus group facilitated by the principal investigator. Individual interviews were conducted with families who were participating in Clark County Washington's Department of Juvenile Justice Connections Program at the time of data collection. A focus group format was used to gather information from the family support specialists currently employed in the Connections program.

The quantitative portion of this study was designed to make use of an existing data set, which came from two sources: (a) an evaluation of the Children's Mental Health System of Care (SOC) initiative that occurred between 1999 and 2004 in Clark County, Washington and (b) arrest data from the Clark County Department of Community Services and Corrections Juvenile Justice records.

#### *Qualitative Design and Sample*

The qualitative portion of the study used a purposeful sampling strategy that included all four family support specialists currently employed by the program as well as 12 family members of youth enrolled in the

Connections program. First, qualitative data were collected from consenting family support specialists employed by Clark County's Department of Juvenile Justice Connections Program. These participants were chosen based on their unique perspective on family participation. In this program, family support specialists are parents who have previous personal experience as a family member involved in some type of human services. One of the primary roles for the family support specialist is to work closely with family members to ensure they have a voice in the planning process. A focus group format was used to draw upon respondents' attitudes, feelings, beliefs, and experiences regarding the relationship between family participation in treatment planning and child outcomes.

The use of a focus group format was intended to capitalize on communication between participants in order to generate data (Morgan, 1997). In this study, the group format was intended to stimulate interaction among participants around the topic of family participation and allow for discussion and consideration of participants' experiences in the context of other participants. The focus group was designed to explore the topic of family participation in general and to inform the individual interviews through identification of the range of thoughts and experiences families might have regarding their participation in the Connections program.

During a regularly scheduled staff meeting, the four family support specialists were informed of the purpose of the focus group and invited to



participate. Potential participants were assured that their participation was voluntary and that any information shared would remain confidential. They were also provided an informational letter (see Appendix A) and a copy of the informed consent which they were asked to sign prior to the start of the focus group (see Appendix B). Additional copies of the informed consent form were made available at the time of the focus group.

The focus group took place at the juvenile court facility. The focus group lasted approximately 90 minutes during which the facilitator presented a series of open and closed-ended questions intended to encourage participant discussion (see Appendix C for the discussion guide). In addition to discussing their own views, the family support specialists were asked to reflect on the experiences of the families with whom they work. Specifically, they were asked to talk about their perception of how the families involved in Connections experience participation in treatment planning both in general and in relation to outcomes for their children.

Additionally, data were gathered through in-person interviews with families currently enrolled in the Connections program. The researcher worked with the Juvenile Justice administrator to recruit family members for the individual interview portion of this study with the intent to select a group of individuals with diverse outcomes and experiences. Potential participants were contacted by the Juvenile Justice staff and provided with an explanatory letter and a copy of the consent form they were asked to sign

allowing the principal investigator to contact them for an interview (see Appendixes D and E for the letter and consent forms).

Interviews followed a semi-structured interview guide (see Appendix F). The interviews lasted approximately one hour, during which participants were asked a series of open-ended questions intended to stimulate conversations regarding their experiences and perceptions of participation in the treatment planning process. The interviews took place in locations chosen by the participants, including their homes, a coffee shop and the juvenile detention center.

In order to collect accurate and complete information, both the focus group and individual interviews were audio recorded. Once the data were collected, all data were transcribed by a professional transcriber hired by the principal investigator. To ensure confidentiality, the audiotapes were stored in a locked file cabinet, and computerized data files of the transcripts were password protected. The audio and computerized qualitative data were only accessible to the principal investigator, her peer debriefer and the chair of her committee.

#### *Qualitative Data Analysis*

The analysis approach used in the qualitative portion of this study was theme identification. The intent was to further develop an understanding of family participation and the role of participation in outcomes from the perspective of families involved in the service process. Specifically, the goal

of the qualitative study was to gain understanding about how families experience their participation related to treatment planning, what facilitates their participation, and the ways in which they feel that their participation has impacted outcomes for their child. To this end, participants were specifically asked a series of questions and consulted throughout the process of data analysis to ensure their experiences were accurately captured.

Focus group data were collected and preliminary analysis was completed prior to the individual interviews to help further inform the semi-structured interview guide. Preliminary analysis of focus group data began with an initial reading of the transcripts to become familiar with the data. Next, the transcripts were re-read and segments of interest were flagged. Memoing was used during this process to document thoughts and ideas about information as it emerged from the data and to record ideas about possible probes for the individual interviews. Flagged quotations were first read as a separate document to identify any emergent themes, then they were re-read within the context of the complete transcript and initial codes were identified.

Following preliminary review of the focus group data, individual interviews were completed. The process of analysis for the interview data followed a similar process as the analysis of focus group data, beginning with an initial reading and re-reading of transcripts and flagging segments of text

for future coding. Memoing was used to record thoughts and ideas about information as it emerged from the data.

The analysis of interview data occurred in four stages beginning with selective coding during which comments were reviewed and assigned initial codes (Emerson, Fretz, & Shaw, 1995). Based on the specific research questions posed for this portion of the study, initial codes were assigned to three categories (components of participation): experience, facilitation, and outcomes. During this process, the researcher continued the use of memoing to document codes, their meaning and interpretations, and to record thoughts and ideas about additional information as it emerged from the data. The process of memoing during analysis allows the researcher to capture emergent themes and also serves as part of the audit trail (Lincoln & Guba, 1985).

Following the identification of the three initial codes (experience, facilitation, and outcomes), the transcripts were revisited and these codes were further categorized to distinguish themes or sub categories and additional emergent information was coded. Next, super codes were created to query information relevant to the research questions. Finally, codes and categories were synthesized into a conceptualization of participation. Networks were created and diagrams were developed to serve as a conceptual model to guide the process of answering research questions.

The resultant conceptualizations were reviewed to answer the research questions and identify additional information that emerged. As a form of member checking, these diagrams and results were reviewed with the focus group participants to assess whether it fit with their experiences. This was done during a group discussion with Connections staff.

Throughout the process of data analysis, the researcher employed a number of strategies to enhance trustworthiness in the qualitative analysis. As previously mentioned, the researcher utilized memoing to document codes, their meaning and interpretations. The researcher also utilized reflective journaling throughout the process to identify personal ideas, responses or biases related to the data during both data collection and analysis. Establishing an audit trail ensures that any findings are traceable back to the data on which it is based and allows for the findings to be verified by additional researchers (Lincoln & Guba, 1985).

Additionally, quotes were marked directly from the text as a preliminary step to coding as a process to stay close to the data and refrain from interpretation too early. The investigator also used peer debriefing as a method for ensuring credibility of the data (Lincoln & Guba, 1985). A colleague familiar with qualitative analysis served as a third party to review coding and memos along with relevant parts of the raw data to ensure the integrity of the analysis. Additionally, the peer debriefer was consulted on final interpretations of the data. The use of peer debriefing contributes to the

rigor of qualitative analysis by guarding against researcher bias (Lincoln & Guba, 1985).

A final strategy used to ensure the trustworthiness of the qualitative analysis was member checking (Lincoln & Guba, 1985). As previously mentioned, the researcher contacted the focus group participants during data analysis to review the preliminary codes and interpretations to ensure they fit the experiences of the participants. Member checking was also incorporated into the process of data collection during individual interviews. Rather than meet with interview participants as occurred with focus group participants, member checking was done as part of the interviews (Kuzel and Like 1991). The researcher reviewed summary statements of the participant's answers to the research questions at the end of each interview to ensure that the researcher understood the essence of information provided. The process of member checking serves as a guard against researcher bias and lends credibility to the findings of qualitative research (Lincoln & Guba, 1985).

#### *Quantitative Design and Sample*

The secondary analysis used two data sets. The first data set was drawn from the SOC evaluation in Clark County, Washington. This evaluation was conducted between 1998 and 2004 as part of a national outcome study funded by the Comprehensive Community Services for Children and their Families Program grant from the federal Center for Mental Health Services within the Substance Abuse and Mental Health Services Administration

(SAMSHA). The data set includes information from families of children age 5 to 17.5 years old who were identified at intake into a public mental health center as receiving, about to receive or needing to receive services from mental health and at least one other service system (i.e. DCFS, Juvenile Justice, and Special Education). Participants were also required to have a Global Assessment of Functioning (GAF) score below 50, a disability that had lasted at least one year, or was expected to last more than one year and a diagnosed or diagnosable DSM-IV disorder. Data were collected on a sample of families who agreed to participate in the interview process. Data were collected from caregivers and youth aged 11 - 17.5 years old at intake and at six month intervals. The current study was designed to use data collected from 217 caregiver interviews at baseline and 6 months.

A second data set was identified for the portion of the study concerning criminal activity of youth with SED. The second data set was obtained from the Clark County Washington Department of Community Services and Corrections juvenile justice information system (JUVIS). The JUVIS system is the statewide database for juvenile offenders and includes information related to the offense histories of youth enrolled in Clark County's Department of Juvenile Justice Connections Program. The sample for this portion of the study is a sub sample of the larger SOC sample and includes 35 youth who entered Connections beginning in October 2001 for whom both JUVIS and SOC data were available at baseline and six months.

## *Measures*

In addition to information from JUVIS, data used for this study were drawn from a number of instruments included in the SOC evaluation. The variables considered for the current study included child and family characteristics, family participation, child functioning, and criminal activity.

### *Child and family characteristics*

Demographic information was drawn from the Descriptive Information Questionnaire (DIQ) which contains 37 items that describe each child and family involved in the study. Information used for this study includes the following variables: child age, child gender, child's caregiver education, and family income.

Information regarding child functioning at baseline was drawn from the Child and Adolescent Functioning Assessment Scale (CAFAS). The Child & Adolescent Functioning Assessment Scale (CAFAS) assesses the degree to which a child's emotional, behavioral, or substance abuse disorder is disruptive to his or her functioning in each of several psychosocial domains (Hodges, Doucette-Gates, & Liao, 1999). The CAFAS is designed to be completed by a clinician or by a lay interviewer familiar with the scoring procedures. A total score is generated based on subscale scores for the following areas: School/Work, Home, Community, Behavior Toward Others, Moods/Emotions, Self-Harmful Behavior, Substance Use, and Thinking Problems. Total scores range from 0 - 240, scores of 40 or below indicate



minimal impairment; scores from 50 - 90 moderate impairment and scores from 100 - 130 indicate marked impairment. Scores of 140 or higher indicate severe impairment. Scores above 40 are considered to indicate impairment at a level that requires clinical care. The CAFAS has demonstrated reliability and validity. Hodges & Wong (1996) reported correlations for the total CAFAS scores ranged from .92 -.96 across four different samples. Intra-class correlations for total scores ranged from .84 -.89. Construct, concurrent and discriminate validity of the CAFAS has also been demonstrated (Hodges, Lambert, & Summerfelt, 1994; Hodges & Wong, 1996).

### *Participation*

The System of Care dataset includes two instruments that measure participation; the Individualized and Tailored Care Questionnaire (ITC) and the Family Satisfaction Questionnaire Abbreviated version (FSQ-A). The Individualized and Tailored Care (ITC) questionnaire was designed by the evaluation team involved with the Clark County System of Care initiative in an effort to capture information specific to families' experiences with their participation in the wraparound planning process. The current study includes the following questions: 1) "Do you or your family have an ITC/Wraparound team?" 2) "Do you have authority and or influence about your team?" and 3) "Do you feel like an equal partner in the team process?" The data produced by these items are categorical: 1 = yes and 2 = no. Although this instrument

has not been tested it was developed with family members and therefore can be considered to have some face validity.

The Family Satisfaction Questionnaire (FSQ-A) is designed to assess the caregiver's satisfaction with services as a whole, child's progress, cultural competence, family focus, service coordination, unconditional care, and global satisfaction (Brunk, Santiago, Ewell, & Watts, 1997). Responses are rated on a five-point scale ranging from "very dissatisfied" to "very satisfied." Items used for this study are related to the caregiver's satisfaction with his or her level of participation in the treatment planning process. The questions include: "How satisfied were you with your level of involvement in planning services?" And "How satisfied were you with the number of times you were asked to participate in meetings where services were discussed?" These items are scored on a scale of 1 = "Very dissatisfied", 2 = "Dissatisfied", 3 = "Neutral", 4 = "Satisfied", and 5 = "Very satisfied". The items collected for the abbreviated version used in this study have not been tested for reliability and validity; however they have face validity and are measuring concrete concepts.

#### *Dependent Variables*

The SOC data includes two measures of child functioning that serve as dependent variables in this study: the Behavioral and Emotional Rating Scale (BERS) scores and the Child Behavioral Checklist (CBCL) scores. The variables that will be used for this study include the BERS strength quotient

and the CBCL total score. For the purpose of this study, information collected at baseline and six months was used.

The Behavioral and Emotional Rating Scale (BERS) is a 52-item assessment tool that identifies the emotional and behavioral strengths of children ages 5 to 18 (Epstein & Sharma, 1997). The BERS is standardized, norm-referenced 52 item scale designed to be completed by caregivers or professionals and rates behaviors on a four-point scale: 0 = "Not at all like the child", 1 = "Not much like the child", 2 = "Like the child", and 3 = "Very much like the child". Subscales assessing academic, social, and emotional competence form a strength quotient ranging between 60 to 139 points with higher numbers indicating greater strength. An overall strength quotient of 100 is considered average. This standardized measure has demonstrated test-retest reliability, interrater reliability and, internal consistency. (Epstein, Harniss, Pearson, & Ryser, 2001). Test-retest reliability coefficients for the BERS subscales ranged from .85 - .99 with a ten day interval between ratings. Interrater reliability was tested using a sample of 96 students with emotional and behavioral disorders rated by special education teachers. Cronbach's alpha coefficients for the scales were .83 or above.

The Child Behavior Checklist (CBCL) (Achenbach, 1991; Achenbach, McConaughy, & Howell, 1987) is designed to provide a standardized measure of symptomatology for children ages 4 through 18. The checklist is a 130 - item caregiver report of social competence, behavior, and emotional

problems in children and adolescents. Item responses are on a three-point scale; 0 = "Not true, 1 = "Somewhat true", 2 = "Very true or often true." The CBCL yields a number of scores. For the purposes of the current study, the total problem score was used. Total problem scores range from 23 - 100. Total problem scores ranging from 60 – 63 are considered borderline and scores above 63 are considered to be in the clinical range. The CBCL has been found to have good internal consistency and test-retest reliability. Achenbach reported good internal consistency for subscales and total problem scores ( $\alpha > .82$ ) (Achenbach, 1991). Construct validity has been supported by correlates of CBCL scales, including associations with analogous scales on the Conners Parent Questionnaire and the Quay-Peterson Revised Behavior Problem Checklist (Achenbach, 1991). The CBCL has also demonstrated concurrent validity by the ability of items to discriminate significantly between referred and non referred children (Achenbach, 1991).

The second quantitative data set (JUVIS) includes information on criminal activity which was used as an additional dependent variable for the subsample in this study. Variables related to criminal activity included the number of offenses before and after intake. For the purpose of this study an offense is defined as any substantiated offense. Both felony and non-felony offenses were included.

### *Quantitative Data Analysis*

This study examined the relationships among child characteristics (i.e., age, gender, and CAFAS total scores), family characteristics (i.e., education, income, and number of caregivers), family participation in treatment planning (i.e., ITC and FSQ items), and youth outcomes (i.e., change in BERS and CBCL scores). Additionally, the relationship between participation and child outcomes related to criminal activity was examined. As described in previous sections, this study involved two sets of quantitative data. The process of data analysis for the two data sets will be presented separately beginning with the larger SOC data set. SPSS was used to analyze both sets of quantitative data.

#### *Data preparation for SOC data*

Prior to analysis, each variable was evaluated for missing values. The original SOC data set comprised responses from 217 families. The missing values in this data set fell into two categories: "not applicable" and "missing." Missing values in the "not applicable" category were related to a skip pattern on the ITC instrument. The ITC measures of participation were only completed if the respondent answered "yes" to the question "Do you or your family have an ITC/Wraparound team?" The sample size of respondents who answered yes to this question and had complete data on all other variables of interest in this study was 46. There were 64 cases with "missing" values due to unanswered items.

Independent Samples T-tests were computed to compare the complete sample ( $n = 217$ ) with the group with no missing data ( $n = 153$ ) on all independent and dependent variables. No significant differences were found between groups and therefore the cases with missing data ( $n = 64$ ) were dropped from analysis and only those cases with complete data ( $n = 153$ ) were included in the analysis (Carpenter & Kenward, 2006).

