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# Caregivers' Perceptions of Day Treatment Programs

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# Caregivers' Perceptions of Day Treatment Programs

by

Julie Lochen, B.S.W

MSW Clinical Research Paper

Presented to the Faculty of the  
School of Social Work  
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St. Paul, Minnesota  
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Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

## CAREGIVER'S PERCEPTIONS OF DAY TREATMENT PROGRAMS

### **Abstract**

This paper addresses the mental health concerns of millions of children across the United States; especially those with diagnosis of Emotional and Behavioral Disorders. This researcher used a qualitative research design to obtain the perceptions of caregivers who have children placed in day treatment programs. This researcher used an exploratory design with action research theory. Action research theory was used in the hopes that clinicians would empower clients, caregivers, and families. The researcher used an open-ended interview technique to collect data through a qualitative questionnaire with participants, lasting about 15 minutes. The questions that were asked pertained to the perceptions of caregivers whose children receive day treatment services. Inductive coding was used to find common themes in the caregivers' responses. The two themes found among all three caregivers' perspectives was support for the child, and communication. Each caregiver mentioned that day treatment programs provide support either for their child, or for the family. Communication came up as a need for improvement between clinicians and caregivers and possibly between caregiver and child. Caregivers were empowered to be involved in communication with professionals however, may require additional support in doing so.

*Key Words:* Day Treatment, Caregiver, Children, Emotional Behavioral Disorder

# CAREGIVER'S PERCEPTIONS OF DAY TREATMENT PROGRAMS

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# CAREGIVER’S PERCEPTIONS OF DAY TREATMENT PROGRAMS

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### Caregivers Perceptions of Day Treatment Programs

According to the Centers for Disease Control and Prevention (2014), in the National Health Interview Survey 2010-2012, it was found that “about 4% of adolescents aged 12-17 had a serious emotional or behavioral difficulty.” The Centers for Disease Control and Prevention also report that millions of children ages 3-17 suffer from mental health disorders including: Attention Deficit Hyperactivity Disorder, Autism Spectrum Disorder, Anxiety, Depression, and Conduct Disorders (CDC, 2013). Of these millions of children, “approximately one in every four to five youth in the U.S. meets criteria for a mental disorder with severe impairment across their lifetime,” (Merikangas et al., 2010). While there are mental health programs for children, there is a lack of resources for those with the most severe diagnosis. Mental health professionals have noticed a dilemma between education and resources provided for children with severe mental health concerns. Researchers continue to study the most effective ways to assist children through in-school or after-school programs (Swanlund, 2010). Parents, involved with such programs, have reported feeling blamed for their child's disorders by mental health professionals (Swanlund, 2010).

Limited information is available regarding caregiver perceptions related to day treatment programs. There have been trends of research conducted on parent involvement in treating children with Emotional Behavioral Disorders, burn out of professionals and caregivers, and the perceptions of professionals working with children who have these diagnoses. However, there appears to be a lack of information on the caregiver's perspective of treatment programs of children with Emotional Behavioral Disorders.

Mental Health Professionals must be aware of caregivers' perceptions of treatment programs, including their knowledge of the child's diagnosis, the treatment plan, and the specific program in which the child is enrolled. Through further review of the literature, mental health professionals may find a link between caregiver buy-in to the program, and the success of a child through that program and later in life. Researching caregiver perceptions could also lead to an awareness of areas for improvement in the programs, in which could then be amended. The results of a study that assesses caregiver perceptions may show what more can be done for caregivers and answer such questions as: are they aware of what their child is undertaking in this program? Do they feel there needs to be more communication between staff and caregiver? Are they seeing progress in their children in similar ways as the professionals? The caregiver may see very different benefits than the mental health professionals who are working with the child do.

It is important to recognize that several children and adolescents are primarily cared for by someone who may not be legally or biologically related to them. Many children are raised by their grandparents, aunts, uncles, or extended family. Another large portion of caregivers includes foster and adoptive parents. Therefore, this study will include all primary caregivers, rather than focusing on the term "parents." This research study will attempt to answer the question, what are caregivers' perceptions of day treatment programs?

### **Literature Review**

In this literature review I will describe the following themes: a) the population served in day treatment settings and the process of assessing for EBD b) what day

treatment is and its demographics, and c) the importance of family involvement and resources for caregivers.

### **Population**

According to Baek, (2014), emotional and behavioral disorders typically include anxiety disorder, depression, and bipolar disorder. Children with a diagnosis of an emotional behavioral disorder (EBD) are typically in need of attention and support. Those on the severe end of the spectrum need significantly more attention and support (Mendenhall, Demeter, Kowatch, Horwitz, Findling & Frazier, 2011). Behaviors typically exhibited include hyperactivity, aggression, social withdrawal, temper tantrums, extreme fluctuation in emotions, and even self-injury (Mo et al., 2013). Children with emotional and behavioral disorders may display such symptoms within the home, school, or community environments (Mo et al., 2013).

Children diagnosed with Bipolar Disorder are significantly more likely to have severe outcomes such as hospitalizations. According to a study by Mendenhall et al. (2011), children with Bipolar Disorder experience at least one in-patient hospitalization a year, 50% of those children experienced over 30 hospital days a year, and 62% were prescribed psychotropic medications. Of those with Bipolar disorder, 24% to 37% were readmitted to a psychiatric hospital within a year of being discharged. Children ages 11 to 13 with more severe diagnosis of EBD and more than one diagnosis are more likely to experience a hospitalization in their lifetime than those with a depression-related diagnosis (Mendenhall et al., 2011). In fact, studies indicated that 9% of children with an EBD diagnosis experienced in-patient hospitalization, 98% outpatient hospitalization, and 58% consulted with a psychiatrist over their lifetime (Mendenhall et al., 2011). The

mean age for outpatient services for children diagnosed with EBD is 6.3 years, 6.1 for alternative services, 7.4 years for intensive restrictive, and 7.0 years for in-school services (Mendenhall et al. 2011). Mendenhall et al., found that in a study of 370 students, 52% were insured by Medicaid (2011). The children covered by other insurers were significantly more likely to receive more than one service, whereas the 52% were only allotted one service (Mendenhall et al., 2011).

Another serious concern is the effect emotional and behavioral disorders have on a child's success in school. Many children with these diagnoses have lower grades, are more likely to drop out of school, receive detention, or even be expelled (Mo et al., 2013). In many of these cases the child's behaviors are too challenging for the school or parent to manage. Unfortunately, several children with emotional behavioral disorders are at risk for out of home placement (Mo et al., 2013). Studies show they are also more likely to execute delinquent conducts and be involved in the juvenile delinquent system, with property offenses as the most common offense (Sullivan, 2008).

In hopes for improvement and to gain some insight and understanding, the child will be referred to a specialist, such as a psychologist, psychiatrist, or clinical social worker for treatment (Mo et al., 2013). However, because each child is different, there is no way of knowing what is the best age, or how long an intervention should take place (Sullivan, 2008).

### **Assessing for Emotional Behavioral Disorders**

The challenge for professionals is measuring symptoms of these disorders, as there is no objectivity to emotion (Baek, 2014). It is the individual's experience of the symptoms that inform researchers and mental health professionals of the difficulty of

managing the symptoms present (Baek, 2014). As mentioned before, it is difficult to know what symptoms of an emotional behavioral disorder a child or adolescent is experiencing, especially if that child is under the age of ten. In order to receive the most accurate picture of what an individual is experiencing, the mental health professional would be in contact with multiple informants. Having more than one informant is necessary to providing successful psychotherapeutic treatment (Kuglar, 2013). When assessing for an emotional or behavioral disorder, all available sources are sought; sources include the child's teachers, caregivers, and the child (Kuglar, 2013). The term caregiver is used here in place of the parent because research has found it is common for children with emotional and behavioral disorders to not have biological parents available (Kuglar, 2013). The biological parents could be unavailable due to the child being removed from the home. The parents may be suffering from mental illness, traumas, homelessness, or even delinquency. A primary caregiver would be someone who is with the individual on a daily basis and provides all the essential cares (Kuglar, 2013). The caregiver is not necessarily a biological or legal relative, but they are the one that is presenting the closest relationship with the child at that point in the child's life (Kuglar, 2013). Caregivers, whether a biological parent, foster parent, grandparent, other family member, or adoptive parent serve a vital role in the assessment of a child with emotional behavioral disorders, along with the future success of that child in any treatment program. The caregiver can observe a child's behaviors, experiences with others, activities of daily living, language, and emotions (Kuglar, 2013). These observations are essential to establishing the most effective interventions, and continually revising those interventions to serve the child best. Many children, who have been referred to day treatment programs

for emotional and behavioral disorders, have also experienced maltreatment and trauma exposure (Vanderplouq, 2009).

