The Perceptions of Therapeutic Staff Support with Children and its Possible Impact on Future Delinquency

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ABSTRACT

This thesis involves exploratory research investigating the perceptions of Therapeutic Staff Support (TSS) workers to examine if they feel effective in the performance of the wraparound services they provide to their clients. Based on the limited literature regarding wraparound services and delinquency prevention, four hypotheses were tested:

H1. Valuable resources available to TSS workers, such as token economy, social stories, and sensory items, will lead to probable success in preventing juvenile delinquency.

H2. The greater rapport a TSS worker has formed with their client, the more likely such workers will be successful in preventing juvenile delinquency.

H3. The more satisfied a TSS worker feels in their job setting, the more likely such workers will be successful in preventing juvenile delinquency.

H4. The more experience and education a TSS worker possesses, the greater the perception of juvenile delinquency prevention.

A total of fifteen Therapeutic Staff Support workers were surveyed (N= 15), and a total of twelve Therapeutic Staff Support workers responded with both the informed consent form and questionnaire. Two of the four hypotheses were supported in that a TSS worker's level of education and experience as well as rapport with their clients effected their perception of client success in preventing delinquency. Although the findings shed light on this topic, future research should include a larger sample for ample generalizability.

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Chapter One

Introduction

Approximately 600,000 offenders are released from jail every year, with thirteen percent of those offenders suffering from a mental health disorder (Chandler, Peters, Field, & Juliano-Bult, 2004). Mental health is an area often neglected in the Criminal Justice System, since it is not as visible as other physical health problems. Medical conditions such as HIV, cancer, and heart disease are often highlighted more so than mental health, due to the visible, immediate need to address them. In comparison to those without mental health disorders, offenders with mental health disorders have been found to be more likely labeled a "repeat offender" and commit more serious crimes (Chandler et. al, 2004). There are visible patterns those with mental health conditions exhibit, such as unpredictable and erratic behavior, that make offenders more difficult to manage while incarcerated, as well as more difficult to supervise after being released (Chandler et. al, 2004).

With respect to mental health treatment, behavioral intervention has been found useful towards controlling childhood misconduct. For example, within prison, inmates with psychiatric diagnoses were found to have more incident reports filed against them than inmates without psychiatric diagnoses (Chandler et. al, 2004). Behavioral problems are typically addressed that prevents serious harm to oneself or those around him or her when intervention in implemented. Chandler et. al (2004) state, "Those with mental health disorders also experience higher rates of homelessness, poverty, lack of education, and problems with employment far greater than those without these disorders" (p. 434).

Once mental health interventions are implemented, offenders learn prosocial skills that may be necessary for successful community reentry (Chandler et. al, 2004).

Twenty percent of jails still do not have available mental health services, and eighty percent of jails do not require training related to mental health issues (Chandler et. al, 2004). The quality of mental health services available to those incarcerated is far below national standards; non-medical staff in prisons are often unprepared to respond adequately to mental health crises. There has been an overwhelming need to develop the following programs when it comes to those incarcerated with mental health disorders: diversion from certain issues which could escalate for those with mental health needs, coordinated care of those incarcerated with mental health issues, and community transition programs for when those incarcerated are released back into the community (Chandler et. al, 2004).

Since knowledge of mental health disorders within the criminal justice system seems to be sparse, there is not a great amount of attention given to those with mental health disorders before becoming incarcerated. Many adults now within the criminal justice system also experienced the same disorders as they did as youth (Embrett Randall, Longo, Nguyen, & Mulvale, 2015). The transition and bridging of a child with a mental health disorder into an adult with a mental health disorder is typically never seamless. Many of these youth, even today, have found themselves without the professional help they need. Since these youth have not received the mental health care they require, this often leads to increased health risks upon entering adulthood (Embrett et. al, 2015).

A recent study has shown that the use of mental health services declines by forty-five percent once youth reach eighteen to nineteen years of age (Embrett et. al, 2015).

The use of mental health services in turn increases slightly after the age of twenty, but it never quite reaches the initial level. This is partly because some youth no longer are eligible to receive the same mental health services they once were accustomed to when they were considered children (Embrett et. al, 2015). If more attention were given to children with mental health disorders, there may be a greater chance there would be fewer adults incarcerated.

Statement of the Problem

Between 4.5 and 6.3 million youth have what are considered "severe emotional disorders"; this number continues to grow yearly (Chitiyo, 2014). Marcenko, Keller, and Delaney (2001) explain how children's behavioral problems are typically recognized around the age of five, and the most common behaviors to raise the concern of those taking care of these children are "physical aggression towards others, property damage, or verbal threats" (p. 219). According to Weiner, Leon, and Stiehl (2011), children are eight times more likely to have a mental illness when they are placed within the foster care system.

Only 50% of children with a serious mental illness have access to or contact with mental health professionals (Mendenhall, Kapp, Rand, Robbins, & Stipp, 2013). According to Copp, Bordnick, Traylor, & Thyer (2007), "21% of children and adolescents aged 9-17 are diagnosed with a mental health or addictive disorder that causes at least minimal impairment in daily functioning." (p. 723). Anxiety, disruptive, and mood disorders are the most dominant diagnoses for these children and adolescents (Copp et. al, 2007). For a child to meet the criteria of having a severe emotional disorder, he or she must have

> significant mental health symptoms and functional impairments that interfere with daily life, which have persisted for at least 6 months and be expected to persist for a year or longer, and be involved in two or more service systems to include mental health, juvenile justice, child welfare, social services or special education (Mendenhall et. al, 2013, p. 105).

A severe emotional disorder within a child is not very simple to diagnose, but when paid attention to and diagnosed properly, can be managed. A functioning child with behavioral and emotional management skills likely leads to a functioning adult with those same skills (Kerker & Dore, 2006).

Mental health problems are the result of many different factors: the family, the environment of the child, and the primary caregiver of the child.

> Child-related factors associated with poor mental health include difficult temperament, poor physical health, and being male. High-risk family factors have been identified as low socioeconomic status, marital discord, family dysfunction, single parenthood, and large family size with close birth spacing. Caretaker factors that put a child at risk include limited education, mental illness, drug or alcohol addiction, violence in interpersonal relationships, and a history of criminal behavior. (Kerker & Dore, 2006, p. 139).

The likelihood of mental health problems are greater when there are multiple risk factors (Kerker & Dore, 2006).

Roughly 160,000 juveniles are sentenced to jails, prisons, and detention centers annually (Chandler et. al, 2004). In 2013 alone,

> Over 30 million youth in the United States were under the jurisdiction of the juvenile justice system and during that year, departments of juvenile justice processed 1,058,500 new cases with more than half of the cases handled with formal petitions through juvenile court. (McCarter, 2016, p. 250).

Thousands of these offenders are then released back into their home communities every year. While many of these offenders are released, there are some factors that need to be considered upon their return to society. Mental illness, substance abuse, criminogenic thinking, and behavior therapy are all complex needs of these juveniles; unfortunately, not all of these needs are always met. Mental health and substance abuse are often left out. (Chandler et. al, 2004).

Pullmann, Kerbs, Koroloff, Veach-White, Gaylor, and Sieler (2006) address how twenty percent of the youth within the juvenile justice system qualify as having a serious mental health disorder. This is double the rate in the general youth population; 60% of males and 68% of females within juvenile detention centers throughout the nation met diagnostic criteria of having a functional impairment for one or more psychiatric disorders and 67% of these youths have a co-occurring disorder (p. 376). Mental health is clearly a demanding issue within the juvenile justice system after viewing these statistics.

According to Pullmann et. al. (2006), 83% of youth with delinquent behaviors have shown signs of a mental disorder. The juvenile justice system is not equipped to treat and manage the co-occurring behaviors in these youth; being able to manage one of these behaviors is difficult enough for the system. Due to the lack of accessible mental health programs throughout the country, the juvenile justice system has become more or less the, “default mental health service provider for youth with severe problems” (p. 376).

Pullmann et al. (2006) state, "less than half of juvenile justice settings provided access to mental health services beyond screening and medication management" (p. 376).

