

*Child Welfare &
Juvenile Justice*

Chapter 7

Chapter 7: Child Welfare & Juvenile Justice

A Selective Review of Family Reunification Services Research

Introduction

Most children in care typically seek a meaningful contact with family, yet most will continue in care without the benefit of planned opportunities to reestablish, mediate, or maintain links with their family networks. Family contact, in whatever form it takes, has the potential to profoundly impact children, their families and sense of history. While it is estimated that 80 percent or more of children in-care will initiate contacts with their family networks, most of this contact is unplanned and often results in further family conflicts and rejections (Bullock, Little, & Millham, 1993; Thomlison, Maluccio, & Abramczyk, 1996).

Family preservation ideology evokes strong arguments and sentiments from practitioners and policy makers alike regarding whether or not children will be adequately protected from the very families who were unable to protect them in the first place. Certainly, the deleterious effect on children of either returning home to family violence or continuing in less than ideal out-of-home care arrangements is a serious problem. Research suggests that children's biological families continue to influence their well-being throughout the care process until an exit, when children almost always return home (Thomlison, 1997). The consequences of failing to allocate resources and promote opportunities for reconnection or reconciliation may also have long term impacts on child and family development (Thomlison, Maluccio, & Abramczyk, 1996). Therefore, research that addresses and extends

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knowledge of ways the out-of-home care processes can enhance family reconciliation and the outcomes for children deserves considerable attention. In an attempt to contribute to the knowledge base, this summary addresses current services research studies in family reunification.

Method

Based on a call for current research through *Child and Youth Services Review*, eight empirical studies of family reunification services with children who had been in out-of-home care for extended periods of time were identified for examination¹. (These studies are identified and annotated in the *References* section of this summary). Each of these studies makes a contribution in its own right, but as a collective they bring a unique view to services research in family reunification. The intent of this review was to identify where the studies converge and diverge and add new information about the role of biological families as a protective factor in the development of children in-care. It is, however, important to note that few of these studies used comparison groups, and there was limited use of standardized indicators of progress or other outcome related criteria. There is a need to further define specific features of interventions and to use larger samples (Maluccio, Abramczyk, & Thomlison 1996). With this in mind, the results of this synthesis should be viewed as a starting point for future examination of family reunification efforts and effects.

¹ For a complete review of current family reunification services see Maluccio, A. N., Abramczyk, L. W., & Thomlison, B. (1996). Family reunification of children in out-of-home care: Research perspectives. *Children and Youth Services Review*, 18, 4/5, [special double issue].

Results

Following is a brief and descriptive overview from the experiences and outcomes of the studies in Canada, Great Britain, and the United States:

- Reunification is defined as only the physical return home of children to family in all of the studies.
- Reunification rates vary tremendously from 13% to 90% and reentry rates vary from 10% to 33% for children in both short and long-term out-of-home care (Davis, Landsverk, Newton, & Ganger, 1996).
- Factors affecting reunification are complex to isolate and services provided also vary (Courtney & Wong, 1996).
- Intensive and brief family-centered services positively affect reunification rates (Farmer, 1996; Fraser, Walton, Lewis, Pecora, & Walton, 1996; Hiebert & Thomlison, 1996).
- Children are more likely to be reunified when parental visits occur at the level recommended by the courts (Davis, et al., 1996).
- There is no association between parental visiting and return to care of reunited children at 12 months follow up (Davis, et al., 1996).
- Foster care reentry is increased where there are low levels of both parenting skills and social support present (Festinger, 1996).
- Severity of parental or other caregiver problems at the time of reunification is the strongest predictor of reentry (Festinger, 1996).
- First time reunification attempts were equally successful for both delinquent and maltreated children. Second and third reunification attempts had higher rates of failure for both groups (Farmer, 1996).
- Children need psychological support from both biological and foster families to enhance their sense of belonging and identification with the

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biological family unit during the care process (Biehal & Wade, 1996; Thomlison, 1996).

- Children with behavioral or emotional problems were one-half as likely to be reunited as children without mental health problems, even when controlling for background characteristics and type of maltreatment (Landsverk, et al., 1996).

Discussion of Research Themes

Effectiveness of Services

Do family reunification services work? The answer is a tentative “Yes, for some for the children, we think so” (Maluccio, Abramczyk & Thomlison, 1996). Children and families are diverse and services are necessarily varied, complex and highly individualized. Reunification services must focus on maximizing child and family participation in the helping process as a component in decision making and planning toward the goal of family reunification. Problems in achieving reunification success are generally not associated with the length of the separation from family but with the age of the child, parenting abilities, and quality of the helping services. Therefore, it is necessary that visiting activities and services are matched to the developmental levels of children and their families (Bullock, Little, & Millham, 1993; Maluccio, Warsh, & Pine, 1993).

Intensity of Services

Reunification happens; it is the norm, and therefore attending to *how* it happens should be a major service issue. The research reviewed proposes that out-of-home care should be viewed as a period for both child and family work—above all, work with the family during the placement period, providing intensive and extensive supports *before and after* reunification. Parental and child issues must both be addressed at some level. During the care process, practitioners need to encourage and facilitate child-family visiting. The visitation is one

factor over which the worker has some control; thus, maintaining family network continuity during the out-of-home placement must begin at the point of separation. The findings of these studies suggest that providing brief, intensive family-centered services is essential to maintain the reunification for families after care.

Policy Context

Family contact or reconciliation is more likely to succeed when supported by a comprehensive framework of policies, strategies, and resources. Policy frameworks need to review the guidelines for reunification and embody an expanded role for children’s family networks. For example, although all families do not benefit equally from reunification services, in most cases return home should be viewed as a primary goal for children in out-of-home care. The need to address family reunification begins at the time of separation, and if return home is not possible, then the possibilities for maintaining family links must be considered along the service continuum to enhance children’s sense of family and personal identity, improve child’s functioning in foster care, and develop security.

Research suggest that family contact may play a protective role in the development or promotion of resilience for children during out-of-home placement (Kinard, 1995; Thomlison, unpublished). Seeking new ways to assist families to become partners and promote family contact during the care process may play an influential role in children’s psychological and filial processes. Contact with the child’s extended family network should be considered essential in many more cases as a way of promoting resilience and reducing the stressful experiences of separation. These studies also suggest that policy should acknowledge that family poverty and its related circumstances persist as barriers to family reunification.

Recommendations

Although the state of knowledge and scholarship about family reunification services is increasing, it remains notable for what is not known. While it should be recognized that research in children's services has some unique considerations and problems, gaps in research include: (1) identifying strategies to achieve the best practices for family reconciliation; (2) identifying what services are *necessary* and whether these are *sufficient* for the child and family to have a successful outcome, and (3) the need for quality information about the similarities and differences among children in their responses to interventions and outcomes over time. A research agenda is also framed by two further issues. First, there is a need for good data in child welfare services. Second, the best family reconciliation practices would subscribe to the value of using carefully defined and collected information to assist in meaningful clinical intervention and compilation of research data.

To date, the majority of studies relied on measures of process by which services are delivered rather than outcomes achieved for children and families. Process measures are helpful in describing programs but less helpful in learning about effectiveness of the interventions used. Therefore, efforts to measure the level of change in functioning and behavior patterns achieved by children from the time of entry to care, during, and after service is critical, along with measurement of change in parental and family functioning. These studies and related research recognize the need for systems of care providers and researchers to exchange information, model respect, and form stronger alliances with children, their families, and their extended family networks.

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* Citations in bold represent studies contributing to the findings in this summary.

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Thomlison

The Family Networks Program: Family Reconciliation Strategies for Children in Long-Term Foster Care

Introduction

Research on children in long term foster care needs to devote more attention to the issue of promoting resilience through family reconciliation strategies. Understanding how children manage family reconciliations and contacts when they exit from care suggests that ways to promote meaningful contact during the care experience must be addressed. Realistically, children often have no place to go after they exit care except to those families and communities from which they were originally separated. Children initiate contact with their biological or extended families by searching on their own, leaving them vulnerable to further conflicts and rejections due to the unplanned and unmanaged reconciliation initiatives (Thomlison, Maluccio, & Abramczyk, 1996).

In general children facing adversity are considered to be resilient if they are functioning within normal bounds on measures of competency with respect to psychological, behavioral, and social functioning (Kinard, 1995). However, most children in care experience persistent clinical issues surrounding their separation from parents, siblings, kinship and community of origin. These issues tend to persist during the care experience, reducing resilience and often negatively influencing children's functioning and well being (Thomlison, 1997) Such ongoing stressful experiences are associated with multiple placements, permanency planning drift, a limited sense of family and community belonging, identity confusion, cultural distortion, little or no family of

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origin contact, and lack of a family or caregiver support network at the time of exit from care (Thomlison & Warthe, 1996). Parents, siblings, and kinship networks also report impact continuing long after the child's entry into care (Thomlison & Warthe, 1996). Children in-care need: (a) to have a clear sense of the past; (b) an opportunity to explore where they are going; and (c) to be offered a meaningful contact with family and community of-origin.

There are policy, professional, and ideological perspectives which pose ongoing barriers to family ties which underestimate children's abilities and capacities to make sense of their lives. Barriers to family reconciliation include social workers' lack of training about how to promote children's sense of belonging and identity, and a failure to assess meaningful consideration of family involvement and the significance of biological family and others to the child-in-care. All of these issues need to be addressed in the foster care process and treatment services for these vulnerable children.

To promote meaningful family and community contacts in this population, the *Family Networks Program* pilot study was initiated in the summer of 1995 in Calgary, Canada. This summary identifies a model for making, mediating and managing biological family reconnections for children in foster care with severed family, community and cultural ties.

Family Networks Program Overview

The Family Networks Program¹ is an intensive family centered practice model for older children who are in long term foster care due to their severe emotional and developmental needs and behaviors, severe cultural distortions², and separation from their biological parents and extended family networks. Within a context of support and safety, the goal of the 18-month Family Networks pilot study was to promote meaningful contacts for children's reconnections to biological parents, siblings, family

networks, communities of origin and others the child considered significant. Philosophy and guiding practice principles were: (a) the importance of family continuity for children's development; (b) use of individualized services; (c) respect for diversity; (d) necessity of a multisystemic perspective of care; and (e) integrity of family and system partnerships. Services are now complete but follow-up data collection for some participants is still occurring. The following summary describes development of the family reconciliation intervention model.

The program services in this study were designed and provided by a highly skilled team of social workers and foster parents, and ranged from concrete, educational, support and consultation services, to family locator services, and clinical services. The resulting service delivery patterns reflect that family reconstruction for children in long term care is different from reconciliation for the child and family experiencing a short term separation; the crisis of separation has passed, and the child and family systems have changed. A constructivist approach was felt to be a necessary foundation for developing intervention strategies which address each child's and the family's changing qualities, needs, and potentialities.

For this study, *Family reconciliation service* was defined as the planned process of reuniting children

¹ The *Family Networks Program* Pilot Study was a joint practice evaluation pilot study with Alberta Family & Social Services, Child Welfare, Four Directions Foster Parent Association, and Mountain Plains community and Family Services. This author was the senior investigator but acknowledges contributions of Dr. J. Krysik and Dr. H. Coleman. The study was made possible by the dedicated and skilled efforts of clinical project coordinator D. Gaye Warthe, M.S.W. the clinical staff, students, foster and biological families and children. Support for this study was also provided by the Faculty of Social Work, The University of Calgary Canada.

² Cultural distortion here refers to confusion, distorted sense of cultural, ethnic or racial identity; and uncertainty or an absence of one's values, traditions, rituals about the expected roles and norms necessary to deal with one's self and environment.

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in out-of-home care with their parents, siblings, kinship networks, others who are significant to the child, communities and culture by means of a variety of intensive services and supports (Thomlison & Warthe, 1996). The definition of *reconciliation* was broad and viewed as a continuum of connection: from information about family to indirect contacts through other persons, contact by telephone, visits with family, part-time living at home to full family reentry and other forms of contact that affirmed the child's sense of belonging and identity. Service was directed to partnerships with families and communities with specific family reunification objectives.

Method

Child characteristics identified for the study included ethnicity, age, and gender. The sample included sixteen children, eight from each of two units— one regular child welfare unit and the Native child welfare unit. Within each group, gender and age was balanced. Single case evaluation designs were used for this study. Costs and services were also compared.

Description of the Children

Family reconciliation services were provided for sixteen children with permanent guardianship status, between the ages of 10 and 17, who were residing in out-of-home care in the Calgary, Family and Social Service Region. Participation was voluntary and required signed consent from the child, the foster parent/caregiver and the child welfare worker. Most of the children were placed in foster care; one was in a correctional center and one in a group home. Of the sixteen children eight were of Aboriginal descent. The remaining children were of mixed ethnic heritage.

As a group, the children had histories of multiple placement, limited (or no) family of origin contact and a limited sense of family and community

belonging. The children were receiving services from multiple systems and impacted by issues such as: child welfare staff turnover; lack of appropriate and sufficient resources or services for their needs; permanency planning drift; and histories of unstable and inconsistent relationships across settings.

Problems of the children included: two children with Dubowitz Syndrome; one had Fetal Alcohol effects and neurological damage with accompanying developmental delay; two children had multiple developmental delays as the result of severe child maltreatment; one had cerebral palsy complicated by the effects of child maltreatment; one child, as a result of parental neglect, has severe scarring from burn injuries; nine children could be described as functioning within normal range. Six of the children experienced re-abuse during their time in care. Serious educational deficits were evident in the histories of six children. One child had not experienced a single successful school year between the ages of six and seventeen.

Two of the Aboriginal children had severe cultural distortions. Of the remainder, five children had no connection to their community of origin. For twelve of the children, at least one other sibling was also in care. Only two siblings were living together in the same home, although they too, had additional siblings who were placed in different foster homes. Cultural identity was not a presenting issue for the rest of the children in the study. Racism and discrimination were reported to be prevailing issues for all of the children.

Service Objectives and Measures

Measures included both standardized instruments and those developed specifically for the study. Measures were completed at the beginning of service and at 6, 12, and 18 month intervals. The objectives and measures used in the study are shown in Table 1.