### **Day Treatment**

Children who are diagnosed with emotional or behavioral disorders are most often removed from traditional classroom environments as their behavior may interfere with their own, or others learning. Studies show there is a critical need for services and delivery of services in alternative education systems for children with EBD (George, George, Kern & Fogt, 2012). There are significantly more alternative education schools in the country than what was expected thirty years ago. The problem lies in the fact that many alternative education programs are not assisting children in succeeding in school, or in managing their diagnosis. In saying that, when state directors were asked to point out alternative education programs that had excellent programs for children with emotional or behavioral disorders, 40% could not identify a program rated excellent. Research shows an effective alternative is “school-wide positive behavior interventions and supports” (George, George, Kern & Fogt, 2012). In a longitudinal study by George, George, Kern and Fogt, children who were involved in this program showed positive outcomes due to the effective strategies used and that are also suggested (2012). Studies show that about half of all children with EBD use in-school services, and half use both outpatient and in-school mental health services (Mendenhall et al., 2011). One study indicated that in-school therapy may also be an effective therapy option, however children who self-refer have the best success as they typically experience higher levels of distress and improve the most (Sherr & Lorraine et al., 1999).

The traditional education system may not be most effective especially for children with EBD due to the lack of positive praise from teachers (Sutherland, Wehby & Copeland, 2000). One study of 379 hours of direct classroom observation in schools varying from urban to rural areas in four states, found teachers in a typical classroom offered 4.4 praise statements per hour (Sutherland, Wehby & Copeland, 2000). However, in a classroom with children with EBD teachers offered only rates between .02 and .04 praises per hour (Sutherland, Wehby & Copeland, 2000). The most effective praise would be behavior-specific. Teachers should praise only positive behavior and as often as it happens, so the student may learn to shape positive behaviors. One study found that for children between the ages of nine and sixteen, more than one third will meet requirements for a psychiatric disorder (Vanderploeg et al., 2009). Unfortunately, the majority of these children will not receive the treatment they need for a healthy development (Vanderploeg et al., 2009). Services currently available to children and adolescents include after school therapy, day, outpatient, and residential treatment, and the most restrictive being hospitalization. Vanderploeg et al. conducted a study that identified the need for extended day treatment so that children and adolescents would be able to stay in their homes, attend a typical school setting, and be active in the community (2009). Studies show day treatment has improved symptoms in children and adolescents and has made it more likely that they will attend school and be involved in the community (Vanderploeg et al., 2009). Therapy received in day treatment improves the internal and external behaviors of children and adolescents, depressive symptoms, and in turn their self-esteem (Vanderploeg et al., 2009). Day treatment has been shown to

positively progress the social, emotional and behavioral functioning for children and adolescents (Vanderploeg et al., 2009).

Day treatment includes: “comprehensive assessment, treatment planning, structured therapeutic organization, psychiatric evaluations, family therapy, parent training, group therapy, individual therapy, 24 hour crisis services, therapeutic recreation services, youth development activities, and discharge planning” (Vanderploeg et al., 2009, pg. 9). It is a more restrictive placement for children with emotional and behavioral disorders, and the services are individually organized to each child (Gagnon & Leone, 2006). Day treatment is a service that professionals who specialize in EBD agree is necessary to the treatment of children who have such diagnoses (Gagnon & Leone, 2006). Day treatment provides special education and therapy for children along with support for parents and caregivers.

Gagnon and Leone (2006) found a study conducted in 2002 that showed about 80,000 students with an emotional or behavioral disorder diagnosis received residential or day treatment services. Then, in 2006, they discovered that the number had risen 13% within the past ten years (Gagnon & Leone, 2006). The study showed 77% of children who receive day treatment continue on to a typical school setting (Gagnon & Leone, 2006). Studies show most children in day treatment have a diagnosis of emotional and behavioral disorders. One study suggested children with these diagnoses are most likely to have experienced neglect, abuse and the legal system (Gagnon & Leone, 2006). There are high rates of physical, sexual and emotional abuse, and neglect as part of these children's histories (Gagnon & Leone, 2006). Many individuals who receive day

treatment are in the foster care system. With that, many of the psychiatric issues they experience are due to dysfunction in the family (Gagnon & Leone, 2006).

Kuglar et al. (2013) conducted a study regarding caregivers and teachers of traumatized children and their agreement on the child's observed behaviors. A sample of 211 children was administered a trauma symptom checklist, the non-parent caregivers were administered the Child Behavior Checklist, and teachers were administered the Teacher Report Form (Kuglar et al., 2013). This study showed there was more agreement in reports regarding the child between biological parents and teachers, than caregivers and teachers (2013). Kuglar et al. believes this may be due to the child's difficulty adjusting to different placements, the people they observe and relate behaviors to can differ between their home and school (2013). The knowledge and experience, in which the informants or observers have of EBD, may greatly differ (Kuglar et al., 2013). Therefore, each observer has a different perspective on what behaviors are important to therapy. For example, a father may see a particular behavior on a daily basis and is now accustomed to that behavior. Not realizing that is not typical for the child's developmental stage, the father may not report it to the mental health professional as an issue or concern. The study by Kuglar et al. (2013) also found informants and teachers tend to agree on and recognize external behaviors rather than internal behaviors. The researchers believe this may be due to the child not experiencing internalized symptoms around particular audiences (Kuglar et al., 2013). For example, when a child experiences night terrors, that behavior may not be observed by anyone and therefore the internalized symptom goes unnoticed. Another example of where a disagreement could occur is when a child's behaviors are less disruptive in the school setting with peers, than the home

environment. Another consideration may be a lack of trust in adults and more comfort in peers of like ages; therefore the child suppresses feelings of anxiousness or depression while at school (Kuglar et al., 2013). Clinicians at day treatment centers need to be aware of these differences in observations in order to individualize treatment plans accordingly (Kuglar et al., 2013). For that reason, clinicians should receive information from multiple informants, and be aware that there may not always be an agreement in the interviews or assessments. The dissimilarities found may lead to further diagnoses (Kuglar et al., 2013). Also, because clinicians' assessments are used to determine proper interventions, it is important that they are well informed in all aspects of the child's life. For example, medically treating a child for anxiety due to symptoms seen at school due to environment and peer interaction, but that child does not show these symptoms at home or daycare (Kuglar et al., 2013).

### **Demographics of Day Treatment**

Studies show concerns in the staffing and training in children's behavioral health. It is suggested that treatment programs have one professional at a bachelor's level for every four children, a clinician at a master's level for every eight children, and one director or psychologist for each program (Vanderploeg et al., 2009). There have been some important changes over recent years regarding the demographics found on teachers of children with EBD. Earlier studies showed half of the teachers are 35 years old or younger, and 75% are females (Kuglar et al., 2013). Those earlier studies also showed about 20% of teachers of children with EBD were not fully certified in teaching (Kuglar et al., 2013). However, there may be differences across day treatment services due to the school or services organizational structure (Kuglar et al., 2013). A more recent study

conducted by Kuglar et al. found a three to one ratio of female to male teachers nationally educating children with EBD, and those teachers were among all ages. About half of the teachers had a bachelor's degree, and half had a master's degree. More than one-third of those teachers held multiple certificates, and only four of the participants had no certification (Kuglar et al., 2013).

The study by Kuglar et al. found students were over representatively African American, with Asian and Hispanic American's being the least represented (2013). Students were found to be mostly male with a four to one ratio to females. The average length of service was two to three years, with the majority of students graduating to a less restrictive school setting (Kuglar et al., 2013). This study also found students to most likely be in foster care, which greatly affects behavior and learning, showing the need for collaboration between day treatment and other social services (Kuglar et al., 2013).

