FAMILY SUPPORT PROGRAM IN PAYNE COUNTY:

A STUDY OF SELECTED AT-RISK YOUTH

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Submitted to the Faculty of the
Graduate College of the
Oklahoma State University
in partial fulfillment of
the requirements for
the Degree of
DOCTOR OF PHILOSOPHY
December, 1994

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December, 1994

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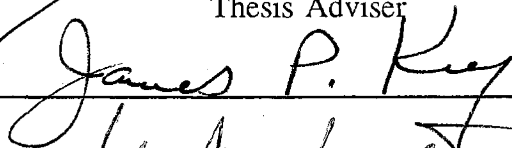

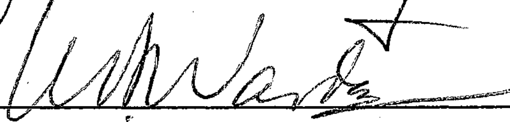

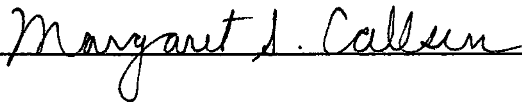

Dean of the Graduate College

ACKNOWLEDGEMENTS

The researcher wants to express a sincere appreciation to the committee members, Dr. Margaret Callsen, Dr. James Key, and Dr. William Warde for their guidance, encouragement, expertise and support throughout my doctoral program and in this study. I want to thank Dr. Joseph Weber, my chairman and dissertation advisor, for his keen sense of insight and knowledge that prepared me to complete this work. I sincerely thank Dr. Louise Latimer for the continued support, patience, assistance and guidance through the completion of this research project.

Finally a tribute is due to my family, my husband, Bertram Ivan Johnson, for his encouragement, support, understanding, and patience throughout my doctoral program. Mr. and Mrs. Leon Vick, Sr., my parents, have always provided me with the emotional support and encouragement to be the best at whatever I chose to pursue in life, and especially for their prayers, which made this possible.

In addition, a very special thanks to my brother, Ronald Vick, and two special friends, Dr. Claud Evans and Mrs. Elayne Evans, for their guidance, encouragement, patience and support through the completion of this research project. I commend my husband, parents, family and friends who have stayed the course along the way in this quest to reach one of my highest goals. Last, but not least, during the time of travels, sometimes I felt alone, but there were two footprints when I started this journey and now there is only one. Thank you "Lord Jesus" for carrying me through this.

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CHAPTER I

INTRODUCTION

The history of program evaluation in this field has been limited because of the newness of the program, which hosts a problem with research design and methodology.

The Payne County Family Support Program is defined as an intensive therapy provider by the Family Support Specialist to at-risk youth returning home from a psychiatric hospital. The Family Support Specialist provides intensive therapy and/or support services to children, adolescents and their families for the purpose of family reunification. The majority of the services are provided in the client's home.

In 1989, the Payne County Family Support Program was designed to provide intensive, in-home services to children at risk of being placed out of the home. Because the Payne County Family Support Program has not been in existence long, it is difficult to evaluate the process of intervention. According to Halpern (1986), we know less than we should about the effect of home-based intervention programs, given the amount of human fiscal investment already made, and likely to be made in the future, in this field of practice. And we know even less still about the underlying change processes set in motion by interventions of this type.

The Payne County Family Support Program provides intensive therapy and/or support services to children, adolescents and their families in resolving problems in

their private home. The Family Support system is an intensive therapy to at-risk youth returning home from a psychiatric hospital. The majority of the programs serve the developmentally disabled or mentally retarded individuals of any age who are at-risk of institutionalization or out-of-home placement and who live with their natural parents (some states allow blood relatives) (Slater, Bates, Eicher, & Wikler, 1986).

The Family Support Services provide intensive case management and outreach services to juveniles who are seriously emotionally disturbed and in the custody of the court system or other agencies. It is believed that the comprehensive and intensive provision by these support services to clients will maximize their ability to avoid institutional placement.

The Family Support Program is expanding in different states. Slater, Bates, Eicher, & Wikler (1986) stated that 23 of the 50 states have been mandated by the state legislature to begin family support services in their areas. Darnton (1989) indicated difficult, disruptive, or disobedient adolescents and children who once might have been sent to juvenile detention centers are now being placed in mental hospitals.

Darnton (1989) found:

> "Overall, inpatient hospitalization for children under 18 has increased from 81,000 to more than 112,000 in 1986, the last year for which statistics are available. Most of that increase was in admissions to private hospitals: roughly 43,000 children were admitted to free-standing private psychiatric hospitals in 1986, compared to 17,000 in 1980 and 6,452 in 1970. These young people, four out of five of whom are white and most of whom are middle or upper class, are frequently sent away by anxious or exasperated parents looking for help. Sometimes the adolescents are seriously disturbed; many have drug or alcohol problems. But in other cases they may be simply rebellious teenagers struggling with their parents over anything from the music they play to the boyfriend or girlfriend they choose" (p. 66-67).

Clients of the Payne County Family Support program are defined in three

different categories:

1. *High Risk Youth* - suicidal gestures, and making homicidal threats.

2. *Mildly High Risk Youth* - problems with controlling temper outbursts that lead to violent behavior, aggressive and impulsive behavior, harsh rejecting parents, and/or youth with runaway behavior.

3. *Low Risk Youth* - argue with parent(s) and family member(s), have problems in school with behavior, such as arguing with teacher(s) or missing classes, and/or youth with low self-esteem and self-worth.

There are two important factors that can place a youth into the Family Support Program. The two factors are: youth *In Need of Treatment* because of mental disabilities and youth *In Need of Services* because of behavior problems in the home. The primary task to be addressed is to determine the degree of success which clients experience after completing the program.

The Family Support Program looks at success for a client as remaining in school until high school graduation, completing a General Educational Development (GED) Program, living in parent(s)' home or foster home and being financially independent. Non-successful youth are defined as juvenile in jail, placed in a psychiatric hospital, dropped out of school and unemployed.

Statement of the Problem

With the continued growth and concentration of new programs and projects focusing on reaching at-risk families, evaluation has become a difficult task. In most Family Support Programs, success or failure is based on the evaluation completed by

youth that have been discharged from the Family Support Program. This client evaluation is important but limited, and does not measure the full quality or impact of the program. Evaluation of individual programs by clients can provide an opportunity for adjustments to the specific needs to improve the program services.

Darnton (1989) indicated a typical psychiatric stay costs $15.00 a month, and the Homebuilder's Family Program costs $2,600.00 a month. The Homebuilder's Family Program is a short-term intensive support program that is paid by the State's child-welfare agency.

Weissbourd and Kagan (1989) indicated that evaluating the outcome of family resource programs has posed a difficult challenge for scholars anxious to ascertain their impact because the program is only three years old. This difficulty works to slow proceedings on the evaluation front, and preliminary data from family support programs is just beginning to emerge.

Purpose of the Study

The purpose of this study was to examine the impact of the Payne County Family Support Program on success or failure of clients in the program. Success was defined as youth continuing their education, living in parent(s) home or foster home, and/or being financially independent. A non-successful and/or failure youth was defined as a juvenile in jail, in a psychiatric hospital, dropped out of school, and/or unemployed. Case studies will be integrated into Chapter V, discussing the success or failure of an at-risk youth based on the risk factors. The purpose of integrating case studies was to provide more qualitative data.

General Questions

The following questions were investigated:

1. What types of behaviors did the youth exhibit at intake?

2. What was the criteria for success?

3. What interventions were most successful in producing desirable behavior?

4. How many of the subjects were judged to be successful? In what areas were they successful or non-successful?

5. What resources did the subject use in the community? Were they successful or non-successful?

6. What behavior changes resulted in risk category changes?

Theoretical Rationale

Family System Theory

The Family System Theory focuses on individual and family interrelation. According to Steinmetz (1988), family system is characterized as open or closed. Any type of changes in the system would be determined by whether the family is an open or closed system. An open system is defined as a family with permeable boundaries, that permits or encourages members to discuss their family values with individuals outside the family system. It permits or allows questioning of values held by individual family members.

According to Broderick (1990), a family can also be a closed system. The main aspect of closed families is that of rigidity, or lack of flexibility. Within the

closed family, little change is permitted and the family isolates itself physically from the community in which it resides.

Family Developmental Theory

According to Kreppner and Lerner (1989), family development implies change in family dynamics over the years. Family development includes two interrelated types of change: (a) change in role content of positions, due to changes in age norms for these positions, and (b) change in interactional patterns within the family. Any changes in the family role content of positions is used to describe family transition from one stage to another. These transitions bring about changes they impose on the family system because change in one part of the system is believed to bring about changes in other parts of the family system.

Assumptions

The following assumptions were made about the study:

1. The Family Support Program can be beneficial to the at-risk youth population by being on call 24 hours per day, 7 days a week.

2. The at-risk youth is more likely to be successful in decreasing negative behavior by attending the Family Support Program.

3. Children/adolescents with severe emotional problems have many of the same needs as youth not in the program.

4. Youth with severe emotional problems and their families need community resources adapted to their needs.

Limitations of the Study

The limitations of the study were examined according to the following:

1. The study was limited to at-risk youth defined as *In Need of Treatment* and *In Need of Services* who are clients of the Family Support Program.

2. The study was limited to rural at-risk youth who have been discharged from the Family Support Program in Payne County.

3. The information in the study was limited by the client's bill of rights.

4. In the case of participant observation, the researcher can only observe a limited number of persons and situations rather than hundreds of participants.

5. The study population was composed only of those youth who consented to participate in the study.

6. The study was limited to at-risk youth who had been a client in the Family Support Program in Payne County, the researcher being the Family Support Specialist.

Definition of Terms

The following definitions are furnished to provide, as nearly as possible, clear and concise meanings of terms as used in this study.

Aid for Families With Dependent Children (AFDC) - funding provided by Department of Human Services for children and youth in need of money to pay rent, utilities and buy clothes.

Assessment - the act of evaluating information from a client.

Client's Bill of Rights - gives privacy concerning his/her treatment. Clients are

free of discrimination based on race, color, age, sex, marital status, religion, national origin, sexual preference, disability or ability to pay.

Close Kin - immediate family members of one of the client's family members.

Discharged Client - a youth that has completed a program.

Family Builders - therapists who provide intensive, home-based therapy and support services to children and their families. Family Builders have a case load of three families at a time and for a period of time such as four to six weeks.

Family Support Specialist - provides intensive home-based therapy and/or support services to children and adolescents and to their families with case loads of eight clients at a time and for a period of six months.

Family Support Services - intensive therapy provided by the Family Support Specialist to at-risk youth returning home from a psychiatric hospital.

Foster Home - a home, certified by the Department of Human Services to care for young children/adolescents who have been removed from their natural homes.

High-Risk Youth - clients with problems which include suicidal and homicidal threats only.

In Need of Services (INS) - youth in need of supervision in the home to decrease any problems in the home.

In Need of Treatment (INT) - youth in need of treatment for severe emotional behavior problems in the home.

Intensive Outreach Services - promote the growth and coping skills of clients by utilizing available community resources.

Job Training Participant Act (JTPA) - designed to assist adolescents (age 14 to

18) and adults in finding employment.

Low Risk Youth - clients with problems which include arguing with parent(s) and family member(s), school behavioral problems (such as arguing with teacher or missing classes), and/or youth with low self-esteem and self-worth.

Mildly High Risk Youth - clients with problems which include problems with controlling temper outbursts that lead to violent behavior, aggressive and impulsive behavior, harsh rejecting parents, and/or youth with runaway behavior based on Payne County Support Program.

Psychiatric Hospital - an inpatient facility where people live for a specified amount of time and receive help from a specialized team or doctor to decrease personal or family crisis or problems.

Referral - an agency that recommends an agency to a client.

Severe Emotional Behavior - child is a risk for out-of-home placement, or is placed out-of-home because of negative behavior.

Significance of the Study

The information from this study will be used to adapt the programs of the Payne County Family Support Program to better serve needs of clients. In addition, finding information for this study will be helpful in assisting local and state government, educational institutions and social service agencies in planning programs with other agencies to help educate the public about therapy work with at-risk youth.

The case studies will provide a more qualitative research and potentially dynamic understanding of the three risk categories (high risk, mildly high risk and low

risk youth), and what the Family Support Specialist did to assist the former clients in need of this service. Also, the case studies will be used to probe more in-depth to identify the problems and techniques used in the research study.

The information can be helpful to other programs by providing an effective evaluation of this program. Other similar programs can utilize the information in securing the necessary financial support to create more services in other counties. This information can also provide other agencies with impact data about the Family Support Program.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

The review of literature focused on information, using literature from the fields of social work and education, to describe the Family Support Program in Payne County and in states currently using the program. This review of literature will describe the services; trends in the provision of services; characteristics of the Family Support Program; primary goals for at-risk families in support programs; causes, consequences, and strengths of at-risk youth; the impact of family support programs; and case study research.

The Family Support Program is expanding in different states. Slater, Bates, Eicher and Wikler (1986) stated that 23 of the 50 states have been mandated by the state legislature to begin family support services in their areas. Family support system refers to intensive therapy provided to at risk youth returning to the home from a psychiatric hospital. The majority of the programs serve developmentally disabled persons or mentally retarded individuals of any age who are at-risk for institutionalization or out-of-home placement and who live with their natural parents (some states allow blood relatives).

The Family Support Program provides intensive case management and outreach

services to seriously emotionally disturbed juveniles in the custody of the court system or other agencies. It is believed that the intensive and comprehensive provision by these supported services to clients will maximize their ability to avoid institutional placement.

Description of Services

According to Wald (1988), most children and adolescents raised in multiple foster homes or an unhealthy family environment were characterized by problems of temper outbursts, poor communication, rebellious behavior toward their parents and/or foster parents were placed into the Family Support Program. The Family Support Specialist provides intensive case management and outreach services to seriously emotionally disturbed youth. The Family Support Program focuses on assisting the families and youth with any conflicts in the home and bringing families back together.