The single case designs are not presented in this summary as the focus is on the specification of the service activities as a framework for practice. However, in all cases, the children made improvements on each objective (Thomlison & Warthe, 1996).

The process used to identify the service activities or interventions for all of the cases included a content analysis of the worker service logs, the children's service logs and a review of the case docket for a description of worker activities, details of interventions, and the number and nature of service sessions. For each case, the child, the foster parent, parent and social worker received a telephone

interview to review the service. At the end of service, focus groups with 7 foster parents and 5 social workers provide more detail on program interventions and activities. The clinical director and this researcher conducted focus groups. File and client log data were collected by a research assistant and analyzed using content analysis processes by the clinical director and this researcher.

The focus of the analysis was primarily concerned with describing the actual treatment interventions being delivered and comparing what occurred with what was proposed in the program manual. The conceptual service framework was then constructed

and each of the four reconciliation workers were asked to independently review the model for accuracy. While this is a highly descriptive analysis of the service process, revisions were made based on the suggestions of the workers and the refinements provided the specific framework used for all of the cases. The service interventions are describe in the results that follow.

Table 1
Service Objectives and Measures

| Objectives | Measures |
|--|--|
| Expand the availability of the child's family network. | Family genogram Follow-up questionnaire to child, family, foster parents, child welfare workers, reconciliation workers |
| Increase the child's coping abilities surrounding family relationship issues | Statement of Coping Assessment Summary Case progress notes Follow-up questionnaire to child, family, foster parents, child welfare workers, reconciliation workers |
| Improve the quality of family relationships. | Hudson Index of Sister/Brother Relations Hudson Index of Family Relations Follow-up questionnaire to child, family, foster parents, child welfare workers, reconciliation workers. |
| Strengthen the child's sense of identity. | My Preference Index Family Ecomap Follow-up questionnaire to child, family, foster parents, child welfare workers, reconciliation workers |
| Increase the continuity of family contact. | Family Contact Log Follow-up questionnaire to child, family, foster parents, child welfare workers, reconciliation workers |

Family Network Program

Results

The following model emerged from an analysis of the service interventions and interviews with children, social workers, and foster parents.

Model of Family Reconciliation – Phase One: Making Contacts and Bridging Tasks

- family genogram
- clarifying members of the family system
- identifying with whom contact is desired by asking the child
- coaching the child to prepare for contact
- teaching child to understand the roles of each family member
- researching cultural information
- brokering between child and family member(s) to be reconnected
- take new photos of family members and child and locate old family photos for reconstructing family history and stories

Phase Two: Mediating Family Contact

- family members and children exchange information, data, personal profiles in preparation for contact
- use of written questions for both children and adults for clarification prior to meeting
- defining boundaries for verbal exchange, questions to be asked, and information to be shared
- exchange of written information
- scripting roles in the family for the child and parent, sibling or other relative
- rehearsing roles and questions for contact
- writing a family log -clarifying family belief systems and perceptions, of each other
- clarifying understandings of parental issues and important data

- recasting family members' histories—photos from past—photos today to link and reconstructing a family picture
- writing letters, exchanging cards—written in preparation for reconciliation
- picture books of traditions, cultural teachings, ethnic identity
- writing of family stories regarding special events, traditions, or significant events

Phase Three: Maintaining Contact

- arrange contact, reconnection, visits, exchange of photos, stories
- record in the family log books for key data, events
- a calendar of important family dates such as birthdays, special occasions
- photos of contacts
- activities for building trust—sports, cultural events, family reunions, birthdays, school
- a drama group
- talking and counseling for longer than usual sessions

The intervention model resulted in positive outcomes (Thomlison & Warthe, 1996) in the relations between children and families, including:

- increased feelings of connection to significant persons in their lives, and communities;
- increased feelings of confidence;
- realization of the endurance of family thoughts and the need to recast positively, as out-of-home care removes children physically but not emotionally from family;
- increased motivation and commitment on the part of the families to maintain contact;
- increased energy and hopefulness of belonging due to reconnections;

- perception of the reunification process as an exciting, eventful and positive time for both the family and child; and
- the development of new partnerships and alliances.

Recommendations

Family reunification services have a key role in permanency planning efforts for family preservation. This pilot study identified three key principles that may shape a policy framework for family reunification services: (a) making contacts, (b) mediating contacts, and (c) maintaining contacts. The study's findings highlight the responsibility of those who retain the guardianship of children to ensure that planned and supported opportunities exist for contact with family and kinship networks. Results suggest that a vision of family, actual family reconnection, or family reconstruction are important components of good child care practice, and may provide continuity that promotes positive developmental and life transitions. Successful family or community reconciliation shows promise for remediating some of the consequences commonly associated with a history of poor social, psychological, and cultural supports, with their accompanying impact on sense of belonging and identity.

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Evaluating a Multi-site Therapeutic Foster Care Program: Issues and Solutions

Introduction

With the advent of Managed Care and increased scrutiny of how mental health dollars are spent, performance accountability is becoming essential for continued service delivery. Most importantly, measurement of outcomes of any child and family services program is good practice, regardless of political and funding pressures (Daly, 1996).

This paper presents the process utilized in evaluating Boys Town's Treatment Foster Family Services (TFFS). TFFS is a large, multi-site therapeutic foster care program which serves about 150 children per day in 11 locations across the country. The program serves psychologically and/or behaviorally troubled children of all ages in community settings, and is typically used as an alternative to more restrictive treatment interventions. Issues that arose during initial phases of program evaluation are reviewed, and potential solutions are discussed. Finally, admissions, discharge, and 3-month follow-up data are presented to illustrate the results of our evaluation efforts.

Issues

Issue: Collecting multi-site data. With 11 sites located across the country, a mechanism to organize data collection and storage was needed.

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Solution: A computerized system was put into place which connected each site by modem to a centralized computer. Protocols were developed, with input from service providers, to collect information (utilizing both standardized and non-standardized measures) upon admission into care, upon discharge, and 3 months and 1 year post-departure. Centralized tracking of when data were due to be collected helped ensure that data were as complete and timely as possible.

Issue : Defining outcome. How should therapeutic foster care “outcome” be defined in order to adequately study it?

Solution: Before it can be determined that positive change has occurred, it is necessary to know “baseline” – the initial problems, difficulties, and competencies that will be impacted by treatment. To accomplish this goal, we identified a series of variables—from basic demographics to placement histories to psychiatric diagnoses—that would be collected on all children served in our program.

Next, we were able to look at how we might define favorable outcomes. Studies in the literature typically define treatment “success” as moving from therapeutic foster care to a less restrictive setting (e.g., adoptive home, reunification with parents/family, independent living). Recognizing that a single variable does not completely capture improvements as a result of treatment, we utilized several standardized and non-standardized ways of measuring treatment effectiveness.

Domains assessed upon discharge included restrictiveness of discharge placement, several indices of behavioral change, assessment of achievement of treatment goals, and prediction of future success. Domains assessed at follow-up included restrictiveness of post-discharge placement(s), number of moves, measures of behavioral difficulties post-discharge, and ratings on the following domains: school attendance and performance; work attendance; relationships with peers; relationships with family; relationships with primary caregivers; use of

mental health services; and overall quality of life. Having multiple outcome measures allowed us to question why one of our standardized measures was yielding data that were inconsistent with other outcome data.

Issue : Creating staff “buy-in” for evaluation. In order for evaluation efforts to be successful, program staff must understand and appreciate the relevance of data collection and research.

Solution: A series of strategies were employed to address this issue. Input was solicited from a variety of individuals regarding what was important to ask and how was best to ask it. Equally as important, efforts were made to demystify the concept of program evaluation. Staff were educated on: how to understand the reports generated by the evaluation team; the positive aspects of evaluation (e.g., it could confirm that they are doing good work); how it might directly impact their program (e.g., by using evaluation data to secure continued funding); and how it could be used to make program modifications. Additionally, research and evaluation ideas are solicited from “front line” staff to ensure a continued connection between research and direct care issues.

Issue : Ensuring fidelity of implementation. A mechanism was needed to ensure that the program as it was designed was in fact being implemented. Without such a system in place, it would be difficult to determine whether unfavorable outcome data reflected inadequacies in the program or merely inadequacies in *implementation* of the program.

Solution: Our agency has two approaches to this problem. First, we use skill-based competency training with agency staff as well as Treatment Foster Parents. Second, we track program implementation in several ways. Progress is monitored on an individual child basis through the use of daily checklists, daily summaries of behavior, and daily reporting of significant events (e.g., physical aggression, noncompliant behavior, suicide ideations, etc.). Additionally, Achenbach Child Behavior Check Lists (CBCL; Achenbach, 1991) are completed upon

Evaluating a Multi-Site Therapeutic Foster Care Program

admission and discharge. Program implementation by Treatment Foster Parents is monitored through weekly consultation visits by program staff, through observation visits twice per month with written feedback, and through an annual formal evaluation process (which includes a visit to the home, an interview with the child in placement, and ratings of the Treatment Parents' skills provided by others involved with the child's case). Similarly, agency staff participate in an annual evaluation process to ensure they are providing the necessary support and guidance to the Treatment Parents.

Issue: Informing Stakeholders. Once data are collected, how can they be most effectively presented to stakeholders (e.g., Boards of Directors, the public, funding agencies)?

Solution: Admission, discharge, and 3-month outcome data for youth served in TFFS over a 31-month period (June 1, 1993 through December 31, 1995) illustrate ways to analyze and display program outcomes. As can be seen in Table 1, children come into care with many psychiatric, psychological, and behavioral problems. Nevertheless, as Table 2 illustrates, program outcome is favorable. Almost three quarters of all presenting problems improved, most children successfully achieved their treatment goals, Achenbach CBCL scores decreased, and almost two thirds of children moved to less restrictive settings after an average of about one year of treatment. Table 3 shows that three months post-discharge, children continued to live in less restrictive settings, and behavior problems continued to improve. The majority of primary caregivers (87%) reported having a positive or extremely positive relationship with the child, and serious conflict was rare (77% reported conflict occurred once

per month or less often). Further, more than 9 out of 10 school-aged children were either attending school or graduated, and the majority of children improved from pre-treatment functioning in academic performance (56%), peer relationships (62%), family relationships (71%), and overall quality of life (85%).

Table 1
Selected Background Variables for Youth in TFFS
(*N* = 336)

| Variable | Categories | Percent |
|-----------------------|-------------------------|---------|
| Gender | Males | 58% |
| | Females | 42% |
| Ethnic Background | Caucasian | 42% |
| | African American | 37% |
| | Hispanic | 15% |
| | Other | 6% |
| Religious Background | Protestant | 54% |
| | Catholic | 22% |
| | None | 22% |
| | Other | 2% |
| Psychiatric Diagnosis | None | 42% |
| | Disruptive Behavior D/O | 23% |
| | Adjustment Disorder | 23% |
| | Depressive Disorders | 21% |
| | Anxiety Disorders | 13% |
| | Other Disorders | 30% |
| Psychotropic Med. | None | 74% |
| | Antidepressant | 14% |
| | Antianxiety | 6% |
| | Stimulant | 6% |
| | Antipsychotic | 5% |
| | Other/Unknown | 3% |

| Variable | Mean (\pm S.D.) |
|---|----------------------------------|
| Age upon Admission (years) | 9.5 (\pm 4.9), range = 0 - 18 |
| Number of Previous Formal Placements | 3.0 (\pm 2.6), range = 0 - 20 |
| Age at First Placement | 5.6 (\pm 4.4), range = 0 - 17 |
| Number of Youth Presenting Problems | 6.9 (\pm 4.2), range = 0 - 19 |
| Number of Family Problems Affecting Youth | 9.7 (\pm 5.8), range = 0 - 27 |

| Variable | Categories | Mean (\pm S.D.) |
|------------------------------------|-----------------------|--------------------|
| Admission CBCL (<i>N</i> = 74) | Internalizing T-Score | 59.5 (\pm 13.0) |
| | Externalizing T-Score | 65.2 (\pm 12.1) |
| | Total Problem T-Score | 64.5 (\pm 12.4) |

Discussion

We are in the beginning stages of our program evaluation effort. As we collect data, we will be able to answer several questions about the children, the Therapeutic Foster Parents, and the biological families we serve. Some questions are program-specific, but others are common across all therapeutic foster care programs and are best answered by cross-program collaboration.

Techniques that would enhance evaluation of therapeutic foster care programs include using similar measures across different programs; conducting studies that utilize control groups and/or random assignment to increase confidence in the findings; a multidimensional approach to outcomes; and conducting post-discharge follow-up studies to ensure that treatment effects are lasting.

Providing evidence of the effectiveness of therapeutic foster care has important policy implications. In a time where program cost is an important factor in considering where to place a child, therapeutic foster care can be a less expensive alternative to other forms of residential care (e.g., residential treatment centers, psychiatric hospitals). Of additional intangible value is the benefit derived by living in a normalized environ-

ment, with a caring, supportive family within a community. Thus, while therapeutic foster care is not for every child, many children with behavioral/emotional disturbances can benefit from this cost-effective intervention, and avoid placement in more restrictive environments.