### **Family Involvement**

Studies show that with family involvement, children in day treatment programs are more successful, and the caregiver has a better understanding of their child's needs. Not only does family involvement in the child's day treatment affect the child, but the family as a whole. Cavendish et al. (2014) state the negative convictions parents have of their children are related to the negative family interactions, such as conflict. Conversely, the more positive the conviction of a child, the more likely the parent is to be nurturing and responsive. With this positive interaction the child and the family will experience less conflict. The parent perspective of an importance for support from professionals and other parents, along with knowledge of their child's disorder, and the time in which an intervention is helpful, was found through a longitudinal study (McAleese, Lavery &

Dyer, 2014). In this study, 83 parents participated in an educational course encompassing Autism Spectrum material. Before and after the course, parents were asked to participate in a questionnaire about their knowledge and understanding of their child's disorder, techniques in managing behaviors, and their experience (McAleese, Lavery & Dyer, 2014). The majority of parents expressed significantly positive experiences being involved in this course (McAleese, Lavery & Dyer, 2014). Parents find it beneficial to have support from professionals and other parents, to be further educated on their child's diagnoses and how they can best manage behaviors.

Research shows family involvement in treatment with emotional and behavioral disorders has a positive influence on school and community supports (Swanlund, 2011). Swanlund (2011) conducted a study consisting of caregivers of children with EBD from online support groups. This study showed parents who were satisfied with school professionals and their assistance, were more likely to seek other essential services (Swanlund, 2011). It was also found that these parents wanted more partnerships between the school and community supports. The study found the keys to satisfaction and family involvement were communication, parent stress, and severity of behavior (Swanlund, 2011). Another study by Curtis & Singh found the following factors important to parent satisfaction were: a) treatment, b) parent-professional relationship and c) information-courtesy (1996). Parents feel more empowered when they understand the system of services their child receives (Curtis & Singh, 1996).

Two major issues identified in mental health services are family involvement and family empowerment (Curtis & Singh, 1996). Mental health services should be empowering families to increasingly gain control over their own lives. Empowerment

could include encouragement, involvement in decision making processes, education on the nature of services and service system, process and progress of treatment for their child (Curtis & Singh, 1996). When services for emotional and behavioral disorders work on family empowerment, it has been proven to lead successfully to positive perceptions and outcomes (Curtis & Singh, 1996). The study by Curtis and Singh found parents who were involved in empowerment activities like advisory, political, legal, assistance, organizing and participation scored higher on the Family Environment Scale (1996). This research also showed parents involved in support groups had higher FES scores than parents who were not in support groups (Curtis & Singh, 1996).

One study regarding the correlations in socio-demographics and services used for children with EBD, conducted the Family Involvement Scale and Family Empowerment Scale with families (Curtis & Singh, 1996). This study found mothers perceived themselves to be more empowered and more involved than fathers. Fathers also shared this view of the mother being most involved. The level of involvement could simply be the perceptions of the parents, or the expectations of our society (Curtis & Singh, 1996). Clinicians may take this into account in working with families to provide more encouragement and support for fathers. Lastly, this study found that the more formal of an education that a parent has, the less involved they reported to be (Curtis & Singh, 1996). Researchers believe this may be due to higher expectations for the clinician from those who have a higher education (Curtis & Singh, 1996). Therefore the parent with a master's degree feels the clinician or day treatment center will take care of everything. It is important to note that this research was conducted in 1996, and if there were more recent studies on the subject, there might be quite a difference in results found.

Although the research has shown how important family involvement is, families experience barriers. Some of those barriers include the following: a) parents personal mental health challenges, b) homelessness, c) work challenges, and d) other family stressors (Yamada et al., 2007). A study by Yamada et al. showed mothers experienced higher stress levels than fathers did (2007). The study found a correlation between the mothers stress and problematic behaviors, but not to adaptive behavior or Autistic symptoms (Yamada et al., 2007). With that, researchers point out there are significantly more studies conducted on Autism than Pervasive Development Disorders, even though PDD is more prevalent (Yamada et al., 2007). Other correlations to mother's stress included a child's self-injury and their trouble with classmates (Yamada et al., 2007). Research has found that parents are sensitive to their child's risk taking behaviors and other behavioral concerns. Mothers and youth showed a correlation in child depressive symptoms and risked behavior and mothers stress (Cavendish, Montague, Enders & Dietz, 2014). Mothers perceived their stress levels to be higher than mothers whose children did not show risky behaviors. This related to greater family conflict and parental stress (Cavendish, Montague, Enders & Dietz, 2014). The mothers of children who were receiving special education services reported lower level of conflict in the family than those who needed services but were going without (Cavendish, Montague, Enders & Dietz, 2014). Researchers believe the lower level of family conflict may be due to the family involvement in programs and treatment plans (Cavendish, Montague, Enders & Dietz, 2014).

Studies show that by directly empowering the caregiver, children's emotional and behavioral development can be more supported (Edwards, 2013). As Edwards (2013)

mentions in her study, the concept of a mother laying the base for a child's learned development of emotions and the use of emotions within the family, is supported by the Schema theory (Markus, 1977). "Which highlights the importance of parental perceptions and considering how mothers may establish early internal beliefs, or mental representations, of their children" (Edwards, 2013, pg. 1). A mother's or caregiver's early perceptions affect the way a child learns and develops emotions and emotion-related behaviors. Children require sensitive and responsive caregivers in order to learn emotional regulation, how to appropriately express anger and distress, and social communication (Edwards, 2013). Research shows a correlation between mother's sensitivity and academic success years later (Edwards, 2013).

### **Resources for Parents**

Often a parent will take the blame for their child, or feel guilt for their child's actions. Parents who have children diagnosed with EBD are no different. Crawford and Siminoff found that parents often felt the stigmatization attached to their child and often felt like outcasts (2003). Parents may feel as though they need to fight, argue, or force their way to retrieve services for their children. Other struggles parents come in contact with are therapists or organizations that continually give their case from one person to another, change staff frequently, present empty promises, undermine other agencies or professionals, lack experience, or use language that is belittling to them or their children (Crawford & Siminoff, 2003).

Helpful resources for parents with children diagnosed with EBD included childcare, communication, support and education. Although childcare equipped to manage children with EBD or other disabilities are rare, parents found it would be most

helpful to have more childcare providers or centers with training and experience in working with children with mental health disorders (Crawford & Siminoff, 2003). For communication, parents felt it would be helpful to have someone connect services between the parents, schools and other involved agencies. Support was noticed as an important value to parents, from other parents and from professionals. Due to parents feeling unsupported because of the stigma against their children, they felt it would be best to have support from a group of other parents in the same or similar situations (Crawford & Siminoff, 2003). Finally, education was a barrier to parents. Parents felt they needed resources to receive or continue education for their children after they had been dismissed from a traditional school (Crawford & Siminoff, 2003).

### **Conclusion**

Research has shown that children with EBD suffer from symptoms not easily treated. It is not uncommon for a child with an EBD to have poor grades, serve detention, experience expulsion, be a part of the foster care system, or be in the juvenile detention system. Many children and adolescents are hospitalized due to their severe symptomology. Day treatment programs may be a beneficial intervention for children and adolescents with EBD, and their caregivers. Studies show day treatment has improved symptoms in children and adolescents and has made it more likely that they will attend school and be involved in the community (Vanderploeg et al., 2009). Day treatment has been shown to positively progress the social, emotional and behavioral functioning for children and adolescents (Vanderploeg et al., 2009).

Through this research study, mental health professionals at day treatment centers may find that they are adequately communicating with the caregiver, or that the caregiver

does not fully understand what is being communicated, or there is a huge lack of communication. There may also be a lack of empowerment within the caregiver and family, causing more stress, in which should be resolved. As studies show, when services for emotional and behavioral disorders work on family empowerment, it has been proven to lead successfully to positive perceptions and outcomes (Curtis & Singh, 1996). This study may locate similarities in the benefits of day treatment services, and areas that are in need of improvement. Most importantly, knowing the perceptions of the caregiver allows mental health professionals to start where the client is. Being aware of the knowledge base a caregiver already has, or knowing where improvement can be made, provides vital information for the way services are delivered to children and families involved in day treatment. The best way to reach goals for day treatment services is by involving the caregiver and forming a partnership with them. Therefore, their perception of treatment relates to the success of the intervention itself. Through this study the researcher will be answering the question, "What are caregiver's perceptions of day treatment programs?"