Weissbourd and Patrick (1988) stated that, the terms "family support" and "family resource" are becoming increasingly familiar as programs bearing those or similar names develop. The term family support is often confusing, having different meanings for different social science disciplines. In the wide spectrum of social services, "family support" refers to programs which enable families to stay together after a crisis. The emerging view is that support for families should be available, ranging from prevention, through early intervention, to crisis management to long-term supportive measures.

Goldstein (1981) stated that within the past fifteen years, Home-Based Family Centered services to children and families have increased in number and in scope. A variety of program models, designed to keep children at home with their families and

in community-based programs, have been created. Ways of strengthening family living are being devised to enable children who otherwise might have been separated from their family structure to remain within that setting. Additionally, the home-based movement is being encouraged financially by federal government and state legislation (Bryce & Lloyd, 1981).

According to Bribitzer and Verdieck (1988) Child Welfare agencies have traditionally cared for children of abusing, neglectful, or otherwise inadequate parents by providing a substitute living arrangement, such as a foster family or group care. In the last two decades, however, the home-based, family-centered approach has been used with increasing frequency. Hutchinson (1986) states that 238 such programs, taking a number of forms and serving a variety of populations, were listed in 1986 by the National Resource Center on Family Based Services. The use of these programs for families who are not meeting their children's needs is based on two premises: that most children are better off growing up in the family they have known since infancy, and that the family, rather than the individual, is usually the appropriate unit for social service intervention (Bribitzer & Verdieck, 1988).

Crutcher (1991) indicated that home visiting is one of the ways professionals provide help to families. Although most families can adapt well to any home visitor, families are infinitely diverse. Some may feel that home visiting puts the professionals on consumer "turf," thereby giving the family an advantage in controlling a situation they may otherwise find out of control. Other families may find a home visit produces stress in the form of extraordinary concern about a good appearance of the home and children. Seitz (1989) stated they were designed to help parents solve their own life problems as well as to better understand their childrens' development.

Trends in the Provision of Services

Whittaker and Tracy (in press) stated that families with children at risk for out-of-home placement have long been a concern in the child welfare field. Traditionally, parents of children at-risk for placement were viewed more as part of the problem, rather than as part of the solution. Out-of-home placement was seen as a substitute for an inadequate family. Few attempts were made to include parents in the decision making process prior to placement, or in the treatment process during placement (Whittaker, 1979). As a result of a renewed emphasis on "permanency," however, child welfare services have experienced a shift from an overriding emphasis on child placement to a focus on family support (Stehno, 1986). This shift has affected the entire continuum of child welfare services. Placement and in-home services need no longer be viewed as mutually exclusive (Small & Whittaker, 1979).

In the broadest sense, permanency planning refers to activities undertaken to ensure continuity of care for children, whether that be action to keep families together, to reunite families, or to find permanent homes for children (Maluccio, Fein, & Olmstead, 1986). Strengthening the family's knowledge, skills, and resources for parenting has become a critical concern. A variety of services designed to strengthen families and to prevent out-of-home placement have emerged. In addition, supportive family services are increasingly recognized as elements in the aftercare service plan following placement (Whittaker & Maluccio, 1988). A small but increasing number of residential programs incorporate services to families as part of pre-placement and after care, as well as during the placement process. Overall, there is increased commitment

to families of children in placement, as well as those at-risk of placement (Whittaker & Tracy, in press).

Characteristics of the Family Support Program

According to Wald (1988), children and adolescents growing up in foster care are subjected to multiple placements. Children or adolescents who have not been placed into a foster home but experience multiple placements such as mental hospitals, and group homes show signs of emotional disturbance. Darnton (1989) indicated not much is done for them in jail. Sometimes the adolescents are seriously disturbed, and many have drug or alcohol problems. In other cases they may be simply rebellious teenagers struggling with their parents over anything from the selection of friends or the time to get home on the weekend.

According to the "1983, Practice Digest," the family has other problems such as frequent arguing in the family, lack of discipline of the children and youth or harsh discipline of the children or youth. The family struggles with children or adolescents stealing, impulsive anger, temper outbursts behavior and poor communication.

Weiss (1989) indicated that family support and education or family resource programs represent a new way of working with families to empower and reinforce them in their development. These include the enhancement of child health and development; prevention of various child and family dysfunctions, such as abuse and neglect; enhancement of parental knowledge, self-esteem, and problem solving; and promotion of informal and formal community support for families.

Tolsdorf (1976) indicated that support was defined as any action or behavior

that assists the focal person in meeting his personal goals or in dealing with the demands of any particular situation. Support can be tangible, in the form of money or other assistance, or intangible, in the form of emotional support, or guidance in achieving certain goals.

Kaplan (1986) stated that families at-risk are identified through the school, health, social service, mental health, and criminal justice systems. Frequently, more than one family member is determined to be at-risk by one of these systems, and it is not unusual for these systems to deal with more than one generation of a family.

According to Jordan and Hernandez (1990), more than 11,000 seriously emotionally and behaviorally disturbed children and youth in California are removed annually from their families and communities by the juvenile courts. They are placed into group homes and residential facilities by child protective service and juvenile probation agencies. The annual cost for placing these children exceeded $500 million for fiscal year 1989-90. These costs have risen at a rate of 15 to 25 percent per year since 1980.

In Ventura County (California), the initial state hospital reduction grew out of what was known as the state hospital "buy-out" plan implemented in 1980-81. The state offered money to counties which would agree to reduce their state hospital bed allocation by taking back the clients and treating them locally.

Prior to 1981, Ventura County typically averaged around 12 children in the state hospital. The buy-out reduced that number to five at any one time, where it has stayed ever since. This reduction translates into a state hospital cost-offset of about $411,000 per fiscal year (Jordan & Hernandez, 1990).

Bedlington, Braukmann, Ramp and Wolf (1988) recognized that community-

based intervention has been recommended over institutionalization programs because of their greater or equal effectiveness, greater cost efficiency, and more humane and less restrictive treatment conditions (Braukmann, Ramp & Wolf, 1981). These same dimensions have been used to compare alternative community-based interventions among themselves, as well (Bedlington, Braukmann, Ramp & Wolf, 1989).

Graham, Richardson and Calhoun (1989) described Homebuilders as a family preservation program developed in Tacoma, Washington in 1974 to improve family functioning and prevent out-of-home placement of disturbed children. Unlike traditional counseling programs in which children and their parents are expected to seek the services of therapists at once-a-week intervals in outpatient clinics, the Homebuilders program sends a therapist or team of therapists into the home to provide intensive family therapy for up to 20 hours per week. Convenient weekend and evening visits are made available, and families pay Homebuilders on a sliding scale based on income.

Halpern (1984) stated that home-based early intervention constitutes a remarkably diverse intervention technology. Differing theoretical frameworks, target populations, and institutional bases, and differences in onset and duration of intervention activity, have contributed to this diversity.

According to Whittaker and Tracy (in press) intensive family preservation services (IFPS), are characterized by highly intensive services. It is delivered generally in the client's home for a relatively brief period of time. Paschal and Schwahn (1986) stated, "The State of Florida's Intensive Crisis Counseling Program (ICCP) provides in-home support services specifically designed to prevent the removal of children or adolescents from their homes and thus avoid their placement in

emergency shelter care, foster family homes and institutional foster care."

According to Tatara, Morgan and Portner (1986), the characteristics of the Supportive Child Adult Network (SCAN) program have become one of the largest not-for-profit organizations in Philadelphia specializing in a multidisciplinary, family-centered approach to the prevention of child abuse and neglect. The characteristics of the SCAN program and of the families at risk who receive program services are representative of many substitute care placement prevention efforts in urban settings. For this reason, the American Public Welfare Association (APWA), under a contract from the National Resource Center of Family Based Services and as part of its effort to help to strengthen substitute care placement prevention programs, chose to document SCAN's program.

According to Callister, Mitchell and Tolley (1986), West Salt Lake County has one of the largest service areas in Utah. The decision to fund the project was based on the belief that children and adolescents should remain with their families whenever possible, and on the expectation that foster care expenditures might be reduced.

Utah's policies toward strengthening families and preventing out-of-home care where appropriate are similar to those of other programs throughout the country. The project's philosophy stresses the following principles: 1) society should be willing to invest as much in a child's own family to prevent placement as it pays for out-of-home care; 2) the family is the most powerful and primary social welfare institution and cannot be replaced; 3) parents are in charge of their families; Family Preservation staff are there to assist them in this role; and 4) staff should be available to assigned families 24 hours a day, seven days a week, for up to 90 days, to help the family remain together. The project's primary objectives are to prevent the unnecessary

removal of children and youth who are in imminent danger of an out-of-home placement, and to empower the family with more effective coping skills and awareness of community family support resources (Callister, Mitchell & Tolley, 1986).

Tracy (1990) indicated child welfare agencies orient their services to avert the placement of a child, or make it possible for a child who has been placed to return to a permanent home. There has been increased interest in identifying the elements of family support (Stehno, 1986) and growing recognition that the resources of the community and extended family are frequently correlated with successful service outcomes (Jenson & Whittaker, 1987; Jenson, Hawkins, & Catalano, 1986). In particular, the critical role that social networks play in providing emotional and material aid to parents, serving as role models for parenting behavior, and material aid to parents, and linking parents with outside sources of child-rearing information has been identified (Cochran & Brassard, 1979; Powell, 1979). In working with at-risk families, social support resources may have the potential to help families avert the need for placement, shorten the duration of placement, or ease the transition of the child's return to the community and family following placement (Maluccio & Whittaker, 1988).

Haapala and Kinney (1988) noted that the Intensive Home-Based Family Preservation Service is based on the belief that most children are better off growing up with their natural families. The author believes that family members can learn to resolve their problems with life and with each other to the point that they can live together productively and safely. Knoll (1989) stated that the majority of families speak of the enormous improvement they witness in their child's physical and psychological condition, once they come home, as the most tangible affirmation of

their decision to provide care at home.

Walker (1988) indicated that the family support programs in Maryland have as one of their objectives the empowerment of families as a key to advocacy for the child with disabilities. The idea is to work with families to help them develop skill and competency as advocates.

Agosta (1985) stated that many states now offer parents of persons with a developmental disability a variety of supportive services including case management, parent education, financial assistance, respite care and family therapy. Clearly, the trend toward encouraging and supporting family-based care is gaining momentum.

According to Horn (1976), a Homebuilder's first job is usually to defuse an explosive situation by talking to each member of the family separately. This gives the therapist an idea of what the main problems are: delinquency, child abuse, drugs, alcohol, or money and also gives family members a chance to ease tension by discussing what's bothering them. This may take hours for each person, and the Homebuilder is ready to spend as much time as it takes.

According to Miller and Whittaker (1988), there is a growing consensus that preventive interventions must be made an integral part of the service continuum. Here again, cooperative planning between child welfare agencies and community-based parent support and education programs would help to fill in the gaps along that continuum. Public agencies face certain barriers in developing preventive strategies that may be less troubling for community-based programs. Many state protective service agencies are recognizing the need for family support services that avoid these constraints and are contracting with community-based programs to provide them.

Telleen, Herzog and Kilbane (1989) stated that family support programs are

diverse, they have some elements in common regardless of the setting. These elements include self-help discussion groups on parenting problems, parent education on child management and parental issues, and parent-child activities. In addition, there may be home visits or programs to reach those parents who cannot come to a center (Weissbourd, 1987; Pooley & Littell, 1986). Family support programs are preventive in nature. They offer services that enhance parenting competence in at-risk families before the need for more intense, secondary, and tertiary interventions are needed (Telleen, Herzog & Kilbane, 1989).

Primary Goals for At-Risk Families In Support Programs

Ronnau (1990) stated, the primary goal of the strengths approach, as exemplified in the Family Advocacy service model, is to reinforce and preserve families by helping them acquire the resources needed to care for their child. Enabling, which entails "helping a person mobilize his own drives and abilities for use in a desired direction," is an essential function of the strengths approach.

Triplett, Preston, Henry and Thompson (1986) stated that in moving toward family-based services, the Department for Social Services assures that every effort is made to maintain the family as a functioning unit, to provide the maximum services to a family at the time of crisis, and to prevent the breakup of the family unit. Services in this context are intended to strengthen and maintain families and to prevent family dissolution and out-of-home placement, and the department's resources are focused on assisting families in regaining or maintaining autonomy while at the same time assuring protection of individuals.

Weissbourd and Kagan (1989) stated most simply, the goals of family support programs focus on enhancing the capacity of parents in their child-rearing roles; creating settings in which parents are empowered to act on their own behalf and become advocates for change; and providing a community resource for parents. To meet these goals, family support programs craft various activities which usually include one or more of the following: a) parent education and support groups; b) parent-child joint activities that focus on child development and promote healthy family relationships; c) a drop-in center, which offers unstructured time for families to be with other families and with program staff on an informal basis; d) child care while parents are engaged in other activities offered by the family resource program; e) information and referral to other services in the community, including child care, health care, nutrition programs, and counseling; f) home visits, generally designed to introduce hard-to-reach families to family support programs, and g) health and nutrition education for parents and developmental checks or health screening for infants and children.

Zigler and Black (1989) stated that family support programs use their focus on the strengths of families to promote their ultimate goal: to enable families to be independent by developing their own informal support networks. Rather than seeing themselves as permanent caretakers, they aim to enhance the self-worth and capabilities of participating family members. As families recognize their strengths, they are more likely to find ways to develop their community.