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Table 3
Selected 3-month Follow-up Variables for Youth in TFFS
(N = 159)

| Variable | Categories | Percent |
|--|----------------------------|---------------|
| Living Situation | Less restrictive than TFFS | 63% |
| | More restrictive than TFFS | 32% |
| | Equally restrictive | 5% |
| School Attendance | In School | 80% |
| | Graduated/G.E.D. | 1% |
| | Dropped out | 6% |
| | Not yet of school age | 13% |
| Relationship w/ Caregiver | Extremely Poor | 0% |
| | Poor | 0% |
| | Neither Bad nor Good | 4% |
| | Fairly Good | 38% |
| | Extremely Good | 49% |
| | Not Applicable | 8% |
| Serious conflict w/ Youth | Not at All | 56% |
| | Once or Twice | 13% |
| | Once per Month | 8% |
| | Once per Week | 8% |
| | More than Once per Week | 5% |
| | Daily or More Often | 2% |
| Not Applicable | 8% | |
| Compared to before TFFS, improvements seen in: | | |
| Academic performance (N = 39) | | 56% |
| Peer relationships (N = 63) | | 62% |
| Family relationships (N = 59) | | 71% |
| Overall quality of life (N = 72) | | 85% |
| Mean (± S.D.) | | |
| 3-Month Post CBCL (N = 144) | Internalizing T-Score | 53.6 (± 11.6) |
| | Externalizing T-Score | 57.6 (± 11.7) |
| | Total Problem T-Score | 56.9 (± 11.4) |

Table 2
Selected Departure Variables for Youth in TFFS
(N = 201)

| Variable | Categories | Percent |
|---|--------------------------|---------------|
| Discharge Placement | Less Restrictive Setting | 64% |
| | More Restrictive Setting | 32% |
| | Equally Restr./Unknown | 4% |
| Goal Achievement | Unsuccessful | 12% |
| | Somewhat Unsuccessful | 11% |
| | Neither | 7% |
| | Somewhat Successful | 30% |
| | Successful | 40% |
| Percent of Youth Problems Improved by Discharge | | 71% |
| Mean (± S.D.) | | |
| Departure CBCL (N = 126) | Internalizing T-Score | 54.9 (± 11.9) |
| | Externalizing T-Score | 60.2 (± 13.0) |
| | Total Problem T-Score | 60.2 (± 13.2) |

Child Factors Related to Positive Outcome in Therapeutic Foster Care

Introduction

Therapeutic foster care is a community-based intervention designed to work with children who have psychological, psychiatric, and/or behavioral difficulties too severe to be managed in a traditional foster care setting, and is typically seen as an alternative to institutional placement. While the idea has been around for at least 40 years (see Bryant, 1981, and Bryant & Snodgrass, 1990, for reviews), therapeutic foster care has become more popular only in the past two decades, resulting in relatively little outcome research.

Studies that have more recently become available typically define "success" as discharge to a less restrictive setting, such as reunification with the biological family, adoption, or independent living (e.g., Bryant & Snodgrass, 1992; Fabry, Hawkins, & Luster, 1994). Based on reviews of the literature, reported positive outcomes range from less than two thirds to more than three quarters of discharged youth, depending upon the program (e.g., Almeida, Hawkins, Meadowcroft, & Luster, 1989; Bauer & Heinke, 1976; Bryant & Snodgrass, 1992; Fabry et al., 1994; Hudson, Nutter, & Galaway, 1994; Snodgrass & Bryant, 1989, 1996; see Meadowcroft, Thomlison, & Chamberlain, 1994, for review).

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Despite the evidence of overall favorable outcomes, little is known about which child or placement characteristics might be related to treatment success. The present study addresses this issue by examining demographic, behavioral, psychological, and placement variables in relationship to program outcome within a multi-site therapeutic foster care program.

Method

Participants

The sample consisted of 193 children (119 boys, 74 girls; *M* age = 9.8 years) who were discharged from Boys Town's therapeutic foster care program (Treatment Foster Family Services or TFFS) during a 31-month period (June 1, 1993 through December 31, 1995). Children were from a variety of ethnic and religious backgrounds.

Procedure

An admissions questionnaire, which taps demographic and historical information, was completed for each child by the referring party (typically a social services worker). A Child Behavior Check List (CBCL; Achenbach, 1991) was also completed upon admission for some of the children. A departure questionnaire, which assesses the child's functioning during treatment, was also completed by agency staff. In addition, a departure CBCL was completed by the therapeutic foster parents on the majority of departed children.

Results

Children served in our therapeutic foster care program had an average of more than three previous placements involving outside agencies, with the first out-of-home placement occurring at the average age of about 5-3/4 years. More than half of the present sample (56.1%) came into our program from a more restrictive setting, such as a psychiatric

hospital, residential treatment, or emergency shelter (rated using the Restrictiveness of Living Scale (ROLES), Hawkins, Almeida, Fabry, & Reitz, 1992). Almost half (45.6%) of school-aged children had previously been placed in special academic programs, and more than half (59.1%) had one or more special educational classification(s).

Children had multiple psychological and behavioral problems: more than half (58.5%) had already received one or more psychiatric diagnoses (e.g., depressive disorders, disruptive behavior disorders); one quarter (24.4%) were taking psychotropic medications upon admission; and average admission CBCL scores fell into the clinical range (*T* score ≥ 64) for both Externalizing and Total Problem scores. Common child presenting problems included difficulties with authority figures, peer relationship problems, sexual and/or physical abuse victimization, and school learning/academic problems.

In order to determine whether outcome varied as a function of demographics or presenting problems, several variables were examined for departed children. Youth were classified into one of two groups: successful (i.e., discharged into a less restrictive setting; *N*=129) and unsuccessful (i.e., discharged into a more restrictive environment; *N*=64). Eight participants who were discharged into an equally restrictive setting (i.e., therapeutic foster care) or for whom outcome could not be determined (e.g., death, ran away) were excluded from the sample and all analyses.

The following variables were examined: gender, ethnic background, religious background, age at first formal placement, number of different formal placements prior to TFFS, restrictiveness of last placement prior to TFFS, age at placement into TFFS, presence of one or more psychiatric diagnoses upon admission, psychotropic medication status upon admission, educational program and classifi-

Child Factors Related to Positive Outcome in Therapeutic Foster Care

cation (for school-age children), admission CBCL scores, number of presenting problems upon admission, length of stay in treatment, percentage of presenting problems showing improvement at discharge, and departure CBCL scores.

The two groups (successful vs. unsuccessful departures) were comparable with regard to gender, ethnic background, religious background, number of previous formal placements, presence of one or more psychiatric diagnoses, psychotropic medication status, educational classification and school program, and CBCL scores upon admission (see Table 1).

As can be seen in Table 1, however, children who departed to less restrictive settings were younger at their first formal placement ($M=5.2$ years vs. 6.8 years, $F(1,187)=5.17$, $p<.05$) and upon admission to therapeutic foster care ($M=8.9$ years vs. 11.4 years, $F(1,191)=11.94$, $p=.001$), were more likely to have come into our program from less restrictive settings ($\chi^2(df=1)=4.50$, $p<.05$), and entered into therapeutic foster care with fewer presenting problems ($M=6.6$ problems vs. 8.1 problems, $F(1,191)=5.31$, $p<.05$).

Not surprisingly, children who were discharged to less restrictive settings also demonstrated better progress during treatment (see Table 2). They remained in treatment for a longer period ($M=14.1$ months vs. 9.4 months, $F(1,191)=6.86$, $p=.01$) and thus may have achieved more therapeutic benefit. Consistent with this possibility, a greater percentage of their presenting problems improved (85.5% vs. 47.3%, $t(116.19)=-8.16$, $p<.001$), and all three departure CBCL scores (Internalizing, Externalizing, and Total Problem scores) were significantly lower compared to children discharged to more restrictive settings (Multivariate $F(3,106)=13.22$, $p<.001$).

Discussion

Children served in Boys Town's therapeutic foster care program came with troubling histories and a variety of presenting problems. After a little more than one year in a behaviorally-based treatment program implemented within a family setting, improvement was noted on both standardized and non-standardized outcome measures.

Comparisons between children who departed care into less restrictive settings (i.e., successful outcome) vs. those who departed to more restrictive settings (i.e., unsuccessful outcome) yielded comparable demographic characteristics, mental health and educational histories, and initial levels of behavioral difficulties. However, successful children were younger at their first formal placement and upon admission to our therapeutic foster care program, were more likely to enter into our program from less restrictive settings, and had fewer presenting problems. Successful children also stayed in care longer, and demonstrated greater progress during treatment on both standardized and non-standardized measures.

Thus, favorable outcomes may be related to a combination of entering care at a younger age (being removed from potentially harmful environments and placed into potentially helpful settings), having fewer initial challenges to overcome, and staying in care longer (receiving maximum benefit from treatment). These children were able to benefit from receiving treatment in a normalized environment, by a caring, supportive family within a community. While therapeutic foster care is not appropriate for every child, a considerable number of behaviorally and emotionally disturbed children can benefit from this cost-effective intervention, and avoid placement in more restrictive settings.

Table 1
Background Variables for Successful vs. Unsuccessful Departures from TFFS

| Variable | “Successful” (Less Restrictive) (N = 129) | “Unsuccessful” (More Restrictive) (N = 64) | Significance |
|--|--|--|---------------------|
| Gender | | | |
| Males | 79 | 40 | NS |
| Females | 50 | 24 | |
| Ethnic Background | | | |
| Black | 42 | 28 | NS |
| Caucasian | 59 | 23 | |
| Hispanic | 20 | 7 | |
| Other | 8 | 6 | |
| Religious Background | | | |
| Protestant | 65 | 37 | NS |
| None | 26 | 11 | |
| Catholic | 26 | 7 | |
| Other | 2 | 1 | |
| % Entering Care from Less Restrictive Settings | 49% | 33% | $p < .05$ |
| % with One or More Psychiatric Diagnoses | 54% | 67% | NS |
| % Taking Psychotropic Medications upon Admission | 23% | 26% | NS |
| % with One or More Special Education Classifications | 60% | 57% | NS |
| % in Special School Program | 44% | 48% | NS |
| # of Previous Placements | 3.2 (± 2.9) | 3.4 (± 3.0) | NS |
| Age at First Placement | 5.2 (± 4.6) | 6.8 (± 4.3) | $p < .05$ |
| Age at Admission to TFFS | 8.9 (± 5.3) | 11.5 (± 3.8) | $p = .001$ |
| # of Presenting Problems | 6.6 (± 4.7) | 8.1 (± 3.4) | $p < .05$ |
| Admission Achenbach CBCL T-scores: | | | |
| | (N = 28) | (N = 9) | |
| Internalizing Score | 57.1 (± 15.1) | 69.3 (± 9.8) | Multivariate p NS |
| Externalizing Score | 63.8 (± 11.2) | 72.7 (± 12.2) | |
| Total Problem Score | 62.9 (± 13.4) | 72.9 (± 9.9) | |

Child Factors Related to Positive Outcome in Therapeutic Foster Care

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Table 2
Progress During Treatment for
Successful vs. Unsuccessful Departures from TFFS

| Variable | “Successful” (Less Restrictive) (N = 129) | “Unsuccessful” (More Restrictive) (N = 64) | Significance |
|---|---|--|-----------------|
| Length of Stay in Months | 14.1 (± 11.1) | 9.4 (± 12.7) | <i>p</i> = .01 |
| % of Presenting Problems that Improved | 86% | 47% | <i>p</i> < .001 |
| Departure Achenbach CBCL T-scores: | | | |
| | (N = 71) | (N = 39) | |
| Internalizing Score | 51.0 (± 11.3) | 59.8 (± 10.5) | <i>p</i> < .001 |
| Externalizing Score | 54.3 (± 11.9) | 68.6 (± 10.1) | <i>p</i> < .001 |
| Total Problem Score | 54.6 (± 12.5) | 68.1 (± 9.6) | <i>p</i> < .001 |

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What Can the Child Behavior Checklist Tell Us About Children in Foster Care?

Introduction

It has become virtual “standard operating procedure” in the children’s-treatment world to use Achenbach’s Child Behavior Checklist (CBCL; Achenbach, 1991). The CBCL’s easy usage, clear output, respected history and psychometric integrity (see Achenbach & Edelbrock, 1981) has made it a popular measure among clinicians seeking diagnostic/descriptive information, program directors trying to monitor progress of children, and researchers looking for sound outcome measures.

Pinebrook Services for Children and Youth has been no exception to this trend, and the present research was driven by four programmatic questions related to our use of the CBCL. First, what is the extent of behavioral difficulties experienced by children in foster care? Second, are children in foster care today experiencing greater behavioral difficulties than those in the recent past, as anecdotal reports have suggested? Third, does the CBCL discriminate children entering Pinebrook’s three levels of foster care (i.e., *regular, specialized, intensive treatment*)? Fourth, is there value in readministering the CBCL at brief intervals while a child is in foster care? There had been some hope among Pinebrook staff that the CBCL might serve well as a repeated-measure outcome that would identify meaningful progress in children. Thus, the present research (a) describes the behavioral status of a large sample of children in various levels of Pinebrook foster care between 1993 and the present; and (b) examines the relative value of repeated, brief-interval administrations of the CBCL.

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Methods

Sample

CBCL data were available from approximately one-third of the total number of children in Pinebrook foster care since 1993, with greatest representation at the initial administration of the CBCL ($n=251$). Sample sizes diminished at second ($n=108$), third ($n=45$), fourth ($n=11$) and fifth ($n=4$) CBCL administrations due to discharges from care (mean length of stay = 16 months).

Dependent Measure

The CBCL (Achenbach, 1991) is a comprehensive measure of a child's behavioral functioning within a specific, recent time interval based on the judgment of a knowledgeable informant (typically a parent). The core information that it provides regarding specific behavioral difficulties is based on informant ratings (0-2) of the typicality of 112 observable behaviors. The ratings then provide information regarding the existence of broad-band difficulties (i.e., total behavior problems, total internalizing behavior problems, total externalizing behavior problems) and narrow-band difficulties (i.e., withdrawal, somatic complaints, anxiety/depression, social problems, thought problems, attention problems, delinquent behaviors, aggression).

Procedure

Pinebrook foster parents routinely completed initial CBCLs on children 45 days after entry into care, and then at subsequent intervals of 5-7 months. The foster parent ratings were then computer scored via the CBCL software.

Analyses

Descriptive statistics were generated from CBCL scores to provide information regarding the behavioral status of Pinebrook foster children (question #1). One-way ANOVAs (with follow-up analyses), using year as the grouping variable,

provided information to answer the question about the behavioral status of children in care today versus those in the recent past (question #2).

Additional one-way ANOVAs on CBCL scores (with follow-up analyses) were used to determine if differences existed based on foster-care program (question #3). Separate repeated measures ANOVAs were used to test effects of repeated administrations on CBCL scores (question #4).