According to McCarter (2016), "adolescents with lower levels of engagement at school were more likely to engage in delinquency" (p. 251). Engagement includes relationships with peers and adults, as well as involvement in social activities or academics. When youth are unable to make connections with others, there is a chance they will then develop antisocial behaviors or attitudes and this in turn can lead to detachment and delinquency (McCarter, 2016).

The systems of care (SOS) model, which includes wraparound services, is designed to provide aid to children in their natural environments and decrease the chances of the child being sent to detention facilities. For the systems of care model to be implemented successfully, the wraparound process tends to be the driving force behind this operation. The wraparound process has also been deemed as "one of the best and cost-effective interventions to prevent out-of-home placements for children with emotional or behavioral problems" (Chitiyo, 2014, p. 105). Children utilizing wraparound services have been less likely to recidivate in future years than those not involved in wraparound services (Pullmann et. al, 2006).

Purpose of the Study

The reason for this project is to better understand those who provide wraparound services, specifically Therapeutic Support Staff, and the perceptions they have with respect to their clients' behavioral health and potential for delinquency. The author has been a Therapeutic Staff Support worker for over two years, and has witnessed the mixed opinions these co-workers have regarding their clients' well-being after being discharged

from services. There has not been an extensive amount of literature written on this topic, so contributing findings on this topic will be beneficial not only to those within the field itself, but for future studies done on wraparound services, as well.

Wraparound services are fairly new, only being implemented approximately twenty years ago (mid 1990s), hence there is limited information on the outcomes these services provide. This project adds to that collection and could be used for future scholarship, if desired.

Chapter Two

Literature Review

Wraparound Services

According to Duckworth, Smith-Rex, Okey, Brookshire, Rawlinson, Rawlinson, Castillo, and Littler (2001), a wraparound system is a "needs-driven process for creating and providing services for individual children and their families" (p. 54). The systems theory is the most relevant theory in relation to determining what services a child will need. The systems theory "spotlights family values, priorities, and needs within a responsive, hierarchical, and methodical environment" (p. 55). Family values, priorities, and needs will differ for a variety of reasons, whether that may be culture, environment, or even religious, among others. For example, a family of six struggling to make ends meet and living in a two-bedroom apartment in New York City would have different needs and priorities than an affluent family of three living in a five-bedroom house in a suburb of Los Angeles.

There are many steps one must take before a child can obtain wraparound services. First, special education services are typically granted within the classroom (see Table 1). The steps that typically take place within the school setting for a child to receive special education services are typically the same throughout the country. First, the teacher within the classroom notices a behavior problem that interferes with a child's progress; the teacher then tells the school principal or school psychologist, which is known as a referral. The school psychologist then observes the child for a certain number of days and gives the child several tests. These tests are then used to determine if the child's behavior fits into the "emotional disturbance" category. If the child's behavior

does in fact fit this label, an individualized education program (IEP) meeting is set up with the child's parent(s), teacher, and principal, among others. Upon reaching an agreement, special education services are then granted to the child (Duckworth et. al, 2001).

After receiving special education services, it is then determined whether additional services are needed, as well. After the school agrees that this is necessary, a referral to a child psychologist takes place and an evaluation is conducted. From there, the psychologist determines whether wraparound services would be beneficial for the child, and then refers the parent to specific behavioral health agencies where the appropriate assistance can be provided. This whole process tends to be lengthy, averaging around three months from start to finish (again see Table 1).

Table 1

Teacher notices behavior problem that interferes with child's progress →	If teacher finds it necessary, then tells principal or school psychologist about behavior problem →	School psychologist observes child for a certain number of days →	Tests are given to the child in order to see if the child fits into an "emotional disturbance" category
An Individualized Education Program (IEP) meeting is set up with the child's parents, teacher, and principal →	Special education services are granted to the child →	School agrees additional services are needed, as well →	Referral to child psychologist takes place

Evaluation takes place →	Psychologist refers wraparound services for the child →	Psychologist refers parents to specific behavioral health agencies where appropriate help can be provided →	Child receives wraparound services from referred behavioral health agency

The wraparound process not only produces positive outcomes for children experiencing complex challenges, but also for the families of the children (Mears, Yaffe, & Harris, 2009). One in ten children suffer from a severe mental illness (Della Toffalo, 2000). Within wraparound services, adherence to prescribed treatment hours within a wraparound service setting are not necessarily related to behavioral outcomes. These behavioral outcomes are related directly to the *intensity* of services provided (Della Toffalo, 2000).

Prescribing children greater treatment hours are not necessarily beneficial to the mental health of these individuals. Della Toffalo (2000) explains what treatment integrity is, "the degree to which a treatment is implemented as planned" (p. 353). This is more important to the treatment plan and the child, as opposed to an increase in contact hours. If the treatment plan is carried out goal by goal and objective by objective, there will likely be a decrease in behavioral problems regarding the child. Based on the work experience this author possesses, this is true if there are only fifteen hours of treatment prescribed per week, or if there are thirty-five hours of treatment prescribed per week. On the contrary, if there are forty hours of treatment prescribed per week, but the treatment

plan is not carried out goal by goal and instead is carried out to the will of the TSS, there will likely be an increase in behavioral problems on the child's part.

The following elements are of utmost importance when working with children with behavioral needs: a strengths-based approach to children and families, family involvement in the treatment process, needs-based service planning and delivery, individualized service plans, and an outcome-focused approach (Kamradt, 2000). Without all these elements, a child in wraparound services cannot thrive the way they could if all these elements were present. For example, if a child's treatment plan was lacking a strengths-based approach and needs-based service planning and delivery, the Therapeutic Staff Support delivering services would likely do something to simply occupy the time allotted, such as constantly play board games with the child, or allow the child to play video games or watch television. A child whose treatment plan does not lack any of these elements would show improvement throughout each session, because his or her needs would be addressed through the strength of the individual child (such as through interacting well with peers or reading a social story), with a major goal in mind. According to Kamradt (2000), care coordination, a mobile crisis team, the child and family team, and a provider network are the broad components that make up the wraparound process throughout the country, as opposed to the wraparound process in Pennsylvania.

The Pennsylvania System of Care Partnership published a System of Care and High Fidelity Wraparound Intake in September of 2016 with data regarding juveniles who have been provided wraparound services. The data obtained are from 726 youth from 13 counties within Pennsylvania, with a variety of 12 and 24-month outcomes.

Conduct and delinquency were the largest of the presenting issues, with a percentage of 49.2%, and substance abuse was the lowest, with a percentage of 14.6%. Mood disorders were the largest of mental health diagnoses, with 53.8%, and substance abuse disorder was the lowest of mental health diagnoses, with 4.5%. The average family income was between $10,000 and $14,999. Strengths and family-driven factors were of utmost importance, with an 83.0% rating, and natural/community supports were of lowest importance, with a 67.7% rating (Pennsylvania System of Care Partnership, 2016).

Yohannan and Carlson (2017) state that there is no attention given to wraparound service treatment results across economically diverse youth groups. They also go on to say, "the majority of research conducted on addressing mental health concerns have been based on individuals of the dominant race and culture" (p. 430). Yohannan and Carlson (2017) conducted a study which suggests there are high levels of attrition within wraparound services and they explained how these special concerns needed to be addressed via treatment fidelity, which is the loyalty of everyone involved regarding the services provided… "if there are high rates of fidelity, outcomes are better for the youth involved in wraparound services" (p. 436).

Oser, Knudsen, Staton-Tindall, and Leukefeld (2009) state, "Individually tailored services may improve the offender's health and increase public safety by reducing recidivism" (p.S82). Wraparound services are designed to positively impact post-treatment outcomes; these services are "psychosocial services that treatment programs may provide to facilitate access, improve retention and address clients' co-occurring problems" (p. S83). Wraparound services are often a lengthy process, averaging around

three years of treatment before completion and discharge is granted; they have also been shown to make a large difference in clients' lives (p.S83).