### **Conceptual Framework Methodology**

The empowerment framework "addresses the dynamics of power and discrimination" (Van Wormer, 2007, pg. 34). Empowerment is the interweaving of self-efficacy, critical thinking and then taking action (Van Wormer, 2007). Katherine Van Wormer (2007) describes three main themes in the empowerment framework: a) concern with power, b) critical consciousness, and c) connection (Van Wormer, 2007). Each of these themes can be applied to the work of mental health professionals in day treatment programs working with children with emotional behavioral disorders.

Mental health professionals in day treatment centers will only be fully equipped to start where the client is, if they have knowledge of the caregivers' perceptions on day treatment programs. Clinicians should be aware of the knowledge base a caregiver has on their child's diagnoses and the treatment program in order to provide the best services. Furthermore, without understanding of where the parent is at, it is challenging to know just where the child is psychologically within the home environment. Lastly, it is important for clinicians to empower the caregiver to provide treatment based interventions at home. Treatment based interventions will provide the most effective treatment for the child. When a caregiver feels empowered and has the necessary tools, they are providing the child the best opportunity for a successful future.

Minority groups hold concerns with power on an individual and political basis when dominant groups of people hold power (Van Wormer, 2007). A minority group who may feel such a concern would be caregivers, teachers, and mental health professionals of children with emotional and behavioral disorders. These disorders, and sometimes the causes for them, are not seen in the dominant group of society. This raises concern in how to educate others, individually treat, and politically advocate for those suffering from emotional and behavioral disorders.

Critical consciousness is the drive to change the system through collective action, which becomes powerful (Van Wormer, 2007). It is the awareness of a problem and the action to make a change (Van Wormer, 2007). Families and professionals alike use this critical consciousness when working with children with emotional behavioral disorders, and when advocating for services. Mental health professionals should be assisting caregivers in this process of understanding critical consciousness. By using critical

consciousness, the caregiver might apply interventions at home and in the community with their child.

Connection refers to the gaining of much needed support from others (Van Wormer, 2007). An example of this would be parent or caregiver support groups. When day treatment programs offer a means for caregivers to feel supported by like individuals and families, they may have a better understanding of how the diagnosis affects others in similar ways. They may also find new ways to cope, intervene, or connect to their child with an emotional or behavioral disorder.

The empowerment perspective theory describes the need for social workers to be partners in solving problems and giving the client the tools to be the agent of change. Doing this allows the individual the emotional ability to feel self-gratification (Van Wormer, 2007). According to Van Wormer (2007), empowerment practice takes on three levels: a) feeling, b) ideas, and c) actions. Feeling is about starting where the client is, identifying their feelings of the problem, their emotional reactions and beliefs about the issue, and giving them the power to name the problem (Van Wormer, 2007). The idea level is closely related to the feelings aspect, but is the process of looking at one's self through a fresh lens, after gaining new insight (Van Wormer, 2007). For example, a couple who recognizes the impact of a strained relationship on their child, or a caregiver who recognizes he/she should be more involved, or a mother who realizes she is not at fault for her child's diagnosis. Lastly, the action level is the political realm of making change. The client joins a self-help group, support group or advocacy group (Van Wormer, 2007).

By using the empowerment perspective framework, mental health professionals and social workers, can better serve their clientele with EBD diagnoses. The empowerment framework supports what research has shown related to caregiver perspectives on social services, and on day treatment programs. It illustrates just how vital a caregiver's perspective on day treatment can be. The lack of such knowledge leaves clinicians in the dark, inept to understanding if their services are empowering the client, family, and caregiver. Studies show the most effective and efficient treatment is through collaboration between the clinician and caregiver when working with children with emotional and behavioral disorders. Therefore, mental health professionals need to know how caregivers view services, if the caregiver is willing to cooperate and practice interventions at home, if the caregiver is determined to make a change in the system, and if the caregiver feels supported by peers. It is important that clinicians understand the caregiver's perspective because they can empower their clients to create change.

## **Methods**

### **Research Design**

This researcher used a qualitative research design to obtain the perceptions of caregivers who have children placed in day treatment programs. Although the research reviewed was targeted toward a younger age group of children, others were not turned away for this study. This researcher used an exploratory design with action research theory. Action research theory was used to empower mental health professionals to discover and understand the perceptions of caregivers in which they serve. This was in the hopes that they can empower clients, caregivers, and families. Participant action research theory supports this study because it is based on the inclusion of participants and

stakeholders in order to reflect their perspectives (Drake & Johnson-Reid, 2008).

Stakeholders in this study would include family members, clinicians and other mental health professionals in day treatment settings. The goal of participant action research theory is to complete the research and then participants or stakeholders will carry on the research construction (Drake & Johnson-Reid, 2008). This theory is based on the belief that participants will continue the research when they feel a sense of ownership and have been provided the skills needed to do so (Drake & Johnson-Reid, 2008). It is collaboration amongst all those affected by the research; children, adolescents, caregivers, psychologists, clinical social workers, and day treatment staff (Drake & Johnson-Reid, 2008).

### **Sampling and Sampling Procedure**

A purposive snowballing sample was used to obtain participants for this study. Purposive sampling was used because the researcher had predetermined characteristics being sought in the population (Faulkner & Faulkner, 2009). The researcher recruited three participants who are caregivers of children or adolescents in day treatment programs. The researcher obtained these participants by asking key individuals in the community such as clinicians and case workers, to pass along a flyer to caregivers (see Appendix A). The researcher located these individuals by searching day treatment programs in Minnesota via Google. Then by using the websites' staff directory, the researcher sent those clinicians a flyer and asked them to pass it along to caregivers. The snowball sampling was used once the researcher obtained the first participant. At which point, the researcher asked if the participant knew another caregiver that would be willing to participate in the study as well. The researcher asked that the participant pass along a

flyer to other caregivers. A consent form (see Appendix C) was provided to the participant who read and signed the form before beginning the questionnaire. The researcher explained that there was minimal risk in participating. The risk was that an individual may feel distress related to who will read their response. The researcher informed the participant that only the researcher and the researcher's supervisor had access to participant responses and that all data is confidential. The researcher informed participants of the benefit of a \$20.00 Target gift card for completing the study. Finally, the researcher described the research study to the participant.

### **Human Subject Protection**

The research participants may have experienced concern regarding confidentiality and what their responses would be used for. The researcher protected participants when collecting responses face-to-face by meeting with the participant in a private room within an agency, or a location of the participant's choice. The researcher asked the participants to place responses in an envelope the researcher provided and then the researcher left the room. This was to assure that the researcher was unable to identify individual participant responses. The researcher then provided an overview of the purpose of the study before reviewing a consent form with the participant. The consent form clearly stated in detail what the researcher was asking the participant to do, and the potential risks and benefits of participating in the study. The researcher informed the participant that all identifying information will be kept confidential, and the participant's name, age, and child's name would not be recorded. Should for any reason the questions asked cause the participant distress, the researcher explained and provided a resource handout to the participant (Appendix D).

### **Data Collection**

The researcher used an open-ended interview technique to collect data through a qualitative questionnaire with participants lasting about 15 minutes (Faulkner & Faulkner, 2009). The open-ended interview technique was used because it allows the researcher to ask participants the same set of open-ended questions (Faulkner & Faulkner, 2009). The questions that were asked pertained to the perceptions of caregivers whose children receive day treatment services (see Appendix E). The participants were asked: a) *please list the demographics of your family members*, b) *how long has your child/children been enrolled in day treatment*, c) *how do you feel the program has benefited your child*, d) *how has day treatment benefited your family*, e) *please describe how you are involved in the treatment of your child*, f) *in what ways do you feel empowered to support your child through treatment*, g) *what are some ways day treatment programs can be improved*, and h) *please describe your experience with day treatment and day treatment staff*.

### **Analysis Techniques**

The analysis process began with the researcher reviewing all data collected through the questionnaires. After reading over the collection several times, the researcher used inductive coding strategy to code the questionnaires. Inductive coding is the process of collecting information from observations and quotes, and organizing those into common themes (Faulkner & Faulkner, 2009). The researcher then used the codes to form themes found through the data collection. After reviewing the themes found through the questionnaires, the researcher reviewed the studies found related to the themes.