Results

Descriptive Statistics

Table 1 displays descriptive information regarding the sample used in this research, with data presented separately by CBCL administrations. The sample was fairly evenly split between males and females across most CBCL administrations, and spanned ages from 4 to 18 years with comparable percentages within age groups across the three major CBCL administrations. The data were derived mostly from 1994, 1995 and 1996, with fewer data from 1993 and 1997. The children represented the three levels of foster care in Pennsylvania: regular foster care (RFC; children requiring out-of-home placement who have no severe/unusual problems), specialized foster care (SFC; children in need of individually designed treatment programs for emotional, behavioral, social, developmental, intellectual or physical problems), and intensive treatment foster care (ITFC; children with very serious disturbances requiring intensively supervised placement). Preliminary analyses by sex and age group did not produce consistent or significant differences on broad- or narrow-band CBCL scores.

What is the extent of behavioral difficulties experienced by children in foster care? On average and across all children at CBCL administration 1, upper-end normal-range functioning was revealed on all CBCL scores (see Table 2). The same findings were obtained at administrations 2 and 3 as well.

What Can the CBCL Tell Us about Children in Foster Care?

These results were a bit surprising given that the vast majority of Pinebrook children were authorized for SFC rather than RFC.

Are children in foster care today experiencing greater behavioral difficulties than in the recent past? Year of entry into care (at administration 1) did not influence CBCL scores at all, suggesting that the present foster children were not evidencing greater psychopathology than in the recent past (i.e., 3 years).

Does the CBCL discriminate children entering RFC, SFC, and ITFC? At administration 1, children in different foster programs yielded significantly different (at least $p < .05$) CBCL profiles (see Table 2). Indeed, the only broad- or narrow-band score to not reveal a significant difference was on somatic complaints. The pattern of differences was fairly stable, with children in RFC and SFC producing comparable scores in the upper end of the normal

range, which in turn were less than those obtained by children in ITFC whose scores fluctuated among the upper-end normal, borderline and clinical ranges. The same pattern of significant differences was obtained at administration 2. However, at administration 3, the number, size and direction of significant differences changed, probably due to the small sample size.

Is there value in re-administering the CBCL at brief intervals while a child is in foster care? No significant differences were found on CBCL broad- or narrow-band scores across the CBCL administrations, whether two-, three- or four-administration models were used in the analyses. In fact, the comparability of scores was quite striking (see Table 2). As in the previous analyses, foster program prevailed as the only significant main effect, even when it was combined in analyses with administration. Also, there were no significant interactions between foster program and administration, suggesting that the CBCL was operating similarly across time for children in different foster programs (see Table 2).

Table 1
Descriptive Statistics

| Variable | Admin1 (n = 251) | Admin2 (n = 108) | Admin3 (n = 45) | Admin4 (n = 11) |
|--------------------|---------------------|---------------------|--------------------|--------------------|
| Sex (%) | | | | |
| Female | 52 | 51 | 53 | 18 |
| Male | 48 | 49 | 47 | 82 |
| Age Group (%) | | | | |
| 4-7 yrs | 27 | 24 | 29 | 18 |
| 8-11 yrs | 30 | 39 | 36 | 64 |
| 12-14 yrs | 25 | 18 | 22 | 18 |
| 15-18 yrs | 19 | 19 | 13 | 0 |
| Year (%) | | | | |
| 1993 | 8 | 1 | 0 | 0 |
| 1994 | 36 | 19 | 7 | 0 |
| 1995 | 27 | 43 | 62 | 46 |
| 1996 | 26 | 37 | 29 | 54 |
| 1997 | 3 | 0 | 2 | 0 |
| Foster Program (%) | | | | |
| RFC | 11 | 9 | 9 | 9 |
| SFC | 79 | 80 | 73 | 55 |
| ITFC | 8 | 11 | 18 | 36 |

Discussion

These findings suggest that the general population of foster children at Pinebrook are functioning within the normal range on all CBCL dimensions, and their normal functioning is as true today as it was three years ago. These findings belie the substantial documented clinical histories that most Pinebrook children bring into foster care, as well as the reports of staff and foster parents attesting to the difficulties of many of these foster children.

The CBCL was fairly effective, however, at discriminating Pinebrook children who entered different levels of foster care, affirming the CBCL's clinical prowess. Indeed, foster program was the variable that yielded the most reliable and significant group differences, with no interactions with other

Phillips

factors (e.g., year of entry into care, repeated CBCL administrations). As we expected, children who entered ITFC evidenced more behavioral difficulties, and ones that more often (although not always) reached the CBCL clinical range. Children who entered RFC or SFC were essentially equivalent in their CBCL ratings, although the ratings for SFC children were typically a bit higher than those for RFC children.

Whether or not the CBCL is measuring all that matters to foster-care professionals, it seems clear that re-administrations of the CBCL over brief intervals of time during the first 16-22 months of care provide little new information. This is true both across and within foster programs. Although our data suggest otherwise, a more thorough design and larger dataset than this one will be necessary to determine if the CBCL can be used effectively as a progress-marking measure for outcome research. The CBCL's value for foster-care programming may be limited to its descriptive, clinical contribution.

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Table 2
Mean CBCL-Scores

| CBCL Score and Foster Program | Admin1 (n = 251) | Admin2 (n = 108) | Admin3 (n = 45) | Admin4 (n = 11) |
|----------------------------------|---------------------|---------------------|--------------------|--------------------|
| Total Problems****1 | | | | |
| RFC | 56.4 | 54.3 | 60.5 | 50.0 |
| SFC | 60.6 | 61.4 | 60.8 | 60.7 |
| ITFC | 73.2 | 73.4 | 71.4 | 72.0 |
| Total Internalizing*1 | | | | |
| RFC | 55.4 | 51.2 | 52.0 | 46.0 |
| SFC | 55.5 | 56.4 | 53.5 | 56.2 |
| ITFC | 62.9 | 62.3 | 61.6 | 68.0 |
| Total Externalizing****1 | | | | |
| RFC | 56.1 | 55.1 | 65.0 | 56.0 |
| SFC | 60.7 | 62.0 | 62.0 | 60.2 |
| ITFC | 74.0 | 76.2 | 71.8 | 71.0 |
| Withdrawal*2 | | | | |
| RFC | 61.1 | 57.3 | 59.0 | 50.0 |
| SFC | 58.2 | 59.2 | 57.5 | 55.7 |
| ITFC | 64.5 | 63.3 | 61.0 | 61.3 |
| Somatic Complaints | | | | |
| RFC | 54.3 | 51.0 | 52.0 | 61.0 |
| SFC | 55.3 | 54.7 | 53.2 | 56.0 |
| ITFC | 57.1 | 58.6 | 55.4 | 59.7 |
| Anxiety/Depression*1 | | | | |
| RFC | 56.5 | 53.4 | 53.3 | 50.0 |
| SFC | 57.6 | 57.7 | 56.1 | 56.0 |
| ITFC | 62.8 | 60.5 | 62.1 | 70.3 |
| Social Problems**1 | | | | |
| RFC | 58.3 | 53.7 | 58.0 | 50.0 |
| SFC | 60.6 | 62.1 | 61.2 | 58.5 |
| ITFC | 67.0 | 69.1 | 70.3 | 64.8 |
| Thought Problems****1 | | | | |
| RFC | 60.3 | 56.3 | 60.0 | 50.0 |
| SFC | 59.6 | 60.3 | 58.0 | 60.3 |
| ITFC | 69.1 | 66.6 | 66.6 | 64.3 |
| Attention Problems*1 | | | | |
| RFC | 61.9 | 55.7 | 59.5 | 50.0 |
| SFC | 62.5 | 62.6 | 60.2 | 64.5 |
| ITFC | 69.4 | 71.3 | 73.1 | 66.5 |
| Delinquent Behaviors****1 | | | | |
| RFC | 59.3 | 55.0 | 63.8 | 50.0 |
| SFC | 62.5 | 63.0 | 62.9 | 64.0 |
| ITFC | 71.0 | 72.5 | 67.5 | 61.2 |
| Aggressive Behaviors****1 | | | | |
| RFC | 58.7 | 58.4 | 65.3 | 58.0 |
| SFC | 61.1 | 62.3 | 62.4 | 63.0 |
| ITFC | 75.5 | 79.1 | 74.3 | 75.0 |

Significant foster-program differences at Admin1 * $p < .05$, ** $p < .01$, *** $p < .001$, **** $p < .0001$;
¹(RFC=SFC)<ITFC; ²(RFC=SFC,ITFC)SFC<ITFC.

The Role of Latency-Age Day Treatment in Community Based Care

Introduction

Previous research has suggested that children with very serious emotional disturbance may not be well suited for day treatment programs (Rivera & Kutash, 1994). Yet there appears to be a subset of children with severe emotional disturbance who may require an intensive day treatment program to most adequately meet their needs. The primary focus of this exploratory study is to determine whether the type and severity of child behavioral characteristics, as measured by a standardized behavioral rating instrument, can help to discriminate and match children in a latency-age day treatment program, compared with other intensive levels of care. A secondary focus of this investigation is to explore if these findings could help identify client characteristics and clinical practice issues inherent in understanding the role and utility of day treatment within a continuum of care for young children, with an early onset pattern of severe emotional disturbance (Moffitt, Caspi, Dickson, Silva, & Stanton, 1996).

Methodology

A sample consisting of over 300 children in three intensive treatment environments (i.e. residential, day treatment, and treatment foster care) was used to compare and contrast the characteristics of a subset of 56 latency-age (5-13) day treatment children. The overall sample was comprised of 97 children in

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residential treatment, 56 children in a day treatment/partial hospitalization program, and 170 latency age and adolescent youngsters in a treatment foster care program. Of this total sample of 331 children, 58.3% were male, and 74.1% were African-American (see Table 1).

The day treatment program is located near Cleveland, Ohio and serves as the organizing structure for a matrix of complex mental health treatment regimes. Nested within the day treatment program are three subspecialty treatment programs: a program to treat children with serious and severe developmental disabilities; a program to treat attachment disordered children; and an abuse recovery program for victimized youth engaging in highly sexualized and/or aggressive behaviors. This mixture of specialized programming and highly individualized treatment planning is carefully integrated with a strong educational component to create a concentrated platform from which to launch treatment.

A valid and reliable behavioral measure, the Devereux Scale of Mental Disorders (DSMD), was

used to investigate behavioral functioning differences within these three levels of care. Subjects were measured on a quarterly basis since October 1994. The Devereux Scales of Mental Disorders (Naglieri, LeBuffe, & Pfeiffer, 1994) is a 110-item (or 111-item for the adolescent version) behavior rating scale designed to evaluate behaviors related to psychopathology in children and adolescents. There are two separate instruments containing comparable items and subscales; one is for children ages 5-12, and the other is for children ages 13-18. The instrument has three composite scores: externalizing, internalizing, and critical pathology. The composite scales are in turn each made up of two subscales— conduct and attention (or delinquency for adolescents); depression and anxiety; and acute problems and autism, respectively. In addition, there is an overall total test T-score. The DSMD total and composite scales have excellent internal reliability (Cronbach's alpha of .97 for Total Scale score) and test-retest reliability, as well as good interrater reliability with a clinical population (Cronbach's alpha of .52 for Total Scale score). The DSMD is well suited for use in evaluating mental health treatment outcome, and reflects the full range

Table 1
Sample Description

| | | Residential N = 97 | Day Treatment N = 56 | Treatment Foster Care N = 170 |
|--|--------------------|-------------------------------|-------------------------------------|--|
| Gender | % Female | 35.5 | 23.1 | 48.8 |
| | % Male | 64.5 | 76.9 | 51.2 |
| Race | % African-American | 41.9 | 71.9 | 89.1 |
| | % White | 54.6 | 18.8 | 6.6 |
| | % Hispanic | 0.0 | 8.1 | 0.7 |
| | % Other | 3.5 | 1.3 | 3.6 |
| Past Physical Abuse (%) | | 40.9 | 43.8 | 30.7 |
| Past Sexual Abuse (%) | | 52.1 | 31.3 | 24.4 |
| Mean No. Of Previous Out-of-Home Placements | | 3.73 | 2.98 | 2.18 |

of psychopathology, including more severe behavioral disturbances that are often missing from other rating scales. A total test T-score of 60 has been empirically determined to be the best cut-off score for differentiating clinical from non-clinical samples. Generally, T-scores can be interpreted as follows:

- 40-56 Average
- 56-60 Borderline
- 60-70 Elevated
- 70+ Very Elevated

Preliminary analyses focused on examining comparisons among youth among three different levels of care. Children's functioning throughout a

Role of Day Treatment

level of care was calculated by averaging their quarterly T-scores. One-way ANOVAs were performed for the six subscale, three composite, and total scale DSMD scores. If the ANOVA was found to be significant ($p < .05$), post-hoc Student-Neuman Keul tests were performed to identify where the differences between levels of care resided.

Results

The DSMD mean T-scores (i.e. subscale, composite, and total-T) for day treatment children were consistently greater than subjects in treatment foster care (except for the attention deficit subscale). The DSMD scores (see Table 2) reliably discriminated children in day treatment versus treatment foster care on two subscales (acute, anxiety) and two composite scales (internalizing and critical pathology). In addition the results suggest:

- As a group, day treatment children appeared to be between two levels of care—residential and treatment foster care. The sequencing of the

discrimination of children followed the expected direction with children in the most intensive treatment environments (i.e. residential, day treatment) having higher scores (indicative of greater dysfunction), and the children in less intensive treatment environments (i.e. treatment foster care) having lower scores.