#### *Analysis of SOC data*

Using a revised SOC data set of 153 cases with complete data on all the variables of interest, quantitative data analysis included bivariate and multivariate statistics. First, descriptive statistics were computed on all the variables in the study. Bivariate scatter plots of each independent and each dependent variable were evaluated to identify any non linear relationships and histograms were examined to assess for normal distribution of dependent variables. Next, relationships (correlations) between predictor variables were examined to identify any problems with collinearity. For the 46 cases with ITC data, Fishers Exact tests were used to examine the relationships between the child and family characteristics and participation (ITC responses). T-tests were used to examine the relationship between participation (ITC responses) and change in BERS scores and change in CBCL scores.

Next, a series of linear regressions were computed with the intent to test a mediating model predicting the relationships among (a) child and

family characteristics, (b) participation, and (c) child outcomes. Specifically the analysis was intended to test whether the relationship between child and family characteristics and child outcomes is mediated by family participation. Mediation would be demonstrated if the relationship between the child and family characteristics and child outcomes disappears (complete mediation) or is reduced (partial mediation) when controlling for participation (Gogineni, Alsup, & Gillespie, 1995).

The regression analyses were proposed to proceed as follows:

- Two separate linear regression models with the child characteristics (age, gender, and CAFAS total scores) and family characteristics (education, income, and number of caregivers) predicting (a) the change in BERS scores and (b) the change in CBCL scores (see Figure 2)
- Two separate linear regression models with the child characteristics (age, gender, and CAFAS total scores) and family characteristics (education, income, and number of caregivers) predicting participation as measured by FSQ items (see Figure 3)
- Linear regression with the child characteristics of age, gender and CAFAS total scores; family characteristics of education, income, number of caregivers; and participation (FSQ items)

predicting (a) change in BERS and (b) CBCL scores (see Figure 4).

The analyses previously outlined were repeated with the Connections only sample (JUVIS data) with the added predictor variable of number of offenses prior to intake and the added outcome variable of number of offenses following intake (see Figures 5 - 7).



Figure 2  
Child and family characteristics predicting change in child functioning

Child Characteristics

Age

Gender

CAFAS

Family Characteristics

Education

Income

Number of caregivers

Functioning

Change in BERS score  
(Baseline - 6 months)

Change in CBCL score  
(Baseline - 6 months)

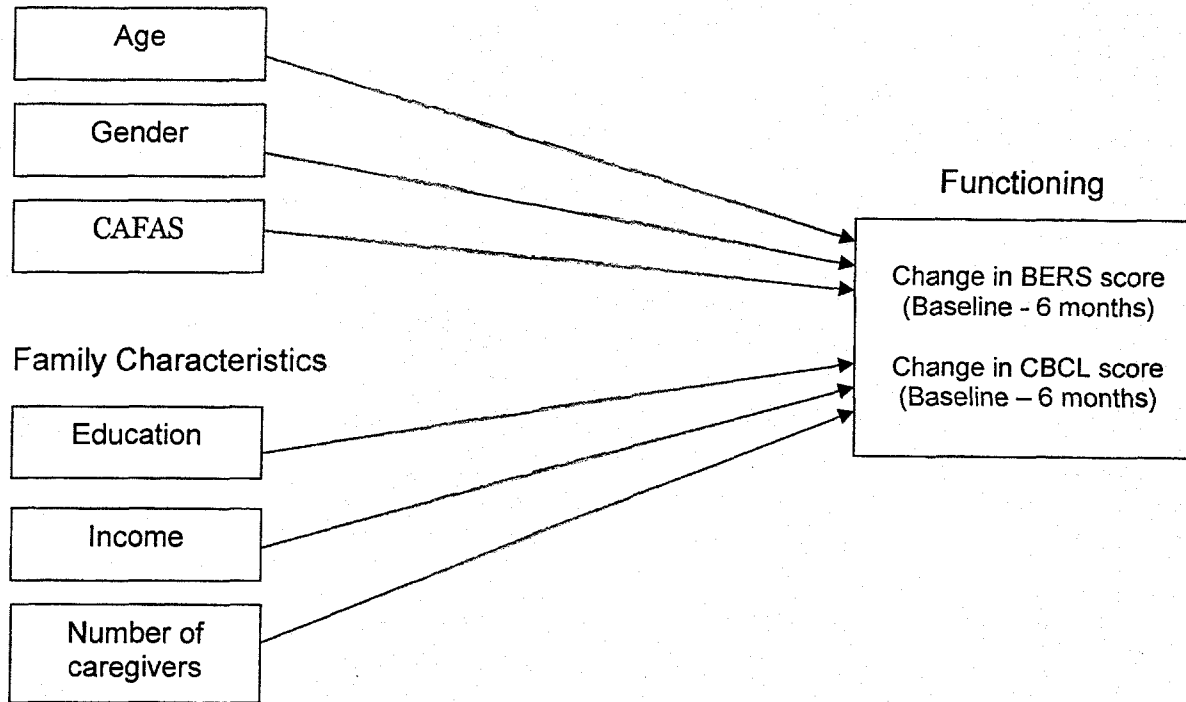


Figure 3  
Child and family characteristics predicting change in participation

Child Characteristics

Age

Gender

CAFAS

Family Characteristics

Education

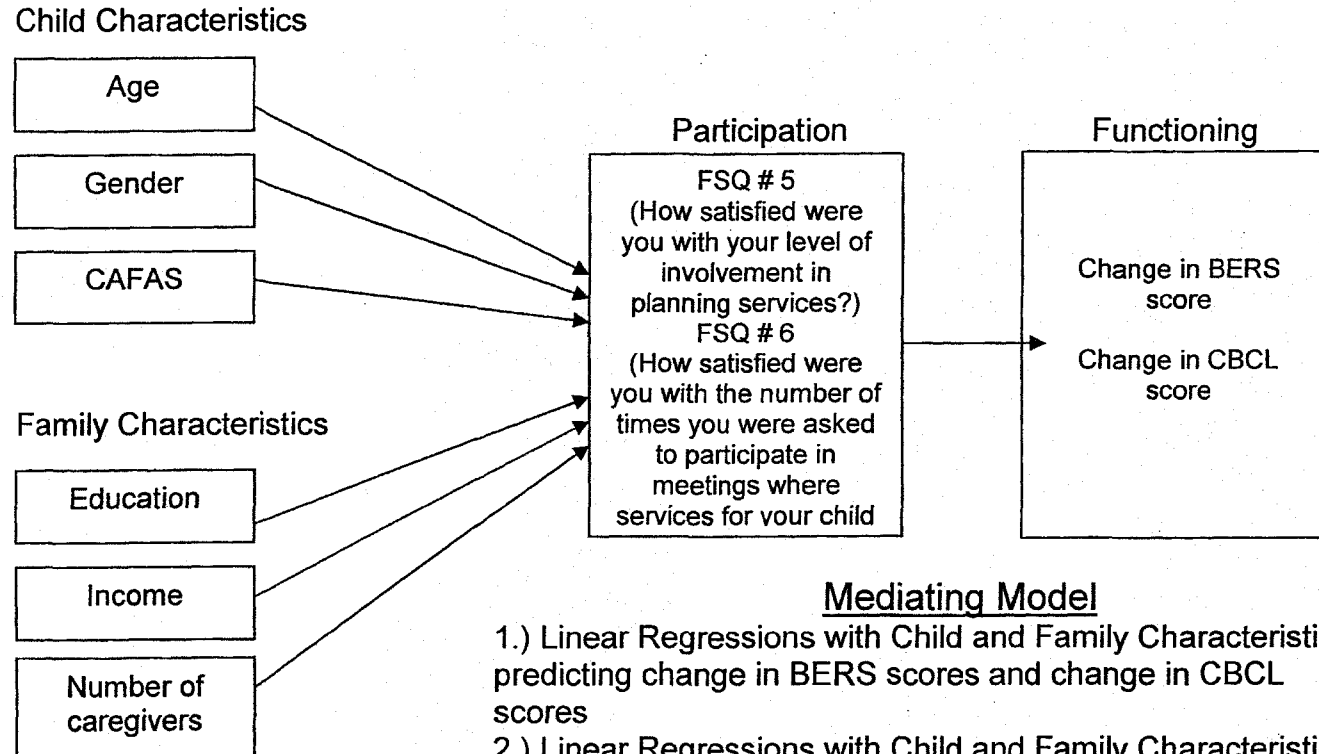
Income

Number of caregivers

Participation

FSQ # 5  
(How satisfied were you with your level of involvement in planning services?)  
FSQ # 6  
(How satisfied were you with the number of times you were asked to participate in meetings where services for you child were discussed?)

Figure 4  
 Mediating model with participation as a mediating variable between child and family characteristics and child functioning



**Mediating Model**

- 1.) Linear Regressions with Child and Family Characteristics predicting change in BERS scores and change in CBCL scores
- 2.) Linear Regressions with Child and Family Characteristics predicting FSQ scores
- 3.) Linear Regressions with Child and Family Characteristics and FSQ scores predicting change in BERS scores and change in CBCL scores.

Figure 5  
Child and family characteristics predicting change in child functioning

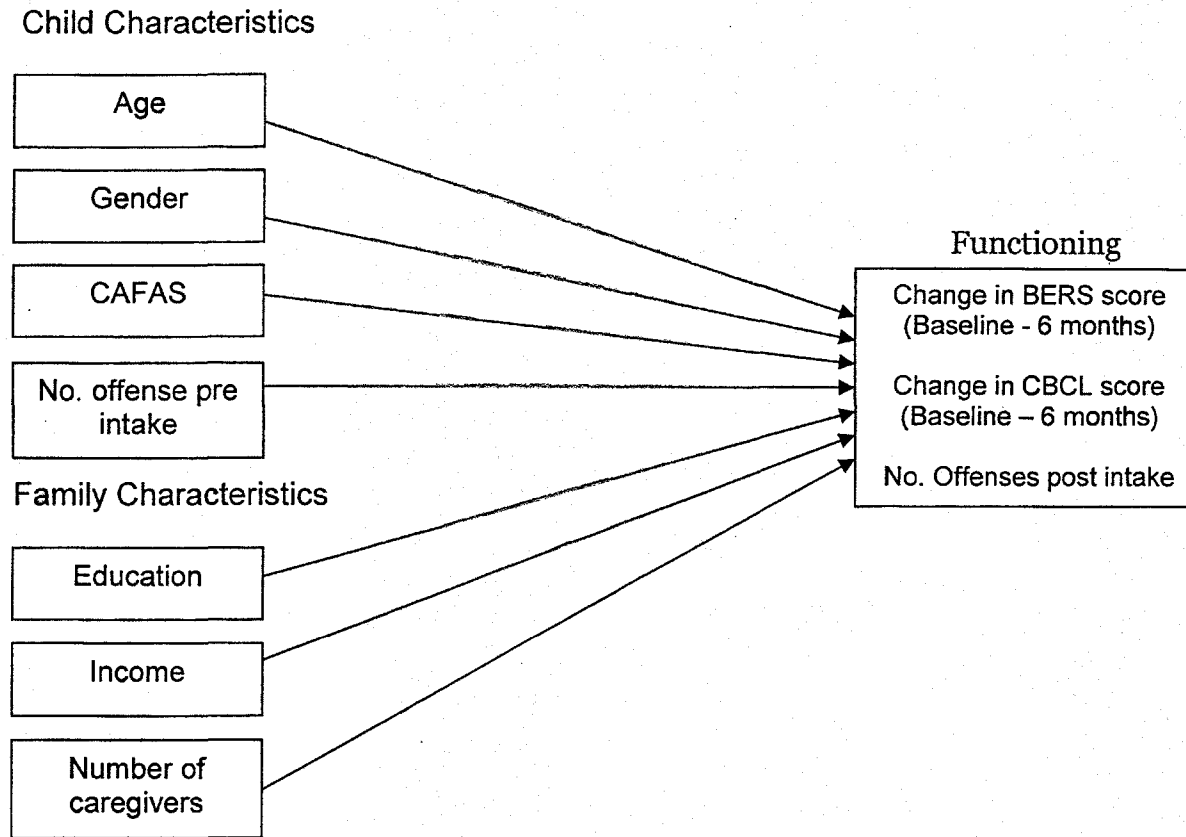


Figure 6  
Child and family characteristics predicting change in participation

Child Characteristics

Age

Gender

CAFAS

No. offenses  
pre intake

Family Characteristics

Education

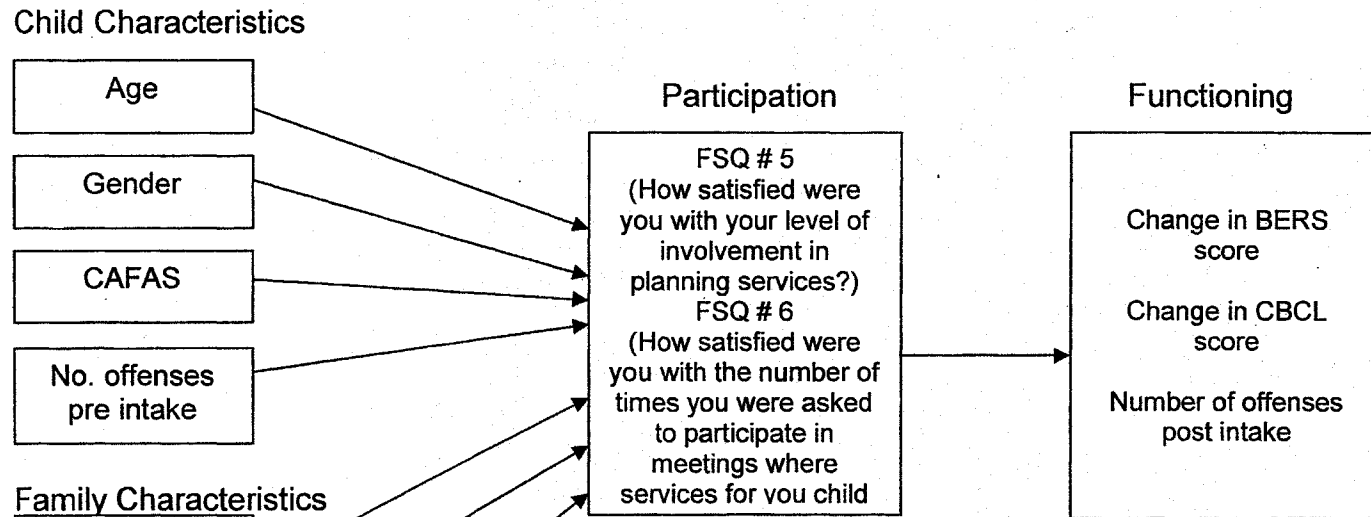
Income

Number of  
caregivers

Participation

FSQ # 5  
(How satisfied were  
you with your level  
of involvement in  
planning services?)  
FSQ # 6  
(How satisfied were  
you with the number  
of times you were  
asked to participate  
in meetings where  
services for you  
child were  
discussed?)

Figure 7  
 Mediating model with participation as a mediating variable between child and family characteristics and child functioning



Mediating Model

- 1.) Linear Regressions with Child and Family Characteristics predicting change in BERS scores, change in CBCL scores and number of offenses
- 2.) Linear Regressions with Child and Family Characteristics predicting FSQ scores
- 3.) Linear Regressions with Child and Family Characteristics and FSQ scores predicting change in BERS scores, change in CBCL scores and number of offenses.

### *Data preparation of JUVIS data*

As previously discussed with the SOC data set, each variable from the JUVIS data set was evaluated for missing values prior to analysis. The missing values in this data set were related to a skip pattern on the ITC instrument. The sample size for the ITC questionnaire in the JUVIS data set with all variables of interest was 24.

### *Analysis of JUVIS data*

Following the analysis previously outlined, the quantitative data analysis for the JUVIS data set included bivariate and multivariate statistics. First, descriptive statistics were computed on all the variables in the study. Scatter plots of independent and dependent variables were evaluated to identify any non linear relationships and histograms were examined to assess for normal distribution of dependent variables. Next, relationships (correlations) between predictor variables were examined to identify any problems with collinearity. For the 24 cases with ITC data, Fishers Exact tests were used to examine the relationships between the child and family characteristics and participation (ITC scores) with the added predictor of number of offenses prior to intake. T-tests were used to examine the relationships between participation (ITC scores) and change in BERS scores and change in CBCL scores and number of offenses post intake.

Next, a series of linear regressions were computed with the intent to test a mediating model predicting the relationships among (a) child and

family characteristics, (b) participation, and (c) child outcomes. Specifically the analysis was intended to test whether the relationship between child and family characteristics and child outcomes is mediated by family participation. As previously mentioned, mediation would be demonstrated if the relationship between the child and family characteristics and child outcomes disappears (complete mediation) or is reduced (partial mediation) when controlling for participation (Gogineni et al., 1995).