**Validity and Reliability**

The researcher conducted reliability of the study by using the same questionnaire with each participant. The questions asked remained the same throughout the study to be sure of stability. Each participant received the same questionnaire to be sure of consistency. The researcher conducted validity by using content validity. Content validity was used in order to be sure the questions being asked represent the content being measured. Therefore, the questionnaire appropriately represented the perceptions caregivers have of day treatment programs.

**Findings****Demographics and Length of Treatment**

Three caregivers of children who have received day treatment services participated in this study. Those participants will be identified as Caregiver A, B, and C. Due to confidentiality purposes, the participants were not to put any identifying information on the questionnaires in which they filled out. Therefore, the researcher is unable to identify if they are male or female. Of the three caregivers, two headed a single-parent household, and only was married. The ages of these caregivers ranged from 23 to 47, with the youngest being a single parent and the eldest being a single parent. Two caregivers reported races in the family being African American, and one caregiver reported being White with biracial children, White and African American. The ages of children in the home included: one, two, and four years of age. With the length of receiving day treatment services averaging one year.

**Program Benefits Related to Child**

Overall the researcher has found that caregivers have seen benefits to their children receiving day treatment services, even if it has been a year's time or less. Caregivers were asked the question, *How do you feel the program has benefited your family?* Caregiver A responded, "It has helped my son see other kids with the same issues. It has given him another outlet to deal with issues." Caregiver B's response was, "he is able to express himself more." Then Caregiver C responded, "I believe it has helped my child so far but still have some behavior problems but his speech has worked really well." Benefits noticed by the caregivers ranged from social to communicative and even emotional support through peers. It is interesting to note the Caregiver's responses such as, "another outlet to deal with his issues." Responses that may infer a responsibility for the child to cope with experiences or disorders may be an indication of attachment concerns. The researcher finds such statements important for clinicians to be aware of as it may relate to a need for psycho-education with caregivers as they may not understand what a child with an emotional behavioral disorder is experiencing, or how their behaviors are related to attachment. It is also important to note that each caregiver saw a benefit to day treatment services.

**Program Benefits Related to Family**

The researcher found continued benefits of a child being involved in day treatment, through the family system. Caregivers feel supported through these services stating, "it has given us more resources" (Caregiver A). Other caregivers found relational benefits such as, "It has helped us to understand him" (Caregiver B), and "it has been fine, I really enjoy having my son in this program" (Caregiver C). Although caregivers

did not go in-depth into these benefits they have seen throughout their family, there is great strength in what was reported. Day treatment services provided caregivers and their families with resources, increased understanding, and appreciation. It would be interesting to know for what reason Caregiver C enjoyed having his or her son in day treatment. It may be because the child's behaviors improved at home, the child is happier, or the caregiver finds the time the child is at day treatment a source of relief. Each of these reasons may be useful to practitioners in knowing where the client is, and how the caregiver views services. There is strength in noting day treatment has provided more resources to families. Some caregivers may have struggled locating or affording services in a large system, therefore these resources may act as a great relief. Increased understanding may relate not only to the caregiver, but possibly any siblings, or others involved in the child's life that does not include the primary caregiver. If clinicians are able to provide understanding to the caregiver, they may then inform others connected to the child receiving services. Increased understanding is strength because it may also provoke empathy for the child and the experiences in which they have had. Understanding may also provide knowledge and therefore confidence in the caregiver, allowing them to not feel lost, confused, or as frustrated. All of these strengths in which caregivers reported increase the positive feelings throughout the family system. Those positive feelings create a more nurturing environment for relational and skill building to occur.

### **Caregiver Involvement**

When caregivers were asked to describe how they are involved in the treatment of their child, they responded: "meeting with entire care team, planning, and organizing all

aspects" (Caregiver A), and "I am his mother and support him through it all" (Caregiver C). Through these responses more strength in the caregiver-child dyad stands out.

Although it may be stressful for caregivers to coordinate services and schedules, they report doing so to support their child. Mothers may feel a sense of pride in the care they provide, or in the child themselves. Although Caregiver A's response exhibits some of the stress a caregiver may feel when caring for a child with emotional and behavioral disorder, the vigor of this response shows empowerment. Caregiver A is showing that he or she is involved in the treatment of his or her child, is meeting with clinicians, planning services, and organizing all of these activities. They demonstrate empowerment by taking this responsibility for coordinating services for their child, and by being actively involved in their care. Caregiver B responded to this question by stating, "I am just his foster parent as of now." Through this response clinicians may find there is a need for increasing empowerment in foster parents, supporting them in feeling as important as they truly are to the child. It may also show a weakness in the child welfare system if some foster parents are not feeling the need to be involved in services with children receiving mental health services.

### **Empowerment**

The researcher found a mix of responses to the question; *In what ways do you feel empowered to support your child through treatment?* Caregiver A's response was, "In many ways I feel my hands are tied." Although it is unknown what Caregiver A meant exactly, it is interesting to hypothesize that this caregiver may feel stress coming from others in the child's life such as the other biological parent, and their opinion on how to support the child. Another hypothesis may be Caregiver A feels overwhelmed by their

child's behaviors, and the services necessary for treatment. This may also be worthy of noting a lack of support, or need for more communication between caregivers and clinicians. Caregiver B felt, "communication with staff is a must" in order to support their child, they added, "lots of love and hugs with kisses." Caregiver C reported, "Help him grow in this program by going from not knowing too much, to knowing and speaking well now and working more on behavior." In general these caregivers felt a source of empowerment was being provided. Although this source is not named in responses, it is important to note caregivers show a desire to support their child whether it is through affection, or helping improve in the day treatment program itself. A note for clinicians is to improve or continue strong communication with caregivers as Caregiver B reported it "is a must."

### **Improvements**

Requests for day treatment improvement varied greatly in the responses given to the question, *What are some ways day treatment programs can be improved?* Caregivers suggested more educational aspects, behavioral interventions, and communication. Caregiver B felt, "to help learn their letters and numbers, their name, daily lifetime things they're going to need to know," would improve the service. Caregiver C was more concerned about emphasis on behavior, "I would just say for my child to work more toward his behavior." It is important to note here that the researcher found a theme in Caregiver C's responses that may allude to the child mentioned requiring speech services, which may have been the primary focus before progressing to behavioral interventions. The researcher may hypothesize that it is difficult to make significant behavioral progression without effective communication; therefore speech was the primary goal.

The researcher does not want to discredit the caregiver, as it is very well possible that this child's day treatment program could improve in behavioral interventions.

Communication was noted again, but this time by Caregiver A, "better communication with parent and child." Caregiver A may have intended this to mean communication needed to improve from the clinician to the caregiver and child. Or that communication between the caregiver and child needed to improve. Either intention is worthy to note as an improvement to be made in day treatment programs.

### **Experience**

Caregivers were asked to describe their experience with day treatment and day treatment staff. The majority gave positive responses reporting, "the staff are wonderful" (Caregiver B), and "I enjoy having my child in the treatment program. I enjoy the staff who are very supportive and they also have good support with my child, I will recommend this to someone else" (Caregiver C). Some negative experiences were reported as well, such as long waiting lists or miscommunication. Caregiver A reported, "There have been ups and downs. A major issue I have had was with communication and follow-through. Staff acted as if they really cared and then suddenly backed away with no explanation." These experiences also help clinicians in noticing ways that services can be improved. Whether these experiences are coming from single episode or continual experiences, wait list time, follow through, and communication in treatment planning could be improved.

### **Conclusion**

Each caregiver brings their own perspective to the questionnaire, and each caregiver comes from a different background, and has differing challenges. Knowing

that, and keeping in mind that this study was conducted using a questionnaire and not a face-to-face interview, the significance of the responses and the intentions of each response are hypothesized by the researcher. The two themes found among all three caregivers' perspectives was support for the child, and communication. Each caregiver mentioned that day treatment programs provide support either for their child, or for the family. Communication came up as a need for improvement between clinicians and caregivers and possibly between caregiver and child. Caregivers were empowered to be involved in communication with professionals, however, may require additional support in doing so. Many caregivers experience daily stressors and therefore may be supported through reminders or written communication.