- The DSMD further helped to identify specific problem domains (e.g. acute psychopathology) related to the most high risk youth placed in day treatment. The significant elevation of day treatment subjects on the acute problems subscale offers valuable insight into the matching of this level of care with children with SED. Items on this subscale include such behaviors as: fire setting, animal torture, injuring self, hallucinating, engaging in inappropriate sexual activities, etc. These behaviors constitute serious safety and liability issues that are poorly managed and treated in less intensive settings.
- The females within the day treatment level of care had more serious disturbances than their male counterparts and manifested the highest

Table 2
Devereux Scales of Mental Disorders (DSMD) Results -- One-way ANOVAs

| | Residential Mean | Day Treatment Mean | Treatment Foster Care Mean | F Ratio | df | FProb |
|--------------------|---------------------|--------------------------|----------------------------------|---------|----|----------|
| Anxiety | 59.06 | 58.89 | 53.70 | 10.410 | 2 | .000** |
| Depression | 68.65 | 61.91 | 59.83 | 16.406 | 2 | .000*** |
| Conduct | 64.17 | 62.13 | 59.29 | 5.788 | 2 | .003* |
| Attention | 61.60 | 59.57 | 60.37 | .670 | 2 | .512 |
| Autism | 63.28 | 62.21 | 58.37 | 5.215 | 2 | .005* |
| Acute | 67.24 | 65.42 | 60.17 | 5.981 | 2 | .002** |
| Critical Pathology | 66.96 | 65.35 | 60.14 | 6.953 | 2 | .001** |
| Internalizing | 64.56 | 60.86 | 57.21 | 13.805 | 2 | .000**** |
| Externalizing | 63.66 | 61.48 | 60.38 | 2.860 | 2 | .058 |
| Total-T | 66.58 | 63.81 | 60.14 | 8.429 | 2 | .000* |

*post-hoc Student-Newman-Keuls test indicates significant differences ($p < .05$) between Residential vs. Treatment Foster Care

**post-hoc Student-Newman-Keuls indicates significant differences ($p < .05$) between Residential & Day Treatment vs. Treatment Foster Care

***post-hoc Student-Newman-Keuls indicates significant differences ($p < .05$) between Residential vs. Day Treatment & Treatment Foster Care

****post-hoc Student-Newman-Keuls indicates significant differences ($p < .05$) between Residential vs. Day Treatment; and Residential & Day Treatment vs. Treatment Foster Care

mean acute problem subscale scores across the continuum of intensive care, including children in residential treatment. Compared to their male counterparts in day treatment, they scored in the elevated range on the acute problems (see Table 3), had more out of home placements, and were more likely to be sexually abused (see Table 4). Females may need to demonstrate greater psychopathology as manifested through significant high-risk behavioral displays before they are matched with more intensive treatment.

Discussion

Behavioral functioning data support the utility of a comprehensive and highly individualized day treatment program within a continuum of care as an important step between levels of care. Therefore, it appears that if this level of intensive based care is properly configured, it can serve the following important roles:

- Divert residential admissions by offering children a very intense community based treatment option.

- Reduce the length of stay in residential treatment by supplying a strong step-down option.
- Ensure that the needs of children with the most severe problems are met through a community based option powerful enough to affect sophisticated treatment interventions.
- Help to assure appropriate levels of individual and community safety by proper matching of treatment need and risk with level of care.

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Table 3
DSMD Scores Comparing Female vs. Male Latency-Age Day Treatment Children (*t*- Tests)

| | Female (N = 20) | | Male (N = 36) | | 2-Tail Sig. |
|--------------------|--------------------|--------|------------------|--------|-------------|
| | Mean | SD | Mean | SD | |
| Anxiety | 61.556 | 12.402 | 57.413 | 11.837 | .223 |
| Depression | 63.674 | 14.663 | 60.933 | 13.500 | .483 |
| Conduct | 64.623 | 13.425 | 60.749 | 12.051 | .273 |
| Attention | 63.985 | 12.570 | 57.129 | 11.817 | .047* |
| Autism | 64.188 | 13.380 | 61.123 | 15.063 | .452 |
| Acute | 73.516 | 24.157 | 60.936 | 16.305 | .046* |
| Critical Pathology | 71.256 | 18.670 | 62.083 | 16.194 | .060 |
| Internalizing | 63.159 | 12.599 | 59.596 | 12.732 | .318 |
| Externalizing | 65.336 | 13.399 | 59.352 | 11.296 | .081 |
| Total T-Score | 68.362 | 15.744 | 61.289 | 13.837 | .087 |

**p* < .05

Table 4
Day Treatment Sample Description

| | Female N = 20 | Male N = 36 |
|--|------------------|----------------|
| Race | | |
| % African-American | 73.0 | 71.5 |
| % White | 18.9 | 18.7 |
| % Hispanic | 5.4 | 8.9 |
| % Other | 2.7 | 0.8 |
| Past Physical Abuse (%) | 50.0 | 38.9 |
| Past Sexual Abuse (%) | 65.0 | 27.8 |
| Mean No. Of Previous Out-of-Home Placements | 3.65 | 2.60 |

The Characteristics of Youth Referred for Mental Health Evaluation in the Juvenile Justice System

Introduction

Many of the youths detained in juvenile detention facilities in the United States suffer from emotional disorders. Youth detained in corrections facilities have been found to have levels of psychopathology similar to the levels of mental illness found in psychiatric hospitals (Davis, Bean, Schumacher & Stringer, 1991; Pumariega, 1996). Because many of these youths reside in low socioeconomic status neighborhoods where there are few mental health services, their emotional difficulties are likely to go untreated prior to incarceration. Few juvenile justice facilities provide extensive mental health services after incarceration (Anno, 1984). Therefore, the mental health needs of this population generally receive inadequate attention.

It is unclear which factors are associated with youth being referred for mental health evaluation and treatment once incarcerated. There is considerable evidence to suggest that there are racial and gender biases that affect who is detained, but there is little evidence as to whether these differences persist when considering who is referred for services. There is, however, evidence to suggest that differences exist in how youth from different racial or ethnic groups are diagnosed. African American youth are more likely to receive a diagnosis of conduct disorder (Fabrega, Ulrich, & Mezzich, 1993). When they do receive a non-conduct disorder Axis I diagnosis, African American youth are more likely to receive an inappropriate diagnosis (Kilgus,

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Pumariega, & Cuffe, 1995). This inappropriate diagnostic labeling may impact the likelihood that youth receive appropriate treatment and experience favorable outcomes.

Beyond the characteristics of race and gender, there is a lack of information in the literature on the characteristics of referred youth. It is unclear whether other demographic characteristics, service use patterns, and juvenile justice history affect the mental health service needs of detained youth.

As a first step toward improving the process of detection of mental health problems and appropriate referral, we studied the referral process in one southern California juvenile justice facility. We examined the demographic, service use, and juvenile justice history variables and their association with three clinical variables in a juvenile justice population. Our working hypotheses were that:

1. youth of minority racial/ethnic status would be less likely to be referred for mental health treatment;
2. minority racial/ethnic status would be positively associated with receiving a diagnosis of conduct disorder; and
3. previous mental health service use would be positively associated with the youth receiving a DSM diagnosis other than conduct disorder.

Methods

The data for this study was obtained by reviewing the probation department records on all youth admitted to a juvenile corrections facility in a six month period ($N = 3283$). Additionally, the mental health department records were reviewed on all youth referred for mental health evaluation/treatment during the same six month period ($N = 244$). All youth were between 10 and 18 years of age and included both pre- and post-adjudicated youth. The youth were referred for mental health evaluation by

nursing staff on intake, detention staff members who work directly with youth on one of 10 housing units, teachers at the school located on the grounds of the juvenile hall, probation officers who worked with the youth prior to detention, or by parents who could contact the mental health staff directly. There was no formal mental health evaluation either at the time of intake or at any time during the youth's stay in juvenile hall.

Variables Studied

Two factors were examined as independent variables in this study:

1. **Internalizing Behavior:** Youth were placed in the internalizing category if they were reported to have the following behaviors: (a) verbal expressions of self harm that were not accompanied by other behavioral problems; (b) sadness and tearfulness; and (c) withdrawn behavior in the absence of other behavioral symptoms. Youth with violent, assaultive, aggressive, or bizarre (as defined by staff) behavior were placed in the externalizing category.
2. **Primary Diagnosis:** The primary psychiatric diagnoses were divided into two groups: (a) disorders for which there was a well prescribed outpatient treatment (adjustment disorders, major affective disorders, anxiety disorders, psychotic disorders, and impulse control disorders); and (b) conduct disorders which do not have a clearly defined outpatient treatment that could be administered to youth over a short period of time in this facility.

The following factors were employed as dependent variables in this study: (a) gender; (b) race/ethnicity (Black, Latino, White, and other); (c) age; (d) past mental health service use; (e) age at first arrest; (f) repeat offender; and (g) violent index offense. Each youth was classified as being a violent offender if his/her index offense (which resulted in incarceration) was one in which physical

Youth Referred for Mental Health Evaluation in Juvenile Justice

force, or the threat of force, was used against another individual, or a weapon was used in the commission of the crime. These included murder, attempted murder, rape and sexual assault, assault with a deadly weapon, assault and battery, and robbery (if a weapon was used).

Chi-square tests and *t* tests were used to compare the total juvenile hall population to the youth referred for mental health evaluation. The association of the independent variables with the dependent variables was explored using two logistic regression models.

Results

The total number of youth referred for mental health evaluation was 244 which represented 8% of the juvenile hall population. Females and non-Hispanic youth, including African American youth, were referred at a higher rate than male and Latino

youth (see Table 1). A larger number of the referred youth were repeat offenders and were more likely to have committed violent crimes.

Among the referred sample, 123 (50%) of the youth reported the current use of alcohol and drugs. Almost half (56) of these youth reported using three or more drugs on a frequent basis. Despite having a significant rate of alcohol and substance use, only five of the 123 youth who stated that they had used alcohol or drugs received a primary diagnosis of substance use disorder. Forty-one youth had a secondary diagnosis of a substance use disorder.

Ninety-seven percent of all referred youth met the DSM IV diagnostic criteria for a psychiatric disorder and received the following diagnoses: Adjustment Disorder (34%), Conduct Disorder (25%), Affective Disorders (13%), Attention Deficit Hyperactivity Disorder (14%), Psychotic Disorders (5%), Post-Traumatic Stress Disorder (4%), and Substance Use Disorders (2%). The diagnostic categories differed based on the job classification of the referrer. For example, those with a diagnosis of conduct disorder were more likely to be referred by probation staff who work directly with the youth on a daily basis (72%) while those who had a psychiatric disorder other than conduct disorder were more likely to be referred by nursing staff (50%).

The two logistic regressions used to examine the impact of demographic, service use, and juvenile justice history variables are presented in Tables 2 and 3. Table 2 shows the association of these factors to internalizing behavior. Youth with a history of prior mental health service use and those with a violent index offense were almost half as likely to be referred to mental health for internalizing symptoms than for aggressive, bizarre, or agitated behavior. Repeat offenders were twice as likely to be referred for depressive symptoms.

Table 1
Characteristics of Detained Youth:
L.A. County Juvenile Hall, 1995

| | Referred (n = 244) | All (n = 3283) |
|---------------------------------|-------------------------------|---------------------------|
| Gender | | |
| Male (%) | 178 (73.0) | 2771 (84.4) ** |
| Race/Ethnicity | | |
| African American (%) | 72 (29.5) | 770 (23.4) * |
| White (%) | 94 (38.5) | 722 (22.0) ** |
| Latino (%) | 71 (29.1) | 1661 (50.6) ** |
| Other (%) | 7 (2.9) | 130 (4.0) * |
| Mean Age (SD) | 15.6 (1.5) | 15.9 (1.5) * |
| First Time Offenders (%) | 140 (57.3) | 2601 (79.2) ** |
| Violent Crimes | 81 (33.2) | 698 (21.3) ** |
| Mean Age at First Arrest | 13.9 (1.8) | 13.8 (1.6) |

* *p* < .05 ** *p* < .001

Table 3 shows the results of the regression examining the effects of the variables on psychiatric diagnosis. Minority youth were almost twice as likely to receive a diagnosis of conduct disorder than non-minority youth. Mental health service use was also significant in determining the psychiatric diagnosis. Juveniles who had previously utilized mental health services were more likely to receive a diagnosis other than conduct disorder.

Discussion

It is disturbing that referred youth represented under 8% of the juvenile hall population since the prevalence of emotional disturbance in this population is conservatively estimated at 14-22% (Otto, 1991). The lack of identification and treatment of the mental health problems of the non-referred youth may have serious and long range consequences. These potentially include future crime and incarceration, poverty, chronic emotional suffering, and persistent substance abuse.

Our study found that both African-Americans and Caucasians were referred at a higher rate while the Latino youth were referred at a much lower rate. The slight over representation of African Americans in the referred sample is inconsistent with our hypothesis and with the former studies. One possible explanation for these findings is the racial makeup of the juvenile hall staff, which is predominantly African American. Staff members from similar ethnic backgrounds as the youth may have a higher sensitivity for abnormal behaviors in youth from similar cultures. The

cultural differences which exist between African American staff and Latino youth, who may be recently immigrated and/or speak English as a second language, may account for staff being less likely to recognize psychopathology in Latino youth. This is especially true if there are no significant behavioral problems.

Being a minority was associated with receiving a diagnosis of conduct disorder when we controlled for the other independent variables. Minority youth were almost twice as likely to receive a diagnosis of conduct disorder than Caucasian youth. Because we do not have an objective measure of psychopathology, we cannot state that there was a diagnostic bias present, however, the present evidence suggests that bias might exist in the diagnoses assigned to minority youth. Cultural factors that affect the expression of psychopathology have also been offered as an

Table 2
Logistic Regression to Explain Internalizing Behavior as the Reason for Referral *

| | Coefficient | Odds Ratio | 95% Confidence Interval | p value |
|---------------------------------|--------------------|-------------------|--------------------------------|----------------|
| Demographic | | | | |
| Male | -.522 | .59 | .31-1.13 | .11 |
| Minority | .000 | 1.00 | .53-1.87 | .99 |
| Age | -.084 | .91 | .48-1.72 | .79 |
| Service Use History | | | | |
| Mental Health Service Use | -.610 | .54 | .29-1.00 | .05 |
| Juvenile Justice History | | | | |
| Age at First Arrest | .484 | 1.62 | .83-3.14 | .15 |
| Repeat Offender | .746 | 2.11 | 1.11-4.01 | .02 |
| Violent Index Offense | -.674 | .51 | .26-1.00 | .05 |

* The 95% CI is based on odds ratios.

