



STRAINING THE TIES THAT BIND

Limits on Parent-Child Contact in Out-Of-Home Care

Current policy and practice in children's mental health recommends family centered, community-based systems of care that keep children with their families while receiving mental health treatment, rather than removing them from the natural contexts of their family, community, and cultural group. System of care principles also feature individualized services and models of service delivery that wrap services around families as well as a view of family members as partners actively participating in decision-making about their children's treatment.

Despite these advances in community based services, there are still significant numbers of children who are placed out-of-home to receive treatment. In out-of-home treatment, the principles of family-centered services may be less central and parents may find it difficult to maintain active participation in their children's treatment. For example, residential programs often use points and levels systems as a therapeutic technique. Under such systems, the acquisition of privileges is conditioned on positive behavior. Parent child contact may be considered as one of these "privileges", with the result that contact may be denied at any time.

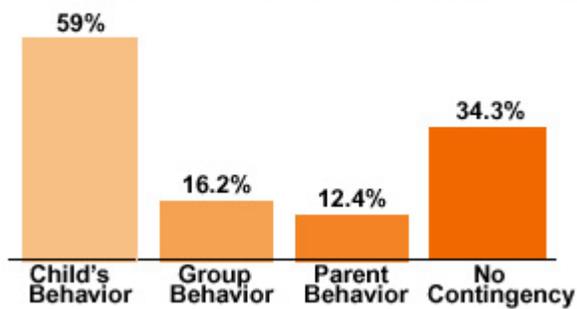
In 1996 and 1997, we conducted a series of focus groups with family members and residential treatment providers. Family members reported that in many residential treatment centers, group homes, and residential facilities, their contact with their children was limited by program policies and staff practices. For example, many parents reported that they were not allowed to have contact for an initial period (frequently 14 weeks) after admission to allow the child to "adjust" to the new environment. Even after this settling-in period, parents reported that agency policy limited visits at the facility, day visits, and home visits as well as telephone contact with their children. Residential program staff confirmed that these practices were common in the facilities they represented.

Such limitations on parent-child contact are a concern in the light of research findings related to attachment theory and the importance of preserving children's attachments as a foundation for the capacity to form caring relationships throughout life (Bowlby, 1988). Further, there is some evidence that maintaining parent-child relationships during out-of-home care facilitates child well-being and more rapid family reunification (Davis, Landsverk, Newton, & Ganger, 1996).

These emergent themes were used as a framework for the development of a larger survey designed to examine the experiences of families participating in their children's mental health treatment, particularly those receiving services out-of-home. A sample of 105 parents with children receiving mental health treatment in residential care facilities, group homes, and psychiatric hospitals or units responded to our survey about their experiences with limitations on parent-child contact. Fifty-seven percent of respondents said that when their child first entered the out-of-home placement, contact was limited for an initial period of adjustment. Fifty-three percent of respondents reported that contact with their children was governed by a levels system. Levels systems were used across treatment settings. Parents whose children were in placements that had a levels system were significantly more likely to have contact limited for an initial period of adjustment, but initial contact was also limited in programs that did not have a levels program. Most families reported that contact was predicated on the child's behavior (59%), but facilities also used unit or group behavior (16.2%) and parental behavior (12.4%) as criteria (see graph 1). For instance, one caregiver reported that she was unable to visit her child because:

[The] group [was] on lockdown... they cancelled my visit that afternoon after [the] hotel was confirmed and paid.

Graph 1. Contingencies for Parent-Child Contact



Parents were also asked if, after an initial adjustment period, there were restrictions on various types of contact. These respondents reported restrictions on telephone calls, visits at the facility and away from the facility, as well as home visits (graph 2). According to VanderVen (1995) the withholding of activities that are at the core of treatment (such as caregiver contact and visitation) “is probably the most frequent—and the most misinformed—misuse of points and levels [systems]” (p. 356). Withholding contact is destructive to the child’s relationships with and commitment to caregivers and agency staff. The practice of withholding contact may stem from underlying agency beliefs that caregivers are the cause of their child’s problems, beliefs that often divide caregiver, agency, and child. One respondent to our survey wrote,

She needed time to “adjust”...they used the time to teach her that I had caused her problems....

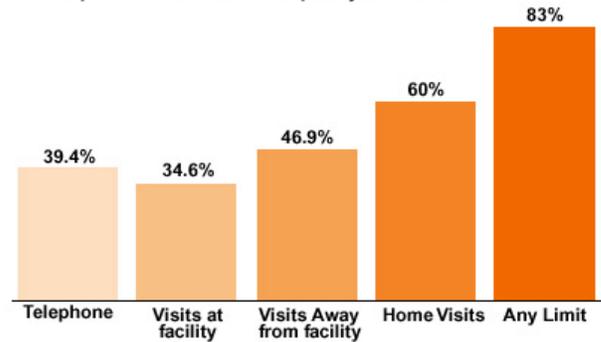
Another wrote,

Do not underestimate the power of the bond between child and family even when it appears dysfunctional. Do not restrict contact between family and child when [the] child is diagnosed [with] Attachment Disorder—I felt I was “pathologized” as “enmeshed” when I protested [after] 2 months total [of] no contact.”