The regression analyses were proposed to proceed as follows:

- Two separate linear regression models with the child characteristics (age, gender, CAFAS total scores, and number of offenses prior to intake) and family characteristics (education, income, and number of caregivers) predicting (a) the change in BERS scores and (b) the change in CBCL scores and (c) number of offenses following intake (see Figure 5)
- Two separate linear regression models with the child characteristics (age, gender, CAFAS total scores, and number of offenses prior to intake) and family characteristics (education, income and number of caregivers) predicting participation as measured by FSQ items (see Figure 6)
- Linear regression with the child characteristics of age, gender, CAFAS scores and number of offenses prior to intake; family characteristics of education, income, number of caregivers; and



participation (FSQ items) predicting (a) change in BERS and (b) CBCL scores and (c) number of offenses following intake (see Figure 7).

## Chapter 5

### Results

Results of the qualitative portion of this study are presented first, followed by results of the quantitative analysis. The results are presented in the order of each research question following a description of the sample for each section. For the quantitative portion, results of the analysis of the System of Care (SOC) data set are presented first beginning with descriptive statistics for independent and dependent variables followed by results of bivariate analyses and finally multivariate analyses. The results of the analysis of the juvenile justice (JUVIS) data set follow the same format and are presented last.

#### *Qualitative Results*

##### *Description of Sample*

The focus group consisted of the four family support specialists employed in the Department of Juvenile Justice Connections program in Clark County, Washington. Three of the participants worked in the program since its inception 5 years ago; the fourth participant joined the Connections team 4 years ago. All of the family support specialists are parents who have personal experience as family members involved in some type of human services for their children.

The sample for the individual interviews consisted of 12 families currently enrolled in the Connections program. Participants were identified by

the Juvenile Justice staff as having diverse outcomes and experiences within the Connections program. The length of time participants were involved in the Connections program varied from three months to over one year. Three of the families reported having previous involvement with Connections.

### *Focus group*

The analysis of the focus group data began prior to the completion of the individual interviews. Initial reading of the transcripts alerted the researcher to the potential difficulty families might have in conceptualizing their participation specific to treatment planning. In talking about experiences of families in the program, the family support specialists raised the issue that their program represented a “new way” of interacting with families. One participant stated: “I think it is really a new experience for a lot of the families...it is different for everybody...some people [are used to]...you are here and these professional are going to [say] what is best [for the family]”... Another participant stated: “I think [participation]... for some of our families is hard...it is hard for families...it is an overwhelming process...” A third participant added: “...they don’t always understand what we are asking them to do.” These comments suggested that participation is a subjective experience and discussions around the topic will be framed by individual interpretations and perspective regarding that experience.

When the topic of outcomes arose, focus group participants also commented on potential problems families might have identifying outcomes.

One respondent stated: "...outcomes might not occur for perhaps a year after they have gotten out of Connections... [the] outcomes may be delayed."

Another participant suggested that identifying child outcomes may be difficult for families because the outcomes might not be that specific. She stated: "I think...the greatest outcomes come to the family as a whole... and are probably very difficult to measure." Another participant added: "...a lot of times families don't recognize the progress they have made because all they know is that their kid is still acting up and they are still angry."

When asked about what type of questions they would like to ask the families in their program, the family supports specialists indicated they were primarily interested in learning about how families experience the program and how the program staff could better facilitate family participation. Some of the comments included: "I would like to know what would make it easier for them...to feel a part of the process." Another participant added: "I want to know if they feel that they are being respected and heard...what their experience is." Another participant stated: "I would like to know if they see their participation as contributing to...a positive outcome for the kid....And if the outcome for their child isn't successful, if their participation is still valuable."

These findings supported design of the semi-structured interview guide used in the individual interviews. Data from the focus group also provided valuable insight that served to guide the interpretation of the

interview data. Specifically, the data indicated the extent to which parents' conceptualizations of participation and outcomes are dependent on the amount and type of experiences they have had in Connections and other service programs.

### *Individual Interviews*

Individual interviews were conducted with the intent to better understand family participation. To this end, the interviews were designed to answer the following questions:

- How do families experience their participation related to treatment planning?
- What facilitates participation?
- How do families perceive their participation in relation to the outcomes experienced by their child?

The following section describes the results of the individual interviews beginning with a presentation of the data gathered to answer each research question. Additional themes that emerged during analysis are presented last.

#### *How do families experience their participation related to treatment planning?*

Participants were invited to discuss their experiences related to participating in the process of treatment planning. They were prompted to include both positive and challenging aspects of their experiences.

Families in this study experienced their participation related to treatment planning in a variety of ways. Some families talked about their experience in relation to other programs their child had been involved with, while others described their experiences in relation to specific activities they do. A number of the participants talked about their participation in terms of their role in relation to other team members.

One woman who had previous experience with a child in juvenile services described her participation in relation to her previous experiences within that system. She stated:

I have been through things where I flat out was not involved except for to take him to the appointments, which was frustrating for me, because here, hello, I am his parent. I am responsible for him, but yet ... you totally exclude me. It is more interactive...than regular probation, they [Connections staff] don't dictate.

Another parent used a similar example to express his experience participating in the treatment planning process when he described the differences in his experiences with another child in the juvenile justice system. He explained:

Basically with [sibling] I kind of wish they did have it [Connections/wraparound]...but just going through the juvenile courts... we were told what was going to happen with him.

Didn't care if we disagreed with it or not, this is what is going to happen step by step... You have no say.

[But in this program] Oh, we have 100 percent say, and if somebody has concerns about it, they voice their opinion and we talk it out to where we all agree... it involves all of us.

In reference to other services, where parents had no input and were told to try interventions that they knew would not work, one mother stated: "It is like... you are reinventing the wheel. With Connections you are going with people who are already components of the wheel, and fine tuning it."

Many of the participants also discussed their participation in relation to specific activities they do as a member of the team. One mother said: "They would give me suggestions and I would get on the phone and do whatever I needed to do to find out, the paperwork involved." Another mother stated: "I go to the meetings...I voice my concerns...I go to court with him... I've taken him to community service."

Several families talked about their participation in terms of their role in relation to other team members. One parent exclaimed: "I [am] basically the head honcho." Another woman talked about her experiences in the team meetings. She said: "We would go around... start with positive values first. Yeah, I absolutely felt very much a part of the team." Another parent said: "I felt like an equal partner. I feel I am completely [a] partner, it is all a partnership." In describing her experience, another parent said: "We [the

family] choose...the things we want to work on...it puts [us] on the same page...everyone has a common goal...they are my backup." Another stated: "[I am] more than an equal partner...they listen to what I say...they brainstorm off what I have to say."

Other parents talked about their experience of feeling heard by the team. One parent stated: "They [are] very good at letting us speak our minds, get our ideas." Another parent said: "I am listened to and they take what we have to say seriously." Another parent stated: "I feel I can say what I think needs to happen."

When prompted to talk about aspects of their experience that were less than positive, many participants had nothing to say. This was expressed by comments such as: "There weren't any negatives...everything about it was absolutely great" or "I cannot say one bad thing about my experience". A few of the participants commented on the time commitment required by the program. One woman said: "Connections, the whole thing is time consuming with me being a single mom." Another parent stated: "It requires a lot of my time."

Other participants talked about trust and the tension they sometimes felt during meetings. One parent spoke of trust when she shared: "When you grow up in a background where you have had the courts involved before, there are a lot of walls built...there are trust issues there." Another parent



reported feeling anxious about involving herself with the justice system. She stated:

Well, it's like walking on rice paper wondering when you are going to not put the right pressure and fall through. Even though there is support it is still part of the justice system. As a parent you are still afraid of screwing up.

Another parent expressed a similar sentiment as she discussed her experience entering the Connections program. She stated: "...I really had to open my family to scrutiny. There is a lot of stigma to that and there is a lot of fear."

Another parent recounted an experience of feeling uncomfortable in a team meeting when she shared:

There have been times when it has been challenging, when there has been maybe some miscommunication, where I've felt like there are some things that have been said or have happened that I have misinterpreted or whatever, and we've had to bring those out. Sometimes that gets uncomfortable.

Taken together, data related to families' experiences with this program highlights the complexity of the concept of participation and illustrates some of the various ways it is experienced by families involved in the Connections program.

*What facilitates their participation?*

In addition to talking about their experiences, participants were asked to talk about their views on what facilitates family participation. Most of the families in this study were able to identify a number of examples from their own experiences.

Responses were sorted into several related themes including flexibility, availability, and extra efforts by team members, and program strategies designed to foster family involvement in the program. In addition to talking about examples related specifically to team meetings, families also commented on activities outside of the actual meetings. In terms of the team's flexibility, one mother recounted: "They go wherever is good for everybody...they have even come here to my house when my car wasn't working." Another parent talked about the flexibility of the rest of the team given her struggles to maintain full time employment and participate in wraparound meetings. She pointed out: "If traffic is bad, they wait for me, and they meet with me after 5:30 most of the time... [when] everyone else is gone." Other parents also noted flexibility in scheduling and meeting times as important. Some of the comments included: "We book around me, the meetings are booked around my times" and "We always meet when it is convenient; they try to work around our schedules and everything."

The participants in this study also talked about the availability of team members as helpful. Many of these comments about the team were

specifically addressing their experiences with their family support specialist. A number of participants commented that they can telephone members of their team as needed. One parent said: "Oh yeah... she is on my speed dial, I can call her anytime." While talking about her experiences with one of the members of her team, one woman commented:

I have called at midnight, or called at 10:30 at night...she never acts like we are taking her away from something. It is not just the wrap meetings. I mean, they are there, I feel like they are there for us 24/7.

In addition to the flexibility and availability, several parents commented on the extra efforts of Connections staff both during the actual meetings and in other settings. One parent said: "It's just the whole structure...they are supportive...they *want* to support you." A couple of participants recounted team efforts to engage them in activities outside the meetings. Two parents shared their experience with the parent support specialist. One parent shared: "She has called and come out and taken me for coffee down at Starbucks and console with me." Another stated: "She will drop by my house just to see how I am doing when we are going through a rough patch. She goes above and beyond." Another parent talked about things the team did to engage her son: "They went above and beyond what they should to try to help. I mean all the way from picking him up and taking him...just to keep him involved..."

The participants in this study also identified a number of strategies used to foster family involvement within the program. One woman said: "They order pizza, made it feel comfortable for [child]." Other's noted that the team shared resources and kept notes for the parents. One woman said: "They even send a typed up letter and stuff saying, with all the notes and stuff, what was discussed and stuff like that." Another had a similar response: "They give you a notebook with all kinds of different resources in it ...they give us typed notes from the meetings." Several parents also commented on some community based events that make them feel welcome and part of the program such as summer picnics and holiday parties.

In summary, the families in this program identified a number of things that they felt facilitated their participation in the Connections program including practices, activities, and programmatic structure. It is worth noting that when asked, none of the families interviewed for this study identified any additional things they thought could be done to further facilitate their participation.

*How do families perceive their participation in relation to outcomes experienced by their child?"*

In order to answer this question, families were first asked to talk about outcomes experienced by their children. Many parents reported that their children were not "getting better". Comments included: "It didn't work" or "It's not working". In talking about her son, one parent said: "He is blowing it off.

He is not doing what he is supposed to do; the cops have been here 20 times last year." Another parent commented: "He has been in juvie 14 times, one month he was in there three times...things are getting a little worse."

Although most parents did not identify their children as "getting better", many of them did comment on how things would be worse if they were not involved in Connections. Throughout the interviews, many parents commented on "what if" situations related to outcomes for their children. For example, when sharing her thoughts about her son's current situation, one mother stated: "If I didn't have the Connections team there to help me through this...I think the kids would be in foster care and I would probably be in a mental hospital..." Another parent shared: "Without them ... they [children] would just go and still do the things they want to do and I would just be basically lost." After describing her disappointment with her son's lack of progress in recent months, one mother stated: "[without Connections]...I think he would be a lot worse off than he is now."

Several parents shared how they had contemplated having their children voluntarily removed from their home prior to Connections. One parent shared: "My daughter was at the point where we were seriously thinking of having her taken out of the house." Another parent stated: "[without Connections]... he wouldn't be here. He would be in a foster home or something...I mean; if I didn't have Connections...he would be gone."

Another parent shared: “[Before Connections]...I really thought about getting him...put him in foster care. I really thought about it.”

There were a few parents who identified positive outcomes for their children. One parent stated: “He is at the point now that I think, you know, he is going to school and doing what he is supposed to be doing. There has been a lot of progress.” Another parent indicated that progress was somewhat sporadic. She reported: “At times he is [doing better]. We had an entire week in which there was no problem. It seemed like he was progressing.” At least one parent, who initially did not identify his son as “getting better”, talked about an immediate positive outcome for his son. He said: “At least...no matter where he is at or something, he has got a number that he can get a hold of.”

Following the discussion of outcomes, parents were asked to reflect on the relationship between family participation and child outcomes. As previously discussed, many parents perceived their children as having less than positive outcomes, yet most parents commented on the value of participation.

Only one parent specifically addressed the question relating family participation to child outcomes. She said:

I think [my participation makes a difference] because as a parent they [child] doesn't pay attention to you always. But when they feel like they are an active participant and you are using the different suggestions

that are made out of these meetings, then she is more open to receiving that type of information.

Overall, the data from this study indicate that family participation is multifaceted and it is experienced differently by different people. Additionally, there are a number of things that facilitated families' participation in the Connections program. The data from this study does not allow for conclusions to be drawn about the impact of participation on child outcomes. However, a number of interesting themes surfaced that offer insight into the concept of participation and how it might relate to other outcomes.

#### *Family Outcomes*

One of the most salient themes found in the data was related to family outcomes. Although family outcomes were not an identified area of interest in this study, and families were not asked directly about it, many families commented on their own outcomes. For example, one parent, who did not identify positive outcomes for her child, shared that the most significant change in relation to her situation was the support she felt from the program. She said: "I have backup in what goes on...my kids know." Another parent stated: "...to be involved in decision making... it helps because everyone is on the same page...there is no arguing... and I feel better because I have people I can turn to." Another parent, who did not identify her child as having positive outcomes, stated: "... it helped the family." Another parent who previously shared her child was not improving stated: "It has been helpful for

me...they know that they can push mom so far, but you know what, mom is standing up and is getting stronger." Another parent, whose son was recently sentenced to a state institution, identified the outcomes for her family in terms of her ability to feel good about herself as a parent. She stated:

Despite what happens...I can now say that I tried everything I possibly could to keep my son...I feel good about it. I can literally say I tried everything in my power to help my son...there is not one thing I could say well maybe if we had done this.

Some parents related their participation in this program to getting appropriate services for both themselves and their children. One parent commented on the positive results she has experienced as a result of training she received related to her child's disability. She said: "The one thing ...I was really, really grateful for is they helped me go to a fetal alcohol seminar and that helped me understand [how to parent] more." Another parent discussed how he viewed his participation in Connections as benefiting him in interactions with other systems. He shared: "I got a lot of things addressed... like with my IEP..." He added: "...it [participation] is important...each child is different...and it is the family that is going to know best with that child." Additional comments regarding family outcomes include: "...it helped me concentrate on me, because I was taking care of everyone else and not me" and "For me it is successful. They help with everything...they help the whole family".



In hearing families talk about their experiences it became apparent that their experiences were shaped in part by an emotional connection they experienced in relation to staff in the Connections program. Throughout the interviews and especially during discussions of their own outcomes, families described their relationships with Connections staff on a very personal level. One woman, a single mother, talked about the emotional support she received as part of her outcomes when she said: "It is kind of like having a husband." Another woman said: "I love them I really do...we are really close..." Another parent said: "I like going there because it is all like family...they are like my family... I really think of them that way." Another parent also expressed her experience in terms of an emotional connection as she shared: "I look forward to going and having coffee...just sitting down with another adult...I have someone."

#### *Child experience*

Another interesting theme was related to child experiences with the team process. Families were asked about their thoughts on the relationship between family participation and child outcomes, but they commented on the relationship between child participation and child outcomes. Although they were not directly asked, many families commented on their child's participation, specifically the lack of their participation as related to their lack of progress.

The majority of families in this study did not feel their children were engaged in the program. A number of comments related to participation were framed in the context of poor outcomes. One woman stated: "It didn't work, and that's because of [child]." Another woman whose son was recently sentenced to a juvenile institution said: "[Child] just went up there [to a juvenile institution]...it [Connections] is not helping; [child] did not seem at that point to want to change."

One mother said: "He [child] won't cooperate", the problem has been [child] himself, and [he] is not convinced that staying clean is the answer." Another parent whose son is in treatment for substance abuse stated: "Well, he is currently using...he is showing up to treatment high...he has not bought into it."

#### *System issues*

Participants in both the focus group and the individual interviews were not directly asked to describe the process of treatment planning in the Connections program. Yet, a number of themes arose in the context of conversations regarding the families' experiences that suggest that the families in this study were not all experiencing the same process.