Effectiveness of Wraparound Services Throughout the Nation

Fries, Carney, Blackman-Urteaga, and Savas (2012) state, "a student drops out of high school every nine seconds" (p. 119). In turn, high school dropouts typically require over $200,000 for costs related to court involvement and needs for social services (p. 119). Similarly only 75% of freshman will graduate from high school within four years (p. 120). As a solution to help children having difficulty in the school setting throughout the country, wraparound services have been implemented in many communities. Intervention is critical to prevent delinquent behavior (Carney & Buttell, 2003). Carney and Buttell state, "multisystem, family-focused, community-based programs to address juvenile delinquency and divert juveniles from the court system are prevalent" (p. 552). Fries et. al. (2012) state, "Wraparound services are offered in many communities in the United States by agencies that are tasked with meeting the needs of high-risk youth who may well end up in out-of-home placements." (p. 121). The wraparound process in these situations tends to identify and support these individual's strengths and encourage goal setting; for example, a child that is a visual learner would learn well from charts with rules or pictures strategically placed where he or she can always see them.

It has been shown that there is a reduction in truancy, problem behavior, as well as academic problems within school districts where mental health services are provided. Coordination that is needed for the delivery of wraparound services is lacking between teachers and TSS workers. Not only may communication be missing, but school and mental health personnel responsible for the children may not have adequate knowledge in

terms of the requirements for their counterparts' jobs. To improve this lack of understanding and communication between the different personnel, the following may help. Before services begin, obtaining and exchanging information between the teacher and TSS worker may be beneficial, as well as outlining the needs of the client, outlining the responsibilities and positives of the TSS, and addressing and resolving differences as professionally as possible (Bugaj & Manning, 2002).

Within this wraparound process, a wraparound facilitator is required; this person acts as a coach and helps the youth identify positive people to support the individual throughout the many steps of stabilizing his or her life. Natural supports (for example, elements within everyday life, such as families or community involvement) are then identified by the youth, and from there paid agency supports are developed. There are four phases of this wraparound process and they are the following: engagement and team preparation, initial plan development, plan implementation, and transition (Fries et. al, 2012). The wraparound facilitator is the one person who is trained to facilitate the youth in the direction of his or her goals; this process averages between three to eighteen months, depending on how motivated the youth is.

Positive youth development is another term used to guide these youth towards certain long-term and short-term goals. According to Bradshaw, Brown, and Hamilton (2008), "Positive youth development is an ecological, asset-based approach that promotes healthy human development through supportive environments and community connections." (p. 209). This is a term that has increased within the past fifteen years, and it is becoming more common for youth with serious behavior problems. This approach tends to stem from a positive approach, rather than a problem-centered approach, as well

as focusing on assets instead of deficits (Bradshaw et. al, 2008). This then leads to the strengths-based assessment, which according to Clark, Lee, Prange, and McDonald (1996), "focuses on the strengths and potentials of the children and their families, while recognizing the problems that exist in their lives" (p. 42). This assessment is typically received rather well among youth, since they feel built up with strengths, as opposed to beaten down with weaknesses.

There is a disconnect between those who take care of children and the children themselves with respect to their need for services (Painter, 2012). These children typically do not see that they require support and help in ways other children do not, that is, until around the twelve to eighteen-month mark of services (Painter, 2006). According to Painter, wraparound services are "the most common method of service delivery adopted by states and communities as a way to adhere to systems of care philosophy" (p. 409). LaPorte, Haber, and Malloy (2014) state "wraparound was recently recommended as a 'best practice' for these youth by a consensus panel report of the Substance Abuse and Mental Health Services Administration" (p. 612). Rosen, Heckman, Carro, & Burchard (1994) found that youths' satisfaction of services were greatly associated with feelings of unconditional care and participation, as opposed to conditional care and lack of participation (p. 55).

There are complications that arise among youth as they age, as well as the emotional support in their lives. For example, Haber, Cook, and Kilmer (2012) state, "studies of youth with mental health conditions and their families suggest that conflict may persist and even escalate as adolescents age, or it may decrease, but due to disengagement of caregivers rather than resolution of associated issues." (p. 455). As

youth approach life transitions, increases in behavior problems can also arise to increasingly strained relationships with parents. As the youth approach adulthood, parents may tend to feel that they are no longer responsible for the well-being of their children, which in turn leads to them no longer feeling the need to support them (Haber et. al, 2012).Youth that do benefit from wraparound services tend to continue to benefit from the support of others well into their 30s; this is because young adults that feel supported by caregivers tend to feel more independent, as opposed to less (LaPorte et. al, 2014).

According to Bruns, Suter, and Leverentz-Brady (2008) the wraparound process is still known to be "on the weak side" due to the application of different designs, such as the Wraparound Fidelity Index (p. 241). The Wraparound Fidelity Index "assesses adherence to the established principles of wraparound for an individual youth and his or her family throughout interviews with multiple respondents." (p. 241). In other words, the Wraparound Fidelity Index measures devotion to the wraparound process, as well as those involved with the process, through interviews conducted with multiple people. The recommendation for its use in federal grant programs and the discussion in research literature was due to the results of studies, success stories from different communities, and the popularity among families based upon this Wraparound Fidelity Index. In turn, these scores have been found to connect results from both children and family, regarding devotion to the wraparound process. (Bruns et. al, 2008).

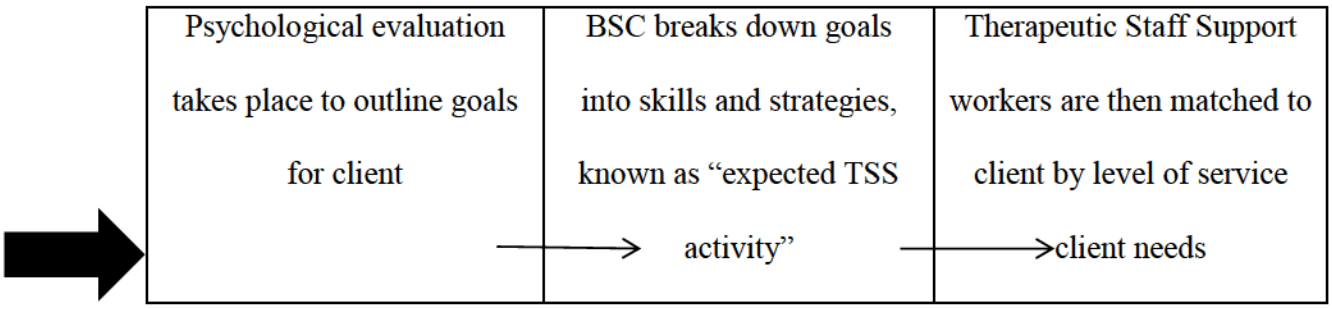
The Role of Therapeutic Staff Support

The position of a Therapeutic Staff Support, or TSS, is an isolated position, developed extensively only in Pennsylvania. While wraparound services exist throughout the country, the specific role of a Therapeutic Staff Support is limited to this one state.

The role of a Therapeutic Staff Support was developed in the 1990s, when wraparound services for Pennsylvania schools and communities were introduced. According to Cautilli and Rosenwasser (2001), the role of a Therapeutic Staff Support is to "provide proactive child management, time structuring, positive behavioral support, and crisis intervention to children with serious mental health diagnoses via a federal entitlement program, Early Periodic Screening Diagnosis and Treatment" (p. 155). The Therapeutic Staff Support is the most commonly used mental health service within schools in the state of Pennsylvania. TSS workers are usually in unfamiliar territory when entering different schools' domains, and work independently without an everyday backing of their agency (Bugaj & Manning, 2012).

The process of how a Therapeutic Staff Support is supposed to be implemented within wraparound services is based on the following (see Table 2 below). A psychological evaluation takes place to create broad treatment goals geared towards the client and family. The treatment team leader, also known as the Behavioral Specialist Consultant, or BSC, then breaks down the treatment goals into individualized tasks based on skills and strategies needed for each client. This results in an hour-by-hour breakdown of what is called "expected TSS activity" (p. 155). The skills of each Therapeutic Staff Support worker are then matched by the level of service each child needs (Cautilli & Rossenwasser, 2001). The way this system currently works is meant to be as comprehensive and strengths-based as possible.

Implementation of Therapeutic Staff Support within Wraparound Services



Many Therapeutic Staff Support workers are not well prepared to handle different levels of emotional severity in clients. In part, this is because of the generalization of the treatment plans and guidance given. Cautilli and Rossenwasser (2001) state, "clear procedures omit the need for empathy, warmth, and individualization such as the tone and type of words used by staff, physical proximity, timing, and gradual increase in child expectations" (p. 156).