In contrast to practices that limit parent child contact, a large body of research has shown that ongoing contact with caregivers is related to positive behavior of children in care, the child’s ability to adapt to care, and more rapid family reunification in foster care (Davis, Landsverk, Newton, & Ganger, 1996; Noble & Gibson, 1994; Tam & Ho, 1996). Logically, if the ultimate goal of residential treatment is to return the child to the family, then ongoing contact is necessary (Thomlison et al., 1996).

In addition, restrictions are different for children hospitalized for the treatment of mental illnesses than for those hospitalized for the treatment of physical illnesses.

Graph 2. Restrictions on Frequency of Contact



Today, most hospitals not only allow, but encourage parental contact with a child who is to have her appendix removed, but our results show that many hospitals, residential treatment centers, and group homes have rigid rules regarding contact with a child who is receiving mental health treatment.

From our focus groups and survey, it is clear that parents routinely experience limitations in contact with their children. Caregivers’ words indicate that there is much work to be done to make out-of-home treatment family-centered, to reduce the stigma associated with placing a child out of home, to build specific supports for increasing parent participation, and to value the critical significance of parent-child contact. Caregivers’ words say it best.

- Caregivers want to feel respected:
“Honor the parents who suffer chronic grief and stress over the loss of their child.”
- Caregivers ask for specific help with contact:
Treatment facilities need to be flexible in scheduling, especially when parents work and/or live out of town.”
- And finally, parents emphasize the value of contact with their child:
“Parents should be allowed to be as involved in their child’s care in the same way as parents of physically ill children.” “Frequent contact with the child, program staff, program psychiatrist, clinician, caseworker is a must”. “Remember that nobody knows your child as well as you and that subtle changes can be picked up more quickly by the parent and not always by the staff.”

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The National Center on Education, Disability, and Juvenile Justice: A Resource for Families, Educators, and Advocates

The National Center on Education, Disability, and Juvenile Justice (EDJJ) is a project designed to develop and promote more effective responses for youth with disabilities involved in the juvenile justice system, and those at-risk for delinquency. EDJJ, funded by the U. S. Department of Education and the U. S. Department of Justice, represents a major federal commitment to addressing the overrepresentation of youth with disabilities in the juvenile justice system—a longstanding and complex problem.

Youth with disabilities are three to five times more likely than their non-disabled peers to be incarcerated in a juvenile correctional facility. Nationally, about 10 percent of students are identified by the public schools as needing special education. In contrast, most researchers find that 30 to 60 percent of youth in the juvenile justice system have disabilities and require special education services.

The majority of youth with disabilities involved in the juvenile justice system are classified as having emotional or behavioral disorders, learning disabilities, mental retardation, and attention deficit disorders. Other disabilities, such as speech and language disorders and traumatic brain injury, are identified less frequently among this population.

WHY ARE YOUTH WITH DISABILITIES OVERREPRESENTED IN THE JUVENILE JUSTICE SYSTEM?

Disability does not cause delinquency, but research consistently identifies a strong relationship between negative school outcomes and delinquent behavior among youth with disabilities. Various theories have been advanced to explain this link:

- *School failure* and *susceptibility* theories suggest that disability-related characteristics increase the likelihood that youth will demonstrate delinquent behavior.
- *Differential treatment* theory suggests that youth with disabilities are more likely than their non-disabled peers to be labeled as delinquent, referred to the courts, and subject to punitive treatment at every stage of their involvement with the juvenile justice system.

These theories differ in their emphasis on the relative importance of personal characteristics (e.g., deficits such as language impairment or behavioral problems) and contextual factors (e.g., access to appropriate services in school and in the community). However, school failure plays a consistently prominent role in explanations of the development of delinquency.

FOCUS AREAS

EDJJ is developing and disseminating strategies to help youth stay in school and out of the juvenile justice system. A sizeable number of youth entering correctional settings have experienced course failure, suspension, expulsion, and school drop out. While a wide range of academic skills can be found among at-risk and delinquent youth, typically these students have marginal academic skills. Because higher levels of literacy are associated with lower rates of recidivism, education programs for incarcerated youth provide an invaluable opportunity to provide intense instructional services. EDJJ is carrying out research, policy analysis, training, and technical assistance activities in three broad focus areas: preventing delinquency, providing quality education programs for incarcerated youth, and ensuring transition supports as youth reenter their schools and communities.

HOW TO CONTACT EDJJ

The EDJJ staff encourages input from families, educators, school and correctional administrators, and advocates. Your comments can help identify topics for regional conferences and other professional development activities. Resources available through EDJJ are on the website: www.edjj.org.

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