Causes, Consequences, and Strengths of At-Risk Youth

Reis, Orme, Barbera-Stein and Herz (1987) stated that although family support programs vary in the scope of services offered, target populations, and intensity of program effort, they are predicated on the belief that the most effective way to create and sustain benefits for children is to improve family functioning within the broad community environment. Slater, Bates, Eicher and Wikler (1986) stated, while the remaining states have ongoing family support programs on either a statewide or pilot basis, they have no formal state legislation authorizing program development. As a consequence, these services must be "bootlegged" on the "backs" of other legislated programs. In Montana, for example, family support services are provided as a part of statewide developmental disabilities services without empowering legislation. In contrast, Wisconsin conducted a pilot family support program as a basis for the development of statewide legislation and implementation.

Gordan and Arbuthnot (1988) noted that professionals trained in family therapy most often are in private practice rather than community mental health centers. Since most officially reported delinquency occurs among low-income families who lack either income or comprehensive medical insurance, these professionals rarely serve the delinquent population. The most promising solution to this dilemma, assuming no substantial influx of public funds to increase the availability of mental health professionals to low-income populations, is to train professionals to deliver the most effective intervention.

Commer and Hill (1985) indicated that one out of every two black children

lives in poverty as compared to one out of every seven white children. In recent years there have been major reductions in federal spending in support of the poor. Children's Defense Fund (1983), further reduces access to social programs and other resources.

Lovell and Hawkins (1988) stated that recent research in the fields of social networks and social support suggests evidence that intact well-functioning networks serve a norm-enforcing function and influence the utilization of help. Salzinger, Kaplan and Artemyeff (1983) found that mothers in families being treated in hospital-based programs for child abuse and neglect had less well-connected social networks and fewer friends than mothers in a demographically comparable control group where children were not subject to maltreatment. Gaudin and Pollane (1983) found that maltreating parents had significantly weaker and less supportive ties with neighbors than would be expected. There appears to be a relationship between the lack of support from friends and poor child care (Lovell & Hawkins, 1988).

Junge and Ellwood (1986) found that certain trends were identified as influential in changing American families and, consequently, the needs of these families. The trends included higher family mobility, a decreased number of families who lived near extended family members, an increase in the divorce rate and in the number of single parents, an increase in chemical abuse and increase in child abuse.

According to Cabral and Callard (1982), children can become lost in the foster care system. This concept has come to describe thousands of youngsters who are removed from their homes, often because of parental abuse or neglect, children who then may be shifted from one foster home to another throughout their important developing years but who are not eligible for adoption because there is a chance that

their parents will be able at some time to reclaim them. Indeed, the parents may desperately want the child back but be overwhelmed with their own problems, some personal, some societal. These problems are exacerbated by the contemporary breakdown of caring and intact extended families and by communities that fail to sustain parents in the nurturing task.

Ware, Osofsky, Eberhart-Wright and Leichtman (1987) noted that the intervention program was facilitated greatly by the fact that it was able to link up with an ongoing program, *The Health Department Mother and Infant Project*, which provided a readily available clientele. McCroskey and Nelson (1989) indicated that the *Family Connection Project* established in 1983 has served over 15,000 people from five service locations throughout Los Angeles County. Initially conceived of as an early intervention program for families at-risk for child abuse or neglect, the *Family Connection Project* has come to serve an increasingly troubled population, at least in part because of limitations in the public social services system. Currently, about 50% of client families are referred by protective services or the courts.

According to Kinney, Haapala, and Booth (1991), even when families are in crisis, suffering from the painful effects of abuse, conflicts, or violence, there are usually parallel feelings of concern, yearning, hope, and love that can blossom as family members learn new ways of coping with their problems and differences. It is good for families to learn how to handle their own problems, rather than depending on outpatient services to assist the family in all crises. In the *Homebuilders's* program, families learn new behaviors in the environment where they will need to use them. In a majority of cases, parents learn to set limits, control their emotions, and provide for

their children's basic needs. Children learn to assess their own goals and to control their behavior in ways that lead to more reward and less punishment. When family members participate in solving their problems together, individual family members are less likely to feel rejected, inadequate, or like failures, and are less likely to use blaming, separating and giving up as ways to solve problems. Wahler and Afton (1980) indicated that recent data show that mother/child interaction problems can be changed in durable fashion through the social learning guidelines of parent training.

Zigler and Black (1989) stated that families have always been faced with difficulties ranging from meeting their basic needs to coping with intrafamilial conflict. Environments in which families live have often compounded these difficulties and have also provided support to help families survive them. Poverty is another stress on families which is exacerbated by contemporary economic conditions. The percentage of children born into poverty has increased significantly since the 1970's. In fact, children now comprise 25% of the nation's poor population. Further, one-quarter of all young children and close to half of nonwhite children live in families that suffer the stresses of poverty (Halpern, 1987).

Single parenthood, which has also been increasing in recent years, often brings with it both types of stress mentioned above: the stress of poverty and the stress of having the primary caregiver working outside the home. There has been a dramatic increase in single-parent families, most of which are headed by women. Ironically, the fact that this type of flexibility is a key principle of the family support movement is the primary reason that the term "*family support program*" is so difficult to define.

Another common principle of family support programs is their dedication to building on the strengths of families rather than to "curing deficiencies." Family

support programs facilitate this power by reflecting the culture of their community in their staffing and programming. Often, staff members are similar enough to parents in heritage that they can act as friends and peers, which better enables them to serve as supporters and educators.

Another important strength, particularly to the grass roots family support movement, is a dedication to working with all families regardless of income, race, or ethnicity. There are grass roots programs located in rich, poor, urban, rural, white, minority, and mixed communities (Zigler & Black, 1989).

Impact of the Family Support Program

According to Kinney (1978), during the first three years *Homebuilders's* saw 207 families (including 100 single parent families) involving all potential placements in foster, group or institutional care. To date the need for placement has been averted in 87 percent of the cases, and follow-up studies indicate that the positive results of intervention continue beyond the period of case treatment. Placement has been avoided in over 90 percent of the cases, and thus over $312,000 has been saved. "We think the savings in pain to family members when they can work things out is an even greater consideration," (Human Behavior, 1976).

Graham, Richardson and Calhoun (1989) stated, success rates (i.e., out-of-home placement was prevented and the family preserved) greater than 80 percent are common, and the *Homebuilders's* program remains successful in 97 percent of its cases. Additionally, the care is provided in a more cost-effective manner than hospitalization and other forms of residential treatment.

According to the U.S. Congress (1990), supportive and client-centered

techniques tend to merge in practice. Supportive psychotherapy is not intended to produce change in the patient through the therapist. Instead, the objective is to make the patient feel better about him or herself, and to provide gentle help and advice about activities of daily living. The therapist assists the patient's return to a prior functional level, and helps him or her to learn to tolerate difficult situations.

Kinney, Dittmar and Firth (1990) stated that *Homebuilders* is able to reach a much wider range of clients and much more seriously disturbed clients by seeing them on their "turf." In time of crisis, many families are too disorganized to get themselves scheduled for and transported to office visits. No-shows, drop-outs, and cancellations are very rare if services are brought to the client.

Workers are able to make much more accurate assessments because they can see lifestyle and routines. They can observe family members using new behaviors, revise plans as needed, and provide support until clients no longer need assistance. Therapists can witness and experience the clients' family problems, instead of just hearing about them and possibly making incorrect assumptions about what happens. Ultimately, families need to be able to use new skills at home. If they learn them in an office, it is often difficult to carry the knowledge to a new situation. When the therapist is on the spot coaching them, they begin to feel confident.

Starkey and Sarli (1989) indicated that family support services have been and remain a primary need of parents and caretakers which require the full attention of human services systems. According to Waite (1988), these programs serve families where there are such serious child protection concerns that the children are in danger of apprehension. Studies (Bryce & Lloyd, 1981) have shown that placing children outside their families once increases the risk that they will again be placed outside

their homes, relative to the population of children who have never been placed. Thus, the home-based family-centered treatment program promises to relieve human suffering as well as to be a cost-effective method of intervention with troubled families (Waite, 1988).

Case Study Research

According to Dalen (1979), a case study is difficult to explain because its method is organizing data which analyzes the life of a social unit. The researcher gathered data from a small unit, rather than a large number of social units, because it is an intensive study of a limited number of representative cases.

According to Stainback and Stainback (1988), a qualitative research investigation is based on one of several perspectives. One of the perspectives is multiple subject or site investigation. A lot of researchers select case studies as one of their initial qualitative inquiry attempts. The researcher examines in-depth information in several areas which include a single person, situation, event, or group of documents to have a detailed case study.

The case studies will also include research information on qualitative investigations. According to Stainback and Stainback (1988), qualitative investigations can also be participation observation, which is an in-depth interview, document collection or videotaping. The researcher often participates in the lives and environmental settings of the people he/she is studying and collects data on what the person does or says. An in-depth interview is common and frequently used in case study. The researcher conducts an in-depth study that is unstructured, open-ended interview, directed toward understanding people's perspective on their lives, daily

experiences or situations as expressed in their own words.

According to Patton (1980), case analysis involves organizing the data by specific cases. The case study approach to qualitative analysis is a specific way of collecting data, organizing the information and analyzing the data. The purpose is to gather comprehensive, systematic, and indepth information about each case of interest to give a clearer picture of the research study.

According to Feagin, Drum and Sjoberg (1991), a case study is an indepth investigation, using qualitative research methods, a single social phenomenon. The study is in full detail and often relies on the use of several data sources, such as participant observation, and background information.

According to Armer and Grimshaw (1973), there are disadvantages of a case study. The disadvantages are: the limitation of sample size, difficult to replicate, and the low number of selected cases. According to Williamson, Karps and Dalphin (1977), a researcher can observe only a limited number of persons or situations. A researcher would find it difficult to catalogue the behavior of hundreds when focusing on an in-depth situation.

According to Jorgenson (1989), participant observation is when a researcher observes an individual, group or situation. When conducting a case study, the researcher identifies the variables that relate to the problems. The case study data can also provide useful information when the researcher needs to illustrate statistical findings. The reader should have a clearer understanding of the research study after the development of an indepth investigation of statistical data in the case studies.

Summary

This review examined a variety of prevention and intervention programs. Program features were identified which likely related to program effectiveness and suggestions for future programs. While it appears that evaluation research of the Family Support Program was still in the beginning stages, researchers and educators were committed to the improvement of evaluation practiced.

According to Halpern (1986), we know less than we should about the effect of home-based intervention programs, given the amount of human and fiscal investment already made and likely to be made in the future, in this field of practice. And we know even less still about the underlying change processes set in motion by interventions of this type. The history of program evaluation in this field has been very little which hosts a problem with research design and methodology. However, studies of the Family Support Program were still in the beginning stages, researchers and educators were committed to the improvement of evaluation practiced.

The researchers did a qualitative investigation which included an in-depth interview, and collection of documents such as personal interviews, and/or observation notes. The case studies are found in Chapter V.

CHAPTER III

METHOD AND PROCEDURES

Introduction and Methodology

This chapter describes the methodology used in this study. A detailed description of the selection of the sample and subjects, instruments used for the collection of the data, and the procedures used for the analysis of the data is included. The researcher gave a description of statistics to describe the degree of success or failure of the *Family Support Program.*

This study examined the impact and success of the *Family Support Program* on at-risk youth. The program is primarily focused upon intensive home-based services. The *Family Support Program* provides intensive therapy and/or support services to children, adolescents and their family in resolving problems in their private home. The purpose of this research study was to examine the impact, of the Payne County *Family Support Program* on clients in the program. A successful youth was defined as continuing their education, living in parent(s) home or foster home, and/or being financially independent. A non-successful youth was defined as a juvenile in jail, in a psychiatric hospital, dropped out of school, and/or unemployed.

The case study approach was integrated into the research. The case study provides the description of the evaluation. The researcher randomly selected

participants from each risk category. The cases focused on high risk, mildly high risk and low risk youth. The at-risk youth were categorized by their behavior. The researcher reviewed documents of youth behavior, school attendance, treatment, time spent in the home and updated reports.

According to Patton (1980), a case study is a narrative description of an individual's history, symptoms, behavior and response to treatment. Case studies allow the researcher to be a participant observer in the attempt to describe in-depth, intensive investigation to explain the variables of the statistical findings.

Research Design

This is a descriptive research study. The descriptive research approach was chosen for the design since the research variables are somewhat complex and also, the program is new and it is necessary to determine what situations exist. The descriptive data collection research was used to interpret the degree of success of at-risk youth in the *Family Support Program.* The descriptive method describes and interprets the behavioral patterns of the participants. It is primarily concerned with the present, although it often considers past events and influences as they relate to current conditions (Best, 1981).

According to Saslow (1980), a case study is a narrative description of an individual's history, symptoms, behavior and responses to treatment. The case studies were developed to reveal information that the researcher could measure qualitatively. The researcher conducted an in-depth study using unstructured, open-ended interviews, directed toward daily behaviors and experiences. The researcher collected data from Payne County youth who had been discharged from the *Family Support Program.*

The research questions were designed to seek responses to specific information to determine whether the at-risk youth are successful in the *Family Support Program.* The procedure utilized in conducting this research was to use primary sources of data which included information collected at intake and a follow-up interview. Telephone calls and personal interviews with respondents were used to collect data (Appendix B). All information was coded to protect confidentiality.

The case study approach was developed for refining the research techniques. According to Patton (1980), the beginning stage for case analysis is making sure that the information for each case is as complete as possible. A case study approach is qualitative research in which data consists of personal interviews, observation, documents and statements from others about the case.

Selection of Subjects

The research population was composed of 22 former clients of the *Family Support Program.* The ages ranged from 13 to 18 years old. The researcher mailed consent forms inviting 30 former participants from the *Family Support Program* to participate (Appendix A). Only 22 respondents participated in the research study. The researcher received 22 consent forms signed by the participants and parent(s) or guardian(s). The number of participants in the study was limited because of the newness of the program.