Therapeutic Staff Support and Educational Level

The way wraparound services within the school and community work now is all Therapeutic Staff Support workers are considered the same, regardless of experience or education. While the minimum requirements for being a Therapeutic Staff Support are having an Associate's degree with thirty hours towards a Bachelor's degree and three years of paid experience working with children, this person may very well be getting paid equally to someone with a Master's degree and five years of paid experience working with children, depending on the behavioral health agency. With that being stated, there is no set level of experience needed to work with different levels of severity among clients. Someone with no experience and a Bachelor's degree may get assigned a three year old

nonverbal client with autism, while someone with five years of experience and a Master's degree may get assigned a twelve year old client with depression and anxiety.

Orientation and training need to be extensive for potential Therapeutic Staff Support workers to be successful. Initially, a new Therapeutic Staff Support worker needs twenty-four hours of orientation and six hours of on site assessment and assistance training. After that, an additional twenty to forty hours of training are needed within the first year of employment, depending on the agency. After the first year, an additional fifteen hours of training are required annually, regardless of agency. Because there is so much training associated with this position, it needs to focus on the following: behavioral management, social skills training, offering praise, building a relationship, and creating token systems (Cautilli & Rossenwasser, 2001).

Ideally, Cautilli and Rossenwasser (2001) state a certain orientation and training strategy should be implemented for first-time Therapeutic Staff Support workers. This includes the following: information on child behavior management should first be introduced, as should CPR, then information regarding the position and Behavior Specialist Consultants, followed by the assignment of a mentor to each TSS, and finally the introduction of a specific case so the TSS is prepared in how to successfully transition towards focusing on the specific client's needs.

According to Cautilli and Rossenwasser (2001), "Training objectives should have three components, which are *performance*- what behaviors are to be developed, *conditions*- the context that behavior should be displayed, and *criterion*- how will we know that the objective is reached" (p. 158). With the proper training, TSS workers can apply required interventions successfully and can assist in producing stable changes in

behavior. If a TSS does not have the proper training, it can be detrimental not only to the success of the client's behavioral health, but also to the treatment plan. If the TSS does not have the knowledge in what to do, the treatment plan can in turn get delayed several weeks or months to allow the TSS to develop the proper skills.

Along with training, weekly supervision is a requirement, as well. If a TSS has worked less than twenty hours per week, a half hour of supervision is required; if a TSS has worked twenty hours or more per week, an hour of supervision is then required. The weekly supervisions allow the treatment team leader, the Behavioral Specialist Consultant, to grasp an idea of how the implementation of interventions are going and if anything needs to be adjusted within the treatment plan, such as goals or interventions. If this is the case, the BSC will then adjust the treatment plan as necessary. Therapeutic Staff Support workers have been shown to be extremely effective in assisting children to succeed and manage different behaviors within different settings (Cautilli & Rossenwasser, 2001).

The Importance of Job Satisfaction for Wraparound Service Providers

Job satisfaction is a very important part of success; if job satisfaction is not achieved, burnout often happens as a result (Khalatbari, Ghorbanshiroudi, and Firouzbaksh, 2013). Khalatbari et. al. (2013) explain how job stress is a combination of physical, mental, and social stress, which then combines into psychological stress, in relation to specific jobs. Job satisfaction is an important factor in accumulating performance and causing progressive views of a job, which is a connection with salary level, social value of the job, and conditions of the work environment. Burnout, in turn, is a state of getting disappointed and tired easily as a result from a job that may not be

rewarding for an individual. Employed women are more likely to be stressed than men and are more exposed to stress, as well. The more uncommon the work condition, the more likely stress will result from the occupation (Khalatbari et. al, 2013).

Happiness derives from increased positivity; positivity also reduces negativity and apathy. Positivity lowers focus on negative emotions, while having the power to put people's minds at rest and decreasing depression, as well. The more positive employees' outlook and well-being are in regard to their jobs, the lower burnout and turnover rates. According to Hamama, Ronen, Shachar, and Rosenbaum (2012), "Positive emotions encompass an important part of human functioning and a fundamental facet of human life quality that includes happiness, satisfaction, and morale." (p. 733). The more positive one thinks, the healthier his or her lifestyle will be, both physically and mentally. It is also noted that when people feel positive emotions such as happiness, joy, satisfaction, energy, and relaxation, these people will in turn see more possibilities. In contrast, when people feel negative emotions such as fear, worry, hate, guilt, and anger, less possibility is seen and attention is then narrowed (Hamama et. al, 2012).

There are different types of justice that come into play with respect to job satisfaction. These types include the following: organizational, distributive, procedural, and interactional. Organizational justice tends to be called interactional justice within the workforce, and this is because of the way in which supervisors talk and confront employees. If supervisors and employees have positive interactions and a positive professional relationship, organizational justice will then be positive; if supervisors and employees have negative interactions and do not respect each other, the organizational justice within that company will then be very low and negative. In turn, Nojani,

Arjmandnia, Afrooz, and Rajabi (2012) explain that distributive justice is the "fairness of outcomes and results to which an employee will receive" (p. 2900) and procedural justice is "justice that states the fairness of procedures used to determine these outcomes" (p. 2900).

Teachers and those working within school systems, which include Therapeutic Staff Support workers, have a less than average perception of organizational justice and have shown feelings of anger and distrust within the school district they work for. Depending on the school type, the dissatisfaction changes as well. Teachers and employees working in non-profit schools were much more satisfied than those working within for-profit schools (Nojani et. al, 2012). This may be because the primary focus of non-profit schools may tend to be on the children's education, as opposed to fundraisers and events that will help turn the school a profit.

According to Khalatbari et. al. (2006), "job exhaustion is a multidimensional structure with three components of emotional exhaustion; which are losing an individual's emotional energy, depersonalization so the individual is not considered as a human being and feeling a low situation." (p. 862). While there is no connection between job exhaustion and psychological pressure, it is extremely possible for people who are stressed due to work to suffer from job exhaustion, as well (Khalatbari et. al, 2006). Within the mental and behavioral health fields, burnout occurs very often, and this is frequently due to individuals getting minimum compensation for tedious work. While burnout does occur repeatedly in these fields, it is very rare behavioral health agencies have programs in place for employees who are feeling job exhaustion or stress. This then regularly leads to the employee leaving the organization and acquiring a job elsewhere.

While job satisfaction is very important in all organizations and companies, behavioral health agencies and schools would benefit from taking more interest and action. If an employee is dissatisfied with a company or the management they work for, it can take a detrimental toll on many factors, including treatment plans within behavioral health agencies, or learning and education in general within schools. These employees are very valuable, and if these agencies and schools had programs in place to help assure satisfaction from the employees, there could very well be an increasing number of productive employees within not only education, but the mental and behavioral health fields, too.

Overall, mental health is a topic that should be of more importance within society, but with the implementation of wraparound services regardless of state, it is becoming better managed through the years. While there are still weaknesses associated with it, there are many strengths and successes that overpower those weaknesses. The wraparound process is beneficial not only to the child each treatment plan involves, but to the communities, as well.

Chapter Three

Methodology

Hypotheses

Based on the literature review to date, I have developed four hypotheses to test in this study. They are the following: H1. Valuable resources available to TSS workers, such as a token economy, social stories, and sensory items, will lead to workers' success in perceiving juvenile delinquency prevention with their clients. H2. The greater rapport a TSS worker has formed with their client, the more likely such workers will be successful in perceived juvenile delinquency prevention with their clients. H3. The more satisfied TSS workers feel in their job, the more likely such workers will be successful in perceived juvenile delinquency prevention with their clients. H4. The more experience and education TSS workers possess the greater the perceived prevention of juvenile delinquency for their clients.

Elements of Survey Questionnaires and Samples

A Therapeutic Staff Support worker with a positive relationship with his or her client may prevent that child from becoming delinquent. However, a Therapeutic Staff Support worker with a negative relationship with his or her client may have little to no effect on whether or not that child becomes delinquent. This exploratory research investigates the perceptions of Therapeutic Staff Support workers to examine if they feel effective in the performance of the wraparound services they provide to their clients. The research design consists of using survey data and the sample population consists of Therapeutic Staff Support workers providing clinical services within an elementary school setting in Western Pennsylvania, due to the co-investigator's convenience. There

are no contact directories of Therapeutic Staff Support workers, so the co-investigator found respondents due to convenience of having worked with them in different classroom settings.