The subject of variations in practice first arose during the focus group discussion as participants were talking about the extent to which they thought parents felt like equal partners in the planning process. One participant stated: "...given that it is the court. I would say sometimes they don't....when

of course, it is a legal issue...somebody else is making decisions." Another focus group participant added: "In those meetings the probation officer has all the power." A third participant provided a differing opinion as she stated: "...depending on the relationship ...with the probation counselor [I think] that it is not that they don't have say, I think... [they] feel that can voice their concerns and they will be taken in to consideration."

In response to a clarifying comment from the facilitator regarding probation issues being addressed separately, one participant stated: "Well, we have separate meetings. We have our wraparound process going on over here and then the kids meet with their probation counselor...in a separate meeting." Another participant agreed: "It is very separate." A third participant stated: "Ours aren't always." One of the participants added the comment: "Our team always talks about probation stuff as part of the wraparound", to which another participant responded: "See, we never do."

There were also a number of comments in the interview data that suggested these differences in practice impacted the experiences of families in this study. For example, at the beginning of each interview families were asked about how often their team met. In the context of this discussion, some families commented that they were unsure when their next meeting was. In at least one case the child was near the end of his probation and the parent was unsure if the wraparound team would continue to meet or not. Others

were not only clear about when their next meeting was, but what the agenda would be.

Additionally, when describing their experiences, some of the families commented that the team helped arrange for whatever services they needed. For example, one parent stated: "If there was something, anything I need they were right on it...anything." Another parent shared that the team helped her husband secure medical coverage. However, there were some parents who describe very different experience. One parent who reported wanting respite services stated: "...but, they don't provide respite." Another parent expressed a similar experience when she reported being told: "...that's not part of our function", when she suggested the need for a crisis contact for her daughter.

Another discrepancy arose around the issue of natural supports. Although families were not asked about the composition of their teams, some shared that they had a number of natural support people on their teams while others reported having none. These examples from the data speak to the issue of practice specification which is a concern frequently discussed in the literature surrounding wraparound programs. They also highlight some of the issues that complicate research around family participation.

A final issue worth noting is that while many families identified a number of positive outcomes for themselves, none of them were aware of any goals on their child and family plan that included their own needs.

Further, when this finding was discussed with the participants from the focus group, they acknowledged that in most cases this was true.

### *Quantitative Results*

Results for the analyses of the SOC data set are presented first. The results of the analyses for the subsample from the Connections program are presented last

#### *Quantitative Results for SOC Data*

##### *Description of SOC Sample*

The sample consisted of 153 families involved in the SOC evaluation in Clark County between 1998 and 2004 for which there were complete sets of data at baseline and six months. Caregiver characteristics are shown in Table 5.1. The majority of caregivers (80%) were biological parents. Forty-eight percent of families identified biological mothers only as the custodial parent, and 3% identified biological fathers only as the custodial parent. Twenty-nine percent of families identified two custodial parents. The caregivers were well educated. Over half of the respondents had a high school diploma or higher (80%) and most had some college education (51%). The average income per person in a household was \$6071 (SD = \$4523).

Table 5.1

(SOC) Family Characteristics (n = 153)

Item	M or n	SD or %
Custody status		
2 biological/ 1 bio and 1 step	44	28.8
Biological mother	74	48.4
Biological father	4	2.6
Grandparent(s)	12	7.8
Other family relative(s)	3	2.6
Adoptive parent(s)	6	3.9
Ward of the State	5	3.3
Other	5	3.3
Education		
Less than high school diploma/GED	26	16.9
High school diploma/GED	48	31.4
Associate degree/Some college	55	36.0
Bachelors degree or more	24	15.7
Income	\$6071	\$4523

The characteristics of the youth described by caregivers are shown in Table 5.2. Most were male (60.8%) with an average age of 12.4 years (SD = 3.3). The majority of the youth were white (85.6%), and the average CAFAS

score at intake was 132 (SD = 50) which indicates moderate impairment in functioning.

Table 5.2

(SOC) Child Characteristics (n = 153)

Variable	M or n	SD or %
<b>Gender</b>		
Male	93	60.8
Female	60	39.2
<b>Race/Ethnicity</b>		
American Indian	1	.7
Black/African	4	2.6
American		
White	131	85.6
Hispanic	7	4.6
Biracial	9	5.9
Other	1	.7
Age	12.4	3.3
CAFAS	131.6	50.0

*Note:* CAFAS = Child and Adolescent Functioning Assessment Scale

### *Participation*

Two measures of participation were used in this study. First, the Individualized and Tailored Care (ITC) questionnaire was used with those

participants who reported having an ITC or wraparound team. Forty-six respondents (32%) reported having a team. Table 5.3 shows the majority of participants who reported having a team also reported feeling like they had authority and or influence about their child and family plan and like an equal partner in the planning process.

Table 5.3

(SOC) Individualized and Tailored Care Measure (n = 46)

ITC Item	yes	no
Do you have authority and/or influence about your child and family plan?	40 (87%)	6 (13%)
Do you feel like an equal partner in the team process?	32 (70%)	14 (30%)

The second measure of participation comprised two items from the family satisfaction questionnaire (FSQ). This questionnaire was completed by the entire sample (n = 153). The majority of respondents were either satisfied or very satisfied with the extent to which they were involved with their team and the number of meetings they were asked to attend. The average score on this 5 point scale was 3.75 (SD = 1.22). The majority of respondents were also satisfied or very satisfied with the number of times they were asked to participate in the meetings where services were discussed. The average



response on the second item was 3.78 (SD = 1.25). Table 5.4 and Table 5.5 show the frequency distribution for each response for both items.

Table 5.4

(SOC) Responses to FSQ question "How satisfied were you with your level of involvement in planning for services?" (n = 153)

Response	n	%
Very Dissatisfied	11	7.2%
Dissatisfied	15	9.8%
Neutral	25	16.3%
Satisfied	52	34.0%
Very Satisfied	50	32.7%

Table 5.5

(SOC) Responses to FSQ Item "How satisfied were you with the number of times you were asked to participate in meetings where services were discussed?" (n = 153)

Response	n	%
Very Dissatisfied	12	7.8%
Dissatisfied	15	9.8%
Neutral	22	14.4%
Satisfied	50	32.7%
Very Satisfied	54	35.3%

### Outcome Variables

Two measures of child functioning from the SOC data set served as outcome variables in this study: The Behavioral Emotional Rating Scale (BERS) and the Child Behavioral Checklist (CBCL) were administered at baseline and at six month intervals. For the current study, change scores between baseline and six months were used. Table 5.6 shows descriptive statistics of these measures at baseline, 6 months and change scores. The average change score for the BERS indicates an increase in strengths from baseline to 6 months. The average change score for CBCL indicates a decrease in problem behaviors from baseline to 6 months.

Table 5.6

(SOC) Descriptive Statistics for Outcome Variables (n = 153)

Outcome Measures	Baseline	6 months	Change scores
	<u>M (SD)</u>	<u>M (SD)</u>	<u>M</u>
BERS	104 (16.83)	108.76 (18.27)	-4.72
CBCL	73 (9.88)	68.88 (8.01)	4.14

Note: n = 153

BERS = Behavioral Emotional Rating Scale

CBCL = Child Behavioral Checklist

### *Bivariate Analysis for SOC Data*

This section will address the questions related to the ITC questionnaire measurement of participation. The following research questions were addressed at the bivariate level due to the small sample size for the ITC questionnaire.

- How are child and family characteristics related to participation (as measured by ITC scores)?
- How is family participation (ITC scores) related to changes in BERS and CBCL scores?

Due to a small  $n$  within cells, Fisher's exact tests were used to analyze the first question: How are child and family characteristics related to participation as measured by ITC scores? Table 5.7 shows that the relationship between income and participation was marginally significant,  $p = .06$ . Ninety-six percent of the group who reported they did have authority and influence about their child and family plan also reported household income above the federal poverty level. For the group reporting a household income below the federal poverty level, only 76% reported having authority and influence about their child and family plan.

Table 5.7

(SOC) Fisher's Exact Tests for ITC Measures of Participation (n = 46)

Variable	ITC 9 <sup>a</sup>		ITC 18 <sup>b</sup>	
	%Yes	P value	% Yes	P value
<b>Gender</b>				
Male	90.3% (n = 28)	.297	74.2% (n = 23)	.259
Female	80 % (n = 12)		60% (n = 9)	
<b>Age</b>				
5-11 years	86.7% (n = 13)	.649	86.7% (n = 13)	.649
12-18 years	87.1% (n = 27)		87.1% (n = 27)	
<b>CAFAS score</b>				
Mild-Moderate	94% (n = 18)	.195	73.7% (n = 14)	.430
Severe	81.5% (n = 22)		26.3% (n = 5)	
<b>Education</b>				
High school	84.2% (n = 16)	.484	57.9% (n = 11)	.132
Some college	88.9% (n = 24)		77.8% (n = 21)	
<b>No. of adults</b>				
One	83.3% (n = 15)	.436	61.1% (n = 11)	.250
More than one	89.3% (n = 25)		75% (n = 21)	

Table 5.7 Continued

Income				
Below federal poverty level	76.2% (n = 16)	060	61.9% (n = 13)	238
Above federal poverty level	96% (n = 24)		76% (n = 19)	

Note. CAFAS = Child and Adolescent Functioning Assessment Scale

<sup>a</sup> ITC 9 = Do you have authority and/or influence about your child and family plan?

<sup>b</sup> ITC 18 = Do you feel like an equal partner in the team process?

T-tests were used to answer the second question: How is family participation (ITC scores) related to changes in strengths quotient (BERS) and problem behaviors (CBCL scores)? Table 5.8 shows results of the comparison of the first ITC item and child outcomes. The group of respondents (n = 40) who reported having authority or influence regarding their child and family plan reported an increase in strengths for their child from baseline to 6 months (M = - 4.53, SD = 18.5) while the group of respondents (n = 6) that reported not having authority or influence regarding their child and family plan reported a decrease in strengths for their child from baseline to 6 months (M = 6.0, SD = 10.0). This difference was marginally statistically significant,  $t(11.04) = -2.09$ ,  $p = .06$ . The group that reported having authority and or influence regarding their plan reported a slightly smaller decrease in problems for their children from baseline to 6 months (M = 4.48, SD = 8.17) than the group that reported not having

authority and or influence regarding their plan ( $M = 5.17$ ,  $SD = 6.91$ ). This difference was not statistically significant  $t(7.27) = -.233$ ,  $p = .83$ .

Table 5.8

(SOC) T-test Comparison of SOC ITC 9 and Child Outcomes

Child	Authority		No authority				
Outcome	(n = 40)		(n = 6)				
	M	SD	M	SD	df	t	p
Change in BERS	-4.53	18.5	6.0	10	11.04	-2.09	.06
Change in CBCL	4.48	8.17	5.17	6.91	7.27	-.223	.83

Note: ITC 9 = Do you have authority and or influence about your child and family plan?  
 BERS = Behavioral Emotional Response Scale  
 CBCL = Child Behavioral Checklist

Table 5.9 shows results of the comparison of the second ITC item and child outcomes. The group of respondents who reported feeling like an equal partner in the planning process ( $n = 32$ ) reported an increase in strengths for their child from baseline to 6 months ( $M = -6.25$ ,  $SD = 17.92$ ) while the group of respondents who reported not feeling like an equal partner in the planning process ( $n = 14$ ) reported a decrease in strengths from baseline to 6 months ( $M = 3.93$ ,  $SD = 16.43$ ). This difference was marginally statistically significant  $t(26.99) = -1.88$ ,  $p = .071$ . The group that reported feeling like an equal partner in the planning process also reported a larger reduction in problems

for their children from baseline to 6 months ( $M = 5.46$ ,  $SD = 8.47$ ) compared to the group that reported not feeling like an equal partner in the planning process ( $M = 2.5$ ,  $SD = 6.38$ ). This difference was not significant  $t(32.66) = 1.31$ ,  $p = .20$ .

Table 5.9

(SOC) T-test Comparison of SOC ITC 18 and Child Outcomes

Child Outcome	Equal Partner (n = 32)		Not equal partner (n = 14)		df	t	p
	M	SD	M	SD			
Change in BERS	-6.25	7.92	3.93	16.43	26.99	-1.88	.07
Change in CBCL	5.47	8.48	2.50	6.38	32.66	1.31	.20

Note. ITC 18 = Do you feel like an equal partner in the team process?

BERS = Behavioral Emotional Response Scale

CBCL = Child Behavioral Checklist

Given the small n and concerns regarding normality of distributions, the Mann-Whitney test was also computed to confirm the results of the t-tests. Mann-Whitney is a non-parametric equivalent of the t-test that can be used when the assumption of normal distribution is in question (Agresti & Finlay, 1997). This analysis yielded the same results as the t-tests.

### *Multivariate Analysis for SOC Data*

This section will address the following research questions:

- How are child and family characteristics related to change in BERS scores?
- How are child and family characteristics related to change in CBCL scores?
- How are child and family characteristics related to participation (FSQ items)?

These research questions were posed to assess the relationship between (a) child and family characteristics and child functioning and (b) child and family characteristics and participation. Multiple regressions were used to examine these relationships. Relationships between independent variables were evaluated by conducting correlation analysis. A review of the correlation matrix did not suggest any problems with collinearity. Regression residuals were also examined and no violations regarding the assumptions of multiple regression were identified. The results of the series of regression analysis for the SOC data are shown in Tables 5.10 - 5.13.

The first regression analysis in this series examined the relationship between child and family characteristics and changes in BERS scores. The overall model was not significant. Table 5.10 shows that none of the independent variables were predictive of change in BERS scores.



Table 5.10

(SOC) Regression Analysis for Child and Family Characteristics Predicting Change in BERS Scores (n = 153)

Variable	B	SE B	$\beta$	t	p
Sex	1.39	2.47	.05	.56	.58
Child age	-.04	.38	-.01	-.10	.92
CAFAS total	-.01	.03	-.04	-.50	.62
Education	.81	.60	.12	1.35	.78
Income	.00	.00	-.04	-.47	.64
No. of adults	-2.24	1.50	-.12	-1.48	.14

Note. CAFAS = Child and Adolescent Functioning Assessment Scale

Table 5.11 shows the results of the regression analysis for child and family characteristics predicting change in CBCL scores. The overall model was not significant; however, the results indicate that child age was predictive of change in CBCL scores. Specifically, for each year increase in age there was a .43 increase in the amount of change in CBCL scores. In other words, as children got older, fewer problem behaviors were reported. Given the lack of significance in the overall model, this relationship was verified through examination of bivariate correlation. The results confirmed that age is positively correlated with change in CBCL scores,  $r = .213$ ,  $p < .01$ , and that age accounted for approximately 4% of the variance in this model.

Table 5.11

(SOC) Regression Analysis for Child and Family Characteristics Predicting Change in CBCL scores (n = 153)

Variable	B	SE B	$\beta$	t	p
Sex	.47	1.34	.03	.35	.73
Child age	.43	.21	.18	2.06	.04*
CAFAS total	.02	.01	.11	1.22	.22
Education	-.41	.33	-.01	-1.3	.90
Income	.00	.00	-.01	-1.0	.92
No. of adults	-.01	.82	-.01	-.11	.91

Note. CAFAS = Child and Adolescent Functioning Assessment Scale

\*p < .05.

As previously outlined, the first step in evaluating a mediating model is to establish a relationship between independent and dependent variables. Given that age was the only predictor of child functioning in this data set, the next step; examination of the relationship between the predictors and mediator was done at the bivariate level. Results of this analysis showed no statistically significant relationship between age and participation as measured by the FSQ items and therefore additional analyses to test for mediation were not possible.

Given that there were no relationships in which participation could be tested as a mediating variable, additional analyses were completed to explore the relationship between (a) all the child and family characteristic

variables used in this study and participation and (b) participation and child functioning. The results of the regression analysis for child and family characteristics predicting FSQ scores are shown in Tables 5.12 and 5.13.

These results show that CAFAS scores were predictive of responses to the question of whether families felt satisfied with their level of involvement in the treatment planning process. Specifically, lower CAFAS scores (less problems) at intake were predictive of very small increases in levels of participation as measured by the FSQ item regarding level of involvement in treatment planning. Additionally, the increases in income were correlated with very small increases on this measure of participation; this relationship was marginally statistically significant. The R squared for this model is .081, meaning that approximately 8 % of the variability in the FSQ item regarding level of involvement is accounted for by the variables in this model. None of the child and family characteristics were predictive of the other FSQ item included in this study: How satisfied were you with the number of times you were asked to participate in meetings where services for your child were discussed?