In developing the questionnaire, the family support specialist created categories of risk in order to refine this study. Clients of the Payne County Support Program are defined in three different categories. High risk youth have suicidal gestures, and make homicidal threats. Mildly high risk youth have problems with controlling their temper

outburst behavior, have harsh rejecting parents, and/or are clients that run away. Low risk youth have behavioral problems in school, such as, arguing with teacher(s) and/or parent(s) or missing classes, and have low self-esteem and self-worth.

Population and Sample Selection

The participants in this study included at-risk youth residing in Payne County. The participants of the Payne County Family Support Program are defined in three different categories of risk. The researcher had access to the respondent addresses by working with the Family Support Program. Consent forms inviting participation were sent to 30 youth who had been in the Family Support Program and discharged from the program in the past 26 months (Appendix A). Only 22 respondents signed and agreed to participate in the interview schedule. They ranged in age from 13 to 18 years.

Several procedures were used to gain information about the respondents. They were as follows: 1) names of adolescents discharged from the program were determined and intake data were compiled; 2) a letter and consent form were sent to the parent or guardian to inform and to obtain the agreement for the youth to participate in the study; 3) after the consent forms were received, telephone or personal contact was made to make an appointment for the interview; 4) interviews were conducted, primarily by telephone by the researcher. Those who did not have a telephone were interviewed in their home by the researcher.

Instrument Development

In the preparation of the study, a pilot study was conducted to evaluate the

appropriateness of the follow-up questionnaire for clarity and understanding. The researcher compiled the information on five at-risk youth for the pilot study. The primary purposes of the pilot study were to determine the time frame for administering the instrument and testing procedures. Revisions consisted of eliminating the town in which the respondent resided and his or her race to reduce any bias in the research study.

The pilot test also yielded the approximate amount of time one could expect to spend on completing the questionnaire. Completion times ranged from 30 minutes to one hour, with an average time of approximately 45 minutes. After the pilot test, the forms were revised to simplify and clarify some items. The Oklahoma State University Institutional Review Board (IRB) reviewed the questionnaire and revisions were made to eliminate any bias or sensitive questions.

The purpose of the questionnaire was to determine if the *Family Support Program* meets its goals in keeping youth from being placed outside the home which is indicated as progress for the program. Youth continuing to be placed in inpatient facilities after entering the *Family Support Program* could indicate that there was failure of the youth for not completing the program or failure of the program because of inappropriate or lack of support of the clients.

The instrument was designed to collect information about: 1) living arrangements, b) education, c) the utilization of community resources, and d) behavioral changes. The set of basic questions were developed to organize the information which could be used to fulfill the purpose of the study.

The questionnaire has four sections. Instrument one collected information about the at-risk youth's behavior at intake. The instrument also collected background

information on the at-risk youth to provide the basic demographic data, such as, gender, age, behavior and grades. Instrument two collected information about behavior after discharge. Instrument three reported time spent by the Family Support Specialist and instrument four measured client and specialist satisfaction with the program. These instruments were administered to adolescents discharged from the Family Support Program in Payne County. The instruments contained both closed and open-ended questions.

A cover sheet was attached which explained the purpose of the research and provided brief instructions (Appendix A). The researcher mailed the cover sheet to the participant and his or her parent(s). Parental consent forms were included to protect the subjects and meet the requirements of the Oklahoma State University Institutional Review Board. The parental consent form allows parent(s) or guardian(s) to protect the subject from any offensive, threatening or degrading question in the instruments. The parental consent forms were collected and placed in a file before contacting subjects for information. After the consent forms were signed by parents and youth in agreement to do the survey, the researcher contacted the youth and presented the questionnaire.

The case study approach was used in the research to describe in detail the findings and areas of risk factors of participants. The researcher randomly selected participants from each risk category and reviewed documentation of behavior, school, treatment, time spent in the home and updated report. The case studies were developed to reveal information that the researcher could measure qualitatively.

According to Leigh and Peterson (1986), qualitative approaches can be used to conduct exploratory research by examining the normative patterns, and to gain indepth

insight to the everyday experiences of the participants. The researcher was a participant observer in order to gain a more indepth investigation on the research study.

Data Collection

After the consent forms were signed by parents and youth the researcher contacted the youth and made an appointment for an interview. It was very important that the respondents gained trust of the researcher through establishing a rapport because the survey required a telephone or personal interview. The researcher presented the questionnaire in the same style to avoid biasing the respondents' answers. The time for each interview was 30 minutes to 1 hour. Instrument one, two and four were telephone interviews completed by 17 participants. There were 5 in-person interviews conducted in the participants' home because of no telephone.

Case study data collection was integrated in the research. According to Patton (1980), in the first step of processing a case study, the researcher assembles the raw case data. This information consisted of all data about the person and/or program.

The second step in case analysis is to write a case record. The case record pulls together and organizes the voluminous research data in a comprehensive, primary resource package. This includes all the major information of the case analysis and study. The researcher edited the information, redundancies were sorted out, parts were pieced together, and the case record was organized for ready access in chronological order. The case record is complete and manageable; it included all the research information for subsequent analysis, and it organized at a level beyond that of the raw case data.

The next step is the case record which is used to construct a case study. The case study includes the information that is communicated in the final report which represents the data presentation in the research. The report consists of the case studies of high risk youth, mildly high risk youth and low risk youth. The case study information provided descriptive, analytic, interpretive, and valuative treatment of the more comprehensive descriptive data that is in the case record.

Analysis of Data

A content analysis of the data was presented emphasizing the following major areas of interest: living arrangement, remaining in school until high school graduation, category of risk, and client's satisfaction with the program. Case study data collection and analysis design is utilized in Chapter IV.

The follow-up form data was converted into a numerical code representing attributes related to each variable. The four instruments used in this research project were coded by the researcher for the computer analysis. The information received from the 22 respondents was hand coded on Fortran coding forms and entered into the computer systems. The data errors were corrected during this process and the data were placed on the mainframe using the Statistical Analysis System (SAS) for analysis. Analysis provided the frequency distributions by summarizing the raw data and the percentage of respondents to each item.

Statistical Procedures

Data used for statistical analysis were obtained from the instruments section in this chapter. Data were analyzed on the mainframe using the Statistical Analysis

System (SAS) to determine the frequency distributions by summarizing the raw data and the percentage of respondents to each item.

The statistical procedures applied to the data were descriptive statistics. The descriptive data were used to interpret the degree of success of at-risk youth in the *Family Support Program.* Descriptive statistics were used to summarize the follow-up information forms (Appendix B). This information pertained to living arrangement, remaining in school until high school graduation, category of risk, time spent in the program and client's satisfaction with the program.

The frequency distribution was summarized and the percentage of respondents to each item was used to examine the success or failure of the *Family Support Program* between the independent variables of the respondent problems; by measuring the degree of success or failure based on the risk factors of client problems before, during, and after intervention; and specifying treatment methods in the case studies. By documenting client change, case specific outcome evaluation helps determine if the *Family Support Program* intervention is effective. Unlike the aforementioned research procedures, outcome research gives the family support specialist information that can guide and improve the program. The method of analyzing the frequency distribution and percentage of respondents was used to examine the impact of the *Family Support Program* and whether or not the program was successful.

Summary

The four instruments used to gather data were created by the family support specialist to collect information on the effectiveness of the *Family Support Program*

on assisting former clients. To describe the at-risk youth, descriptive statistics were used to summarize the degree of success in the *Family Support Program.* The descriptive method was used to describe and interpret the behavioral patterns of participants. The researcher collected information from Payne County youth that had been discharged from the *Family Support Program.* This chapter gave a description of the methods and procedures to complete this study. A telephone and personal interview schedule was completed. Data were collected from 22 respondents, representing an overall 90 percent response rate. Analysis of the data was completed using Statistical Analysis System (SAS) procedures.

The case study approach was integrated into this research to provide a description of the evaluation. The researcher selected participants from the high risk, mildly high risk and low risk categories. The case study document reviews the participant's behavior, school attendance, treatment time spent in the home and updated reports. The cases are a descriptive study explaining in detail the findings.

CHAPTER IV

ANALYSIS OF THE DATA

Introduction

The purpose of this study was to determine the impact of the *Family Support Program* on success or failure of clients in the program. Successful clients are defined as continuing their education, living in parent(s) home or foster home, living independently after graduation and being financially self-supporting. Non-successful and/or failure youth are defined as a juvenile in jail, placed in a psychiatric hospital, dropped out of school, and unemployed.

Data collected during this study are presented in this chapter. For each former client who participated, an introductory paragraph was presented by the family support specialist. Case studies were developed to describe in detail the techniques used from the research information to give a clearer understanding of the data collected. The case studies focus on high, mildly high and low risk categories of participants that were in the *Family Support Program* in Payne County.

Description of Subjects at Intake

The data in this study were collected from a target population of 22 at-risk youth who were discharged clients of the *Family Support Program* in Payne County.

They ranged in age from 13 to 18 years, and lived in Payne County. There were five females and seventeen males. It was noted that teenage females are less likely to be placed into an inpatient or outpatient facility for a long period of time. Most teenage males in this study were placed in facilities out of the parental home.

Table I shows the frequency and percentage of the gender and age as reported by the at risk youth at intake. Intake clients of the program tend to be relatively young, with 59 percent being 13 or 14 years of age. Adolescents who were 16 or 17 make up 36 percent of the clients and 5 percent were 15 years of age.

Data presented in Table II shows the distribution of respondents by living arrangements at intake. The data shows 11 (50%) of clients lived in a single parent

TABLE I

DISTRIBUTION OF RESPONDENTS BY GENDER AND AGE AT INTAKE

Gender and Age	N	%
Male	17	77.3
Female	5	22.7
Age 13	8	36.5
14	5	22.7
15	1	4.5
16	5	22.7
17	3	13.6
Total	22	100.0

TABLE II

FREQUENCY AND PERCENTAGE OF RESPONDENTS BY LIVING ARRANGEMENT AT INTAKE

Living Arrangements	N	%
Both Biological Parents	1	4.5
Biological Mother	9	40.9
Biological Father	2	9.1
With a Relative	2	9.1
Foster Parent(s)	8	36.4
Total	22	100.0

family. The data shows only 1 (4.5%) lived with both biological parents; and 8 (36.5%) were placed into a foster home to live until further notice.

At intake 19 of the clients were attending school, three reported not being enrolled in school. Table III shows the distribution of respondents by grade at intake. Clients are more likely to be enrolled in the seventh or eighth grade with over 40 percent reporting enrollment in these grades; 1 (4.5%) in the ninth grade; 5 (22.7%) in the tenth grade; 3 (13.7%) in the eleventh grade and 3 (13.7%) were non attendants at school, and they did not answer this part of the survey. Grade levels are in agreement

with the age of the client (see Table I). The 3 (13.7%) not enrolled in school enrolled after intake. School attendance is one of the conditions of participation in the *Family Support Program.*

TABLE III

FREQUENCY AND PERCENTAGE OF RESPONDENTS BY GRADE LEVELS AT INTAKE

Grade	N	%
7	5	22.7
8	5	22.7
9	1	4.5
10	5	22.7
11	3	13.7
Not Enrolled	3	13.7
Total	22	100.0

For those 19 clients attending school, grade point averages ranged from 1.00 to 2.50 (see Table IV). The grade point average scale used was based upon a scale with A equaling 4 points.

The 19 (86.4%) reported in school at that time had the opportunity to work voluntarily after school when school is in session or work voluntarily during summer break. No client is forced to work after school or during summer break. No clients were employed at intake.

TABLE IV

FREQUENCY AND PERCENTAGE OF RESPONDENTS BY GRADE POINT AVERAGE

Grade Point Average	N	%
1.00 - 1.50	17	81.8
1.51 - 2.00	1	9.1
2.10 - 2.50	1	9.1
Total	19*	100.0

* Includes only clients enrolled in school at time of intake.

TABLE V

FREQUENCY AND PERCENTAGE OF RESPONDENTS BY TREATMENT AT INTAKE

Treatment Episodes	N	%
Never Admitted	3	13.6
Number of Times Inpatient		
Once	8	36.4
Twice	6	27.3
Three	2	9.1
Four	3	13.6
Total	22	100.0

Table V shows the treatment episodes and number of times clients were in an inpatient facility. The data shows 19 (86.4%) had been placed in an inpatient facility at intake and 3 (13.6%) had never been in an inpatient facility at intake. Data shows 8 (41.1%) had been in an inpatient facility only once at intake; 6 (36.2%) had been in an inpatient facility twice at intake; 2 (9.1%) had been in an inpatient facility three times at intake; and 3 (13.6%) had been in an inpatient facility four times at intake (see Table V).

Risk Factors at Intake

Presented in Table VI are behavior problems that the youth had at intake. Of the respondents, 18 (81.8%) had temper outburst behavior; and 7 (31.8%) had runaway behavior. Clients had problems in school with 15 (68.2%) reporting problems relating to school. This included 9 (40.9%) who had a problem with fighting in school; and 6 (27.3%) had a problem with missing classes. There were 21 (95.5%) clients who reported problems at home. The data shows 21 (95.5%) had a problem with arguing with family members and 21 (95.5%) had a problem with arguing with parents. There were 13 (59.1%) who had low self esteem and self worth. A total of 18 (81.8%) had other behavior problems. The (no) column indicates that they did not specify a problem in that area (see Table VI).

TABLE VI

DISTRIBUTION OF RESPONDENTS BY BEHAVIOR AT INTAKE

Behavior Problems	(Yes) N	%	(No) N	%
Temper Outburst	18	81.8	4	18.2
Runaway	7	31.8	15	68.2
Fighting in School	9	40.9	13	59.1
Missing Classes	6	27.3	16	72.7
Arguing with Teacher(s)	16	72.7	6	27.3
Arguing with Parent(s)	21	95.5	1	4.5
Arguing with Family Member(s)	21	95.5	1	4.5
Low Self-Esteem and Self-Worth	13	59.1	9	40.9

Description of Subjects at Discharge

Table VII through XXVII describe clients discharged from the *Family Support Program.* Changes in the clients are reported as they relate to previously stated research questions. Some clients had more than one behavioral problem.