The survey instrument consisted of twelve questions consisting of six open-ended and six close-ended questions regarding opinions on the success of clients, as well as factors regarding the length of employment as Therapeutic Staff Support.

According to Maxfield and Babbie (2015), a survey is "a method for collecting data by applying a standard instrument in a systematic way to take measures from a large number of units" (p. 442). Surveys are typically considered to be the most appropriate technique in regard to studying individual attitudes and opinions (Maxfield & Babbie, 2015). Surveys are also used to evaluate changes within attitudes or perceptions (p. 237). According to Maxfield and Babbie (2015), a questionnaire is "an instrument specifically designed to elicit information that will be useful for analysis" (p. 237).

According to Maxfield and Babbie (2015), "self-administered questionnaires are generally the least expensive and easiest to complete" (p. 246). The mail survey is considered to be the traditional method and it consists of a letter of explanation, letter of informed consent, and an addressed envelope for returning the questionnaire. Open-ended and close-ended questions are necessary for this project, in order to allow respondents to elaborate and expand on responses, as opposed to choosing an answer that may not adequately fit for their situations.

A convenience sample is when people are easy to find based on their availability (Schutt, 2001). These respondents could be found on street corners, through work, or walking through a populated area. Schutt states an availability sample is most appropriate

when "exploring a new setting and trying to get some sense of prevailing attitudes or when a survey researcher conducts a preliminary test of a new set of questions" (p. 130). Overall, convenience sampling typically ruses as a more demanding form of research; self-administered surveys are more appropriate with sensitive issues, since they offer anonymity (Maxfield & Babbie, 2015). Since the research question posed may be considered a sensitive topic for some respondents, a survey approach where the respondents are derived from availability sampling is the most ideal choice in this research.

Survey Questions

The questions within this survey instrument consist of open- and close- ended questions, which total twelve questions. Each of these questions pertain to the nature of working in the behavioral health field, and the position of a Therapeutic Staff Support worker. Four questions are Likert Scale questions, another two are close-ended questions, and the remaining six are open-ended questions.

In order to view the survey instrument used, please refer to Appendix 1. The more resources available to TSS workers, the more likely such workers will be successful in preventing juvenile delinquency with their clients. For wraparound services to be beneficial, TSS workers must have appropriate tools at their disposal to work with their clients. The first question in this survey asks, "For a 5 year old child with autism and ADHD who has just started services in the school setting, what valuable resources do you think would work best?" This relates to whether the child in question has a severe emotional disorder, and if he or she has access to a mental health paraprofessional, at the very least. From there, the Therapeutic Staff Support will need to use his or her

judgement to determine what resources would work best for that situation, whether that may be social stories, behavior charts, or visual presentations, just to name a few.

The greater the rapport a TSS worker has formed with their clients, the more likely such workers will be successful in preventing juvenile delinquency with their clients. I included the scenarios, "How would you intervene with a 10-year-old client who is a danger to others (hitting, kicking, biting, throwing objects), has autism, and is nonverbal in the school setting?" and "How would you go about building a professional relationship with a client who is 17 years of age, has PTSD, and lives with a foster family in the home/community setting?" This infers the children have a severe emotional disorder and access to a mental health paraprofessional. Since the children show signs of being a danger to others, a mental health problem is likely involved, as well. The TSS will need to use judgement once again to determine the best interventions for this situation, whether that may be close proximity between the TSS worker and client, identifying expectations of the client, or breaking down complex tasks for the client, among other choices. Building rapport is an important factor, because developing trust is essential to the success of children such as this. Not only do these youth have a severe emotional disorder, but he or she may also have delinquent behaviors, due to the home life he or she may have endured and the PTSD he or she experiences.

Painter (2012) states, "wraparound is effective for improving functioning, strengths, and mental health symptoms for youths experiencing SEDs [serious emotional disorders]; it is not known which factors or combination of factors that contributed to the improvement." (p.422). With respect to the two aforementioned scenarios, judgement is the most important factor; this is because no two children are identical, so although two

children may have the same diagnosis, there is an incredibly small chance they will act indistinguishable when faced with the same situation. Thus, these questions give insight into the judgement of the Therapeutic Staff Support workers providing services to the client.

The following questions revolve around the TSS workers themselves, more so than a scenario. "How long have you been working as a Therapeutic Staff Support (TSS)?" and "How many clients have you worked with total since beginning as a TSS?" These questions are asked to gauge the experience he or she possesses with different clients and disorders. I asked these questions, because according to Cautilli and Rosenwasser (2001), "Most TSS are under prepared to handle the severity of the problems of children qualified to receive intensive community-based services" and "clear procedures omit the need for empathy, warmth, and individualization such as the tone and type of words used by staff, physical proximity, timing, and gradual increase in child expectations" (p. 156). Therefore, experience is important to measure and I hypothesize that the more experience and education a TSS worker possesses the greater the prevention of juvenile delinquency for their clients.

"What is your highest level of education?", and "How many training hours are you required to complete annually?" This question gauges how much formal education the respondent has, as well as how experienced they are. The more extensive training an individual is required to have, the more that individual may be exhausted from the number of hours they complete.

The more satisfied a TSS worker feels in their job, the more likely such workers will feel successful in preventing juvenile delinquency with their clients. The following

question, "What is your favorite part about working as a TSS; least favorite part? Please explain." This question falls under "The Importance of Job Satisfaction for Wraparound Service Providers", where the TSS self-assesses what they enjoy or dislike about their job. Job stress is an important factor to look at in this field, since TSS workers tend to acquire a large amount of stress; burnout usually happens in this field, as well.

"What do you do to build a professional relationship with your clients?" This question involves building rapport and the importance of developing trust with clients. Since all clients and TSS workers are different, the answers will probably vary widely since different techniques work better for some TSS workers more so than for other workers. "What do you feel are the most valuable resources to provide children with to help them achieve a successful future? Please explain." This question assumes that these children have access to wraparound services, which means they are exhibiting a severe emotional disorder. Looking at each child's strengths is important in assessing the most valuable resources for each child at hand, and the needs-based planning and delivery for each child. I asked these questions, because Chitiyo (2014) states, "when implemented with fidelity wraparound has the potential to make sustainable changes in helping individuals with severe emotional disorders" and "connecting positive behavior strategies and wraparound approaches has the potential to yield more positive outcomes" (p. 107).

There is also a direct question related to wraparound and delinquency. "How much impact do you feel you have in preventing juvenile delinquency among your clients?" with the choices being "little impact", "average impact", or "huge impact". Research shows "a student drops out of high school every nine seconds" and "only 75% of freshman will graduate from high school within four years" (Fries et. al, 2012, p. 119-

120). The TSS will be self-assessing whether they feel they have positively contributed to the success of his or her clients. "Of the home/community clients, on average what percentage do you believe has turned out to be juvenile delinquents?" with choices of "0%", "25%", "50%", "75%", and "100%". This question is pivotal to this thesis. It directly links the efforts of TSS and delinquency prevention. I asked this question, because according to Chitiyo (2014), "the evidence base for the wraparound approach appears to be still weak" (p. 107). There is no literature that connects wraparound services and perceived delinquency outcomes, so using an opinion-based first-hand perspective may help tremendously in better understanding if such a connection exists.

Administering and Collecting Results of Survey

According to Maxfield and Babbie (2015), anonymity is, "a state in which the identity of a research subject is not known, and it is, therefore, impossible to link data about a subject to an individual's name. Anonymity is one tool for addressing the ethical issue of privacy." (p. 435). Anonymity is important to use in this survey to ensure privacy of the respondents' identities regarding these personal questions. I have gotten to know all the respondents personally through my work experience. I contacted fifteen for this survey, so my sample size is n=15. The respondents' all work in different classrooms within different schools and all have different clients. The respondents work for different behavioral health agencies, as well. I have worked with some of them for as long as one consecutive year, and others I have only worked with for approximately two months.