Youth Referred for Mental Health Evaluation in Juvenile Justice

explanation to explain similar findings (Cross, Bazron, Dennis, & Isaacs, 1989). Although almost 60% of the youth that were referred to mental health were from minority racial/ethnic backgrounds, there were no minority mental health staff at this facility. Cultural, social, and economic differences between the mental health staff and the youth that they treat which impact the outcomes of diagnostic evaluation.

Despite the limitations of this study, it is a first step in understanding the clinical service needs of a population of youth housed in a short term juvenile corrections facility. The study found clear patterns in terms of under-representation of Latino youth among those referred for mental health services, and the increased likelihood that both Latino and African-American youth are given a primary diagnosis of conduct disorder rather than another DSM IV Axis I disorder. Additionally, youth who received previous mental health services were less

likely to receive a diagnosis of conduct disorder and more likely to receive another Axis I diagnosis.

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Table 3
Logistic Regression to Explain Primary Diagnosis *

| Variables | Coefficient | Odds Ratio | 95% Confidence Interval | p value |
|---------------------------------|-------------|------------|-------------------------|---------|
| Demographic | | | | |
| Male | -.109 | .93 | .48-1.79 | .82 |
| Minority | -.519 | .54 | .29-1.00 | .05 |
| Age | .001 | .97 | .78-1.21 | .82 |
| Service Use History | | | | |
| Mental Health Service Use | .858 | 2.07 | 1.10-3.88 | .02 |
| Juvenile Justice History | | | | |
| Age at First Arrest | .156 | .85 | .70-1.03 | .10 |
| Repeat Offenders | .055 | 1.00 | .52-1.91 | .99 |
| Violent Index Offense | .351 | 1.15 | .89-1.50 | .28 |

* The 95% CI is based on odds ratios.

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Adult Arrests Records and Court Outcomes of Adolescents with Serious Emotional Disturbance

Introduction

Previous studies have demonstrated that many youth with serious emotional disturbance (SED) are arrested between adolescence and adulthood (Wagner, D'Amico, Marder, Newman & Blackorby, 1992; Brown & Greenbaum, 1995). Some of the factors associated with lifetime arrest or incarceration included dropping out of school (Wagner et al., 1992), being older, male, of minority ethnicity, having a lower reading grade level, having conduct disorders and externalizing behavior symptoms, and not having phobic disorders (Brown & Greenbaum, 1995). Neither of these studies examined differences between juvenile and adult charges. Understanding the risk of adult charges helps determine whether youth with SED continue to be at risk for arrest, or whether this phenomenon begins or desists in adulthood. Understanding who is at greatest risk for adult arrest may also guide preventive interventions. The present study used archival data to examine adult charges and court outcomes for adults who had been treated in public mental health services as adolescents.

Methods

Subjects consisted of 82 individuals who had received publicly contracted adolescent mental health services in the greater Boston area between 1988 and 1994. Subjects were between 21.5- 28.5 years of age as of July 1, 1996. The clinical

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record of each subject was reviewed from their adolescent day treatment (18%), residential (23%) or hospital program (58%). Subject sociodemographics, clinical diagnosis, treatment variables, significant history, and family configuration were recorded from the clinical record. Clinical records indicated that subjects were 51% male, 38% minority, and 50% came from single-parent households. The average number of prior hospitalizations was 2.6 ($S.D.= 2.0$). The most common clinical diagnosis was a mood disorder (49%), followed by anxiety or personality disorders (27% each), disruptive behavior disorders (25%) and substance abuse disorders (15%). Twelve percent had a psychotic disorder diagnosis.

Subject identification numbers were generated from their name, gender and birthdate, and were used to search the data base of all clients receiving case management services from the department of mental health. This database records the frequency of case management encounters, the duration of hospitalizations, and the frequency of emergency room contacts for case managed clients. Their name, gender, birthdate, and social security numbers were used to search the Criminal Offender Record Information (CORI) system. The CORI contains the arraignments and dispositions heard and rendered in all Massachusetts' state adult criminal courts. CORI records were not available for juvenile court involvement, thus the present study does not assess the contribution of juvenile delinquency to adult charges. CORI records were accessed on July 1, 1996, at which point subjects had been discharged from the adolescent treatment program for an average of 5.9 years ($S.D.=1.4$).

Chi square analyses were conducted to examine differences on categorical variables between individuals who had and had not had an arraignment on an adult charge. *T*-tests were used to examine differences in continuous variables among arraigned and non arraigned individuals. Logistic

regression was used to examine how variables predicted the odds of arrest while controlling for all other variables. Three regression analyses were conducted. The first examined just the variables from the clinical record. The second added whether adult case management services had been received, the number of years since discharge, and age as of 7/1/96. The third and fourth conducted the same analysis for males only (the sample size was too small to examine these among females).

Results

Subjects had a total of 117 arraignments and 352 charges in CORI records. Overall, 37 of the 82 subjects (45%) had at least one adult charge. The average number of charges per charged individual was 9.0 ($S.D.=11.4$), with a range of 1-56. The average age at the time of the first adult charge was 18.6 years ($S.D.=1.7$). Chi square analysis revealed significant differences in gender (67% of males and 23% of females had been arraigned); adolescent treatment program (27% of day treatment, 32% of residential, and 56% of hospitalized subjects had been arraigned); and history of court involvement noted in clinical record (91% of those with court history in clinical record had been arrested versus 39% of those without): Chi squares gender ($df=1$)=14.4, $p < .001$; treatment program ($df=4$)=12.7, $p < .02$; court history ($df=1$)=7.7, $p < .01$. Minority status, clinical diagnosis, single parent head of household, discharge residence type, and whether or not they had received adult case management services were not significantly different.

As can be seen from Table 1, *t*-tests revealed significant differences in age at first hospitalization [t ($df=66$)=2.03, $p < .05$], age at admission to the adolescent treatment [t ($df=80$)=3.50, $p = .001$], and the number of years since adolescent discharge [t ($df=78$)=3.8, $p < .001$]. There were no significant differences in their age in 1996, the number of prior

Adult Arrest Records of Adolescents with SED

hospitalizations or out-of-home placements, the length of stay, or the discharge global assessment of functioning levels. Entering all adolescent clinical records variables into logistic regression revealed that male gender ($OR=3.8$), clinical record of court involvement ($OR=12.9$), and younger age of admission to adolescent program ($OR=0.4$) were significant, and correctly classified 79.3% of cases. Adding adult case management, age in 1996, and the number of years since adolescent discharge to clinical records variables revealed significant effects of male gender ($OR=8.3$), and more years since adolescent discharge ($OR=1.9$). Charged males averaged more charges than did charged females [males mean=10.8 \pm 12.3 *S.D.*, females mean=2.6 \pm 2.2 *S.D.*, $t(df=33.3)=3.4$, $p<.003$]. No regression models could be generated to predict the odds of being charged within males from clinical record variables, but more years since adolescent discharge ($OR=2.0$) did significantly predict risk, and correctly classified 71.4%.

Analysis of the number of adult charges per person per age, among those who had been charged, revealed that subjects were most frequently charged

at age 18, with most of the charges encompassed between ages 17-20 (see Figure 1). Twenty-eight percent of all subjects had been charged with an adult charge before turning 18 years, another 11% had been arrested before turning 19, the remaining 6% were arrested by the age of 22.

The most common group of charges were serious property offenses (e.g. theft, grand larceny), followed by serious offenses on persons (e.g. assault and battery with a dangerous weapon, assault to kill). Misdemeanors involving public disorder and car or driving-related offenses were also common (see Figure 2). Seventy percent of charged individuals had been charged with misdemeanors involving public disorder and car or driving-related offenses, 54% had a serious property charge, and 46% had a serious crime on person charge (see Figure 2). Examination of the most serious offense with which individuals were charged revealed gender differences [chi square ($df=7$)=14.5, $p<.05$]. The most serious charge for males was overwhelmingly serious crimes on person (71% of males vs. 22% of females), followed by serious on property (11%), drug-related (7%), threatening (7%) and other misdemeanors (7%). While the

most common most serious charge for females (33%) was misdemeanors of public disorderliness and auto-related, followed by serious on person or property (22% each), sex-related misdemeanors and other types of offenses (11% each).

Charged subjects did not contest or were found guilty of 77% of all charges, and 38% of charged individuals were sentenced to some time. The CORI does not record the amount of time served.

Table 1
Characteristics of Charged Adults

| Variable | (N) | Charged Mean (S.D.) | Not Charged Mean (S.D.) |
|--|-----|---------------------|-------------------------|
| Age at 1st Hospitalization | 68 | 14.0 (3.6) | 15.4 (2.3)** |
| Age at Adolescent Admission | 82 | 17.0 (1.6) | 18.0 (0.9)* |
| Time since Discharge (yrs) | 80 | 6.5 (1.5) | 5.4 (1.1)* |
| Age in 1996 | 82 | 23.6 (1.4) | 23.6 (1.1) |
| Length of Stay (days) | 80 | 58.6 (55.3) | 86.0 (130.1) |
| Discharge Global Assessment of Functioning | 44 | 44.5 (16.5) | 46.7 (11.0) |
| # Prior Placements | 81 | 4.5 (3.9) | 5.2 (5.4) |
| # Prior Hospitalizations | 68 | 2.8 (1.9) | 3.1 (2.0) |

t-test * $p<.01$, ** $p<.05$

Conclusions

Many youths, especially boys, served in intensive public mental health services will have significant adult corrections involvement. The period of greatest risk of adult arrest is between 17 and 20 years of age. Those who are charged are found guilty of serious offenses, though this is less so for females. While the current study was suggestive of risk factors, many likely risk factors, such as peer or family relations, could not be captured from clinical records. More detailed, prospective studies, with large sample sizes, are needed to identify factors that differentiate between those most at risk of getting into trouble with the law as adults. It is particularly important to determine the specific contribution of SED to that risk. Finally, those treating adolescents with SED need to be aware of the likelihood of them becoming involved with adult corrections, and programs and interventions need to be targeted to prevent this poor outcome.

Figure 1
Charges by Age

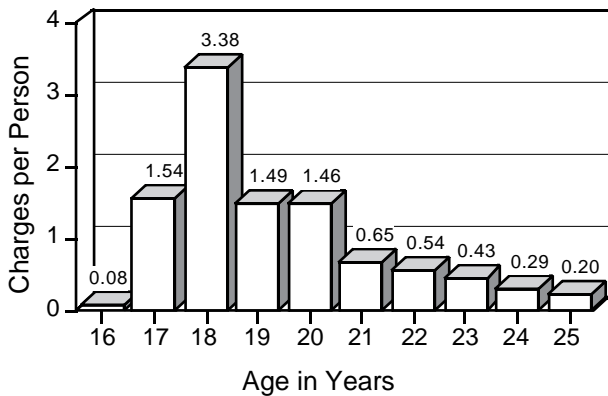
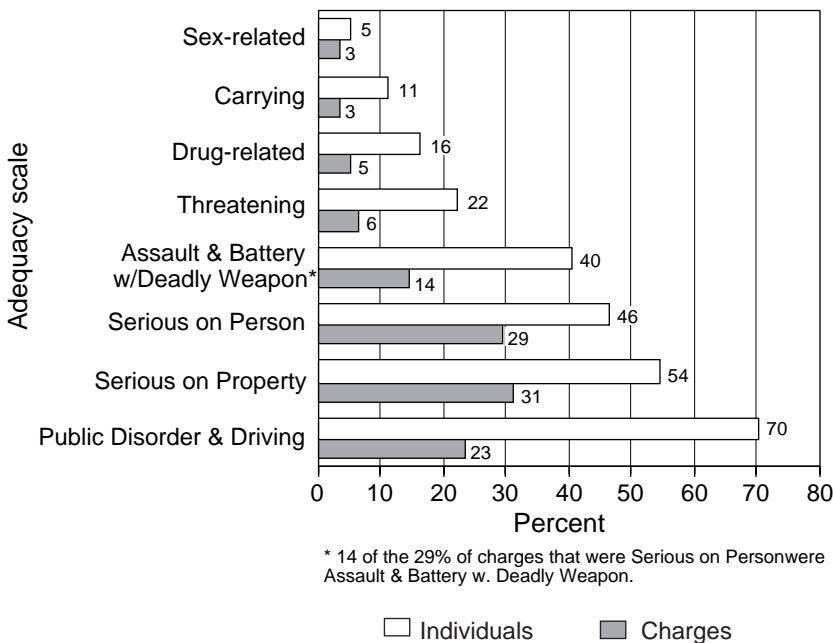


Figure 2
Distribution of Types of Charges



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The Prime Time Project: Preliminary Review of the First Year of a Community- Based Intervention for Youth in the Juvenile Justice System

Introduction

The Prime Time Project is an assertive, community-based intervention designed to address the specific needs of an extremely high-risk group of adolescents – those with a history of both severe emotional disturbance and involvement in the juvenile justice system because of repeated or violent offenses. The intervention aims to decrease criminal behavior (recidivism, severity of offenses), increase prosocial behavior (attendance, performance, and behavior at school/work, family, peer, and community involvement), and stabilize psychiatric symptoms. Youth are identified and referred while in juvenile detention. Referrals come from judges, detention staff, probation counselors, family members and health clinic staff. Services begin in detention and follow youth as they return to the community; with intervention taking place over a year-long period with intensity of services tapering over the course of treatment.

Development of the Prime Time intervention began with the specification of a causal model that informs and directs the nature of the program (see Figure 1). This model is both risk-based and interactional, portraying the links between background risk factors, more proximal antecedent risk factors, the intervention itself, and target outcomes. The causal model focuses on three areas of risk: attachment and the nature of the parent-child relationship during early childhood (Loeber, 1991; Greenberg & Speltz, 1993); the nature of parenting skills and strategies to which the child is exposed (Patterson, 1982; 1993; Greenberg & Speltz, 1993); and the child's ecological and community context (Costello, 1989; Jessor, 1991).