TABLE VII

COMPARISON OF LIVING ARRANGEMENT OF RESPONDENTS AT INTAKE AND AT DISCHARGE

Living Arrangement	At Intake N	At Intake %	At Discharge N	At Discharge %
Both Biological Parents	1	4.5	4	18.2
Biological Mother	9	40.9	9	40.9
Biological Father	2	9.1	4	18.2
With a Relative (Same at Intake)	2	9.1	1	4.5
Foster Parent(s)	8	36.4	1	4.5
Other	0	0.0	3	13.6
Total	22	100.0	22	100.0

Living Arrangement

Data presented in Table VII compares the distribution of respondents by living arrangements at intake and at discharge. At discharge 7 (31.8%) had moved back into the community from foster homes. Out of the seven, 2 (9.1%) moved into their biological father's homes; 3 (13.6%) moved back into their biological parents' home; and 2 (9.1%) are attending college, 1 (4.5%) was working and living independently.

TABLE VIII

COMPARISON OF GRADE LEVELS OF RESPONDENTS AT INTAKE AND AT DISCHARGE

Education and Grade	At Intake		At Discharge	
	N	%	N	%
Attending School	19	86.4	19	86.4
Completed School	0	00.0	3	13.6
Grade 7	5	22.7	2	9.1
8	5	22.7	4	18.2
9	1	4.5	4	18.2
10	5	22.7	2	9.1
11	3	13.6	4	18.2
12	0	00.0	3	13.6

<u>**School Progress**</u>

Data presented in Table VIII shows education and grade level after discharge. Data reported show that 19 (86.4%) were attending school after discharge. The remaining 3 (13.6%) that enrolled in school after intake had to because this is a policy of the *Family Support Program.* Grade levels after discharge, include 2 (10.5%) in the seventh grade; 4 (21.1%) in the eighth grade; 4 (21.1%) in the ninth grade; 2 (10.5%) in the tenth grade; 4 (21.1%) in the eleventh grade; and 3 (15.8%) in the twelfth grade. Only 3 (13.6%) respondents completed high school. Of the 3 who completed high school, 2 (9.1%) are attending college, and 1 (4.5%) was employed

and lived independently. None of the clients failed a grade.

It is noticed that grades rose markedly at discharge. Table IX shows grade point average at discharge. The data shows the grade point average at discharge by participants: 4 (21.4%) had a grade point average between 1.00 to 1.50 at discharge; 6 (37.7%) had a grade point average between 1.51 to 2.00 at discharge; 5 (25.9%) had a grade point average between 2.10 to 2.50 at discharge; 2 (10.5%) had a grade point average between 2.51 to 3.00 at discharge; 2 (10.5%) and had a grade point average between 3.10 to 3.50 at discharge. At intake no client had a grade point average above a 2.50. At discharge the highest grade point average was 3.50.

TABLE IX

COMPARISON OF GRADE POINT AVERAGE OF RESPONDENTS AT INTAKE AND AT DISCHARGE

Grade Point	At Intake		At Discharge	
Average	N	%	N	%
1.00 - 1.50	17	77.4	4	18.3
1.51 - 2.00	1	4.5	6	27.4
2.10 - 2.50	1	4.5	5	22.5
2.51 - 3.00	0	0.0	2	9.1
3.10 - 3.50	0	0.0	2	9.1
Not Enrolled	3	13.6	0	00.0
Completed School	0	00.0	3	13.6
Total	22		22	100.0

Presented in Table X are treatment episodes. The data shows 5 (22.7%) had been placed in an inpatient facility after discharge from the *Family Support Program.* There were 17 (77.3%) who had not been in an inpatient facility after discharge. Data shows 8 (27.7%) were placed into inpatient facilities at intake, only 4 (18.9%) had been placed once into inpatient after discharge; and 1 (4.5%) had been placed twice into an inpatient facility after discharge. Of the 5 (22.7%) that entered back into inpatient facilities, all had runaway behavior at intake, all of them were in foster homes and were 15 to 17 years of age.

TABLE X

COMPARISON OF TREATMENT EPISODES OF RESPONDENTS AT INTAKE AND AT DISCHARGE

Treatment Episodes	At Intake N	At Intake %	At Discharge N	At Discharge %
Inpatient	19	86.4	5	22.7
Number of Times Inpatient				
One	8	36.4	4	18.2
Two	6	27.3	1	4.5
Three	2	9.1	0	0.0
Four	3	13.6	0	0.0
Not Inpatient	3	13.6	17	77.3
Total	22	100.0	22	100.0

TABLE XI

COMPARISON OF RESPONDENTS BY BEHAVIOR AT INTAKE AND AT DISCHARGE

	At Intake				At Discharge			
Behavior Improvements	(Yes) N	%	(No) N	%	(Yes) N	%	(No) N	%
Temper Outburst	18	81.8	4	18.2	6	27.3	16	72.7
Runaway	7	31.8	15	68.2	7	31.8	15	68.2
Fighting in School	9	40.9	13	59.1	1	4.5	21	95.5
Missing Classes	6	27.3	16	72.7	7	31.8	15	31.8
Argue with Teacher(s)	6	27.3	16	72.7	4	18.2	18	81.8
Argue with Parent(s)	21	95.5	1	4.5	11	50.0	11	50.0
Argue with Family Member(s)	21	95.5	1	4.5	7	31.8	15	68.2
Low Self Esteem and Self Worth	13	59.1	9	40.9	11	50.0	11	50.0

Table XI presents a comparison of behavior problems at intake and at discharge. The greatest improvement appeared to be in the areas of arguing with family members and parents. At intake 21 (95.5%) argued with family members; and

21 (95.5%) argued with parents. At discharge 7 (31.8%) still argued with parents. Of the respondents at discharge, 16 (72.7%) had no temper outburst behavior; 21 (95.5%) had no problem with fighting in school; 15 (83.3%) had no problem with missing classes; 18 (81.8%) stopped arguing with teachers; and 11 (50.0%) had no problem with low self esteem and self worth after discharge. There was no improvement in runaway behavior problems (see Table XI).

Maintenance Improved Behaviors

During the interview clients were asked to assess their own progress in changing behavior. Their perceptions of nonsuccess are shown in Table XII. Of the 22 respondents 16 (72.7%) made improvement or stopped having temper outburst behaviors; 17 (77.3%) improved or stopped arguing with parents; and 21 (95.5%) made improvement on stopping family arguments. The improvement scale is based on the guideline from the program policies of the *Family Support Program* (see Table XII). It is interesting to note that 5 runaways felt that they had improved.

Progress Toward Goals

At intake clients are asked to set goals for changes to be made in the areas of family life, education and employment. Family Support Specialists use these goals as the basis for their work with the client and family. Table XIII describes the assistance given and the frequency of the assistance. Of the 22 respondents, 20 (90.9%) had improved on communication when goal was set at intake; 22 (100.0%) had assistance from the Family Support Specialist on helping the family with problems in the home, school and in the community; 16 (72.7%) had assistance on the goal of helping with school problems; and 22 (100.0%) had goals set with the Family Support Specialist,

TABLE XII

CHANGES IN BEHAVIOR AS PERCEIVED BY RESPONDENTS AT DISCHARGE

Risk Factors	Improved Behavior		Stayed the Same		Worse		Not Certain		Does Not Apply	
	N	%	N	%	N	%	N	%	N	%
Temper Outburst	16	72.7	1	4.5	0	0.0	0	0.0	5	22.7
Runaway	5	22.7	1	4.5	0	0.0	0	0.0	16	72.7
Fighting In School	8	36.4	0	0.0	0	0.0	0	0.0	14	63.6
Missing Classes	4	18.2	1	4.5	0	0.0	0	0.0	17	77.3
Argue with Parent(s)	17	77.3	2	9.1	0	0.0	0	0.0	3	13.6
Argue with Family Member(s)	21	95.5	1	4.5	0	0.0	0	0.0	0	0.0
Low Self Esteem and Self Worth	13	59.1	0	0.0	0	0.0	0	0.0	9	40.9
Other	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0

youth, and with the family. Examples of skills taught by the Family Support Specialist include developing listening skills when the family communicates, learning to stop using profanity when the family is communicating, and decreasing physical

violence. Assistance given by the Specialist on other problem areas are working with client, family and school officials with client's behaviors at school and goal setting in resolving school problems.

TABLE XIII

FREQUENCY AND PERCENTAGE OF RESPONDENTS BY ASSISTING FAMILIES WITH GOALS

Goals of Family Life/Improvement	N	%
Goals of Family Life/ Improvement		
Communication	20	90.9
Help with Family Problems	22	100.0
Help with School Problems	16	72.7
Setting of Goals to Improve Client and Family Life Style	22	100.0

Resources Used

Clients were asked to list community resources that they used during the time they were in the program. Of the 22 respondents, 15 (68.2%) had used the YMCA as a resource; 6 (27.3%) had used the Stillwater Parks and Recreation as a resource; 7 (31.8%) had used the Project Potential Program as a resource; 18 (81.8%) had used

the Summer Program (JTPA) as a resource; 9 (40.9%) had used other resources in the community. Other resources mentioned included Cushing Youth Center, and Camp Fire Programs (see Table XIV).

TABLE XIV

FREQUENCY AND PERCENTAGE OF RESPONDENT'S USE OF COMMUNITY RESOURCES

Resources in the Community		N	%
YMCA	(Yes)	15	68.2
	(No)	7	31.8
Stillwater Parks and Recreation	(Yes)	6	27.3
	(No)	16	72.7
Project Potential	(Yes)	7	31.8
	(No)	15	68.2
Summer Program (JTPA)	(Yes)	18	81.8
	(No)	4	18.2
Other	(Yes)	9	40.9
	(No)	13	59.1

Services Provided by the Family Support Specialist

Presented in Table XV is the time spent in the home on assisting the clients with problems during weekly sessions. The types of problems that the clients had

TABLE XV

FREQUENCY AND PERCENTAGE OF RESPONDENTS OF TOTAL TIME SPENT BY THE FAMILY SUPPORT SPECIALIST ON ASSISTING CLIENT WITH PROBLEMS IN THEIR HOME

Behavior Problems	N	Time Spent (by hours and minutes)	Average Time
Temper Outburst	18	135 hrs., 41 min.	7.5
Runaway	7	123 hrs., 42 min.	17.6
Fighting in School	9	130 hrs., 39 min.	14.4
Missing Classes	6	124 hrs., 14 min.	20.7
Argue with Teacher(s)	6	145 hrs., 55 min.	24.2
Argue with Parent(s)	21	145 hrs., 55 min.	6.9
Argue with Family Member(s)	21	155 hrs., 00 min.	4.5
Low Self Esteem and Self Worth	13	119 hrs., 15 min.	40.9

while in the *Family Support Program* were temper outburst behavior, runaway behavior, fighting in school, arguing with teachers(s), arguing with parent(s), and low

self esteem and self worth. The Family Support Specialist spent 155 hours with 21 (95.5%) clients at their home in assisting the clients with not arguing with parent(s) and 145 hours and 55 minutes with 21 (95.5%) clients who argued with family members. There were 18 (81.8%) clients that had 135.41 hours spent in their home on controlling temper outburst behavior (Table XV). The "No" column represents the number of hours spent with clients in their home working on each individual problem.

When Table XV was examined it was noted that the specialist spent more time on clients with certain problems. The average amount of time spent by the specialist when working with a client with a given problem is ranked as follows: 24.3 hours for arguing with teacher; 20.5 hours for missing classes; 17.5 hours for runaway behavior; 9.1 hours for low self esteem and self worth; 7.5 hours for temper outburst behavior; 7.3 hours for arguing with family member(s); and 6.9 hours for arguing with parent(s).

Table XVI and Table XVII identifies the types of assistance given by the Family Support Specialist to help clients change behavior during the time in the program. During the interview, 22 (100.0%) of the respondents stated that the Family Support Specialist presented problem solving techniques in the home. Some of the types of problem solving techniques used were: teaching clients how to communicate with his or her family by talking to client and family about not using profanity, resolving problems without physical violence, using time-out periods, and teaching clients to talk out problems with parents. Stress reduction techniques taught include going walking, reading a book, and talking to the Family Support Specialist about problems. Data reported shows that 22 (100.0%) of the respondents had received help from the Family Support Specialist who was on call 24 hours a day to resolve problems in the home, school or in the community (see Table XVI and XVII).

TABLE XVI

FREQUENCY AND PERCENTAGE OF AREAS IN WHICH HELP WAS GIVEN BY CHANGED BEHAVIOR

Areas of Assistance		N	%
Improve Communication with Client and their Family	(Yes)	20	90.9
	(No)	2	9.1
Help with Family Problems	(Yes)	22	100.0
	(No)	0	0.0
Help with School Problems	(Yes)	16	72.7
	(No)	6	27.3
Help in Problem Solving in the Home	(Yes)	22	100.0
	(No)	0	0.0
On Call 24 Hours to Resolve Problems	(Yes)	22	100.0
	(No)	0	0.0

In Table XVI, clients were least satisfied with help from the Family Support Specialist with school problems. It had been reported earlier in this chapter that there was a marked improvement in grade point average, school attendance and progress. The researcher surmises visits to the school by the Family Support Specialist in order to try to resolve school problems may have made the clients uncomfortable.

The three most used skills involved talking to the Family Support Specialist, parents and friends. The next most frequently used skill by females that was reported was going walking. Males reported such physical activities as lifting weights and playing basketball. The least used skill was reading a book and listening to music.