IRB approval was needed for this project due to surveying respondents; it was received, as well. To ensure anonymity for all respondents, they each received a letter describing the project and an informed consent document, which was signed and mailed

back to the co-investigator prior to the respondents receiving the survey packets. The addresses of each respondent was acquired ahead of time between the respondent and co-investigator. The informed consent document states all information is confidential and participation in this survey is completely voluntary and the respondent may withdraw at any time. Included with this informed consent document and letter describing the project was a stamp and an envelope addressed with a return address of the co-investigator. The survey packet was mailed out after the co-investigator had received the signed informed consent document, and included the questionnaire itself, a stamp, and an envelope addressed with a return address to the co-investigator.

The respondent then filled out the questionnaire to the best of their knowledge, which took approximately ten to fifteen minutes to complete. After the questionnaire was filled out, the respondent then enclosed the questionnaire in the envelope provided with the survey packet they had received. After enclosing these materials, the respondent then placed the stamp on the envelope and mailed out the envelope. The respondent's part in the survey was then completed and no further action was required on their part. From there, the co-investigator received the packets and began recording and collecting the data needed for the project.

Chapter Four

Analysis and Findings

This chapter discusses the results from the responses of TSS workers surveyed for this thesis. There were four hypotheses tested after reviewing the literature in the field regarding wraparound services and its impact on delinquency. The four hypotheses are:

H1. Valuable resources available to TSS workers, such as a token economy, social stories, and sensory items, will lead to workers' success in preventing juvenile delinquency with their clients.

H2. The greater rapport a TSS worker has formed with their client, the more likely such workers will be successful in preventing juvenile delinquency with their clients.

H3. The more satisfied a TSS worker feels in their job, the more likely such workers will be successful in preventing juvenile delinquency with their clients.

H4. The more experience and education a TSS worker possesses the greater the possible prevention of juvenile delinquency for their clients.

Survey Respondent Profile

As shown in table 3, 67% of respondents have bachelor's degrees and another 33% of respondents have master's degrees. There is some connection between education and the prevention of juvenile delinquency with half of those with master's degrees (50%) feeling as though they have an average impact in preventing juvenile delinquency and the other half (50%) feeling as though they have a great impact in preventing juvenile delinquency among clients. 60% of those with bachelor's degrees feel as though they have a great impact in preventing juvenile delinquency, 13% of those with bachelor's degrees feel as though they have an average impact in preventing juvenile delinquency,

and 25% of those with bachelor's degrees feel as though they have little impact in preventing juvenile delinquency. It should be noted that none of the respondents with master's degrees felt as though they made little impact in preventing juvenile delinquency among their clients, whereas 25% of those with bachelor's degrees did. Therefore, it could be predicted that those with master's degrees do feel as though they have a greater impact in preventing juvenile delinquency, when compared to those with bachelor's degrees.

In terms of experience, there is also a connection between experience and the prevention of juvenile delinquency. Most respondents had five years or less of experience as a TSS worker (75% of respondents). Of those with five years or less of experience, 11% of those respondents believed they had little impact in preventing juvenile delinquency, 33% believed they had an average impact in preventing juvenile delinquency, and 56% of respondents believed they had a great impact in preventing juvenile delinquency. Of those with eleven to fifteen years of experience, 50% believed they had little impact in preventing juvenile delinquency, and another 50% believed they had a great impact in preventing juvenile delinquency. Of those with sixteen to twenty years of experience, 100% of respondents believed they had a great impact in preventing juvenile delinquency. From these percentages, it could be predicted that those who have greater experience as TSS workers feel as though they have a greater impact in preventing juvenile delinquency, when compared to those with lesser experience. This tells us that TSS with more experience builds confidence that they are successful with their clients.

Hypothesis 4

The more experience and education a TSS worker possesses the greater the prevention of juvenile delinquency for their clients.

Table 3

Education

Impact	**Associates**	**Bachelors**	**Masters**	**Doctoral**	Total
Little		2			2
Average		1	2		3
Great		5	2		7
Total	0	8	4	0	12

Experience (years)

Impact	**0-5**	**6-10**	**11-15**	**16-20**	Total
Little	1		1		2
Average	3				3
Great	5		1	1	7
Total	9		2	1	12

*Each number in the two-way table above equals the number of respondents who answered both answers (1 is equal to one person, while 3 is equal to three people).

As shown in table 4 below, the average percentage of home and community clients believed to be delinquent is 14%, out of a potential 100%, although 42% of respondents did not answer this question, due to either not having home and community clients or not having much experience as a TSS worker yet (less than 3 months).

The number of clients a TSS worker had connected to experience, with those having more years of experience typically having more clients, with one exception being a TSS worker with four years of experience who has worked with twenty clients. As stated previously, the average amount of hours needed for training per year was twenty-two, with two outliers; one respondent needed between 0-10 hours per year, and another respondent needed between 41-50 hours per year.

After the data are collected and then analyzed, the results do not support the hypothesis that valuable resources available to TSS workers', such as token economy (providing them rewards such as stickers or behavior charts), social stories, and sensory items, will lead to workers' success in preventing juvenile delinquency with their clients, however the findings do support the hypothesis of the more rapport a TSS worker has formed with their client, the less delinquent their client will likely be.

Additionally, the data collected do support the hypothesis of the more experience and education a TSS worker has will positively affect the prevention of juvenile delinquency for their clients, but it does not support the hypothesis of the more satisfied a TSS worker feels in their job, the more likely such workers will be successful in preventing juvenile delinquency with their clients. The impact TSS workers feel they have in preventing juvenile delinquency does not show a connection to any significant independent variable, such as education, experience, or number of clients the TSS worker has worked with. An explanation of the results follows.

Table 4

Survey Respondent Profile (N=15)

Level of Education	*N*	Percentage
Associates	0	0
Bachelors	8	67
Masters	4	33
Doctoral	0	0
Training Hours Annually		
0-10	1	8
11-20	5	42
21-30	5	42
31-40	0	0
41-50	1	8
Years Experience as TSS		
0-5	9	75
6-10	0	0
11-15	2	17
16-20	1	8
Mean= 5		
Median= 3		
Number of Clients Since Start as TSS		
1-5	5	42
6-10	2	17
11-15	3	25
16-20	2	17
Mean= 9		
Median= 9		
Impact in Preventing Juvenile Delinquency		
Little Impact	2	17
Average Impact	3	25
Great Impact	7	58
Percentage of Clients Believed Delinquent		
0	4	33
25	2	17
50	1	8
75	0	0
100	0	0
No Answer	5	42
Mean= 14		

Median= 0

Descriptively, the average experience of respondents was five years, working with an average of nine clients. The highest educational level of respondents was a Masters degree (33%), followed by a Bachelors degree (67%). None of the respondents' highest educational level was that of an Associates degree. The average amount of hours needed for training per year was twenty-two, as well.

When asked to explain the most valuable resources to provide children with in order to help them achieve a successful future, the top responses were the following: social supports (33%), support in general (33%), structured interventions (17%), and self-control (17%). In order to build a professional relationship with clients, 33% of respondents said rapport building worked best, 25% of respondents said reviewing and addressing treatment goals worked best, another 25% said learning the clients' interests worked best, and 17% said giving praise to clients worked best. Furthermore, 58% of respondents said they believed they were making a great impact in preventing juvenile delinquency among clients, 25% said they believed they were making an average impact, and 17% said they believed they were making little impact. When asked to rate what percentage of home/community clients would be expected to turn out to be juvenile delinquents (with zero percent being no clients would become delinquent that they worked with, and 100% being all clients would turn out delinquent), 33% of respondents said they believed zero percent of their clients have turned out to be juvenile delinquents.

When respondents were asked what their favorite part of the job was, bettering the child was the top answer (58%), followed by viewing a child's progress (25%), different clients (8%), and flexibility of the job (8%). Moreover, when asked what their least

favorite part of the job was, inconsistency was the top answer (33%), followed by stress and pay (25%), unsupportive schools and families (25%), and de-escalating children (17%).