## **Discussion**

### **Introduction**

Studies show day treatment has improved symptoms in children and adolescents and has made it more likely that they will attend school and be involved in the community (Vanderploeg et al., 2009). Many day treatment programs include services such as case management, speech therapy, occupational therapy, individual psychotherapy, skills work, and family-relational therapy. Day treatment has been shown to positively progress the social, emotional and behavioral functioning for children and adolescents (Vanderploeg et al., 2009). Studies show that with family involvement, children in day treatment programs are more successful, and the caregiver has a better understanding of their child's needs. Not only does family involvement in the child's day treatment affect the child, but the family as a whole. When services for emotional and

behavioral disorders work on family empowerment, it has been proven to lead successfully to positive perceptions and outcomes (Curtis & Singh, 1996).

The researcher found the following themes among the participant responses: a) program benefits to child, b) program benefits to family, c) caregiver involvement, d) empowerment, e) improvements needed, and f) positive experience with day treatment programs. Similarities occurred among the importance of communication between caregivers and professionals, and between caregiver and child. Each caregiver gave a response related to the support they have received through the day treatment program, or how they support their child. Finally, day treatment programs have shown to be beneficial to not only the child's well-being, but also the family's resources and other services.

First, responses showed a theme related to how the program benefitted the participants' children. Studies show therapy received in day treatment services improve the internal and external behaviors of children and adolescents, depressive symptoms, and in turn their self-esteem (Vanderploeg et al., 2009). It is a more restrictive placement for children with emotional and behavioral disorders, and the services are individually organized to each child (Gagnon & Leone, 2006). Day treatment is a service that professionals who specialize in EBD agree is necessary to the treatment of children who have such diagnoses (Gagnon & Leone, 2006). As seen among these studies, there are many benefits to a child with EBD receiving day treatment services. This study correlates with previous studies in stating there are benefits to day treatment programs. However, findings in this study indicate that children in day treatment programs are able to see they

are not alone in their experiences. As one caregiver reported, it has provided his son with the opportunity to see other children who are learning to cope with similar disorders.

Second, responses showed a theme related to program benefits for the family. Many individuals who receive day treatment services are in the foster care system. With that, many of the psychiatric issues they experience are due to dysfunction in the family (Gagnon & Leone, 2006). Each participant in this study noticed day treatment services for their child has also been beneficial to their family, including the participant who was a foster parent. As previous studies discuss a dysfunction in the family system when a child has been placed in foster care, findings in this study support the importance of day treatment services. Families experience more positive regard toward one another creating a more nurturing environment. Cavendish et al. (2014) state the negative convictions parents have toward their children are related to the negative family interactions, such as conflict. Conversely, the more positive the conviction of a child, the more likely the parent is to be nurturing and responsive. This supports the data that caregivers notice benefits for their families through day treatment services.

Many children in day treatment programs may exhibit more aggressive behaviors either at home or at school. Kuglar et al. considers this may be due to the child's difficulty adjusting to different placements; because the people they observe and relate behaviors to can differ between their home and school (2013). The knowledge and experience in which the informants or observers have of EBD may greatly differ (Kuglar et al., 2013). Therefore, findings in this study may add to the existing literature that it is caregivers' perceptions that day treatment services are beneficial to the family. Services are beneficial because they provide psycho-education so that caregivers may have a better

understanding of their child. With that understanding there is a sense of relief that the caregiver is not to blame or that they can be included in their child's healing. Previous studies have found helpful resources for parents with children diagnosed with EBD included childcare, communication, support and education. This study supports caregivers' perception that day treatment programs have resources for the family as a whole. These resources may include family therapy, transportation, or case management.

Third, caregiver involvement and empowerment were common themes. Research shows family involvement in treatment with emotional and behavioral disorders has a positive influence on school and community supports (Swanlund, 2011). Findings in this study support previous research indicating how caregivers were involved in many ways; from coordinating services for their child, to providing affection and support.

When services for emotional and behavioral disorders work on family empowerment, it has been proven to lead successfully to positive perceptions and outcomes (Curtis & Singh, 1996). A study by Curtis & Singh (1996) found the following factors important to parent satisfaction: a) treatment, b) parent-professional relationship and c) information-courtesy. These were common themes within this study as well. Caregivers perceived that they were involved and empowered through communication and support. Parents feel more empowered when they understand the system of services their child receives (Curtis & Singh, 1996). As caregivers in the present study stated, communication is important. Caregivers feel they are both involved in their child's care, and empowered through communication with professionals. Empowerment can also include encouragement, involvement in decision making processes, education on the nature of services and service system, process and progress of treatment for their child

(Curtis & Singh, 1996). A participant in this study supported this finding by stating that they felt empowered through helping their child grow through the program. Studies show that by directly empowering the caregiver, children's emotional and behavioral development can be more supported (Edwards, 2013). This was found accurate through caregivers' common theme of feeling supported by day treatment staff, and by feeling supportive of their child. It may be appropriate to say that these participants felt empowered and involved in their child's treatment.

Finally, suggested improvements and positive experiences were themes in this study. Caregivers perceived staff as wonderful and supportive to them and their child. One participant recommends the services to other caregivers. Although participants had positive experiences with staff, they also recommended some improvements for day treatment services. One participant reported they would like to see more educational aspects incorporated in day treatment. Caregivers felt learning numbers, colors, and daily living skills would be an improvement for their children and would like those skills obtained through day treatment. Another caregiver reported there was a need for improvement with behavioral interventions. It is important to note that while day treatment services improve children's behaviors, each program may have a different theory in which they follow. Some programs may be intensely behaviorally focused, while others may be focused on attachment and psychoanalytic theory. Therefore, there may be differences between each program and child. A study by Crawford and Siminoff found other struggles parents come in contact with are therapists or organizations that continually give their case from one person to another, change staff frequently, present empty promises, undermine other agencies or professionals, lack experience, or use

language that is belittling to them or their children (2003). Findings in this study support this through caregivers' suggestions of increased communication and follow-through. One participant expressed a negative experience in which staff did not follow-through on something that was of importance to them. This could have been a treatment plan, a meeting, or a phone call. Therefore clinicians should note the importance of such follow-through to caregivers and the effects it could have on their experience, and involvement. Another suggestion for improvement, which was not found through previous research, was the improvement of communication between caregiver and child. A suggestion for day treatment programs could be to increase support and education with caregivers on how to communicate with their child. A recommendation for improving communication is by keeping caregivers informed on the language and meanings behind terms used in day treatment. This will allow consistency for the child, and the caregiver can understand importance of therapeutic language.

The researcher will continue to relate reviewed literature to present study throughout the discussion. Many challenges occurred throughout this research which will be critically examined and discussed. Topics of discussion include strengths and limitation to the study, the process of data collection, and implications for further research.

### **Strengths and Limitations**

This study is important because it allows professionals to start where the client is and to see day treatment from the perspective of the caregivers. Studies have shown the importance of family involvement, empowerment, and communication between services. We have yet to ask caregivers what they view as important, or how professionals can

assist them in being involved, empowered and communicate. This study provides mental health professionals the opportunity to understand caregivers' experiences with day treatment programs. It allows professionals with the knowledge of what day treatment programs are doing right, and what areas can be improved. This study is also helpful to the researcher in future work with caregivers and children receiving day treatment services. The information found is useful in knowing how to best empower families, encourage involvement, and be sure there is proper communication amongst services and the family.

A limitation to the study was the sample size. The greater the sample size, the more valid the research findings could be. Another limitation was time. The researcher would be able to collect more participants and data if this study were not time-limited. It was also difficult to get assistance from agencies for collaboration. This may have been due to the agency having their own institutional review board or that the managers were actively working and unable to relay the message to clinicians. With more time the researcher would have the study approved by other IRB's, or met with those in managerial positions to discuss the importance of the study and possibly present the study to other clinicians. In addition, the researcher currently interns at a day treatment program, barring access to families involved at that particular site. A greater incentive may have increased participation. It is a limitation that this researcher did not have a grant and the study was self-funded. With an offer of grand incentives, the researcher may have received more interested parties.