TABLE XVII

FREQUENCY AND PERCENTAGE OF COPING SKILLS USED BY CLIENTS

Coping Skills		N	%
	(Yes)	22	100.0
Talk to Parent(s)	(No)	0	0.0
	(Yes)	21	95.5
Talk to Friend(s)	(No)	1	4.5
	(Yes)	10	45.5
Go Walking	(No)	12	54.5
	(Yes)	7	31.8
Read a Book	(No)	15	68.2
Talk to the Family Support	(Yes)	21	95.5
Specialist	(No)	1	4.5
	(Yes)	1	4.5
Listen to Music	(No)	21	95.5
	(Yes)	21	95.5
Other	(No)	1	4.5

Identification of Resources

All clients reported using the following services which were available from the Family Support Specialist: assistance in identifying resources available in the community, from private agencies and from the family itself. All of the clients used the help of the Specialist in meeting their own special needs and all received services in the home. Only one client did not use the 24 hour a day on call services of the Specialist.

Skills Used After Discharge

During the interview clients were asked which skills they had continued to use to maintain behaviors learned while in the *Family Support Program.* Presented in Table XVIII are the responses to the question. The most frequently used skills were those of coping with specific problems and communication. Coping skills included time out from each other, and looking at the problem from the other person's point of view. The Family Support Specialist assisted clients by teaching them how to communicate with their families and talk to parents about their day. Another skill that the Family Support Specialist taught the client was how to relax from a busy day or to reduce conflicts in the home such as, walking or exercising. The *Family Support Program* assisted the client with needs such as, paying for a membership card to the YMCA program in order to have an activity to go to and relax. The Family Support Specialist helped clients to find employment and, when needed, assisted clients in getting food, clothes, rent and transportation.

The study also included case studies to give in-depth information on techniques used in the research information to clarify the statistical data. These variables in the

case studies include behavioral problems, school status, treatment and time spent, also updated reports. The case studies discuss in detail a high, mildly high and low risk category of participants that were in the *Family Support Program* in Payne County.

TABLE XVIII

FREQUENCY AND PERCENTAGE BY SKILLS USED ON HELPING THE CLIENT TO STAY IN THE HOME

Skills Used on Helping Client Stay in Home		N	%
Learned Coping Skills	(Yes)	21	95.5
	(No)	1	4.5
Learned Communication Skills	(Yes)	21	95.5
	(No)	1	4.5
Learned Relaxation Skills	(Yes)	10	45.5
	(No)	12	54.5
Stress Reduction	(Yes)	16	72.7
	(No)	6	27.3
Assist the Family with Other Resources	(Yes)	22	100.0
	(No)	0	0.0

CHAPTER V

PRESENTATION OF DATA

Introduction

Data collected during this study is presented in this chapter. For each of the 22 respondents, an introductory paragraph is included (Appendix B). Under a subsequent heading, the two interviews conducted with former clients are instruments 2 and 4. Instruments 1 and 3 are information from the files. Three case studies were randomly selected based on the categories of high risk youth, mildly high risk youth and low risk youth. The best way to illustrate how these methods integrate together is to provide case examples.

Presentation of Case Studies

Case 1: High Risk Youth

Background Information and Problems

Subject one (S-1) lived in a dysfunctional home in the Payne County area, which consisted of a single parent home and one brother. S-1 is a 17 year old male, who had been in and out of foster homes and inpatient facilities since 1988. S-1 returned to his biological mother's home from a state juvenile institution. Once home,

he refused to follow any directions from his mother. He had severe temper outburst behaviors when he could not get his way after being at home for one month. S-1 was referred to the *Family Support Program* because he refused to obey rules in his mother's home, and had severe temper outburst behavior.

The referral of S-1 came to the *Family Support Program* at 11:00 a.m. from a telephone call from the client's biological mother. The Family Support Specialist called the biological mother immediately and was able to arrange an in-home appointment for later that evening. When the Family Support Specialist arrived, S-1 and his biological mother were arguing about S-1 staying out late at night. S-1 was verbally threatening to physically harm his mother because he wanted to stay out as late as he (client) wished. The Family Support Specialist completed an intake form to place him (client) into the *Family Support Program.* S-1 indicated that he became very angry when his biological mother refused to let him do whatever he wished. He did not want to obey the rules in the home. S-1's goals were to stop having temper outburst behaviors, to stop threatening his biological mother and to follow the rules in the home.

School

S-1 was enrolled in school at intake. S-1 has never dropped out of school. He attended school regularly and his grade point average was a 2.00 at intake. S-1 indicated that he does not get into trouble at school and that he is in the tenth grade in Payne County. S-1 was held back one year because of poor attendance and grades.

Treatment and Time Spent in the Home

S-1 was in the *Family Support Program* for seven months. During month one,

a rapport was established with S-1 and his mother. Also in the first month, there were 28 hours spent in the home reaching S-1 on how to stop having temper outburst behavior and teaching him to obey his biological mother. One of the strategies that was used to help the client was teaching him how to stay calm in a stressful situation by not having a temper outburst behavior. Another strategy was to communicate with his mother, and by having family nights together and doing a weekly activity together they could learn to build up their communication in a positive manner without profanity.

During month two, there were 32 hours spent assisting S-1. We discussed what made him have temper outburst behaviors and how to start controlling this behavior by taking time out, counting up to five minutes and thinking out his problem to reduce his anger. Another technique was putting himself into his mother's role, to reflect on the reasons why she made the rules for him to obey and how the rules benefitted him. One of the rules was for the client to be home by 9:00 p.m. during the weekday so he would be able to get up in the morning to go to school. Another rule was for the client not to associate with youth who were into drugs. A third rule was not to argue with family members.

In the third month, there were 25 hours spent assisting S-1 with learning to accept the home rules without arguing or having a temper tantrum. The Family Support Specialist talked to S-1 about the problems he was having in the home and encouraged him to accept the rules in the home. The Family Support Specialist assisted S-1 with different solutions such as putting his energy into positive things like exercising to release stress, playing a video game, talking to his biological mother if possible, calling the Family Support Specialist to discuss the problem or taking a time

out period for ten or thirty minutes in his room.

In the fourth month, there were 21 hours spent in S-1's home assisting him in controlling his temper outburst behavior and learning to accept his biological mother's rules without being defiant. The Family Support Specialist did role playing this month to demonstrate how S-1 behaved in the home when he refused to follow his biological mother's rules. Also the temper outburst behavior was demonstrated. This helped S-1 to actually see how he reacted to his biological mother's rules and the out of control behavior clients have in the home. This helped S-1 a lot because his behavior started changing for the better. S-1 started reducing his temper outburst behavior and began to follow his biological mother's rules in the home.

During the fifth month, there were 15 hours spent in S-1's home assisting him to control his temper outburst behavior and obey his mother's rules. The Family Support Specialist assisted S-1 with learning how to release stress in a positive manner by taking several deep breaths, letting the body relax and gently massaging the tension from his neck and head. This helped him to stay calm and relax when he felt stress overcoming him.

In the sixth month, there were 12 hours spent in S-1's home helping the client set short term goals on improving his behavior in the home by writing down what he wanted to accomplish each week. In the seventh month, there were 12 hours spent in S-1's home reviewing his progress and assisting client on how to continue setting positive short term goals each week to improve his behavior.

Update Report

After two years and six months, the Family Support Specialist had the

opportunity to administer a questionnaire to see if the youth was successful or not. S-1 graduated from high school and is presently working. By his senior year in high school, S-1 indicated that he had a grade point average of 3.00.

Case II: Mildly High Risk Youth

Background Information and Problems

Subject two (S-2) was a 16 year old female, who lived with her biological mother in the Payne County area. At the time of referral, S-2 had a poor school attendance record. S-2 had frequent verbal confrontations with family members, including her biological mother. She exhibited low self esteem and runaway behaviors at intake. S-2's biological mother was frightened for herself and family member's safety and opposed to the friends she sometimes brought home from the street. Her biological mother and the referring worker agreed that unless S-2's runaway behavior, verbal confrontations with family members, poor attendance at school, and low self esteem behaviors could be minimized, S-2 would have to be placed in a group home for her own safety.

The referral of S-2's family came to the *Family Support Program* at 9:30 a.m., from the Department of Human Services. The Family Support Specialist called the family immediately and was able to arrange an appointment for later that same afternoon. When the Family Support Specialist arrived, all five family members were slumped around a television in their crowded apartment living room. S-2's biological mother turned the television off and began introducing everyone in the home. An intake form was completed on that day.

School

S-2 was enrolled in school at intake. Her grade point average at intake was 1.00. S-2 had a poor school attendance. S-2 indicated that she did not like school and preferred to stay at home. S-2 indicated that she got expelled from school about a year ago for fighting.

Treatment and Time Spent in the Home

S-2's goals focused on controlling her impulsive/aggressive behavior, stop running away, decreased arguing with family members, building self esteem and improving school attendance by 99%. Over the next ten months, each conflict was discussed in the weekly sessions. S-2 had several sessions per week. In the first month, there were only 6 hours spent at S-2's home working on assisting the client with techniques to control temper outburst behavior by creating a behavior assessment chart (see Figure 1). S-2 had an understanding that she could call the Family Support Specialist any day of the week because the worker was on call 24 hours a day, seven days a week.

In the first half of the second month, there were seven hours spent on trying to locate S-2 because she had run away from home. In the second half of the month, there were 13 hours spent assisting client on not running away from home. S-2 indicated that the reason for running away from home was she enjoyed being with the friends that her mother didn't like, and also because there were family disagreements between other members in the home. One of the techniques the Family Support Specialist had the family do was have a family night three times a week to discuss any problems in the home and also have dinner together to learn about each other's

FIGURE 1

WEEKLY SELF-ASSESSMENT RECORD
(Based on Behavior Problems)

Name ______________________________:

Date ______________________________:

(This form is to help the clients to self assess the problem areas he/she needs or wants to change.)

Behaviors	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Temper Outburst (Per Day)							
Number of Fights (Per Day)							
Number of Arguments with Family Member(s) (Per Day)							
Number of Times Missing Classes (Per Day)							
Goals Met (Yes/No)							

feelings and what was going on in each person's life or school. These techniques helped the family members to learn about how each feels and thinks about a situation. Also, this procedure assisted the family in improving their communication in the home.

During the third month, there were 21 hours spent in S-2's home on helping the client to not run away, decrease impulsive/aggressive behavior and to stop missing classes. The Family Support Specialist assisted the client by teaching S-2 to take a ten or twenty minute break to think out a positive solution to the problem, put herself

in the other person's situation and think of how she could make the situation better. The Family Support Specialist talked to S-2 about the dangers of running away from home, such as getting raped, killed, or beat up by a person on the streets.

In the fourth month, there were 33 hours spent assisting client with not missing classes, decreasing impulsive/aggressive behavior, and stop arguing with family members. One way the Family Support Specialist assisted S-2 to stop missing classes was to arrange monthly meetings at the client's school with teachers, parent(s), Family Support Specialist and client. Also, the school teachers contacted the Family Support Specialist weekly and gave a progress report on absences.

During the fifth month, there were 18 hours spent in S-2's home on helping her not to argue with family members/parent(s), and stop having impulsive/aggressive behavior. The Family Support Specialist and S-2 reviewed the behavior assessment chart weekly and checked which goals were met and which goals needed to be completed. If the goal of temper outburst was not yet met, other skills were applied such as having the youth to reduce stress by exercising, walking, getting involved in school activities like sports or contacting the Family Support Specialist to talk out her problems.

In the sixth month, there were 14 hours spent with S-2 on assisting with temper outburst behavior and arguing with family members. Some of the skills that the Family Support Specialist used while assisting S-2 included having the client talk to her parents about the problem or taking a break and playing a video game to relax.

During the seventh month, there were 12 hours spent in S-2's home on reviewing her progress and the problems she needed to work on more to overcome the conflicts in her life. The Family Support Specialist had S-2 set short term goals on

what she would like to improve over the next few weeks and think of solutions on how to decrease her conflicts in a positive, lawful manner. The Family Support Specialist also included that S-2 had to say two positive things about herself daily to build up her self esteem.

In the eighth month, there were 8 hours spent in S-2's home. The Family Support Specialist reviewed the progress S-2 had made over the past months and documented the information on the behavioral assessment chart. S-2 indicated that she had been documenting her behavior on a weekly basis on the chart to check on her own progress, both in the home and in school.

In the ninth month, there were 6 hours spent in S-2's home. The tenth month there were only 4 hours spent in S-2's home preparing the youth to not depend on the Family Support Specialist for solutions to her problems. She agreed to continue to set short term goals and think of solutions to resolve any problems. By the last two months, nine and ten, S-2 had stopped missing classes and running away from home. S-2 had reduced her arguing with family members and was thinking positively about herself.

Update Report

A year and seven months later, the Family Support Specialist did a follow-up survey regarding success or failure on former clients and S-2 was still in school and doing very well. S-2 indicated that her grades had improved to a 3.50 grade point average by her senior year and she was enrolled in college.

Case III: Low Risk Youth

Background Information and Problems

Subject three (S-3) was referred to the *Family Support Program* in Payne County because of low self esteem and poor grades at school. S-3 was a 17 year old male, who had been in one foster home for a short period of time. Once home, S-3 refused to go to school and stayed in bed the majority of the day.

During a meeting with another agency worker in Payne County, the agency worker called the *Family Support Program* for assistance with this client. The Family Support Specialist was assigned to work with S-3. Later that afternoon an intake was completed.

School

S-3 was enrolled in school but refused to go, because he stayed in bed the majority of the day. S-3 indicated that he did not like school. He was not a student who got into trouble at school. S-3's grade point average at intake was 1.00. S-3 indicated that he only attended school when he was forced by the other agency worker to keep from being placed out of the home.

Treatment and Time Spent in the Home

During the first month, there were 20 hours spent in S-3's home working on his goals of building up his self esteem and improving his grades. The Family Support Specialist strived to prepare S-3 to build up his self esteem by teaching him how to think positively. The Family Support Specialist had S-3 list all the things he wanted in life, and how successful he wanted to be in the future. This was done to

give subject three some future goals to work toward and to motivate him to go to school, and this seemed to work.