Qualitative Summary

As shown in table 5 below, while the co-investigator was hoping to get material resources listed by respondents in terms of "valuable resources", respondents tended to list more abstract resources than concrete, such as support and self-control. In fact, there none of the resources respondents listed were concrete or tangible. In terms of "valuable", there is no connection between valuable resources and the prevention of juvenile delinquency. It seems that support tended to be the resource connected to a greater impact of the prevention of juvenile delinquency. 75% of respondents (*N=15)* who listed support as a resource felt as though they had a great impact in the prevention of juvenile delinquency, while 25% of respondents who listed support as a resource felt as though they had little impact in the prevention of juvenile delinquency. By support, respondents meant the following: working one on one, a good education, encouragement, love, being a successful role model, and taking on a role as a mentor with clients.

The only resources respondents listed that were not connected to the "little impact" response in the prevention of juvenile delinquency, were social supports and self-control. All of the respondents who listed self-control as a resource felt as though they have a "great impact" in prevention of juvenile delinquency. By self-control, respondents meant respecting boundaries and "that rules need to be followed". The co-investigator understood what the respondents meant by reading answers from each questionnaire. Those who listed social supports as a resource stated 50% felt as though

they had an average impact and another 50% stated they felt as though they had a great impact. By social supports, respondents meant the following: a collaborative treatment team, good community settings, counseling, early intervention, occupational therapy, physical therapy, and speech therapy. 50% of those who listed structured interventions felt as though they had little impact in the prevention of juvenile delinquency, and another 50% of those who listed structured interventions felt as though they had an average impact in the prevention of juvenile delinquency. By structured interventions, respondents meant the following: positive reinforcement, token rewards, goal management, coping skills, and transfer of skills to all environments.

Hypothesis 1

Valuable resources available to TSS workers, such as token economy, social stories, and sensory items, will lead to workers' success in preventing juvenile delinquency with their clients.

Table 5 Resources

	Support	**Social Supports**	**Structured Interventions**	**Self-Control**	Total
Impact					
Little	1		1		2
Average		2	1		3
Great	3	2		2	7
Total	4	4	2	2	12

*Each number in the two-way table above equals the number of respondents who answered both answers (1 is equal to one person, while 3 is equal to three people).

As shown in table 6 below, there is a connection between the more rapport a TSS worker has formed with his/her clients, the more positive an impact these workers feel their work has on juvenile delinquency prevention. 75% of respondents (*N*=15) who stated building rapport was the most important way to build a professional relationship with clients said they felt as though they had a great impact in preventing juvenile delinquency. 25% of respondents who stated building rapport was the most important way to build a professional relationship with clients said they felt as though they had an average impact in the prevention of juvenile delinquency. Of those who listed rapport as the most important way to build a professional relationship with clients, none of them said they felt as though they had "little impact" in the prevention of juvenile delinquency. This again reflects the view that TSS wraparound service providers believe they can make a positive difference with their clients, because it shows each respondent who answered in this way personally believed forming a professional relationship or connection with their clients was a progressive step in the prevention of juvenile delinquency.

According to respondents, the other ways to build professional relationships were: treatment goals, interests, and praise. By treatment goals, respondents meant observing clients' needs and meeting them where they are in terms of their needs. 67% of respondents who listed treatment goals as the most important way to build a professional relationship with clients stated they felt as though they made little impact in the prevention of juvenile delinquency and 33% of respondents who listed treatment goals as the most important way to build a professional relationship with clients stated they felt as though they made an average impact in the prevention of juvenile delinquency.

By interests, respondents meant the following: playing games with clients and talking about any interests the clients mention. 33% of respondents who listed interests as the most important way to build a professional relationship with clients stated they felt as though they made an average impact in the prevention of juvenile delinquency and 67% of respondents who listed interests as the most important way to build a professional relationship with clients stated they felt as though they made a great impact in the prevention of juvenile delinquency. By praise, respondents meant modeling positive behavior. 100% of respondents who listed praise as the most important way to build a professional relationship with clients stated they felt as though they made a great impact in the prevention of juvenile delinquency.

Hypothesis 2

The greater rapport a TSS worker has formed with their client, the more likely such workers will be successful in preventing juvenile delinquency with their clients.

Table 6 Professional Relationship

	Rapport Building	**Treatment Goals**	**Interests**	**Praise**	Total
Impact					
Little		2			2
Average	1	1	1		3
Great	3		2	2	7
Total	4	3	3	2	12

*Each number in the two-way table above equals the number of respondents who answered both answers (1 is equal to one person, while 3 is equal to three people).

As shown in table 7 below, there is no connection between the more satisfied a TSS worker feels in their job and the likelihood such workers will be successful in

preventing juvenile delinquency with their clients. Table 7 reflects a subset of hypothesis 3, and does not represent the actual job satisfaction as perceived by TSS workers. The best part of the job of Therapeutic Staff Support were the following, according to respondents: bettering the child, viewing the child's progress, different clients, and flexibility. In terms of bettering the child, 17% of respondents who wrote it as the best part of the job felt as though they had little impact in the prevention of juvenile delinquency, while 83% of respondents who wrote it as the best part of the job felt as though they had a great impact in the prevention of juvenile delinquency. By bettering the child, respondents meant the following: creating a better quality of life for the child, helping and interacting with the children, modeling positive behavior, one on one support, and seeing clients smile.

According to respondents, viewing the child's progress was another "best part" of the job. By viewing the child's progress, respondents meant the following: when the child makes therapeutic changes, and seeing a child's on-going development. 50% of respondents who chose this as the best part of the job felt as though they had an average impact in the prevention of juvenile delinquency, and another 50% who chose viewing the child's progress as the best part of the job felt as though they had a great impact in the prevention of juvenile delinquency.

The "different clients" was another "best part of the job", according to respondents. By different clients, respondents did not elaborate on what they meant, but it is assumed they meant the diversity of diagnoses within the field. 100% of respondents who chose this as the best part of the job stated they felt as though they had little impact in the prevention of juvenile delinquency. Flexibility was another "best part" of the job,

with 100% of those who stated they felt as though they had an average impact in the prevention of juvenile delinquency. By flexibility, respondents did not elaborate what they meant, but it is assumed they meant the ability to make their own schedule. The only items that did not seem to be a pattern in terms of little impact in the prevention of juvenile delinquency were "viewing the child's progress" and "flexibility".

Hypothesis 3

The more satisfied a TSS worker feels in their job, the more likely such workers will be successful in preventing juvenile delinquency with their clients.

Table 7 Best Part of Job

Impact	**Bettering Child**	**Viewing Child's Progress**	**Different Clients**	**Flexibility**	Total
Little	1		1		2
Average		2		1	3
Great	5	2			7
Total	6	4	1	1	12

*Each number in the two-way table above equals the number of respondents who answered both answers (1 is equal to one person, while 3 is equal to three people).

As shown in table 8 below, the least favorite parts about working as a TSS include the following: inconsistency, stress and pay, unsupportive schools and families, and de-escalation. By inconsistency, respondents meant the following: instability and inconsistent hours. By stress and pay, respondents meant the following: "feeling as though the responsibility of the child's progress rests solely on me", documentation required for the job and constant mobility. By unsupportive schools and families,

respondents meant the following: “the parents do not use the skills we transfer to them” and watching children have to live everyday with these disabilities. By de-escalation, the respondents did not elaborate but it is assumed to refer to when the child is escalating and becoming extremely frustrated, so the TSS must attempt to de-escalate the child and calm them down in the best way possible at the time.

“For a 5 year old child with autism and ADHD who has just started services in the school setting, what resources do you think would work best?”, the majority of respondents wrote the environment is the biggest factor that would work best in that situation. By “environment”, respondents meant the following: a school that specializes in ABA (Applied Behavior Analysis), a small setting, an aide, an Emotional Support room, and a positively reinforced environment. 33% of respondents believed environment was the best resource for this situation, with another 25% stating social supports would work best, 25% stating structured interventions would work best, and 17% stating support would work best.

By social supports, respondents meant the following: a social skills group, wraparound services, speech therapy, physical therapy, occupational therapy, sensory integration therapy, and early intervention. By structured interventions, respondents meant the following: token economy, sensory items, time limits, BSC material, a schedule, calm down area, sensory stimulation, and proper communication skills. By support, respondents meant the following: praise, understanding, and patience.