Table 5.12

(SOC) Regression Analysis for Child and Family Characteristics Predicting  
FSQ 5 Scores (n = 153)

Variable	B	SE B	$\beta$	t	p
Sex	.02	.20	.01	.10	.92
Child age	.00	.03	.01	.08	.94
CAFAS total	-.01	.00	-.21	-2.46	.02*
Education	-.07	.05	-.12	1.48	.14
Income	.00	.00	.16	1.88	.06
No. of adults	-.19	.12	-.13	-1.58	.12

*Note.* CAFAS = Child and Adolescent Functioning Assessment Scale

FSQ 5 = How satisfied were you with your level of involvement in planning services?

\*p < .05.

Table 5.13

(SOC) Regression Analysis for Child and Family Characteristics Predicting FSQ 6 Scores (n = 153)

Variable	B	SE B	$\beta$	t	p
Sex	.11	.21	.04	.53	.60
Child age	.00	.03	.00	.04	.97
CAFAS total	.00	.00	-.05	-.59	.56
Education	-.07	.05	-.12	-1.6	.12
Income	.00	.00	.12	1.44	.15
No. of adults	-.20	.13	-.13	-1.56	.12

Note. CAFAS = Child and Adolescent Functioning Assessment Scale  
 FSQ 6 = How satisfied were you with the number of times you were asked to participate in meetings where services were discussed?

An additional step in the exploratory analysis involved an examination of the bivariate correlations between FSQ items and child functioning. This analysis found no statistically significant relationships between the FSQ items measuring participation and child outcomes (change in BERS scores and change in CBCL scores).

The final two regression models in the proposed series of analyses were designed to answer the following research questions:

- To what extent is the relationship between child characteristics and child outcomes mediated by family participation in treatment planning?

- To what extent is the relationship between family characteristics and child outcomes mediated by family participation in treatment planning?

As previously mentioned, these research questions were not possible to answer in this study due to a lack of findings related to previous questions. To test for mediation the independent variable must be related to both the outcome variable and the mediator (Gogineni et al., 1995). Although previous results showed some relationships between (a) child characteristics and family characteristics and (b) child outcomes, they did not detect a relationship between (a) those same child and family characteristics and (b) participation. Therefore, there were no relationships in which participation could be tested as a mediating variable.

#### *Quantitative Results for JUVIS Data*

##### *Description of Sample for JUVIS Data*

The sample consisted of 35 families involved in the Connections program for whom there were also complete sets of data (baseline to 6 months) from the SOC evaluation conducted in Clark County between 1998 and 2004. Caregiver characteristics are shown in Table 5.14. The majority of caregivers were biological parents (71%). Forty percent of families identified biological mothers only as the custodial parent and 9% identified biological fathers only as the custodial parent. Thirty-one percent of families identified two custodial parents. The caregivers were well educated. Over half of the

respondents had a high school diploma or higher (74%) and most had some college education (43%). The average income per household member was \$8069 (SD = \$5322).

Table 5.14

## (JUVIS) Family Characteristics (n = 35)

Variable	M or n	SD or %
Custody status		
2 biological/ 1 bio and 1 step parent	11	31.4
Biological mother	14	40.0
Biological father	3	8.6
Grandparent(s)	3	8.6
Adoptive parent(s)	3	8.6
Ward of the State	1	2.9
Education		
Less than high school diploma/GED	6	8.6
High school diploma/GED	11	31.4
Associate degree/Some college	12	34.3
Bachelors degree or more	6	8.6
Income	\$8069	\$5322

The characteristics of the youth described by caregivers, including the added variable of number of offenses prior to intake, are shown in Table 5.15. Most were male (65.7%) with an average age of 15.5 years (SD = 1.3). The majority were white (83%), and the average CAFAS score at intake was 163 which indicates severe impairment in functioning. The average number of offenses prior to intake were 3.6 (SD = 1.9).

Table 5.15

(JUVIS) Child Characteristics (n = 35)

Variable	M or n	SD or %
Gender		
Male	23	65.7
Female	12	34.3
Race/Ethnicity		
Black/ African American	2	5.7
White	29	83.0
Other	4	11.4
Age	15.5	1.3
CAFAS	162.9	42.6
No. of offenses pre-intake	3.6	1.9

Note. CAFAS = Child and Adolescent Functioning Scale



### *Participation*

Two measures of participation were used in this study. First, the Individualized and Tailored Care (ITC) questionnaire was used with those participants who reported having an ITC or wraparound team. Twenty-four respondents (70 %) reported having a team. As shown in Table 5.16, the majority of participants who reported having a team also reported feeling like they have authority and or influence about their child and family plan and like an equal partner in the planning process.

Table 5.16

(JUVIS) Individualized and Tailored Care Measure (n = 24)

ITC Item	yes	no
Do you have authority and/or influence about your child and family plan?	21 (88%)	3 (13%)
Do you feel like an equal partner in the team process?	17 (71%)	7 (29%)

The second measure of participation comprised two items from the family satisfaction questionnaire (FSQ). This questionnaire was completed by the entire Connections sample (n = 35). The majority of respondents were either satisfied or very satisfied with the extent to which they were involved with their team and the number of meetings they were asked to attend. The

average score for this item on the 5 point scale was 3.71 (SD = 1.20). The majority of respondents were also either satisfied or very satisfied with the number of times they were asked to participate in meetings where services were discussed. The average response on the second item was 3.7 (SD = 1.3). Table 5.17 and Table 5.18 show the frequency distribution for each response for both items.

Table 5.17

(JUVIS) Responses to FSQ Item "How satisfied were you with your level of involvement in planning for services?" (n = 35)

Response	n	%
Very Dissatisfied	2	5.7%
Dissatisfied	5	14.3%
Neutral	4	11.4%
Satisfied	14	40.0%
Very Satisfied	10	28.6%

Table 5.18

(JUVIS) Responses to FSQ Item "How satisfied were you with the number of times you were asked to participate in meetings where services were discussed?" (n = 35)

Response	n	%
Very Dissatisfied	3	8.6%
Dissatisfied	5	14.3%
Neutral	4	11.4%
Satisfied	12	34.3%
Very Satisfied	11	31.4%

#### *Outcome Variables*

There were three measures of child functioning from the JUVIS data set that served as outcome variables in this study. In addition to the outcome variables previously discussed in the SOC data set (change in BERS score and change in CBCL score), the JUVIS data set also included number of offenses following intake. The average number of offenses following intake was 1.6 (SD = 1.86). Table 5.19 shows descriptive statistics of the outcomes measured at baseline and 6 months. The average change score for the BERS indicates an increase in strengths from baseline to 6 months. The average change score for CBCL indicates a decrease in problem behaviors from baseline to 6 months.

Table 5.19

(JUVIS) Descriptive Statistics for Outcome Variables (n = 35)

Outcome	Baseline <u>M (SD)</u>	6 months <u>M (SD)</u>	Change scores <u>M</u>
BERS	101.03 (17.12)	107.94 (19.58)	-6.91
CBCL	73.11 (9.50)	66.43 (11.77)	6.69

Note. BERS = Behavioral Emotional Rating Scale (range 70-154)  
CBCL = Child Behavioral Checklist (range 44-93)

#### *Bivariate Analysis for JUVIS Data*

This section will address the questions related to the ITC questionnaire measurement of participation. The following research questions were addressed at the bivariate level due to the small sample size for the ITC questionnaire.

- How are child and family characteristics related to participation (as measured by ITC scores)?
- How is family participation (ITC scores) related to changes in strengths quotient and CBCL scores and number of offenses post intake?

Due to a small n within cells, Fishers exact tests were used to answer the first question: How are child and family characteristics related to participation as measured by ITC scores? Table 5.20 shows that no significant relationships were found between child and family characteristics and both ITC items used in this study; (a) do you have authority and/or

influence about your child and family plan, and (b) do you feel like an equal partner in the team process?

Table 5.20

(JUVIS) Fisher's Exact Tests for ITC Measures of Participation (n = 24)

Variable	ITC 9 <sup>a</sup>		ITC 18 <sup>b</sup>	
	% Yes	P value	% Yes	P value
<b>Gender</b>				
Male	93.3% (n = 14)	.308	80% (n = 12)	.208
Female	77.8% (n = 7)		55% (n = 5)	
<b>Age</b>				
12-15 years	90.0 (n = 10)	.565	81.8% (n = 9)	.264
16-18 years	84.6% (n = 11)		61.5% (n = 8)	
<b>CAFAS score</b>				
Mild-	87.5% (n = 7)	.723	75% (n = 6)	.572
Moderate	87.5% (n = 14)		69% (n = 11)	
Severe				
<b>No. offenses</b>				
1-2	91.7% (n = 11)	.500	66.7% (n = 8)	.500
4-8	83.3% (n = 10)		75% (n = 9)	
<b>Education</b>				
High school	100% (n = 10)	.180	80% (n = 8)	.357
Some college	78.6% (n = 11)		64% (n = 9)	

Table 5.20 Continued

No. of adults				
One	85.7% (n = 6)	.664	71.4% (n = 5)	.682
More than one	88.2% (n = 15)		70.6% (n = 12)	
Income				
Below federal poverty level	77.8% (n = 7)	.332	77% (n = 7)	.418
Above federal poverty level	92.9% (n = 13)		64.3% (n = 9)	

Note. CAFAS = Child and Adolescent Functioning Assessment Scale

<sup>a</sup>ITC 9 = Do you have authority and/or influence about your child and family plan?

<sup>b</sup>ITC 18 = Do you feel like an equal partner in the team process?

T-tests were used to answer the second question: How is family participation (ITC scores) related to changes in strengths quotients (BERS) and child problems (CBCL scores) and number of offenses post intake. The analysis previously outlined for the SOC data set was repeated for the JUVIS data set with the added outcome variable of number of offenses after intake. The results of the comparison of the first ITC item and child outcomes with the added outcome variable of number of offenses post intake are shown in Table 5.21.

The group of respondents (n = 21) who reported having authority or influence regarding their child and family plan reported an increase in strengths for their child from baseline to 6 months (M = - 9.29, SD = 18.07)

while the group of respondents ( $n = 3$ ) who reported not having authority or influence regarding their child and family plan reported a decrease in strengths for their child from baseline to 6 months ( $M = 10$ ,  $SD = 14.11$ ). This difference was not statistically significant  $t(3.01) = -2.13$ ,  $p = .122$ . The group that reported having authority or influence regarding their plan reported a larger decrease in problems for their children from baseline to 6 months ( $M = 8.12$ ,  $SD = 9.01$ ) than the group that reported not having authority or influence regarding their plan ( $M = 3.43$ ,  $SD = 4.36$ ). This difference was also not statistically significant  $t(4.74) = .64$ ,  $p = .55$ . However, there was a statistically significant difference between groups regarding number of the offenses post intake. The group that reported having authority had a lower average number of offenses following intake ( $M = 1.24$ ,  $SD = 1.64$ ) compared to the group who did not report having authority or influence regarding their plan ( $M = 3.33$ ,  $SD = .577$ ). This difference was statistically significant  $t(8.18) = -4.28$ ,  $p = .003$ .



Table 5.21

(JUVIS) T-test Comparison of ITC 9 and Child Outcomes

Child Outcome	Authority (n = 21)		No authority (n = 3)		df	t	p
	M	SD	M	SD			
Change in BERS	-9.29	18.07	10	14.11	3.01	-2.13	.122
Change in CBCL	7	8.65	5	4.36	4.74	.64	.554
No. of offenses	1.24	1.64	3.33	.577	8.18	-4.28	.003*

Note. ITC 9 = Do you have authority or influence about your child and family plan?

BERS = Behavioral Emotional Rating Scale

CBCL = Child Behavioral Checklist

\*p < .05

Table 5.22 shows the results of the comparison of the second ITC item and child outcomes with the added outcome variable of number of offenses post intake. The group of respondents (n = 17) who reported feeling like an equal partner in the planning process reported an increase in strengths for their child from baseline to 6 months (M = -10.53, SD = 19.56) while the group of respondents (n = 7) who reported not feeling like a partner in the planning process reported a decrease in strengths for their child from baseline to 6 months (M = 2, SD = 12.95). This difference was marginally statistically significant  $t(16.96) = -1.84, p = .08$ . The group who reported

feeling like an equal partner in the planning process also reported a slightly smaller decrease in problems for their children from baseline to 6 months ( $M = 8.12$ ,  $SD = 9.01$ ) compared to the group that reported not feeling like an equal partner in the planning process ( $M = 4.79$ ,  $SD = 20.17$ ). This difference was not statistically significant ( $t(20.17) = 1.65$ ,  $p = .11$ ). The group that reported having authority had a slightly lower number of offenses following intake ( $M = 1.47$ ,  $SD = 1.74$ ) compared to the group who did not report having authority or influence regarding their plan ( $M = 1.57$ ,  $SD = 1.72$ ). This difference was also not statistically significant ( $t(11.35) = -.130$ ,  $p = .899$ ).

Table 5.22

(JUVIS) T-test Comparison of ITC 18 and Child Outcomes

Child Outcome	Equal Partner (n = 17)		Not Equal Partner (n = 7)		df	t	p
	M	SD	M	SD			
Change in BERS	-10.53	19.56	2	12.95	16.96	-1.84	.08
Change in CBCL	8.12	9.01	3.43	4.79	20.17	1.65	.11
No. of offenses	1.47	1.74	1.57	1.72	11.35	-.130	.89

Note. ITC 18 = Do you feel like and equal partner in the planning process?  
 BERS = Behavioral Emotional Rating Scale  
 CBCL = Child Behavioral Checklist

As reviewed in previous analysis, the Mann-Whitney test was also computed given the small n and concerns regarding normality of distributions. Mann-Whitney is a non-parametric equivalent of the t-test that can be used when the assumption of normal distribution is in question (Agresti & Finlay, 1997). This analysis yielded the same results as the t-tests.

#### *Multivariate Analysis for JUVIS Data*

This section will address the following research questions:

- How are child and family characteristics (including number of offenses prior to intake) related to change in BERS scores?

- How are child and family characteristics (including number of offenses prior to intake) related to change in CBCL scores?
- How are child and family characteristics (including number of offenses prior to intake) related to number of offenses following intake?
- How are child and family characteristics (including number of offenses prior to intake) related to participation (FSQ items)?

These research questions were posed to assess the relationship between (a) child and family characteristics and child outcomes and (b) child and family characteristics and participation. Multiple regressions were used to examine these relationships. Relationships between variables were evaluated by conducting correlation analysis. A review of the correlation matrix did not suggest any problems with collinearity. Regression residuals were also examined and no violations regarding the assumptions of multiple regression were identified. The results of the regression analyses for the JUVIS data are shown in Tables 5.23 through 5.27.

The first regression analysis in the series examined the relationship between child and family characteristics and change in BERS scores. The overall model was marginally statistically significant and accounted for 35% of variability in BERS change scores,  $R^2 = .356$ ,  $p = .07$ . Table 5.23 shows that sex was a statistically significant predictor of change in BERS scores. Specifically, girls had a decrease in strengths quotient of

approximately 11.5 points from baseline to 6 months. Additionally, the relationship between the number of adults in the family and change in BERS scores was marginally statistically significant; for each additional adult in the family, the change in BERS scores improved by approximately 5 points.

Table 5.23

(JUVIS) Regression Analysis for Child and Family Characteristics Predicting Change in BERS Scores (n = 35)

Variable	B	SE B	$\beta$	t	p
Sex	11.46	5.42	.34	2.11	.04*
Child age	-2.40	2.29	-.20	-1.05	.30
CAFAS total	-.02	.07	-.06	-.34	.74
No. pre offenses	.88	1.33	-.11	.66	.52
Education	1.15	1.24	.16	.93	.36
Income	-.00	.00	-.21	-1.23	.23
No. of adults	-5.36	2.90	-.30	-1.85	.08

Note. CAFAS = Child and Adolescent Functioning Scale  
\*p < .05

Table 5.24 shows the results of the regression analysis for child and family characteristics predicting change in CBCL scores. The overall model was not significant; however, sex was a statistically significant predictor of change in CBCL scores. Specifically, being female was associated with a 5.36 point decrease in change scores. In other words, girls had higher total

problem scores at 6 months than they did at intake. Given the lack of significance in the overall model, this relationship was examined through bivariate correlation. The results failed to confirm a significant relationship between sex and change in CBCL scores.

Table 5.24

(JUVIS) Regression Analysis for Child and Family Characteristics Predicting Change in CBCL Scores (n = 35).