Finally, a limitation to this study was the access to caregivers who have children in day treatment programs. In many cases such families are struggling with financial

stress, are working odd hours, are unable to leave their home, or are busy caring for their children and families. It can be difficult for clinicians to contact caregivers, which makes it even more difficult for a researcher.

### **Process**

The process of recruiting for participants for this study began in November, when the researcher was granted approval from the University of St. Thomas Institutional Review Board. The next morning the researcher began contacting agencies in the metro area via e-mail. The researcher sent e-mails explaining where the researcher was at in the Masters of Social Work program, what the study was about, the importance of the study, and the need for assistance in recruitment. The researcher also contacted agencies in the Winona and St. Cloud areas. Besides e-mails, the researcher made phone call contact with almost ten clinicians from different agencies or programs in attempt to get leads or participants. Other contacts included family, friends, case managers, classmates, students, supervisors, and colleagues. Often, the researcher would receive hopeful responses however, nothing came of them. A month later, the researcher again sent out e-mails to the same clinicians as a reminder, and broadened the search by directly e-mailing clinicians who were listed on agency directories. The researcher also asked assistance from committee members who graciously contacted at least six of their connections, in which the researcher followed up with each one.

Classmates also assisted in offering leads to clinicians or caregivers, whom the researcher also e-mailed or called. The researcher contacted previous 682 students who had experience in day treatment settings, or were currently interns at a day treatment program. Furthermore, the researcher asked several day treatment programs within a

particular agency to place flyers into children's backpacks, providing the caregiver the opportunity to accept or deny the invitation without any coercion. It is the researcher's knowledge that one clinician certainly did place flyers in each child's backpack, the others are unknown. The researcher then included this as a suggestion in further contact with clinicians.

Each time the researcher made contact with a caregiver, the researcher asked that the caregiver pass along a flyer, or spread the word about the study and the incentive to participate. Participants responded to the researcher in two ways. They either made a positive statement with implication that they knew of someone interested, or would state understanding, but did not have a referral. Some caregivers responded to the flyer, set up an appointment to meet with researcher, and then did not show. When the researcher contacted these caregivers, they chose to set up another appointment, and again did not show. The researcher followed up with the caregiver one more time, and did not receive a response.

The researcher continued to make connections with clinicians up until the deadline for gathering data. Some clinicians expressed concern regarding time limitations and not being able to see potential participants until the study was over. Another clinician admitted to forgetting to pass along the flyer or contact the caregiver. Others felt it was too inconvenient to get the study approved by their supervisor in order to pass along to caregivers. Many clinicians did not reply to the researcher at all, and others simply wished the researcher luck and stated this was not something they were able to assist with due to agency policy.

Caregivers may not be easily accessed due to their own financial, time, physical or mental limitations. For instance, they may not have had transportation to meet with researcher. A caregiver may have been physically injured and therefore unable to participate. Another reason for incapability to participate could be inability to speak, read or write English. Many caregivers are suffering from mental health concerns in which could have been a component to lack of participation. All of these barriers affected the researcher's ability to successfully complete the goal of eight interviews. Without the assistance of clinicians, agencies, or snow-ball sampling from caregivers, the researcher was limited to further data collection.

### **Implications for Future Research, Practice, and Policy**

#### **Implications for Research**

The researcher began this study with acknowledgement that it would be difficult to locate and reach out to caregivers of children in day treatment programs. For confidentiality, time, and ease for caregiver purposes, the researcher chose a questionnaire. In future research studies it would be beneficial to interview caregivers face-to-face or over the phone in order to receive more in-depth and detailed responses. An interview would also provide more concrete meaning to findings rather than hypotheses by the researcher. Although the researcher contacted over 25 day treatment programs and clinicians, it is suggested that with more time available, future research could be conducted state-wide. The researcher provided a \$20 gift card incentive, however future research may increase the incentive or provide cash if possible. Another suggestion may be to provide an incentive to clinicians who provide flyers to caregivers. One concern mentioned when accessing clinicians through day treatment programs was

that providing flyers directly to caregivers could be coercive. Therefore, future researchers may want to focus on case managers, and ask that they provide the information regarding the study and that there is no connection to any day treatment program. Finally, an implication for further research could be for individual programs to provide a similar survey, or brief interview at three, six, and twelve months to notice any significant changes. This will also assist clinicians in gauging their own performance.

### **Implications for Practice**

Implications for practice include the emphasis for consistent communication, support in communication between caregiver and child, and continuation of support. It is suggested that clinicians follow through with treatment plans that may have been previously discussed, or that any changes be communicated to the caregiver as soon as possible. Caregivers stressed the need for communication; this may mean gentle reminders for appointments, change in transportation schedule, or how the day treatment session went that day. Another suggestion for practice is for clinicians to assist and support caregivers in communicating with their child. It may be challenging for some caregivers, especially if they are new foster or adoptive parents, to communicate appropriately with a child who is suffering from a mental health disorder. It may be helpful to communicate statements or responses that have worked well in the day treatment session with the caregiver so that they may also provide consistency, and can be confident that this is also working in therapy. Not only will improved communication between caregiver and child be beneficial to the caregiver with the improvement of behavior, but also the treatment for the child will be significantly more effective and efficient. Finally, it is suggested that day treatment programs and clinicians continue

with the support they have provided to caregivers and families. Caregivers' perceptions have shown that they feel supported through such programs, and that this is an area of strength for practice. Support may appear as validation, referral to resources, or encouragement to caregivers. Each of these means of support is important, and should be used consistently.

### **Implications for Policy**

Implications for policy can be provided for the micro, mezzo and macro levels. On a micro level, clinicians should advocate within their agency for changes regarding length of time families are on a wait-list. One participant mentioned this as a means for improvement, and through this researcher's experience it is a common issue among agencies. Clinicians assess an individual or family's needs directly, and then can advocate to higher levels for change, such as within an agency, state, or federal policies. Not only can they advocate, but they can empower the individual or families they work with to advocate for themselves.

On a mezzo level, clinicians need to provide information to agency directors, who then must adjust services to the needs of the clients. Adjustments specific to this study are, the need for support in transportation, reminders, wait-lists, and communication. For example, one day treatment program has found the importance in clinicians' communication among caregivers and other providers. Typically professional engagement is not considered billable hours, leaving no incentive for clinicians to communicate sufficiently with caregivers, educators, or other service professionals. Therefore, this program has created a budget to compensate clinicians for their time doing so.

Finally, it is suggested that clinicians and families advocate for change on a macro level. Families who are involved in day treatment programs experience significant barriers and challenges. The need for affordable day care, or care centers equipped to care for children with emotional and behavioral disorders is significant. Other needs for change include access to services, and transportation to and from services. Caregivers may not live near an agency, and therefore may require assistance in getting to a service provider. Often they experience difficulties with transportation issues. Caregivers might benefit by advocating for improved transportation services in day treatment programs. Many children in day treatment programs have suffered from adjustment disorders. Several reasons for children experiencing adjustment disorders may be homelessness, or frequent changes of environment. This provides us with an insight that there is a need for supportive housing for families. It is another example of a need for change in the child welfare system, as foster children experience multiple settings, without a secure base. Although foster care may be an improvement for many children, the frequent changes of placement are not. Additionally, it is difficult for a family who suffers homelessness to be involved in the services they may need.

Although the data collection for this study is insignificant, there are many implications for policy, practice and further research. Each implication may be considered at a micro, mezzo or macro level and should be addressed by individual clinicians and within agencies as well. The first steps may be to advocate for client needs related to the barriers considered in this study. Then, when individuals collaborate change can happen on a larger scale.

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## Appendix A

# We Need You!

For a research study examining the perceptions of day treatment programs!

- We want to know how day treatment has helped you, your child, or your family. We also want to know ways programs can be improved!
- You will be asked to fill out a very brief questionnaire that will take about 15 minutes.
- Sample Questions: How do you feel the program has benefited your child? What are some ways day treatment programs can be improved? Please describe your experience with day treatment and day treatment staff.