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The Prime Time intervention emphasizes skill building and behavior change in the youth's natural environment. The model seeks to facilitate transition from a delinquent life style with limited support to a prosocial lifestyle with a solid base of family and community support. The intervention seeks to stabilize youth, enhance and/or teach skills and competencies to youth and parents, and create or strengthen links between the youth, family and other community systems.

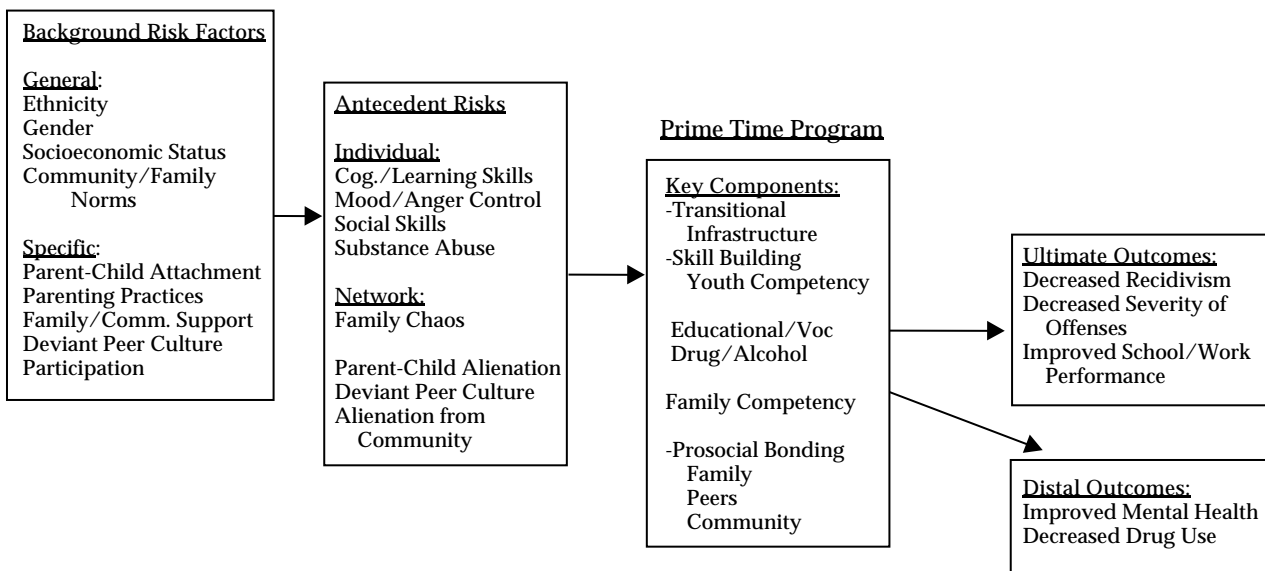
Central components of the Prime Time intervention:

- Establish a supportive infrastructure (through case management, convening a community-based team, intensive monitoring, group-based day program).
- Build skills: (a) Youth Skills: affect management, interpersonal problem-solving, educational, vocational, and substance refusal; (b) Parent/Family Skills: parenting competency, parental advocacy, communication.
- Foster prosocial bonding of youth to family, peers, and community.

Key features of the Prime Time intervention:

- Close collaboration with the juvenile justice system.
- Services are delivered in the community.
- Services are comprehensive, incorporating mental health treatment, drug/alcohol treatment, competency enhancement, and community support.
- Services are based on assessment of strengths and needs of each youth and family.
- Intervention is targeted to risk factors that are specific to "double jeopardy" youth.
- Assertive case management is provided by experienced therapists/case managers.
- A diverse staff, sensitive to the needs of ethnic minority youth, provides culturally relevant services.
- Services are coordinated across boundaries of the juvenile justice system, schools, mental health system, child welfare, public health, and other community resources.

Figure 1
Prime Time Project: Causal Model



Prime Time Project

This summary reviews the first year of the Prime Time intervention. A sample of the client population is described, and juvenile justice data are used to explore the intervention's preliminary impact on involvement with the juvenile justice system (new charges; new admissions to detention).

Method

Demographic and functional assessment data (WRAT-3: Wilkinson, 1993; K-BIT: Kaufman & Kaufman, 1990; CAFAS: Hodges, 1995) are used to describe the population served by the Prime Time intervention. School enrollment status and CGAS (Shaffer, et al., 1983) ratings of Prime Time participants were also tracked over the first year of the project. Trained graduate-student clinicians administered assessment instruments, with most assessment taking place in participants' homes or other community settings. We then compared the juvenile justice records of 24 Prime Time participants, retrospectively, with records of a matched sample of 24 youth not enrolled in the Prime Time intervention, but meeting entrance criteria (currently in detention with at least two admissions, age 12 to 17, adjudicated for a violent offense or documented history of violence, and presenting with a diagnosable mental health disorder).

We obtained a comparison sample using the following procedure: County detention health clinic charts are filed chronologically, based on the date of youth's first admission to detention. Matches were obtained by using the health clinic charts of Prime Time participants as an index point and searching for the first chart of a non-participant that meets Prime Time entrance criteria and matches the index youth as to age (within 1 year), sex, and ethnicity.

We reviewed the juvenile justice records of the resulting sample of 24 Prime Time participants and 24 comparison youth using the King County Juvenile Justice on-line database. We compared youth

based on (a) number of admissions to detention and (b) number of new charges in juvenile court, both pre- and post-enrollment in the Prime Time Project.

Results and Discussion

Demographic data. The mean age of the 24 youth in the Prime Time sample was 14.9 years old ($SD= 1.25$); mean for youth in the comparison sample was 15.9 ($SD=.88$). Both samples included about 50% males. Youth were 54% Caucasian, 29% African American, 13% Native American and 4% were of mixed heritage.

Diagnoses and history of treatment. Primary and secondary diagnoses (comparison sample diagnoses as reported in medical charts in Detention Health Clinic) are reported in Table 1. These data highlight the profound impact of substance abuse on the lives of these youth. Similarly, these initial findings support previous research noting the high rate of co-occurring mental health and substance abuse diagnoses. As we continue to specify the nature of the Prime Time intervention model, integrating substance abuse treatment with mental health interventions will take the forefront.

The majority of youth in both samples had received outpatient mental health treatment only (58% of Prime Time sample and 75% of comparison), with 30% of the Prime Time sample and 21% of the comparison sample having had both in- and outpatient treatment. Twelve percent of the Prime Time sample and 4% of the comparison sample had received no mental health treatment.

Intellectual functioning and academic achievement. At the time of enrollment, youth in the Prime Time sample scored in the "average" range of intellectual functioning ($M=93.6$, $SD=9.0$) as measured by the K-BIT. Non-verbal performance ($M=98.1$, $SD=9.6$) was consistently better than verbal ($M=90.2$, $SD=9.8$), most likely reflecting the

extent to which these youth are disconnected from the public school system. Similarly, at the time of enrollment, youth in the Prime Time sample performed, on average, between the fifth and sixth grade levels in reading, spelling and arithmetic (WRAT-3).

Overall functioning (CAFAS). At the time of enrollment, 20 of the 24 youth scored in the CAFAS range labeled “likely requires intensive treatment.” The remaining 4 scored in the range labeled “may require care more intensive than outpatient.”

Table 1
Co-occurrence of Mental and Substance Abuse Disorders

| | Prime Time group <i>n</i> = 24 | | Comparison group <i>n</i> = 24 | |
|---|--------------------------------|------|--------------------------------|------|
| | <i>n</i> | % | <i>n</i> | % |
| Primary diagnoses¹ | | | | |
| Dysthymia | 6 | 25 | 7 | 29.2 |
| Depression | 6 | 25 | 7 | 29.2 |
| Bipolar disorder | 4 | 16.7 | 2 | 8.3 |
| ADD/ADHD | 2 | 8.3 | 5 | 20.8 |
| PTSD | 4 | 16.7 | 2 | 8.3 |
| Other | 2 | 8.3 | 1 | 4.2 |
| Secondary diagnoses¹ | | | | |
| Dysthymia | 9 | 37.5 | 5 | 20.8 |
| Depression | 1 | 4.2 | 3 | 12.5 |
| Bipolar disorder | 0 | 0 | 2 | 8.3 |
| ADD/ADHD | 6 | 25.0 | 3 | 12.5 |
| PTSD | 4 | 16.7 | 5 | 20.8 |
| Other | 3 | 12.5 | 2 | 8.3 |
| None | 1 | 4.2 | 2 | 8.3 |
| Co-occurring substance abuse: | | | | |
| Identified substance abuse problems | | | | |
| | 23 | 95.8 | 18 | 75 |
| No identified substance abuse problems | | | | |
| | 1 | 4.2 | 6 | 25 |

¹ Conduct Disorder and substance abuse disorders are excluded.

School attendance. At enrollment, 20 of the 24 youth in the Prime Time sample were not attending any school. Twelve months after enrollment, all but 2 youth were either attending a public school or enrolled in a GED or alternative school program. These data suggest that an intervention emphasizing skill building along with monitoring and support may be effective in enhancing youths’ survival in the school setting.

Family involvement. Of the 24 youth in the Prime Time sample, 10 lived with at least one parent, 7 lived with a family member other than a parent, 6 lived in foster or group care, and 1 was homeless. While youth were not always able to live with parents or other family members, family members were almost always important sources of support. Of the 24 youth in the sample, all but 2 had a family member involved in their care in some way. Four youth receive support from two parents, 13 from their mother only, 3 from grandmother, and 2 from other family members.

Juvenile Justice Involvement

Admissions to detention. A retrospective comparison of admissions to juvenile detention was conducted for the Prime Time and comparison samples at 5 points: (a) prior to enrollment in the Prime Time intervention, (b) 3 months, (c) 6 months, (d) 9 months, and (e) 12 months. Wilcoxon matched-pairs signed ranks tests were conducted for each comparison. The Prime Time sample ($M=5.54$, $SD=1.93$) had a history of more admissions to detention than the comparison sample ($M=4.04$, $SD=2.44$; 2-tailed $p=.01$). However, admissions to detention at 3, 6, 9 and 12 months did not differ between the Prime Time and comparison samples.

New charges. A retrospective comparison of new charges in juvenile court is reported for the Prime Time and comparison samples at 5 points: (a) prior to onset of Prime Time intervention,

Prime Time Project

(b) 3 months, (c) 6 months, (d) 9 months, and (e) 12 months (see Figure 2).

Wilcoxon matched-pairs signed ranks tests were conducted for each comparison. The Prime Time sample had a history of more charges in juvenile court ($M=13.29$, $SD=6.83$) than the comparison sample ($M=8.33$, $SD=4.06$; 2-tailed $p=.001$). However, as depicted in Figure 2, the direction of difference reversed at 3, 6, 9, and 12 months, in that the Prime Time sample received fewer new charges in court than the comparison sample.

These retrospective comparisons suggest that participants in the Prime Time intervention do not differ from the matched comparison sample with regard to the number of times they return to detention at 3, 6, 9, or 12 months after enrollment in the intervention. This finding may be understood in either of two ways: (a) the Prime Time intervention has no impact in this domain, or (b) Prime Time youth are returning to detention for some reason other than new delinquent behavior.

The differential rate of new charges in juvenile court supports the latter explanation. While Prime

Time youth had a history of more charges than the matched comparison group, they received fewer charges at 3, 6, 9 and 12 months. In concert with the finding of “no difference” in admissions to detention, this lower rate of new charges suggests that Prime Time youth are returning to detention as a result of closer supervision and monitoring of compliance with the terms of probation.

While the preliminary nature of this report precludes drawing any conclusions, these comparisons suggest that the Prime Time model may be effective in facilitating more consistent monitoring and supervision of youth in this population, and in decreasing delinquent behavior.

Discussion

Youth served during the first year of the Prime Time Project represent the “deep end” of the continuum of need for services, reflected in their level of disconnectedness from family and community, delinquent behavior, mental health and substance abuse problems. Families of these youths, for both obvious and subtle reasons, were often unable to provide the level of support and monitoring that they would like. In working with these youth, we have found that our ability to

Figure 2
Number of New Charges in
Juvenile Justice System:
Prime Time and Comparison Groups

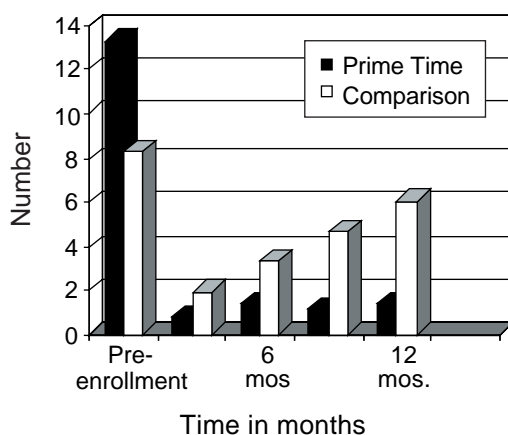


Table 2
New Charges in Juvenile Justice System:
Prime Time and Comparison Groups

| | Prime Time | Comparison | <i>n</i> | <i>p</i> |
|-----------|----------------------------|----------------------------|----------|----------|
| 3 months | $M = .83,$ $SD = 1.23$ | $M = 1.96,$ $SD = 1.46$ | 24 | .01 |
| 6 months | $M = 1.45,$ $SD = 1.63$ | $M = 3.35,$ $SD = 2.30$ | 20 | .00 |
| 9 months | $M = 1.14,$ $SD = 1.56$ | $M = 4.71,$ $SD = 1.90$ | 14 | .00 |
| 12 months | $M = 1.42,$ $SD = 1.38$ | $M = 6.08,$ $SD = 2.61$ | 12 | .00 |

address treatment goals often hinged on close collaboration with the juvenile court, probation counselors and police (in addition to families and other child-serving agencies). Aided by these systems' capacity to monitor and enforce limits and boundaries, the Prime Time interventions could focus more directly on skill-building and enhancing pro-social bonds to family and community.