Variable	B	SE B	$\beta$	t	p
Sex	-5.36	2.62	-.36	-2.05	.05
Child age	1.16	1.11	.22	1.05	.30
CAFAS total	.01	.03	.08	.43	.67
No. pre offenses	-.42	.64	-.11	-.65	.52
Education	-.40	.60	-.12	-.67	.51
Income	.00	.00	.21	1.16	.26
No. of adults	-.47	1.40	-.06	-.34	.74

Note. CAFAS = Child and Adolescent Functioning Scale

The results of the regression for child and family characteristics predicting the number of offenses following intake are shown in Table 5.25. The number of adults in a family was predictive of the number of offenses following intake. The expected number of offenses increases by one for each additional adult in the household. Additionally, the relationship between age and number of offenses following intake was marginally statistically

significant. Specifically a one year increase in age corresponds to .5 drop in the number of offenses. The overall model was statistically significant and accounted for 40% of the variability in number of offenses post intake, R-squared = .40,  $p = .035$ .

Table 5.25

(JUVIS) Regression Analysis for Child and Family Characteristics Predicting Number of Offenses Following Intake (n = 35)

Variable	B	SE B	$\beta$	t	p
Sex	-.39	.61	-.10	-.64	.53
Child age	-.47	.26	-.33	-1.82	.08
CAFAS total	.01	.01	.12	.73	.47
No. pre offenses	.25	.15	.27	1.68	.11
Education	-.16	.14	-.19	-1.17	.25
Income	.00	.00	.23	1.40	.17
Number of adults	.80	.32	.39	2.48	.02*

Note. CAFAS = Child and Adolescent Functioning Scale

\* $p < .05$

As previously outlined, the first step in evaluating a mediating model is to establish a relationship between independent and dependent variables. Given that the number of adults in household, child age, and child sex were the only predictors of child functioning in this data set, the next step; examination of the relationship between the predictors and the mediator was

done using these three variables. Number of adults in the household, child age, and child sex were entered as the independent variables and the FSQ items were dependent variables. Results of these analysis showed that none of these variables were predictive of participation and therefore additional analysis to test for mediation were not possible.

Given that there were no relationships in which participation could be tested as a mediating variable, additional analyses were completed to explore the relationship between (a) all the child and family characteristic variables used in this study and participation and (b) participation and child functioning. The regression analysis for child and family characteristics predicting FSQ scores are shown in Tables 5.26 and 5.27. The results show that for the JUVIS sample, none of the child and family characteristics were predictive of either of the FSQ items included in this study: (a) How satisfied were you with the number of times you were asked to participate in meetings where services for your child were discussed? (b) How satisfied were you with the number of times you were asked to participate in meetings where services were discussed?



Table 5.26

(SOC) Regression Analysis for Child and Family Characteristics Predicting  
FSQ 5 Scores (n = 35)

Variable	B	SE B	$\beta$	t	p
Sex	-.52	.46	-.21	-1.14	.27
Child age	.14	.19	.16	.74	.46
CAFAS total	-.07	.01	-.21	-1.21	.24
No. pre offenses	.06	.11	.10	.56	.58
Education	-.05	.11	-.09	-.45	.66
Income	.00	.00	-.13	1.46	.16
Number of adults	-.18	.25	-.13	-.73	.47

*Note.* CAFAS = Child and Adolescent Functioning Assessment Scale

Table 5.27

(JUVIS) Regression Analysis for Child and Family Characteristics Predicting FSQ 6 Scores (n = 35)

Variable	B	SE B	$\beta$	t	p
Sex	-.24	.51	-.09	-.48	.64
Child age	.08	.22	.08	.38	.71
CAFAS total	.00	.01	.05	.23	.82
No. pre offenses	.04	.13	.06	.32	.75
Education	-.07	.12	-.11	-.57	.58
Income	.00	.00	.23	1.14	.26
Number of adults	-.35	.27	-.24	-1.28	.21

*Note.* CAFAS = Child and Adolescent Functioning Assessment Scale

As previously described, an additional step in the exploratory analysis involved an examination of the bivariate correlations between FSQ items and child functioning. For the JUVIS data set, this included the added outcome variable of number of offenses following intake. This analysis found no statistically significant relationships between the FSQ items measuring participation and child outcomes (Change in BERS scores and Change in CBCL scores, and number of offenses post intake).

The final two regression models in the proposed series of analyses were designed to answer the following research questions:

- To what extent is the relationship between child characteristics and child outcomes mediated by family participation in treatment planning?
- To what extent is the relationship between family characteristics and child outcomes mediated by family participation in treatment planning?

As was the case with the larger SOC data set, these research questions were not possible to answer with the subsample of JUVIS data due to a lack of findings related to earlier questions. As previously mentioned, testing for mediation requires that the independent variable be related to both the outcome variable and the mediator (Gogineni et al., 1995). Although analysis of the JUVIS data set showed a relationship between (a) child and family characteristics and (b) child outcomes, they did not show any relationships between (a) those same child and family characteristics and (b) participation. Therefore there were no relationships for which participation could be tested as a mediating variable.

## Chapter 6

### Discussion and implications

#### *Discussion*

Exploration of the concept of family participation and how it relates to child outcomes was the primary objective of this study. The quantitative portion of this study was designed to test the mediating effects of participation on the relationship between (a) child and family characteristics and (b) child outcomes. It was predicted that child and family characteristics were related to child outcomes and that this relationship might be mediated by family participation in treatment planning. Although the results of this study did not allow for testing of the full model proposed, they do illuminate a number of relationships among variables of interest. Specifically, the findings from this study add to the knowledge base linking (a) child and family characteristics to child outcomes, (b) child and family characteristics to family participation, and (c) family participation to child outcomes. The significant findings of the quantitative analysis are summarized in Table 6.1.

Table 6.1

## Summary of Quantitative Results

Outcome Variable	SOC Data	JUVIS Data
Change in BERS score	Having authority about plan* (p = .06)	Child sex** (p = .04)
	Feeling like an equal partner* (p = .07)	No. of adults* (p = .08)
		Feeling like an equal partner* (p = .08)
Change in CBCL score	Child age* (p = .04)	Child age* (p = .08)
		No. of adults** (p = .02)
		Having authority about plan** (P = .003)
No. offenses post intake		
Having authority or influence about team Feeling like an equal partner	Income* (p = .06)	
Satisfaction with level of involvement	CAFAS** (p = .02)	
Satisfaction with no. times asked to participate	Income* (p = .06)	

The results of the quantitative analysis in this study lend support to previous research linking child and family characteristics to child outcomes (Hodges & Wotring, 2000; Xue et al., 2004; Bourduin et al., 1995; Friedman et al., 1995; Quist & Matshazi, 2000). In the current study, results showed that child age was predictive of change in CBCL scores, child sex was predictive of change in BERS scores, and the number of adults in the household was predictive of the number of offenses following intake. Specifically, as children got older, fewer problem behaviors were reported overtime and for girls, less strengths were reported overtime. Additionally, more adults in the household was correlated with an increase in number of offenses following intake. This last finding is somewhat unexpected as the number of adults in a household is generally considered a protective factor, however it is possible that in relation to criminal activity more adults in the household also provides more opportunity for offenses to be detected and reported. There were also some marginally significant findings that showed more adults in the household was correlated with an increase in strengths and that as children get older, the number of offenses decreased.

The results also show that child and family characteristics are related to participation. Specifically, in this study, income was predictive of two measures of participation. First, although marginally statistically significant, differences were found between groups in the SOC data set who reported having authority or influence about their child and family plan and those who

did not. Specifically, 96% percent of the group who reported they did have authority and influence about their child and family plan also reported household income above the federal poverty level. For the group reporting a household income below the federal poverty level, only 76% reported having authority and influence about their child and family plan.

Income was also predictive of how satisfied families were with their level of involvement in planning services. Although the effects were very small, higher incomes were predictive of slight increases on this measure of participation. Additionally, lower problem scores at intake were predictive of small increases in levels of participation as measured by the FSQ item regarding level of involvement in treatment planning. These findings fit with existing research identifying level of child functioning as a predictor of participation (Baker, 1993; Curtis & Singh, 1996).

Contrary to previous research (Curtis & Singh, 1996; Elliot, Koroloff, Koren & Friesen, 1996), the family characteristic of education was not related to participation in this study. The reasons behind the contradictions between the findings in this study and previous research are not readily apparent, however it may be due differences in populations studied. For example, the sample for this study was highly educated with reported incomes well above the federal poverty level.

In addition to showing relationships between child and family characteristics and (a) child functioning and (b) participation, the findings

from this study also suggest a link between family participation and child outcomes. This study found for both the overall SOC sample and the subsample from the JUVIS data set, that the majority of respondents who reported having a team felt like they had authority and influence about their family plan and felt like they were equal partners in the planning process. Respondents from both groups also reported improvements in child functioning with one exception; results from analysis of the SOC data set showed that the group of respondents who felt they had authority or influence in their child and family plan reported a smaller decrease in problem behaviors than the group who did not feel they had authority or influence in their plan.

Additionally, the majority of respondents from both the overall SOC sample and the JUVIS subsample were satisfied with their level of involvement in the planning process and the number of times they were asked to participate in meetings where services were discussed. These respondents also reported improvements in child functioning. These findings suggest a relationship between participation and outcomes which supports some of the major principles behind wraparound as a process for treatment planning; Wraparound is a collaborative activity that recognizes that the likelihood of positive outcomes increases when the perspectives and priorities of families are included.



At the bivariate level, marginally statistically significant differences were found between groups in the SOC data set who reported having authority or influence about their plan and those who did not and between groups who felt like an equal partner in the process and those who did not. Specifically, the group who reported having authority or influence about their plan reported an increase in strengths over time, while those who did not have authority or influence reported a decrease. Similarly, the group who reported feeling like an equal partner in the process reported an increase in strengths over time, while the group that did not feel like an equal partner reported a decrease.

Similarly, in the JUVIS data set, marginally statistically significant differences were found between groups who felt like an equal partner and those who did not. Specifically, the group that felt like an equal partner reported more strengths over time, while the group that did not feel like an equal partner reported a decrease in strengths from baseline to six months. Additionally, in the JUVIS data set having authority or influence about ones team was significantly related to a decrease in the number of offenses following intake. These findings support previous research linking family participation and outcomes for children (Aeby et al., 1999; Bylan, 1990; Benedict & White, 1991; Cantos & Gries1997).

Taken together, the findings from the quantitative portion of this study lend support to existing literature regarding youth with SED and contribute to

the understanding of family participation and how it relates to outcomes.

Although the mediating effects of participation were not possible to test in this study, the results do suggest that family participation is an important variable to consider in outcomes for youth and families.

The nature and importance of participation is further illuminated through the qualitative portion of this study. The qualitative information in this study expands upon our understanding of family participation through the perspective of families involved in a wraparound program within the juvenile justice system.

The families who participated in the qualitative portion of this study brought diverse experiences and provided useful data regarding family participation and how it relates to outcomes. In general, the families expressed positive attitudes regarding their experiences in the Connections program. They described their participation in a variety of ways ranging from feeling heard to attending meetings to making decisions. The unique perspectives and experiences shared by families in this study were informed in part, by their previous experiences with services for their children and their current relationships with Connections staff. These findings fit with existing literature supporting the notion that family participation is a perception based phenomenon that is only meaningful to the extent that the context in which it occurs is carefully described or understood (Singh, Curtis, Wechsler, Ellis & Cohen, 1997). The findings also underscore one of the key challenges to

studying this construct identified in the literature; the lack of a commonly accepted conceptual definition of family participation (Curtis & Singh, 1996).

Participants in this study also identified a number of ways in which they felt the program facilitated their participation. Specifically, families in this study spoke of flexibility, availability and extra efforts of staff as key aspects of the program that contributed to their ability to participate. These findings lend support to existing literature that identifies practical ways that agencies can support families which will enhance participation of families (Friesen, Kruzich & Schultz, 1995; Friesen, Kruzich, Ogilvie, Pullman, Gordon & Jivanjee, 2001). Additionally, it has been argued that this type of information is particularly important in the context of a juvenile justice setting. Advocates suggest that family participation is especially crucial when a youth with a mental health disorder becomes involved with juvenile justice. This is especially imperative in the earlier stages because intake often happens after hours and is unplanned. Consequently, youth frequently enter the juvenile justice system without any referral or background information provided. Advocates contend that families' knowledge of their children, their diagnosis, treatment history, medication use, and their patterns of responding to others; information that might not be readily available from other sources, is vital to keeping children stable and safe in settings like detention. (Osher & Hunt, 2002).

Although the focus of this study was on the relationship between family participation and child outcomes, families did not directly tie their participation to outcomes for their children. Rather, families in this study related their participation to other outcomes such as: (a) feeling better, more empowered or less stressed, (b) having the ability to cope with their children's problems or feeling supported and (c) getting the right services.

This finding is particularly important because it provides a constructive reframe for conceptualizing outcomes. The participation of families in the process of treatment planning is typically presumed to result in a better match between services and interventions for their children, which in turn is intended to yield better outcomes for children. Yet somewhat contrary to this idealized scenario of better outcomes for youth, the families interviewed for this study indicated that the benefits of their participation is often more directly related to their own well-being.

Additionally, not only did families relate participation to their own outcomes, they also connected poor outcomes for their children to a lack of participation on the part of the child. These findings support the importance of participation in general and highlight the significance of what proponents of wraparound refer to as "voice, choice, and ownership" for both youth and their families (Miles 2000). This principle recognizes the unique stake that youth and families have in the outcomes of their plan. This principle also reflects the view that when plans reflect the perspectives of youth and

families they are more likely to engage in the treatment process and thus increase the likelihood of positive outcomes. The struggles around involving youth in wraparound planning processes are often mentioned in the literature but youth engagement has yet to be identified as a primary focus in the movement toward family centered practice. The findings from this study suggest youth engagement is an essential part of involving families and improving outcomes.

A final theme illuminated in this study is related to practice specificity in the wraparound model. The qualitative findings in this study identified a number of differences in the process of wraparound planning in the Connections program. The variations in practice strategies and organization of services affected the experiences of families participating in the Connections program. While these findings are not surprising given the individualized nature of the wraparound model, they do complicate understanding of how families experience participation. The findings from this study support previous research suggesting that family participation must be viewed from the context in which it occurs and that our understanding of how families experience participation will be enhanced to the extent that the context can be understood.

The quantitative portion of this study examined family participation as defined in one evaluation of a SOC setting. The qualitative portion of this study explored the construct of participation from the perspective of families

receiving services within the context of that SOC setting. Taken together, the findings from this study add to the growing knowledge base regarding family participation and carry a number of implications for social work practice, policy and research. However, prior to the discussion of these implications, there are a number of limitations that must be considered.

### *Limitations*

As with any research, the findings presented here must be viewed within the context of the limitations of the study. The limitations related to the qualitative portion of this study will be discussed first, followed by a discussion of limitations for the quantitative portion of the study.

#### *Qualitative limitations*

The primary limitations of the qualitative portion of this study are related to the sample and the interview schedule. First, the qualitative interviews involved a relatively small sample of the families enrolled in the Connections program and therefore will not be representative of all families in the program. An additional issue related to this sample is that participants were limited to those who agreed to and were able to participate in individual interviews. The sampling strategy of Connections staff identifying parents to participate was used to ensure that cases were selected where there was some level of participation and there was some diversity in outcomes. However, the subjective experiences of Connections staff may have impacted participant selection such that the families selected had a more

positive experience than usual. Despite these obstacles, the researcher was able to discern a range of experiences related to parent participation.

Another possible limitation of this study is that the focus group participants may have associated the principal investigator with previous roles related to the implementation and evaluation of the system of care evaluation that involved the Connections program. The researcher addressed this issue at the beginning of the focus group by clarifying her current role and encouraging participants to speak openly about their experiences in the program. Despite the potential confusion related to the role of the researcher, the data suggest that this was not an issue. It should also be noted that at the beginning of the focus group respondents indicated that they felt comfortable.

Another potential limitation relates to the design of the interview guide. The order of the questions may have contributed to difficulties most families had in answering questions about how they view their participation as contributing to outcomes of their children. However, many parents who reported poor outcomes for their children also identified Connections as a vital program and family participation as a positive aspect of their experience.

#### *Quantitative limitations*

In addition to the limitations previously discussed, there are a number of limitations specific to the quantitative portion of this study. The limited amount of data available was a primary limitation in this study. Although this

did not preclude the use of these data, it did limit the options for statistical testing of results. For example, data related to the ITC questionnaire required examination at the bivariate level and could not be included in a mediating model.

There are additional limitations related to conducting secondary data analysis that should be acknowledged. First, the focus of this study is family participation in treatment planning. The measures of participation used were designed for the original SOC evaluation and were asked in the context of satisfaction with participation. Thus, the measures used for this study may not be a direct indicator of degree of participation. Second, the data were collected by various interviewers at each data collection point which presents a threat to inter-rater reliability; however interviewers all received extensive training and followed a specified protocol related to data collection.

Another limitation is that the variability in type and amount of services received by youth and families is unknown. Although the specific details related to the interventions received by the youth and families in this study is unknown, the services were provided in the context of a system of care which presumably incorporated a common set of guiding principles. Despite potential limitations of this study, findings from both the qualitative and quantitative findings are informative and have important implications for social work practice, policy and research.