**Participants will be given a \$20 gift card to Target for completing the study!**

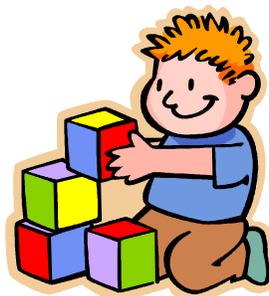
If you have any questions about your rights as a subject/participant in this research, or if you feel you have been placed at risk, you can contact the Chair of the Human Subjects Institutional Review Board, through St. Catherine University at

(651) 690-7739

About the researcher: My name is Julie Lochen and I am in my final year at the University of St. Thomas working towards my Masters in Clinical Social Work. This research project is important because mental health professionals need to know how caregivers view their services in day treatment programs. This study will be my Master's thesis and is supervised by Dr. Catherine Marrs Fuchsel; your participation is greatly appreciated!

**Please e-mail me at: [loch2421@stthomas.edu](mailto:loch2421@stthomas.edu)**

**Or call me at: (320) 282-9348**



## Appendix B

## Researcher Script Before Consent Form

## Caregivers Perceptions of Day Treatment Programs

Researcher's e-mail to clinicians or caseworkers:

Hello,

My name is Julie Lochen and I am an MSW student at St. Catherine University and the University of St. Thomas. For my final research study I would like to answer the question, What are caregivers perceptions of day treatment programs? Through this study I hope to find ways that programs can be improved, along with what is going well, and how clinicians can better empower families. However, I need your assistance in obtaining participants. I will need 8-10 caregivers of children or adolescents enrolled in day treatment programs. I would greatly appreciate your assistance in providing caregivers with the attached flyer. My information is provided on the flyer and the caregiver may contact me from there. Your assistance will significantly affect the outcome of this study and improve our research knowledge related to day treatment programs! Please note, participants will be given a \$20 gift card to Target for completing the brief questionnaire.

Thank you,

Julie Lochen, LSW

MSW Student

When distributing questionnaire to caregiver:

My name is Julie Lochen and I am a student at St. Catherine University and the University of St. Thomas. The purpose of this study is to find caregivers perceptions of day treatment programs. Through this study I hope to find ways that programs can be improved, along with what is going well. I will provide you with a questionnaire that will cover questions regarding how day treatment has benefited your child and your family, how the staff can empower you to support your child, and how we can improve day treatment programs.

(Provide participant with consent form at this time)

Read over consent form and ask if participant has any questions. Please repeat to me the purpose of this study so that I can be sure you understand.

I will now provide you with a list of resources in case you should experience any distress after the completing this study.

(Provide participant with resource form at this time)

I will now distribute the questionnaire; please do not put your name on it as this is a confidential study. If you have questions at any time please do not hesitate to ask. When you are finished please put your questionnaire in the envelope provided. This will ensure that I am not able to identify the responses of individual participants. I would like to thank you again for your participation, your responses will have a great impact on this research.

(Researcher will then leave the room)

If contacted by caregiver via phone call or e-mail:

Hello, my name is Julie Lochen and I am a student at St. Catherine University and the University of St. Thomas. The purpose of this study is to find caregivers perceptions of day treatment programs. Through this study I hope to find ways that programs can be improved, along with what is going well. I will provide you with a questionnaire that will cover questions regarding how day treatment has benefited your child and your family, how the staff can empower you to support your child, and how we can improve day treatment programs.

I will first provide you with a consent form; by completing this survey you are providing consent to participate in this study. From there I will provide you with the questionnaire. You will not put your name or any identifying information on it as this is a confidential study. After completing the questionnaire you will place it in an envelope that I will provide, this will ensure I am unable to identify participants responses. You will then return the envelop to me and I will provide you with a \$20 Target gift card. Where would be a good place for you and I to meet?

Thank you again for completing this study, your participation will greatly impact this research!

## Appendix C

### Information and Consent Form

**Introduction:**

You are invited to participate in a research study investigating caregiver's perceptions of day treatment programs. This study is being conducted by Julie Lochen, a graduate student at St. Catherine University and the University of St. Thomas under the supervision of Dr. Catherine Marrs Fuchsel, Ph.D., LICSW, a faculty member in the School of Social Work. You were selected as a possible participant in this research because you are a primary caregiver of a child or children who are receiving day treatment services. Please read this form and ask questions before you agree to be in the study.

**Background Information:**

The purpose of this study is to gain knowledge on the perceptions caregiver's have of day treatment programs in which their child/children are enrolled. Approximately 8-10 people are expected to participate in this research.

**Procedures:**

If you decide to participate, you will be asked to fill out a questionnaire regarding how day treatment has benefited your child/children and your family, how day treatment staff can empower you to support your child/children through treatment, and what ways day treatment programs can be improved. This questionnaire will take about 15 minutes to complete. This will be a one-time study, so no repetition will be needed. This study will take approximately 15 minutes over one session. You may skip survey questions that you do not want to answer and or may quit taking the survey at any time without impacting your relationships with St. Kate's, the University of St. Thomas and/or any agency that you are involved with.

**Risks and Benefits of being in the study:**

The study has minimal risks. You may experience distress or concern with whom will see your responses. The researcher and research supervisor will be viewing your responses, but no identifying information will be recorded. The researcher will provide all participants with a list of resources should you experience any distress. If at any time you wish to end the study, you may do so.

A benefit of participation is a \$20.00 gift card to Target upon completion of the study.

**Confidentiality:**

Any information obtained in connection with this research study that can be identified with you will be kept confidential. In any written reports or publications, no one will be identified or identifiable and only group data will be presented. No one in the agency will know your responses. Any quotes used from the questionnaires will be identified using pseudonyms, not the participant's real name.

I will keep the research results on a password protected computer and only I and my advisor will have access to the records while I work on this project. I will finish analyzing the data by May 18<sup>th</sup>, 2015. I will then destroy all original reports and identifying information that can be linked back to you.

**Voluntary nature of the study:**

Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future relations with the agency in which your child receives day treatment, or St. Catherine University in any way. If you decide to participate, you are free to stop at any time without affecting these relationships.

**Contacts and questions:**

If you have any questions, please feel free to contact me, Julie Lochen, at (320) 282-9348. You may ask questions now, or if you have any additional questions later, the faculty advisor, Dr. Catherine Marrs Fuchsel (651) 690-6146, will be happy to answer them. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher, you may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739 or jsschmitt@stkate.edu.

You may keep a copy of this form for your records.

**Statement of Consent:**

You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Even after signing this form, please know that you may withdraw from the study.

---

I consent to participate in the study.

---

Signature of Participant

Date

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Signature of Researcher

Date

## Appendix D

## Resources

For questions regarding the research study:

- Julie Lochen, researcher (320) 282-9348
- Dr. Catherine Marrs Fuchsel (651) 690-6146
- Chair of the Human Subjects Institutional Review Board, through St. Catherine University at (651) 690-7739

For support after the study:

- Minnesota Crisis Line 612-379-6363 or toll free 1-866-379-6363
- HopeLine 919-231-4525 or 1-877-235-4525
- Mental Health America: Compassionate Ear, dial 1-866-WARM EAR or 913-281-2251
- Metro Area Mental Health Crisis Lines:
  - Anoka County** 763-755-3801
  - Carver/Scott Counties** 952-442-7601
  - Dakota County** 952-891-7171
  - Washington County** 651-777-5222
  - Ramsey County, Adults** 651-266-7900
  - Ramsey County, Children** 651-774-7000
  - Hennepin County, Adults** 612-596-1223
  - Hennepin County, Children** 612-348-2233

## Appendix E

## Caregivers' Perceptions of Day Treatment Programs

## Research Participant Questionnaire

1. Please list the demographics of your family members (for example: age, race, gender, relation to you).
  
  
  
  
  
  
  
  
  
  
2. How long has your child/children been enrolled in day treatment?
  
  
  
  
  
  
  
  
  
  
3. How do you feel the program has benefited your child?
  
  
  
  
  
  
  
  
  
  
4. How has day treatment benefited your family?
  
  
  
  
  
  
  
  
  
  
5. Please describe how you are involved in the treatment of your child.
  
  
  
  
  
  
  
  
  
  
6. In what ways do you feel empowered to support your child through treatment?
  
  
  
  
  
  
  
  
  
  
7. What are some ways day treatment programs can be improved?
  
  
  
  
  
  
  
  
  
  
8. Please describe your experience with day treatment and day treatment staff.