In the second month, there were 17 hours spent with S-3 on assisting him in building up his self esteem and improving his grades. The Family Support Specialist assisted the client with his school assignments. The Family Support Specialist assisted S-3 with learning how to talk about his strengths instead of his weaknesses.

In the third month, there were 19 hours spent with S-3 on assisting him with building up his self esteem by enjoying and taking pride in his success. Also he was encouraged to not blame himself for every little thing. By the end of this month, S-3 was setting new goals for himself to be successful in school and in life. In the fourth month, there were 12 hours spent working with S-3 on building up his self esteem by teaching him to seek happiness in life and enjoy every day in a positive way rather than living for negative things in life. At the end of this month, S-3 appeared to be enjoying life and even showed some humor in some of the sessions.

By the fifth month, there were 10 hours spent in S-3's home helping him build up his self esteem. S-3 was progressing very well in the home and his school grades were improving. The Family Support Specialist discharged the case at the end of the fifth month.

Update Report

One year later, the Family Support Specialist did a questionnaire for her graduate study to find out if the *Family Support Program* was successful or not in assisting clients. S-3 was in his senior year of high school and his grade point average has increased to 2.75. S-3 indicated that he was planning to go to college when he

graduated from high school.

In Chapter 5 the researcher has presented the findings from a study to determine the impact of the *Family Support Program* on Payne County youth who were clients of the program. Chapter IV discusses the findings in greater detail.

Summary

Data gathered on each of the three respondents who were randomly selected for the case studies has been presented. Data gathered from each respondent has been summarized based on the risk categories of high risk youth, mildly high risk youth and low risk youth. In Chapter IV, a summary, conclusion and recommendations for the future research are found.

CHAPTER VI

SUMMARY, CONCLUSION AND RECOMMENDATIONS

Introduction

This chapter will present a summary of the study and the conclusions which the researcher has made regarding the accomplishments of the *Family Support Program.* This chapter is divided into three sections. The first section provides a summary of the study, and results of major findings, as it pertains to at-risk youth that were in the Payne County *Family Support Program.* The second section of this chapter contains recommendations, based upon the findings of the study, and the need for further studies, will also be presented.

Summary of Methods

The purpose of this study was to determine the impact of the *Family Support Program* on success or failure of clients in the program. Success is defined as continuing their education, living in parent(s) home or foster home, and/or being financially independent. Non-successful and/or failure youth are defined as a juvenile in jail, in a psychiatric hospital, dropped out of school, or unemployed.

To achieve this purpose, interview instruments were developed and administered. Data were collected from intake forms, and a follow-up interview, using

telephone calls and personal interviews. All data were collected from clients who had been discharged from the *Family Support Program.* The follow-up interviews were administered by the researcher and confidentiality of the respondent was maintained through the use of an identification number on each set of instruments that the subject responded.

There were 22 former clients all residing in Payne County, who voluntarily participated in a personal interview. Phone interviews were conducted with seventeen of the participants. Five participants who did not have a phone were interviewed in their homes. Data were analyzed using frequencies and percentages. The researcher conducted a case study investigation that was intensive and used in-depth interviews. Case studies were developed to discuss more detailed information about the participant's behavior, time spent in the program, treatment and update reports. The researcher's information is qualitative research.

Participants were grouped into one of the three at-risk categories; high, mildly high and low risk. The Family Support Specialist created the at-risk categories to separate the behaviors into different risk categories. The at-risk youth behaviors were based on the severity of the behavior. There were six participants who were in the high risk category, 13 in the mildly high risk category and 3 in the low risk category.

There are two important factors which can place a youth in the *Family Support Program.* These factors include youth *In Need of Treatment* because of mental disabilities and youth *In Need of Services* because of behavior problems in the home. The participants are defined in three different categories of risk. High risk youth exhibit suicidal and threatening homicidal behavior. Mildly high risk youth have problems with controlling their temper outburst behavior, have harsh rejecting parents,

and/or are clients who run away. Low risk youth have behavioral problems in school, such as, arguing with teacher(s) and/or parent(s) or missing classes, and low self esteem and self-worth.

Summary of Findings

Findings of the study indicate that after participation in the program, youth were most successful in returning to and remaining in the home, and raising grade point averages. Clients of the program were making progress in overcoming behaviors such as arguing with parents, teachers and family members.

As a group, clients were successful in raising their grade point averages. At intake, 17 of 19 clients had averages ranging from 1.00 to 1.50. At discharge the range of averages was from 1.00 to 3.50, with 9 clients reporting averages above 2.1. At discharge three clients had completed school; of these, two were in college and one was employed.

Most clients made progress in overcoming behaviors which had caused them to be placed in the program. More clients were able to overcome their problems with arguing with parents and other family members, temper outbursts and fighting in school than problems with arguing with teachers or low self esteem. Clients who had problems with running away made no improvement.

Certain behavior problems required the specialist to spend more time helping clients to overcome them. These behaviors include arguing with teachers, missing classes and running away. It should be noted that clients' attendance increased and they made good progress in school while they were in the *Family Support Program.*

The greatest improvement was in the 17 (77.3%) clients who did not return to

an inpatient treatment facility because of improvement in their overall behavior. Only five (22.7%) had been returned to an inpatient treatment facility after being discharged from the *Family Support Program* for arguing with their teachers or their parents or both. The same five (22.7%) had been placed in an inpatient facility after being discharged for running away. There were 17 (77.3%) who had improved their overall behavior and avoided going back into an inpatient treatment facility after being discharged from the *Family Support Program.*

After discharge the clients perceived that the most helpful things that the Family Support Specialist did to help the family with problems was to be on call 24 hours a day, seven days a week, and teaching the youth how to communicate without using profanity or yelling. Of the respondents, 20 (90.9%) felt that their family relationship had improved because of better stress reduction techniques, such as, walking, talking out problems with the family or the Family Support Specialist. Only two (9.1%) clients felt that their family relationship had not improved while in the program. The researcher selected several behavioral techniques which she had the client use to keep in control of his/her behavior or build up his/her self esteem (see Appendix C).

Case study design was used to examine the statistical variables: behavior, time spent in the home, treatment, and update reports. The study presented in-depth information about each case. From the case studies, the participant's behaviors had improved over several months of intensive, in-home family support services.

Conclusion

According to the criteria used 17 (77.3%) of the clients were successful and

five (22.7%) were not successful. The researcher concludes that the program was moderately successful on meeting needs of the clients. Based on the statistical findings, the program is not meeting the needs of clients with runaway behaviors at intake. The researcher arrived at this decision because seven (31.8%) were running away from home at intake. At discharge, only two participants out of the seven had stopped running away from home. The five who were still running away from home were placed into an inpatient psychiatric facility. It appears that the more time spent with clients, the more successful they will be. Of the 17 clients that were successful, all used some type of community resources as a support.

It was concluded, as a result of this study, that the *Family Support Program* participants in Payne County felt that the specialist coming into the home and assisting the youth was successful. Helping them with resolving personal problems related to family and school conflicts was a very important factor with the *Family Support Program* participants. This leads the researcher to conclude that the *Family Support Program* is meeting the goals on helping young people in the community with resolving problems in the home, school and community.

The final conclusions were reached: The *Family Support Program* helped make a change in the client's attitudes for the betterment of themselves, others, and school. The participants learned behavioral skills to make better decisions for themselves, and the Family Support Specialist strives to prepare participants to manage their problems after the in-home services are gone. Building skills is an important part of this process for participants. The identification of specific community resources the participant will need during the treatment and discharge is also

important. The Family Support Specialist used recreational services and youth centers as community resources to assist the youth.

From the case studies, the Family Support Specialist assisted the participants with behavioral control skills, such as stress relievers and/or aggressive anger management techniques. The case studies focused on behavior, school, time spent in the program, treatment and update reports. Each case study examined a high, mildly high and low risk category of participants that were in the *Family Support Program.*

Case studies were developed to discuss more detailed information about the participant's behavior, time spent in the program, treatment and update reports. The case studies conducted by the participant observer attempted to describe comprehensive and intensive investigation of a research problem. The researcher randomly selected participants from each risk category. The three risk categories are, high, mildly high, and low risk youth. The at-risk youth was categorized by their behavior. From the case studies, the participant's behavior had improved over several months of intensive in-home family support. The case study information also provided comprehensive and descriptive data. The case studies included research information of qualitative investigation based on in-depth open-ended interviews.

Recommendations for the Family Support Program

This study was limited to a two-year time period. A longer period of time would increase the population and provide an opportunity for a rigorous statistical analysis. The current study should be expanded to include more subjects from a wider geographical area. Runaway clients represent special problems that need intensive

treatment such as giving a worker more time to work with the youth and training on handling runaway clients.

The Family Support Specialist needs to continue to work with the school systems because it improves client's behaviors at school such as grade point averages, school attendance, and reduced arguing with teachers. Because of the newness of the program there should be staff time allowed to develop evaluation for the program.

The *Family Support Program* in Payne County needs to have a selected evaluation team representing a variety of youth agencies from other counties to develop an evaluation. States that have a *Family Support Program* need to have the equipment to do the evaluations and have a research team to find out the outcome/success or failure of these programs in the surrounding areas and state-wide. The at-risk families need to be evaluated as a unit. There is a need for educational programs designed to disseminate factual information to other programs and higher education institutions with regard to at-risk youth and their families as a unit.

Based on these findings, the following recommendations are made: Further research will need to be done on other case studies. The case studies need to be integrated into future research after the program has been in existence for a longer time period. The case studies provide an awareness of the opportunities for development of skills that were used by the Family Support Specialist and what was helpful with assisting the youth. Case studies can be useful for collecting data about how youth cope with family conflicts, school attendance and daily situations. Based on the case study findings, the variables can be researched considerably further in the near future as other counties begin to establish similar programs in their areas.

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APPENDICES

APPENDIX A:

CORRESPONDENCE

July 23, 1992

TO: Family Support Director

I am a graduate student in the college of Home Economics at Oklahoma State University doing my doctor's degree in Home Economics Education/Family Relation and Child Development. I am asking for youth assistance to help me gather my research data using the former clients as the research subjects. My topic is "Family Support Program in Payne County: A Study of Selected At Risk Youth."

In order for my research to be thorough and complete, I need your support and assistance. The former clients will be picked randomly from the closed files. The information that is gathered will become a part of my dissertation for my degree and also an able source of information for the *Family Support Program.*

Thank you for your cooperation and your prompt attention to the above request. If you have any questions or wish to discuss this project with me personally, I can be reached at the following number (405) 624-1625, before 9:00 a.m.

Sincerely,

Ms. Gwendolyn L. Vick

August 11, 1992

TO: Family Support Director

I am currently working on a study to determine the impact of the *Family Support Program* in Payne County. I would appreciate it if you would look over the questionnaire and make any suggestions and/or recommendations.

All suggestions and recommendations will be of great help.

Sincerely,

Ms. Gwendolyn L. Vick

Script:

Hello, my name is Gwendolyn Vick. I am employed at the *Family Support Program* for Payne County. I am presently working on my doctoral degree at Oklahoma State University in Stillwater, Oklahoma. I am interviewing clients that were in the *Family Support Program*, to see if the program was successful or non-successful in Payne County.

The information that is given will be kept confidential. No names, addresses or telephone numbers will be on the forms. Are you willing to participate?

All information is confidential. Participation will involve taking part in a telephone interview which will take approximately 30 minutes and at the interviewee's convenience.

Payne County Family Support Program

Consent to Participate

I, ______________________________, the undersigned parent or person having legal custody or the legal guardianship of ____________________ do hereby give consent of participation in the project entitled "Community Support Services in Payne County: A Study of Selected At Risk Youth."

The purpose of releasing this information is to examine the impact of the *Family Support Program* on clients that have been discharged from the *Family Support Program* in Payne County. This will assist in determining the degree of success attained by clients, from the time they spent in the program, and determine client satisfaction with the program. Another purpose is to collect pertinent data regarding the results or impact of the *Family Support Program.* This information will be an asset to the *Family Support Program* in Payne County.

Participation will involve taking part in telephone interviews which will take approximately 30 minutes and will be at my convenience. Questions asked during the interview may remind me of a time in my life when I have been unhappy. Information from my intake interview will also become a part of the study. If deemed necessary additional information may or may not be obtained from the client's file.

An I.D. code number will be used to determine the sex (male or female) of each participant. The questionnaires and responses will be destroyed after August 1, 1993. Participant will be kept confidential. The information provided will not be disclosed, other than as a part of group data, to persons other than agency personnel.

I understand that participation is optional and voluntary, and that I am free to withdraw my consent and participant in this project at any time after notifying the project director. This information will not become part of my record. If additional family support is needed for any reason, contact the Oklahoma Mental Health Center.

I may contact Gwendolyn L. Vick at (405) 624-1625 should I wish further information about the research. I may also contact Dr. Margaret Callsen at (405) 744-5046, 139 Human Environmental Sciences, Oklahoma State University, Stillwater, OK 74078.

I have read and fully understand the consent form. I sign it freely and voluntarily. A copy has been given to me.

Date: ________________________ Time: ________________________

Signed: ____
(Name of Client)

Signed: ____
(Name of Parent/Guardian)

I certify that I have personally explained all elements of this form to the subject before requesting the subject to sign it.

Signed: ____
(Authorized Representative)

APPENDIX B:

PERSONAL INTERVIEW SCHEDULE

I.D. Code No: ______________

Instrument - 1

Family Support Program

INTERVIEW SCHEDULE/FOLLOW-UP INFORMATION FORM

(Prior to Admission)

(All information is confidential.)

Directions: Please circle responses.