### *Implications for Social Work Practice*

The findings of this study contain a number of important implications for social work practice. First, the findings support the notion that family participation is an important aspect of services for youth and families including those provided within a juvenile justice setting. Although the quantitative analysis of the data set used in this study failed to demonstrate the potential mediating effects of this variable, the qualitative findings suggest that it is an important variable to consider.

It can be concluded from these findings that involving families in the process of service planning is associated with positive outcomes. Specifically, the results from this study suggests that coping and social support are important outcomes for families and improvement in these areas is tied to their participation. Additionally, these results suggest that without the type of services provided in the Connections program, kids would be worse off; they would be moved out of their homes or place in foster care. A number of participants in the qualitative portion of this study commented on their enhanced ability to maintain their children in their home as a result of their partnership with staff. The implication here is that providers should invest more directly in engaging families.

The data also suggests a number of techniques that providers can apply in context of existing interventions to facilitate the participation of families. Specifically, providers interested in promoting family participation

need to be flexible in relation to times and locations for family planning meetings. Additionally, service providers would be well served to focus on ways they can build relationships with families that are characterized by trust and respect. One specific strategy employed by the program used for this study is the use of parent partners as members of professional teams. The value of parent partners was emphasized in the data from this study and is well documented in existing literature surrounding peer support.

In light of this study's findings regarding child participation, providers should consider ways they can better facilitate youth involvement. The families in this study identified practices such as "buying pizza" and engaging with youth outside planning meetings as effective ways to involve youth. However, providers may want to go further and reconsider the overall format of their meetings. In follow up discussions with Connections staff, it was suggested that the process of adults sitting around a table is inherently unappealing to youth. An additional strategy might be replicating the parent partner model by providing mentors or partners for youth to enhance participation.

In addition to adapting existing services, providers should also consider developing interventions aimed specifically at increasing participation. One potential avenue for enhancing participation of families is through education, training, and information sharing. Some of the qualitative comments from this study suggest that families can be "overwhelmed" and

“unsure of what is expected of them”. The use of education as an effective tool in facilitating family participation in services is supported in literature (Koroloff & Friesen, 1991; Ireys, Devet & Sakwa, 2002). The Connections program utilizes ongoing consultation for staff regarding the wraparound model. The expansion of such agency trainings to include families both as participants and teachers would not only serve to keep families informed and educate providers, but it could also provide an opportunity for programs to demonstrate true partnership with families.

An additional implication for practice discussed earlier is the need to clarify practices associated with family participation. Service models such as wraparound call for the full participation of families. However, there is no consensus on what constitutes “full participation” or how to achieve it, particularly across providers in different settings. While it is debatable whether participation from the perspective of families can be sufficiently and meaningfully quantified, it can be measured from a practice perspective depending on the extent to which programs can define what participation is within a given setting. Clarifying practice at the program level is a first step in furthering our understanding of family participation and how it relates to other variables. One example from the data in this study is the need to decide if juvenile court issues are a part of the wraparound plan or not and to what extent families have a voice regarding those issues.

In summary, the findings from this study suggest that family participation is an important aspect of services for children and families and there are a number of strategies that can be implemented at the practice level. Further, continued work toward specification of the wraparound model is needed. Many of these propositions support what is currently being advocated in the literature surrounding services for youth and families in the field of mental health. (Stroul & Friedman, 1986a; Stroul & Friedman, 1986b).

#### *Implications for Policy*

The strategies previously outlined will require support at the policy level. At the local agency level, this support centers on creating the context for family-centered interventions to occur. For example, agencies need to adopt employment policies that allow for things such as flexible hours or the hiring of parent partners. Another strategy which is often discussed in the literature is providing training for both staff and families regarding family-centered practice.

At state and federal levels, support comes in the form of funding mechanisms and mandates. One strategy at the regional level might be to require the inclusion of families as a contractual stipulation. At the state level, support could come in the form of legislation that recognizes families as a key component of services. One example of this can be found in recent legislation in the state of Washington which calls for services for children "to be conducted in context of families" and for existing services to "integrate

families into treatment through choice of treatment, participation in treatment, and provision of peer support" (House Bill 1088, 2007).

An additional strategy for supporting family participation that applies to both the local and state level is providing support to parent-administered programs such as a local parent support networks or parent to parent programs. These programs are generally designed to match trained supporting parents to parents requesting assistance and have been shown to be associated with positive outcomes for families (Singer, Marquis, Power, Blanchard, Divenere, Santelli, Ainbinder & Sharp, 1999). The Connections program that served as the setting for the current study, has incorporated this role into the core staff with the family support specialist position, however creating a community resource for this type of service would enhance family participation across the broader service community.

Federal programs such as the Comprehensive Community Mental Health Services Program for Children and Their Families include family participation as a core value and provide funding to develop systems of care in communities throughout the country. Communities receiving SOC funding are required to involve families at all levels of the service process. Many of the currently funded communities are gathering data regarding family participation through local evaluation efforts and thus provide ideal settings for continued research in this area (Elaine Staten, personal communication, March 27, 2007).

### *Implications for Research*

Given the current emphasis on including families in services and the limited attention family participation has received in the literature, additional research is needed. The results from this dissertation provide insight regarding both the direction and design of future research. First, future intervention studies and program evaluations should include larger samples and employ longitudinal designs to effectively evaluate relationship between participation on child outcomes. Additionally, future researchers need to consider a wide range of possible outcomes.

While the primary focus in the context of this study was on child outcomes, it can be concluded that a more relevant focus might center on family outcomes. Studies may focus on family outcomes such as coping or social support as dependent variables. Further, researchers may want to consider family participation itself as an outcome. While parent advocacy groups such as the Federation of Families for Children's Mental Health have long promoted the inclusion of families under the assertion that parental outcomes accrue to children, family participation has yet to be considered among the variables in outcome studies.

Future researchers may also want to continue evaluating the mediating affects of participation in order to add to the understanding of the mechanism through which known predictors affect child outcomes. This study examined child and family characteristics as factors associated with

participation and child outcomes. Future research should also consider service system features as components related to family involvement. Another option would be to consider family outcomes such coping or social support as potential mediators. Mediation models have received little attention in social work literature; however complex multivariate relationships such as those examined in this study lend themselves to this type of analysis (Gogineni et al., 1995).

Some of challenges facing future research in this area are related to issues of measurement. The findings from this study point to two key issues; how we measure participation and where it lies in constellation of variables associated with of services for youth with SED. While there have been a few attempts to develop tools for measuring family participation, there is no widely accepted measure of participation to date, therefore additional work in this area is needed.

The findings in this study support the value of parent perspectives regarding the nature and meaning of family participation. These results also suggest that the development of any measurement of family participation should occur in collaboration with a wide sample of family participants. One place to start is to explore the work being done at the local level across the different system of care communities. Ideally families should be included at all levels of social work practice, but their input regarding research and evaluation is particularly important as we look at broadening the range of

what we consider to be legitimate outcome variables and consider new approaches for measuring them.

### Conclusion

In sum, this study contributes to a growing knowledge base that identifies family participation as an important aspect of services to youth and families. It supports the view that family participation is a dynamic and complex concept that must be considered from within the context in which it occurs. It also gives voice to families involved in services for their children about their experiences and perceptions of participation. This study adds to the existing knowledge base regarding family participation and how it relates to other variables of interest in children's mental health. It provides strategies at all levels of practice for promoting the inclusion of families as partners in the process of service delivery. The findings underscore the need for future research to further explore the construct of family participation, the variables that affect its measurement and the role it plays in outcomes. This study also challenges future researchers to consider how outcomes are conceptualized and suggests considering family participation itself or family well-being as possible variables to include in outcome evaluations. Finally, this study identifies a number of practice, policy and research implications that support the inclusion of families at all levels of the service delivery process.



## References

- Achenbach, T. M. (1991). Manual for the Child Behavior Checklist 14-18 and 1991 profile. Burlington, VT: University Associates in Psychiatry.
- Achenbach, T. M., McConaughy, S. H., & Howell, C. T. (1987). Child/adolescent behavioral and emotional problems: Implications of cross-informant correlations for situational specificity. *Psychological Bulletin*, 101(2), 213-229.
- Aeby, V. G., Manning, B. H., Thyer, B. A., & Carpenter-Aeby, T. (1999). Comparing outcomes of an alternative school program offered with and without intensive family involvement. *The School Community Journal*, 9(1), 17-33.
- Baker, B. L., Blacher, J., & Pfeiffer, S. (1993). Family involvement in residential treatment of children with psychiatric disorder and mental retardation. *Hospital and Community Psychiatry*, 44(6), 561-566.
- Baker, B. L., & Blacher, J. B. (1993). Out-of-Home placement for children with mental retardation: Dimensions of family involvement. *American Journal on Mental Retardation*, 98(3), 368-377.
- Baker, B. L., Heller, T. L., Blacher, J., & Pfeiffer, S. I. (1995). Staff attitudes toward family involvement in residential treatment centers for children. *Psychiatric Services*, 46(1), 60-65.
- Benedict, M. I., & White, R. B. (1991). Factors associated with foster care length of stay. *Child Welfare*, 70(1), 45-58.
- Bickman, L., Smith, C. M., Lambert, E. W., & Andrade, A. R. (2003). Evaluation of a congressionally mandated wraparound demonstration. *Journal of Child and Family Studies*, 12(2), 135-156.
- Borduin, C. M., Mann, B. J., Cone, L. T., Henggeler, S. W., Fucci, B. R., Blaske, D. M., & Williams, R. A. (1995). Multisystemic treatment of serious juvenile offenders: Long-term prevention of criminality and violence. *Journal of Counseling and Clinical Psychology*, 63(4), 569-578.
- Brunk, M., Santiago, R., L, Ewell, K., & Watts, A. (1997). *Family satisfaction with level of cultural competence in systems of care: Development of a cultural competence scale*. Paper presented at the A System of Care for Children's Mental Health: Expanding the Research Base 10th Annual Research Conference Proceedings., Tampa, Florida.
- Cantos, A. L., & Gries, L. T. (1997). Behavioral correlates of parental visiting during family foster care. *Child Welfare*, 76(2), 309-329.
- Clark, H. B., Lee, B., Prange, M. E., & McDonald, M. A. (1996). Children lost within the foster care system: Can wraparound service strategies improve placement outcomes? *Journal of Child & Family Studies*, 5(1), 39-54.

- Clarke, G., Hops, H., Lewinsohn, P. M., Andrews, J., Seeley, J., & Williams, J. (1992). Cognitive-behavioral group treatment of adolescent males: severity of diagnosis predicts 2-year outcome. *Behavioral Therapy, 23*, 341-354.
- Coyne, I. T. (1996). Parent participation: A concept analysis. *Journal of Advanced Nursing, 23*, 733-740.
- Curtis, J. W., & Singh, N. N. (1996). Family involvement and empowerment in mental health service provision for children with emotional and behavioral disorders. *Journal of Child & Family Studies, 5*(4), 503-517.
- DeChillo, N., Koren, P., & Schultze, K. H. (1994). From paternalism to partnership: Family and professional collaboration in children's mental health. *American Journal of Orthopsychiatry, 64*(4), 564-576.
- Emerson, R., Fretz, R., & Shaw, L. (1995). *Writing ethnographic fieldnotes*. Chicago: University of Chicago Press.
- Epstein, M. H., Harniss, M. K., Pearson, N., & Ryser, G. (2001). The Behavioral and Emotional Rating Scale: Test-retest and inter-rater reliability. *Journal of Child and Family Studies, 8*, 319-327.
- Epstein, M. H., Nordness, P. D., Kutash, K., Duchnowski, A., Schrepf, S., Benner, G. J., & Nelson, J. R. (2003). Assessing the wraparound process during family planning meetings. *Journal of Behavioral Health Services Research, 30*(3), 352-362.
- Epstein, M. H., & Sharma, J. (1998). *Behavioral and emotional rating scale (BERS): A strength-based approach to assessment*. Austin, TX: PRO-ED.
- Evans, M. E., Armstrong, M. I., & Kuppinger, A. D. (1996). Family-centered intensive case management: A step toward understanding individualized care. *Journal of Child & Family Studies, 5*(1), 55-65.
- Federation of Families for Children's Mental Health 2007, Definition of Family Driven Care. Retrieved April 17, 2007, from [http://www.ffcmh.org/systems\\_whatism.htm](http://www.ffcmh.org/systems_whatism.htm)
- Freidman, A., Terras, A., & Kreisher, C. (1995). Family and client characteristics as predictors of outpatient outcome for adolescent drug abusers. *Journal of Substance Abuse, 7*, 345-356.
- Friesen, B., & Stephens, B. (1998). Expanding family roles in the system of care: Research and practice. In A. Duchnowski (Ed.), *Outcomes for children and youth with emotional and behavioral disorders and their families*. Austin, TX: Pro-ed.
- Friesen, B. J., & Koroloff, N. M. (1990). Family-centered services: Implications for mental health administration and research. *The Journal of Mental Health Administration, 17*, 13-25.
- Gogineni, A., Alsup, R., & Gillespie, D. (1995). Mediation and moderation in social work research. *Social Work Research, 19*(1), 57-63.
- Goldman, S. K. (1999). The conceptual framework for wraparound: Definition, values, essential elements, and requirements for practice.

- In S. K. Goldman (Ed.), *Promising practices in wraparound for children with serious emotional disturbance and their families* (Vol. 4). Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.
- Grolnick, W. S., & Slowiaczek, M. L. (1994). Parents' involvement in children's schooling: A multidimensional conceptualization and motivational model. *Child Development, 65*, 237-252.
- Gunderson, K., Cahn, K., & Wirth, J. (2003). The Washington state long-term outcome study. *Protecting Children, 18*(1,2), 42-47.
- Hewitt, S., & Lund, S. J. (1990). *Evaluating the very young child for sexual abuse: A challenge to common procedures*. Paper presented at the Allegations of Child Sexual Abuse, Child Protective Services, Portland, OR.
- Hodges, K., Doucette-Gates, A., & Liao, Q. (1999). The relationship between the Child and Adolescent Functional Assessment Scale (CAFAS) and indicators of functioning. *Journal of Child and Family Studies, 8*(1), 109-122.
- Hodges, K., Lambert, W. E., & Summerfelt, W. T. (1994). *Validity of a measure to assess impairment: the Child and Adolescent Functional Assessment Scale (CAFAS)*. Paper presented at the 7th Annual Research Conference, A System of Care for Children's Mental Health: Expanding the Research Base., Tampa, FL.
- Hodges, K., & Wong, M. (1996). Psychometric characteristics of a multidimensional measure to assess impairment: The Child and Adolescent Functional Assessment Scale. *Journal of Child & Family Studies, 5*(4), 445-467.
- Hunter, R. W., & Friesen, B. J. (1996). Family-centered services for children with emotional, behavioral, and mental disorders. In C. T. Nixon (Ed.), *Families and the mental health system for children and adolescents: Policy, services, and research* (Vol. 2, pp. 18-40). Thousand Oaks, CA: SAGE publications, Inc.
- Jones, D. (1994). Effect of parental participation on hospitalized child behavior. *Issues in Comprehensive Pediatric Nursing, 17*(2), 81-92.
- Kamradt, B. (2000). Wraparound Milwaukee: Aiding youth with mental health needs. *Juvenile Justice, 7*(1), 14-23.
- Koren, P. E., DeChillo, N., & Friesen, B. J. (1992). Measuring empowerment in families whose children have emotional disabilities: A brief questionnaire. *Rehabilitation Psychology, 37*(4), 305-321.
- Koroloff, N. M., Elliot, D. J., Koren, P. E., & Friesen, B. J. (1994). Connecting low-income families to mental health services: The role of the family associate. *Journal of Emotional and Behavioral Disorders, 2*(4), 240-246.