This summary presents a preliminary report of the activities of the Prime Time Project. The lack of a comparison sample for some variables, and the retrospective nature of comparisons for the juvenile justice variables, along with the small sample size, preclude any conclusions regarding the treatment model. The reader also may note that for variables reported as time series, the *n* decreased from 24 to 20, 14 and 12 at 3, 6, 9 and 12 months, respectively. This reflects the gradual nature of enrollment of youth over the first year of the Project and is not a function of "drop outs."

We have recently submitted a proposal to NIMH for a development grant. This grant would fund a case study series and manualization of the intervention, followed by a pilot study to prepare for a full-scale, controlled evaluation of the Prime Time intervention.

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Can Specialized After-School Programs Impact Delinquent Behavior Among African American Youth?

Introduction

African American youth increasingly are committing juvenile offenses. There is a preponderance of African American youth between the ages of 13 and 17 that regularly enter our juvenile justice system. This behavior burdens both parents and society with economic and social costs. These costs are reflected in employee absenteeism as parents have to attend court hearings, decreased productivity of workers as their caseloads reach uncontrollable levels, overcrowded jails and detention centers as more and more youth are detained, and an increase in merchandise costs as a result of shoplifting and theft. Given the prevalence of juvenile crime, it is important to develop valid, feasible, prevention-type programs to address the seriousness of juvenile crime.

This summary describes a study examining the impact of a specialized after-school program, the Services to Youth Program (STYP), as one method for decreasing juvenile crime among school-age youth. Using both a cognitive and affective framework, the overall goal of the STYP was to prevent the reoccurrence of criminal activity among delinquent youth. Cognitive goals included: (1) to understand how personal behavior impacts responses from others; (2) to learn new methods for improving negative behaviors; and (3) to learn positive techniques and strategies for addressing personal needs, while avoiding negative behaviors. Affective goals included: (1) to give appropriate expression of personal emotions; (2) to engage in meaningful interaction with peers and others; and (3) to become aware of the personal and social effects of negative behaviors.

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Methods

Participants

Respondents ($N = 14$) were referred by a juvenile court probation officer or judge and were (a) between 13 - 17 years of age; (b) currently enrolled in school; (c) had written parental or guardian consent to participate in the program; and (d) had committed in writing to participate in the program. Dismissal from the program resulted when a youth (a) demonstrated habitual disregard for program rules and regulations; (b) was permanently expelled from school; and/or (c) used alcohol or other drugs while in the program or on program grounds. Group I consisted of 7 African American youth who actively participated in a structured, curriculum-based after-school program. Group II was a matched group of 7 youth who did not participate in the program and who were not involved in any structured activities or after-school programming.

The two groups were matched according to age, gender, race, socioeconomic status, grade level, type of offense, and number of adults in the household. All participants were required to provide written parental/guardian consent for their participation in the STYP. Youths with chronic substance abuse problems were not accepted into the program.

Curriculum-Based Design

Group I met daily after school and on Saturdays (6 days per week total) for 3 hours each day for a 9-month period. Participants progressed through a theoretically-based, four stage curriculum. The curriculum was culturally sensitive and dealt with theory and description relevant to causes and processes related to destructive behavior, and the strategies to prevent, reverse, and/or ameliorate these behaviors (see Table 1). This emphasis was designed to help the youth develop empathy and

understanding for themselves by examining their "social identities" in relation to social dominance and social subordination. Content was based upon one's self-image in relation to social position and negative stereotyping. Through specialized and focused groups, youth, and their families, were challenged to self-actualize, to reclaim the strengths and values of the extended family, and to develop stronger family systems in which parents have well-defined roles and maintain leadership and authority. Participants in Group I progressed through each level based upon personal accomplishments, completion of tasks, and self-awareness. Each youth within this group was monitored and supervised by program staff as he/she matriculated through the levels.

Group II was a control group and consisted of 7 youth who did not participate in any structured activities or after-school programming. Risk Assessment was a standardized measurement tool used by the Division of Youth Services designed to measure level of criminal risk at each stage of the program.

Data Collection

Three instruments¹ were administered at intake and at program termination (i.e., nine months): (1) **Criminal Behavior Assessment/Reassessment of Risk** (Cognitive Outcome Measure). This is a two-part, easily scored risk assessment measurement for use with juvenile delinquents. Part I identifies an individual's delinquent history and socialization practices. Part II records program impact, socialization practices, and youth self-reporting behaviors. The assessment includes quarterly reviews (at conclusion of month 3, 6 and 9) of court records, probation officer reports, and court service worker records on each

¹The three instruments described in this summary may be obtained by contacting the author.

After-School Program

Table 1
Services to Youth Program Curriculum

| Levels | Goals | Objectives/Strategies | Theoretical Orientation |
|---|--|--|---|
| I - Entry/Assessment Phase | <ol style="list-style-type: none"> 1. Orientation 2. Evaluation/Assessment 3. Goal-Setting 4. Relationship Building 5. Risk Assessment | <ol style="list-style-type: none"> 1. Intake Summary Report & Psychological Status Report 2. Ropes Course 3. Life Skills & Socialization 4. Anger Management 5. Risk Assessment Tool | <ol style="list-style-type: none"> 1. Behavior Modification 2. Social Learning Theory |
| II a - Primary Problem Solving II b - Intermediate Problem Solving | <ol style="list-style-type: none"> 1. Self-Awareness/Reflection 2. Academic Enrichment <p style="text-align: center;"><i>Interaction/Didactic Strategies</i></p> <ol style="list-style-type: none"> 3. Problem-Solving & Coping Mechanisms 4. Risk Assessment | <ol style="list-style-type: none"> 1. Conflict Resolution and Violence Prevention Groups 2. Reality Therapy 3. Rites of Passage Program 4. Tutorials 5. Computer Classes 6. Male & Female Parenting Groups 7. Risk Assessment Revisited | <ol style="list-style-type: none"> 1. Operant Conditioning 2. Social Cognitive Theory 3. Race, Class, and Oppression |
| III a - Advanced Problem Solving III b - Skill Building Intervention/Problem-Solving | <ol style="list-style-type: none"> 1. Responsiveness 2. Targeting Behaviors <ol style="list-style-type: none"> 1. Addiction Disorders 2. Social Deviant Behaviors 3. Parent/Child Communications and Relationship Building 4. Community Awareness 5. Job Readiness Skills 6. Risk Assessment | <ol style="list-style-type: none"> 1. A & D Groups (12-step) 2. Family & Individual Counseling 3. Community Networking & Resource Building 4. Sex Offenders Group 5. Community Service 6. Risk Assessment Revisited | <ol style="list-style-type: none"> 1. Behavior Modification 2. Social Learning Theory |
| IV - Termination | <ol style="list-style-type: none"> 1. Maintenance 2. Life Skills Preparation 3. Risk Assessment | <ol style="list-style-type: none"> 1. Post Assessment <i>and</i> Evaluation (Summary, Termination, Discharge) 2. Job Skills & Placement 3. Mentoring Program 4. Support Groups | Reinforcement and Support |

participant to determine the number and type of criminal offenses committed by youth during program evaluation. This instrument was developed by the Division of Children and Youth Services, Atlanta, Georgia; (2) **Profile of High School Students** (Cognitive Outcome Measure), a 20-item self-report instrument that measures three variables– aggressive behavior, self-discipline, and social control. Social control measures were used for the current study; and (3) **Program Evaluation Form** (Affective Outcome Measure), a 30-item scale that measures program satisfaction, program participation, and youth awareness of personal behavior. This instrument was developed by the author specifically for use with STYP.

Results

Demographics

The study population consisted of 14 respondents (29% females, $n = 4$; 71% males, $n = 10$) whose mean age was 14.3. All respondents were African American. The mean level of education was 8th grade. Forty-three percent of the population attended public schools and 57% of the population attended alternative schools. Fourteen percent of the respon-

dents lived with two parent families. 43% of the youth lived in single parent households and the remaining 43% lived in group homes. The average family income was \$16,250.

Clinical assessments of program participants revealed that 43% of the study population met the criteria for a DSM-IV diagnosis of conduct disorder; 43% adjustment disorder; 14% oppositional disorder; and 14% attention deficit disorder. Two participants received a dual diagnosis.

Criminal Behavior Assessment

The type of offenses committed by the youth at intake were misdemeanor (57%; defined as shoplifting, truancy, ungovernable behavior) and felony (43%; defined as armed robbery, murder, drug trafficking, auto theft, and assault). At termination, 43% ($n = 3$) of the Group I study population reoffended. Reoffenses include arrests, charges and convictions. These 3 reoffenses included 2 misdemeanors and 1 felony. Fifty-seven percent ($n = 4$) of this group did not reoffend while actively engaged in the program (see Table 2). At termination of the program, 100% of the youth in Group II had committed felonies, an increase from 43% at intake, while only

Table 2
Comparison of Group I and Group II Offenses

| Group I Offenses | | | | Group II Offenses | | | |
|------------------|--------------------------|-----------------------------|-----------------------------|-------------------|-------------|----------------|----------------|
| Youth # | At Intake | During Program ² | At Termination ² | Youth # | At Intake | During Program | At Termination |
| 1 | Misdemeanor ³ | - | - | 1 | Misdemeanor | Felony | Felony |
| 2 | Misdemeanor | - | - | 2 | Misdemeanor | Felony | Felony |
| 3 | Misdemeanor | - | Misdemeanor | 3 | Misdemeanor | Felony | Felony |
| 4 | Felony | - | - | 4 | Felony | Felony | Felony |
| 5 | Felony | - | Misdemeanor | 5 | Felony | Felony | Felony |
| 6 ¹ | Felony | Misdemeanor | - | 6 | Felony | Felony | Felony |
| 7 | Misdemeanor | - | Felony ⁴ | 7 | Misdemeanor | Felony | Felony |

¹Youth was offense-free for 3 months, committed a misdemeanor in the 2nd quarter, and remained offense-free for the remainder of the program.

²Durring Program refers to quarterly evaluations of youth participatn in the STYP at the conclusion of month 3, 6, and 9. Termination was at 9 months.

³Misdemeanor = shoplifting, truancy, ungovernable behavior, violation of parole, runaway, reckless conduct

⁴Felony = armed robbery, murder, drug trafficking, auto theft, theft by receiving stolen property, assault, stalking, rape

After-School Program

14% of Group I had committed a felony, a decrease from 43% at intake.

Profile of High School Students (PHHS)

Youth within the STYP appeared to demonstrate more behavioral self-control than those youth who did not participate in the program. All youth came into the program with scores reflecting limited behavioral self-control. However at termination, Group I scores suggested improved behavioral self-control when compared to Group II, those youth who had no program intervention. See Figure 1.

Program Evaluation Form (PEF)

Youth who participated in the STYP indicated increasing satisfaction with the program's specialized intervention. Upon entry into the program, these youth expressed a low-to-moderate level of satisfaction with the STYP; however, during the third quarter upon termination, these same youth expressed moderate-to-high levels of satisfaction with the program (see Figure 2).

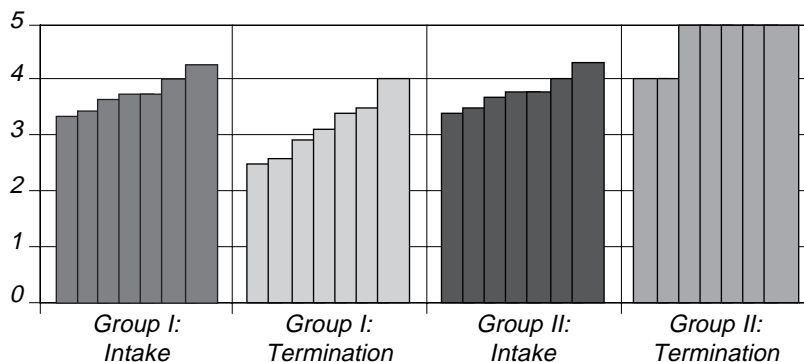
Conclusions

This study indicates that specialized, curriculum-based programs appear to modulate the frequency of serious offenses among African American youth. Without specialized intervention, delinquent behavior among this study group appeared to escalate into more serious crimes against others. The study also appears to indicate that structure and sustained behavioral self-control have a positive effect on retarding delinquent behavior among African American youth. If this is the case, it is essential that policy makers, educators, parents, and members of the juvenile justice system who work with this population employ deliberate and standardized measures to

ensure that delinquent youth benefit from this type of programming.

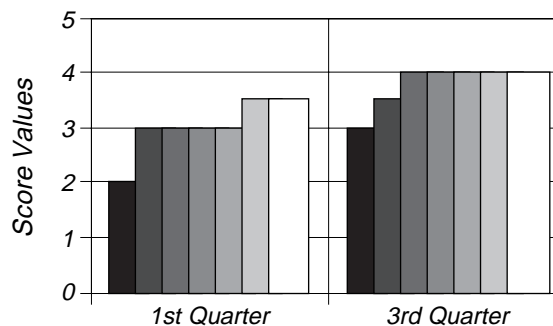
This model provides insight into juvenile prevention. Further studies validating the above findings are needed, as is research on other programs applicable to juvenile prevention. One of the essential purposes of this study was to examine how specialized, after-school programs impact delinquent behavior among African American youth. Future studies should compare STYP results against non curriculum-based programs or other program methods where such success is achieved.

Figure 1
Profile of High School Students:
Individual Self-Control Ratings* by Program Time



*Scores range from 1 = strong self control to 5 = no self control.

Figure 2
First and Third Quarter Program Evaluation Scores* by Program Participants



* Scores range from 1 = Dissatisfied to 5 = Extremely Satisfied.

Barker

Although imperfect, the STYP does provide professionals and parents with insight into prevention and a standard format that can enhance the likelihood that juvenile delinquent behavior can be controlled or modified through strategic planning and monitoring of youth. For the present, it would appear that the STYP could be used as one prototype by parents, social workers, juvenile justice personnel, and other professionals for working with delinquent African American youth.