Gender: Male or Female

1. Who do you live with?

   a. Both biological parents

   b. Biological mother

   c. Biological father

   d. With a relative

   e. Foster parent(s)

   f. Other, please specify ______________________________

Education & Employment:

2. Are you attending school?

   a. Yes, go to question 3

   b. No, go to question 5

3. What grade level? ____________

4. What is your overall grade point average on a 4.00 grading scale?

   Grade Average ______________

5. Are you employed?

   a. Yes, go to question 6

   b. No, go to question 8

6. Yes, employed, do you . . .

   a. Work part-time in the summer (JTPA program)

   b. Work part-time after school (when school is in session)

   c. Work part-time (not in school)

   d. Work full-time (summer only)

   e. Work full-time (all year)

7. If you are working part-time, is it . . .

   a. Voluntarily

   b. Involuntarily

8. No, not employed, but I am . . .

   a. Looking for work

   b. Helping at home (home duties)

   c. Not helping at home, but living with parent(s)

   d. Not employed because of medical reasons

   e. Not looking for work

   f. In jail

   g. Other, please specify ______________________________

9. Have you ever dropped out of school?

   a. Yes, go to question 10

   b. No, go to question 11

10. Why did you drop out of school?

    (Circle all that apply on this question.)

    a. Poor grades

    b. Went to work

    c. Bored

    d. Did not like school

    e. Other, please specify ______________________________

11. What kept you in school?

    (Circle all that apply on this question.)

    a. Friend(s)

    b. Sport(s)

    c. Teacher(s)

    d. Like school

    e. Biological parent(s)

    f. Grandparent(s)

    g. Other, please specify ______________________________

12. Are you trying to get a GED?

    a. Yes

    b. No

13. What profession do you plan to pursue in the future?

    Title: ______________________________

Prior Treatment Episodes:

14. Have you ever been in inpatient treatment?

    a. Yes, go to question 15

b. No, go to question 16

15. How many times were you in inpatient treatment?

a. Once

b. Twice

c. 3 times

d. 4 times

e. 5 times or more

16. At what location did you receive outpatient services?

____

17. How many foster care facilities have you been placed in over the past year(s)?

Number of Times: ____________________

18. What were some of the behavior problems that placed you into an inpatient facility?

______ Temper outbursts

______ Runaway

______ Fighting in school

______ Missing classes

______ Arguing with teacher(s)

______ Arguing with parent(s)

______ Arguing with family member(s)

______ Low self esteem and self worth

______ Other, please specify ________________________________

19. Which resources do you use in the community?

a. YMCA

b. Stillwater Parks and Recreation Activities Program

c. Project Potential

d. Summer program (JTPA)

e. Other, please specify ______________________________

Thank you very much for your responses to this confidential survey.

I.D. Code No: ______________

Instrument - 2

Family Support Program

INTERVIEW SCHEDULE/FOLLOW-UP INFORMATION FORM

(Prior to Admission)

(All information is confidential.)

Directions: Please circle responses.

Gender: Male or Female

1. Who do you live with?

   a. Both biological parents

   b. Biological mother

   c. Biological father

   d. With a relative (same family at the beginning of program)

   e. With a relative (different family member(s)

   f. Foster parent(s) (same family at the beginning of program)

   g. Foster parent(s) (different foster family)

   h. Other, please specify ______________________________

Education & Employment:

2. Are you attending school?

   a. Yes, go to question 4a

   b. No, go to question 4b

3. What grade level? ____________

4a. If yes, what is your overall grade point average on a 4.00 grading scale?

Grade Average: __________

4b. If no, what was your overall grade point average in the past year(s)?

Grade Average: __________

5. Have you completed High School?

a. Yes

b. No

c. Trying to get GED

d. Have a GED

6. Are you in a vocational/job training program?

a. Yes

b. No

c. Completed

Area of study? ____

7. If no, are you enrolled in any type of education program now?

a. Higher education (college)

b. Job Corp

c. Nothing

d. Other, please specify ______________________________________

8. Are you working?

a. Yes, go to question 9

b. No, go to question 10

9. Yes employed, do you work . . .

a. Part-time (less than 40 hours per week)

b. Full-time (40 hours or more per week)

c. What are you doing?/Job Title ______________________________

10. Are you looking for a job?

    a. Yes

    b. No

Prior Treatment Episodes:

11. Are you receiving any type of counseling services from any agency now?

    a. No

    b. Yes, how many times per month? ______________________________

12. Have you ever been in inpatient treatment after being discharged from the Family Support Program?

    a. Yes, go to question 13

    b. No, go to question 14

13. If yes, how many times?

    a. Once

    b. Twice

    c. 3 times

    d. 4 times or more

14. How many foster care facilities have you been placed in over the past year(s)?

    Number of times: ______________

15. What were some of the behavior problems that placed you into an inpatient facility after being discharged from the Family Support Program?

    ______ Temper outbursts

    ______ Runaway

    ______ Fighting in school

______ Missing classes

______ Arguing with teacher(s)

______ Arguing with parent(s)

______ Arguing with family member(s)

______ Low self esteem and self worth

______ Other, please specify ______________________________

16. If you were not placed into an inpatient facility, please check the behavioral problems you are having now?

______ Temper outbursts

______ Runaway

______ Fighting in school

______ Missing classes

______ Arguing with teacher(s)

______ Arguing with parent(s)

______ Arguing with family member(s)

______ Low self esteem and self worth

______ Other, please specify ______________________________

Court System Status:

17. Are you in the court system?

a. Yes, go to question 15

b. No

18. If yes, reason:

a. Never was discharged from court

b. Re-entered the court system

c. In the process of being discharged

d. Other, please specify ________________________________

19. Which resources do you use in the community?

a. YMCA

b. Stillwater Parks and Recreation Activities Program

c. Project Potential

d. Summer program (JTPA)

e. National Youth Sports Program (NYSP)

f. Youth Center

g. Other, please specify ________________________________

Total of Months or Weeks in the Home:

20. How long were you in the Family Support Program?

a. Total of Months ________________

b. Total of Weeks ________________

Note: If follow-up could not be completed, please specify why (e.g., client moved, etc.)

(TO BE COMPLETED BY THE CLINICIAN)

____

____

____

____

____

Thank you very much for your responses to this confidential survey.

I.D. Code No: ______________

Instrument - 3

Family Support Program

INTERVIEW SCHEDULE/FOLLOW-UP INFORMATION FORM

This portion to be completed by the clinician.

Time Frame:

1. How many hours did the Family Support Specialist spend in the home per month?

    a. 1st month total hours _____

    b. 2nd month total hours _____

    c. 3rd month total hours _____

    d. 4th month total hours _____

    e. 5th month total hours _____

    f. 6th month total hours _____

    g. 7th month total hours _____

    h. 8th month total hours _____

    i. 9th month total hours _____

    j. 10 month total hours _____

    k. 11th month total hours _____

    l. 12th month total hours _____

    m. Over 12 months _________

    n. Total _________________

I.D. Code No: ________________

Instrument - 4

Family Support Program

INTERVIEW SCHEDULE/FOLLOW-UP INFORMATION FORM

(All information is confidential.)

Directions: Please circle responses.

Resources:

1. Do you think your family relationship has improved as a result of this program? (If so, in what areas?)

   a. Communication

   b. Help with family problems

   c. Help with school problems

   d. Other, please specify ____

2. Do you think the program assisted your family in identifying and using resources available in the community that you haven't used before?

   a. Yes

   b. No

3. Where do you prefer to receive services?

   a. In the home

   b. In the office

   c. Other, please specify ____

4. What was most helpful in resolving your problems?

a. Family Support Specialist on call 24 hours, 7 days a week to resolve family conflicts

b. Problems were resolved in the home

c. Problems were resolved by telephone

d. Other, please specify ______________________________

5. What did the Family Support Specialist do for you that no other counselor has done?

a. Setting goals with the youth and their family?

b. Advocacy in the . . .

______ School

______ Court System

______ Other, please specify ______________________________

6. What were your reason(s) from question 5 on receiving help?

a. Family Support Specialist on call 24 hours a day, 7 days a week

b. Counselor or Therapist assisting client in the office

c. Received problem-solving techniques in the home

d. Received problem-solving techniques in a clinical setting

e. Other, please specify ______________________________

7. Do you think your family had adequate time in this program?

a. Strongly agree

b. Mildly agree

c. Uncertain

d. Mildly disagree

e. Strongly disagree

8. Did the Family Support Specialist schedule your appointments at times which were convenient for you?

   a. Yes

   b. No

   c. Not sure

9. Would you recommend this program to other families in distress?

   a. Strongly agree

   b. Mildly agree

   c. Uncertain

   d. Mildly disagree

   e. Strongly disagree

10. Did the Family Support Specialist assist the family with other resources in the community?

   a. Yes

   b. No

11. Did the Family Support Specialist assist the client with resources that met the special needs of the client?

   a. Yes

   b. No

Behavior Condition:

12. Please rate behavior change(s) on the following scale, using the numbered indicators below:

   (1) Improved

   (2) Stayed the same

(3) Worse

(4) Not certain

(5) Does not apply

	(1)	(2)	(3)	(4)	(5)
Temper Outbursts					
Runaway					
Fighting in School					
Missing Classes					
Arguing with Parent(s)					
Arguing with Family Member (s)					
Low Self-Esteem and Self-Worth					
Other, please specify					

14. Did the Family Support Specialist receive any emergency calls from you?

    a. Yes, go to question 15

    b. No

15. If yes, how many problems were resolved?

    a. On the telephone/total number ____

    b. In person/total number ____

    c. Problem was not resolved either way

16. Did you learn any types of coping skills in the Family Support Program?

    a. Yes, go to question 17

    b. No, go to question 19

17. What type of coping skills did you learn from the Family Support Specialist?

    a. Talk to parent(s)

    b. Talk to friend(s)

    c. Go walking

    d. Read a book

    e. Talk to the Family Support Specialist

    f. Smoke cigarette

    g. Listen to music

    h. Look at television

    i. Get out of the house

    j. Other, please specify ____________________

18. Did the Family Support Specialist teach you how to handle future problems?

    a. Yes, go to question 19

    b. No, go to question 20

19. If yes, what did the Family Support Specialist teach you on handling future problems?

    a. Learned coping skills

    b. Learned communication skills

    c. Learned relaxation skills

    d. Stress reduction

    e. Other, please specify ____________________

20. Did the Family Support Specialist monitor the status of all goals until the case was terminated?

    a. Yes

    b. No

Thank you very much for your response to this confidential survey.

APPENDIX C:

BEHAVIORAL SKILLS THAT WORK TO ASSIST AT-RISK YOUTH AND SKILLS THAT DO NOT

The following behavioral skills WORKED to assist at-risk youth:

1. *Anger Control Management*: Have the client take a 10-minute break to calm down and think of at least two positive solutions.
2. *Role Reversal Therapy*: Have the youth change roles with their parents, to gain insight on how each responds to problems.
3. *Family Discussions*: The family starts out having two family nights a week, to discuss their problems and daily activities, and to build better communication with each other.
4. *Recreational Time Together*: To help the family learn how to enjoy each other and become more open-minded in doing positive activities together. Some activities include: bowling, video games, sports, movies, etc.

Also, the Family Support Specialist paid for a 1-year pass for the families at the youth recreational centers in each town in Payne County or nearby towns. This enabled the families to have a free relaxation activity together.

The following behavioral skills DID NOT work to assist at-risk youth:

1. Trying to counsel at-risk youth with runaway behavior in their home did not work. The youth was not at home the majority of the time.
2. Asking the parent(s) to bring the at-risk youth with runaway behavior into the office did not work. The youth refused to come into the office for counseling.

APPENDIX D:

HUMAN SUBJECTS APPROVAL

OKLAHOMA STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD
FOR HUMAN SUBJECTS RESEARCH

Proposal Title: Community Support Services in Payne County: A Study of Selected High Risk Youth

Principal Investigator: Margaret Calleson/ Gwendolyn Vick

Date: June 16, 1992 IRB # HE-92-066

This application has been reviewed by the IRB and

Processed as: Exempt [ ] Expedite [ ] Full Board Review [X]

Renewal or Continuation [ ]

Approval Status Recommended by Reviewer(s):

Approved [xx] Deferred for Revision [ ]

Approved with Provision [ ] Disapproved [ ]

Approval status subject to review by full Institutional Review Board at next meeting, 2nd and 4th Thursday of each month.

Comments, Modifications/Conditions for Approval or Reason for Deferral or Disapproval:

Provisions Received

Signature: Maria L. Tilley Date: 7-15-92
Chair of Institutional Review Board

VITA

Gwendolyn LeEsther Vick-Johnson

Candidate for the Degree of

Doctor of Philosophy

Thesis: FAMILY SUPPORT PROGRAM IN PAYNE COUNTY: A STUDY OF SELECTED AT-RISK YOUTH

Major Field: Human Environmental Sciences

Biographical:

Personal Data: Born in Oklahoma City, Oklahoma, April 9, 1962, daughter of Leon and Queen Vick. Married to Bertram I. Johnson on May 1, 1993.

Education: Graduated from Guthrie High School, Guthrie, Oklahoma, in 1980; received Bachelor of Arts Degree in Sociology from Langston University, Langston, Oklahoma in 1984; received Master of Arts Degree in Criminal Justice Management and Administration from University of Central Oklahoma—formerly Central State University, Edmond, Oklahoma in May 1988; completed requirements for the Doctor of Philosophy Degree at Oklahoma State University, Stillwater, Oklahoma in December, 1994.

Professional Experience: Home-based Family Therapist, Edwin Fair Community Mental Health Center, Payne County, 1989 to present; Adjunct Professor, Langston University, Langston, Oklahoma, 1988; Librarian Assistant and Supervisor of Work Study Students, Langston University, Langston, Oklahoma, 1984 to 1988; Program Aide and Counselor, Logan County JTPA (Job Training Participant Act) Program, Logan County, 1984.

Professional Associations: Oklahoma Home-Based Family Therapist Association; Beta Phi Zeta Chapter; Zeta Phi Beta Sorority; Oklahoma State University Alumni (OSUA).