- Koroloff, N.,M & Friesen, B. J., (1997). Challenges in conducting family-centered mental health services research. *Journal of emotional and behavioral disorders*, 5(3), 130-137.
- Littell, J. (2001). Client participation and outcomes of intensive family preservation services. *Social Work Research*, 25(2), 103-113.
- Lourie, I. (2003). A history of community child mental health. In C. N. Winters (Ed.), *The handbook of child and adolescent systems of care* (pp. 1-16). San Fransico: Jossey-Bass.
- Mattingly, D. J., Prislín, R., McKenzie, T. L., Rodriguez, J. L., & Kayzar, B. (2002). Evaluating evaluations: The case of parent involvement programs. *Review of Educational Research*, 72(4), 549-576.
- Merkel-Holguin, L. (2000). Diversions and Departures in the Implementation of Family Group Conferencing in the United States. In J. Hudson (Ed.), *Family Group Conferencing: New directions in community-centered child & family practice* (pp. 224-231). Hawthorne, New York: Walter de Gruyter, Inc.
- Merkel-Holguin, L., Nixon, P., & Burford, G. (2003). Learning with families: A synopsis of FGDM research and evaluation in child welfare. *Protecting Children*, 18(1&2), 2-11.
- Miles, P. (2000). *Individualized and tailored care: Facilitator skills training manual*. Portland, OR: Author.
- Moore, D., & McDonald, J. (2000). Guiding principles of the conferencing process. In J. Hudson (Ed.), *Family Group Conferencing* (pp. 49-57). New York: Walter de Gruyter.
- Morgan, D. L. (1997). *Focus groups as qualitative research* (Second edition ed. Vol. 16). Thousand Oaks: Sage Publications.
- NCMHJJ. (2003). *National policy forum on mental health and juvenile justice: Moving toward an integrated policy for youth*. Delmar, New York: National Center for Mental Health and Juvenile Justice.
- Noser, K., & Bickman, L. (2000). Quality indicators of children's mental health services: Do they predict improved client outcomes? *Journal Of Emotional And Behavioral Disorders*, 8(1), 9-18.
- Osher, T., & Hunt, P. (2002, December). Involving families of youth who are in contact with the juvenile justice system. *Research and Program Brief*.
- Parmelee, D., Cohen, R., Nemil, M., Best, A., Cassell, S., & Dyson, F. (1995). Children and adolescents discharged from public psychiatric hospitals: evaluation of a continuum of care. *Journal of Child & Family Studies*, 4, 43-55.
- Quist, R. M., & Matshazi, D. G. (2000). The child and adolescent functional assessment scale (CAFAS): A dynamic predictor of juvenile recidivism. *Adolescence*, 35(137), 181-192.
- Robinson, A. D., & Friesen, B. (2002). Predicting Family Participation in Service and Treatment Planning for Children in Out-of Home Care. In

- R. M. Friedman (Ed.), *The 14th Annual Research Conference, A System of Care for Children's Mental Health: Expanding the Research Base* (pp. 253-258). Tampa, FL: University of South Florida, The Louis de la parte Florida Mental Health Institute, The Research and Training Center for Children's Mental Health.
- Singer, G. H., Marquis, J., Powers, L. K., Blanchard, Divenere, N., Santelli, B., Ainbinder, J. G., & Sharp, M. (1999). A multi-site evaluation for parent to parent programs for parents of children with disabilities. *Journal of Early Intervention, 22*, 217-229.
- Singh, N. N., Curtis, J. W., Wechsler, H. A., Ellis, C. R., Cohen, R. (1997). Family friendliness of community-based services for children and adolescents with emotional and behavioral disorders and their families: An observational study. *Journal of emotional and behavioral disorders, 5*(2), 82-92.
- Stroul, B. (1996). Introduction: Progress in Children's Mental Health. In B. Stroul (Ed.), *Children's Mental Health: Creating Systems of Care in a Changing Society* (pp. xxi-xxxii). Baltimore: Paul H. Brookes Publishing Co.
- Stroul, B. (2003). Systems of care: A framework for children's mental health. In C. N. Winters (Ed.). *The Handbook of Child and Adolescent Systems of Care* (pp. 17-34). San Francisco: Jossey-Bass.
- Stroul, B. A., & Friedman, R. M. (1986a). *A System of Care for children and youth with severe emotional disturbances* (Revised Edition ed.). Washington, DC: CASSP Technical Assistance Center.
- Stroul, B. A., & Friedman, R. M. (1986b). *A system of care for severely emotionally disturbed children and youth.*: Washington, D.C.: CASSP Technical Assistance Center, Georgetown University Child Development Center.
- U.S. Department of Education. (1994). *National agenda for achieving better results for children and youth with serious emotional disturbance.* Washington, DC: Office of Special Education Programs, U.S. Department of Education.
- U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General. Chapter 3: Children and Mental Health. Chapter 8: A Vision for the Future.* Pittsburg, PA: Children's Mental Health Services.
- Wheeler, C., & Johnsen, S. (2003). Evaluating family group decision making: The Santa Clara example. *Protecting Children, 18*(1&2), 63-69.
- WSIPP. (2004). *Outcome evaluation of Washington state's research-based programs for juvenile offenders.* Olympia, WA: Washington State Institute for Public Policy.
- Xue, Y., Hodges, K., & Wotring, J. (2004). Predictors of outcome for children with behavior problems served in public mental health. *Journal of Clinical Child & Adolescent Psychology, 33*(3), 516-523.

## Appendix A

### Focus Group Questions

1. What is family participation?
  - a. How do families participate?
  - b. What are some of the challenges to participation?
  - c. How much say do families in Connections have deciding what kinds of services and supports they get?
2. Tell me about your experiences with family participation in the process of treatment planning.
  - a. What kinds of things do you do that encourages family participation?
  - b. In what ways do you feel family participation impacts the process of treatment planning?
3. What role do you feel family participation plays in relation to treatment outcomes?
  - a. In what ways do you feel family participation impacts treatment outcomes?
4. How could family participation be improved?
5. How long have you worked with the Connections program?
6. What kinds of things do you do in your role as a family support specialist?
7. If you were interested in learning more about how the families you work with experience their role in your program, what kinds of questions would you ask them?

## Appendix B

## Informational Letter for Focus Groups

[date]

Dear \_\_\_\_\_

*You are invited!* This fall, I will conduct a small group discussion (or 'focus group') as part of a study I am conducting to complete the requirements for my PhD at Portland State University. I hope you can come and share your thoughts and opinions related to your experiences with the Connections program. Because you've been working as a family support specialist in the Connections program, I am interested in your thoughts and comments about family participation and the role it plays in outcomes for youth.

The focus groups will provide an opportunity for you to talk about your experiences related to your work with families in the Connections program. What I learn will be compiled with other data related to family participation to develop understanding of family participation in general and the role it plays in outcomes for youth.

I will be the moderator of the focus group which will take about 90 minutes to complete. The group will include all of the family support specialists employed in the Connections program. You will be asked to discuss a series of questions about your experiences related to the participation of families in the Connections program. If everyone agrees I will use audio recording to ensure your ideas are reported accurately. All tapes will be erased after a report is completed.

The types of questions that you'll be asked include:

1. What kinds of things do you do in your role as family support specialist?
2. Tell me about your experiences with family participation in the process of treatment planning.
3. What kinds of things do you do that encourages family participation?
4. How much say do families in Connections have deciding what kinds of services and supports they get?

Only the other group members and I will hear your comments from the group itself and my dissertation committee will have access to the audio recording. Special care will be taken to keep your identity and information private. The only exception is if during the course of the group it is revealed that someone's hurt you, that you've hurt (or plan to hurt) someone else, in which case I am obligated to make a report to the proper authorities.

***Taking part in a focus group is completely voluntary.*** You can choose to not answer any question, or you may leave the group at any time. If you choose not to participate, it will not affect your position in the Connections program in any way. If you decide to take part, you'll be asked to sign a copy of the informed consent form at the time of the focus group itself. The date and location for the group will be decided once participation has been confirmed. If you are interested in participating or have any questions regarding this letter please contact me at 573-3362 or email me at [kerbsj@pdx.edu](mailto:kerbsj@pdx.edu).

Thank you,

Jodi Kerbs  
Portland State University

## Appendix C

### Informed Consent for Focus Groups

#### Focus Group Informed Consent Form

You are invited to take part in a small group discussion or "focus group" regarding family participation in treatment planning/services. Because you've been working with the Connections program, I am interested in your thoughts and comments about family participation in general and how it affects outcomes for the youth involved in your program.

#### **Why is it being done?**

I am conducting the focus group as part of a dissertation study designed to develop an understanding of family participation and the role that participation plays in relation to outcomes for youth. Your role as a family specialist in the Connections program places you in a unique position of working closely with individual families involved in a wraparound planning process. Your experiences and opinions will help develop an understanding of family participation and the role it plays in outcomes for youth.

#### **What's involved?**

The focus group will meet once and it will include the four family specialists currently employed by the Clark County Connections program. You will be asked to discuss a series of questions about your experiences with family participation. The group will take about an hour-and-a-half. If everyone agrees, groups will be tape recorded because I want to be sure I report your ideas accurately. However, all tapes will be erased after a report is prepared. You may also be contacted by phone following a preliminary analysis of the data to ensure the findings are reflective of your ideas and experiences.

#### **What will you ask me?**

The types of questions that you'll be asked include:

1. What kinds of things do you do in your role as family support specialist?
2. Tell me about your experiences with family participation in the process of treatment planning.
3. What kinds of things do you do that encourages family participation?
4. How much say do families in Connections have deciding what kinds of services and supports they get?

#### **Who gets to hear what I have to say?**

Information gathered through the focus group will be shared with my dissertation committee. I will not share your individual responses with anyone else. I will prepare a report that mixes your responses with other group members' ideas. This summary of feedback and themes will be part of my final dissertation.

#### **How am I protected?**

There is always some risk involved with participating in a research project. I will take steps to protect you from this risk. One risk is that you might feel uncomfortable thinking and talking about your experiences and opinions in front of your peers. To protect you, I want you to know that you can pass on answering any question, and can leave the group at any time.



Another risk is that someone taking part in the focus group could later tell people outside the group what you said. To protect you from this risk, everyone who takes part is asked –and reminded- that the group discussion is to be kept private.

I will also do the following things to protect your privacy of your responses:

- When I am preparing the report, only a code, not your name, will be used to identify your personal ideas.
- When I write up the report, your answers will be mixed together with the answers of other focus group members. No record of your name will be kept.
- Audiotapes of the focus groups will be summarized, and then erased within two weeks of the focus group.

By law, I must report to the authorities if I learn that someone's hurt you, that you've hurt (or plan to hurt) someone else, or if someone has hurt an elderly person.

**Do I have to do this?**

No. The focus group is voluntary. You can choose not to answer any questions. You may leave the group at any time.

A copy of this consent form will be provided to you at the time of the focus group.

By signing below, you agree to take part in a focus group. You understand that all information will be kept confidential to the extent permitted by law. You certify that you have read this consent form or it has been read to you.

---

Your signature please print your name Date

**Consent to audio taping**

By signing below, you agree to have your comments tape-recorded. You understand that your real name will not be connected to anything you have to say. You know that the tapes will be erased after a report has been prepared.

---

Your signature please print your name Date

---

Moderator's signature Moderator's printed name Date

If you have questions about the focus groups, call Jodi Kerbs at 360-521-9457. You can also send e-mail to [kerbsj@pdx.edu](mailto:kerbsj@pdx.edu).

If you have other concerns or experience problems because you took part in this study, please contact the Human Subjects Research Review Committee, Office of Research and Sponsored Projects, 111 Cramer Hall, Portland State University, 503-725-4288.

## Appendix D

## Semi-structured Interview Guide

1. What is family participation?
  - a. How would you define participation in the Connections program?
  
2. Tell me about your experiences of participation in the process of treatment planning?
  - a. How do you define your role in the process of treatment planning?
  - b. What kinds of things do you do to participate?
  - c. What do you see as challenges to participation?
  - d. What types of things facilitate your participation?
  - e. What would make it easier for you to participate?
  
3. How satisfied have you been with your level of involvement in planning services for [child]?
  - a. How much say do you feel you have in deciding what kinds of services and supports you get?
  - b. To what extent do you feel like a partner in the team planning process?
  - c. To what extent do you think families should be involved in the process of planning treatment for their children?
  
4. In what ways do you feel your participation has impacted the outcomes of [child's] treatment?
  
5. How could family participation be improved?
  
6. How long have you been involved in the Connections program?
  
7. Do you have an ITC team?
  - a. How often does your team meet?

## Appendix E

## Informational letter for interview consent

[date]

Dear \_\_\_\_\_

*You are invited!* This fall, I will conduct individual interviews as part of a study I am conducting to complete the requirements for my PhD at Portland State University. I hope you can come and share your thoughts and opinions related to your experiences with the Connections program. Because you are a family member involved with the Connections program, I am interested in your thoughts and comments about family participation and the role it plays in outcomes for youth.

The interview will provide an opportunity for you to talk about your experiences related to your involvement in the Connections program. What I learn will be compiled with other data related to family participation to develop understanding of family participation in general and the role it plays in outcomes for youth.

The interviews will take about 90 minutes to complete. You will be asked to discuss a series of questions about your experiences related to your participation in the Connections program. If you agree I will use audio recording to ensure your ideas are reported accurately. All tapes will be erased after a report is completed. You may also be contacted by phone following a preliminary analysis of the data to ensure the findings are reflective of your ideas and experiences.

The types of questions that you'll be asked include:

1. How long have you been involved in the Connections program?
2. Do you have an ITC team?
3. How often does your team meet?
4. Tell me about your experiences as a family member participating in the process of planning for the treatment of [child].

Only I and my dissertation committee will have access to the audio recording containing your information. Special care will be taken to keep your identity and information private (see the enclosed 'informed consent' paper for details). The only exception is if during the course of the group it is revealed that someone's hurt you, that you've hurt (or plan to hurt) someone else, in which case I am obligated to make a report to the proper authorities.

***Taking part in the interview is completely voluntary.*** You can choose to not answer any question, or you may end the interview at any time. If you choose not to participate, it will not affect your position in the Connections program in any way. If you decide to take part, you'll be asked to sign a copy of the informed consent form at the time of the interview itself. The date and location for the interview will be decided once participation has been confirmed. If you are interested in participating or have any questions regarding this letter please contact me at 360-521-9457 or email me at [kerbsj@pdx.edu](mailto:kerbsj@pdx.edu).

Thanks,

Jodi Kerbs  
Portland State University

## Appendix F

### Informed Consent for Individual Interviews

#### **Individual Interview Informed Consent Form**

You are invited to take part in an individual interview regarding family participation in treatment planning/services. Because you've been working with the Connections program, I am interested in your thoughts and comments about family participation in general and the degree to which you feel it has impacted the services and outcome for you and your child.

#### **Why is it being done?**

I am conducting the interviews as part of a dissertation study designed to develop an understanding of family participation and the role that participation plays in relation to outcomes for youth. Your role as a family member involved in the Connections program places you in a unique position of a family member involved in a program designed to enhance family participation in service planning. Your experiences and opinions will help develop a greater understanding of how families view family participation in general and in relation to outcomes for youth.

#### **What's involved?**

The interview will take about one hour to complete and you will be asked to discuss a series of questions about your experiences with family participation. If you agree, the interview will be tape recorded because I want to be sure I report your ideas accurately. However, all tapes will be erased after a report is prepared.

#### **What will you ask me?**

The types of questions that you'll be asked include:

1. How long have you been involved in the Connections program?
2. Do you have an ITC team?
3. How often does your team meet?
4. Tell me about your experiences as a family member participating in the process of planning for the treatment of [child].

#### **Who gets to hear what I have to say?**

Information gathered during the interview will be shared with my dissertation committee. I will not share your individual responses with anyone else. I will prepare a report that mixes your responses with other family members' ideas. This summary of feedback and themes will be part of my final dissertation.

#### **How am I protected?**

There is always some risk involved with participating in a research project. I will take steps to protect you from this risk. One risk is that you might feel uncomfortable thinking and talking about your experiences and opinions. To protect you, I want you to know that you can pass on answering any question, and can leave the interview at any time.

I will also do the following things to protect your privacy of your responses:

- When I am preparing the report, only a code, not your name, will be used to identify your personal ideas.
- When I write up the report, your answers will be mixed together with the answers of other interview participants. No record of your name will be kept.

- Audiotapes of the interview will be summarized, and then erased within two weeks.

By law, I must report to the authorities if I learn that someone's hurt you, that you've hurt (or plan to hurt) someone else, or if someone has hurt an elderly person.

**Do I have to do this?**

No. Participation is voluntary. You can choose not to answer any questions. You may end the interview at any time.

A copy of this consent form will be provided to you.

By signing below, you agree to take part in an interview. You understand that all information will be kept confidential to the extent permitted by law. You certify that you have read this consent form or it has been read to you.

---

Your signature please print your name Date

**Consent to audio taping**

By signing below, you agree to have your comments tape-recorded. You understand that your real name will not be connected to anything you have to say. You know that the tapes will be erased after a report has been prepared.

---

Your signature please print your name Date

---

Moderator's signature Moderator's printed name Date

If you have questions about this letter or the interview, please call Jodi Kerbs at 360-521-9457. You can also send e-mail to [kerbsj@pdx.edu](mailto:kerbsj@pdx.edu).

If you have other concerns or experience problems because you took part in this study, please contact the Human Subjects Research Review Committee, Office of Research and Sponsored Projects, 111 Cramer Hall, Portland State University, 503-725-4288.