“How would you intervene with a 10 year old client who is a danger to others (hitting, kicking, biting, throwing object), has autism, and is nonverbal in the school setting?”, the majority of respondents wrote de-escalation would work best (42%),

followed by sensory needs, FBA/VB-MAP, and structured interventions. By de-escalation, respondents meant the following: removing other peers, calming down the child, filling out an incident report, isolating the danger, and calling the safe crisis hotline. While 42% of respondents thought de-escalation would work best, another 25% felt as though sensory needs would work best, with another 17% feeling as though an FBA/VB-MAP would work best, and yet another 17% thinking structured interventions would be best in this situation.

By sensory needs, respondents meant the following: sensory breaks, giving the child a chewy and an object to squeeze, and using sensory stimulation. By structured interventions, respondents meant the following: following the behavior plan in place, using social stories, positive reinforcement, situational review, a reward system, creating a routine, and developing language skills with the child. By FBA/VB-MAP, respondents meant determining the cause of aggression and data collection. A FBA is a Functional Behavior Assessment typically done before the client starts services, depending on the diagnosis of the child, and a VB-MAP is a Verbal Behavioral Milestone Assessment and Placement chart that measures the child's progress through treatment and typically helps at the beginning of treatment to show the treatment team where the child lands developmentally in different areas.

With respect to the question "How would you go about building a professional relationship with a client who is 17 years of age, has PTSD, and lives with a foster family in the home/community setting?", the majority of respondents wrote building rapport would work best (58%), followed by activities (25%), and therapy (8%). Another 8% did not give an answer due to never having worked in that type of situation before. By

building rapport, respondents meant getting to know the client and building a professional relationship while doing so.

By "activities", respondents meant the following: setting up activities the client enjoys, and talking to the client while doing activities he or she is interested in. By "therapy", respondents did not elaborate other than to say, "some therapy". The co-investigator attempted to understand this as best as she could, but "some therapy" could have meant a number of therapies, including but not limited to, the following: speech therapy, occupational therapy, physical therapy, sensory integration therapy, counseling, early intervention, or wraparound services.

Table 8

Individual Item Summary (N=12)

For a 5-year-old child with autism and ADHD who has just started services in the school setting, what resources do you think would work best?

Answer	*N*	Percentage
Environment	4	33
Social Supports	3	25
Structured Interventions	3	25
Support	2	17

How would you intervene with a 10-year-old client who is a danger to others (hitting, kicking, biting, throwing objects), has autism, and is nonverbal in the school setting?

Answer		
De-escalation	5	42
Sensory Needs	3	25
FBA/VB-MAP	2	17
Structured Interventions	2	17

How would you go about building a professional relationship with a client who is 17 years of age, has PTSD, and lives with a foster family in the home/community setting?

Answer		
Rapport	7	58
Activities	3	25
Therapy	1	8
No Answer	1	8

What is your favorite part about working as a TSS?

Answer		
Bettering the child	6	50
Viewing a child's progress	4	33
Different clients	1	8
Flexibility	1	8

What is your least favorite part about working as a TSS?

Answer		
Inconsistency	4	33
Stress and Pay	4	33
Unsupportive schools and families	3	25
De-escalation	1	8

What do you do in order to build a professional relationship with your clients?

Answer		
Rapport Building	4	33
Treatment Goals	3	25
Interests	3	25
Praise	2	17

What do you feel are the most valuable resources to provide children with in order to help them achieve a successful future? Explain.

Answer		
Support	4	33
Social Supports	4	33
Structured Interventions	2	17
Self-Control	2	17

Chapter Five

Conclusion

Significance of Questionnaire Results

Overall, what I predicted with some of my hypotheses did not turn out to be supported. I had originally thought that the more satisfied a TSS worker was in his/her job, the greater the likelihood of the possible prevention of juvenile delinquency, and the more valuable resources available to TSS workers', such as token economy, social stories, and sensory items, the greater the likelihood juvenile delinquency will possibly be absent. The answers also varied by experience and education. After looking at the results from respondents, it shows that resources and job satisfaction likely do not play a part in the predicted prevention of juvenile delinquency, at least according to the TSS workers surveyed here. With that being said, there was only a sample size of N=15, so one cannot generalize the findings.

My hypothesis, that the more rapport a TSS worker has formed with his/her client seems to relate to the possibility of delinquency prevention. After looking at the results from respondents, it does seem to show that respondents felt as though rapport carried a great impact in the prevention of juvenile delinquency, due to the great impact respondents believed they had in juvenile delinquency prevention when rapport was listed as the most important part of building a professional relationship with their clients. There was support for my hypothesis that the more education and experience a TSS worker has seems to positively affect the predicted prevention of juvenile delinquency for their clients. It seems the higher a TSS worker's education level, the more confidence he/she is that his/her client will abstain from delinquency. For example, no respondent

with a Masters Degree felt as though they had little impact in the prevention of juvenile delinquency, whereas 25% of those with a Bachelors Degree did feel as though they had little impact in the prevention of juvenile delinquency. In terms of experience, for respondents with sixteen to twenty years of experience as a TSS worker, 100% felt as though they made a great impact in the prevention of juvenile delinquency, compared to 56% of those with five years or less of experience, and 50% with eleven to fifteen years of experience. This supports the notion that the more years of experience a TSS worker has, the more confident they are in delinquency prevention with their clients.

Overall, while only two of the four hypotheses were supported, the results were encouraging. The more rapport, education and experience a TSS worker possess, the more confident he/she is that their clients will be successful. These results may certainly be different had there been a larger sample size, or if there was a variation of education, with more respondents having an Associates Degree or Doctoral Degree, or perhaps more than twenty years of experience. The results may be different if the respondents were located in counties other than in the western side of Pennsylvania, as well, because of different perceptions from different Therapeutic Staff Support workers in different schools and behavioral health agencies.

Contributions

In terms of future research, this study contributes to the field of knowledge regarding wraparound services and, more specifically, its effect on delinquency prevention. Wraparound is recent in social services (being implemented in the mid 1990s), and the presence of academic literature on Therapeutic Staff Support workers or wraparound services is limited. There has not been an extensive amount of literature

written on this topic, so contributing data towards this line of research will be beneficial not only to those within the field itself, but for prospective studies done on wraparound services, and delinquency prevention.

This research is the first step in understanding how Therapeutic Staff Support workers think they positively or negatively affect their clients in terms of delinquency prevention. This is also the first step to identifying potential problems in the behaviors of children before these behaviors escalate into more severe issues. Once these problems are identified, different research strategies can be developed utilizing different resources and interventions, such as close proximity for children with ADHD or social stories for children with autism. There have been multiple research studies explaining how beneficial wraparound services are to children, but limited literature explaining how wraparound services and TSS workers specifically benefit in helping prevent delinquency.

This research is also the first step in figuring out what education and experience level should be required for TSS workers, as well as addressing the inconsistency in the current required education for TSS workers. The current education and experience requirements for a TSS worker are at minimum an Associates degree, with thirty hours towards a Bachelors degree and three years of paid experience working with children. However, while all respondents had a minimum of a Bachelors degree and two weeks of experience, four also had a Masters degree with a minimum of two years of experience, with two others in the process of working towards a Masters degree with a minimum of three years of experience. This in turn accounted for exactly half of respondents acquiring, or in the process of acquiring, a Master's degree.

There is a great chance that those holding a Bachelors degree and those holding a Masters degree are getting paid equally, or there is a small monetary difference, at best. This leads to the proposition that requirements for a TSS worker either needs to be set at an Associates or Bachelors Degree, with pay raises given to those who attain higher education and experience, or raised to a Bachelors Degree. Education matters and I've learned that education requirements for TSS workers are very inconsistent. It is possible that hiring TSS workers with a higher education will be beneficial towards client success.

In 2001, Cautilli and Rosenwasser proposed different experience requirements for a TSS system, with the levels ranging from level one to level five. At a level one, a TSS Aide would require a high-school diploma and three years of experience, a level two TSS Associate would require an Associates Degree and two years of experience working with children, or sixty hours of college credits and two years of experience working with children. At a level three, a TSS Full would require a Bachelors Degree and one year of experience working with children, while at a level four, a TSS Diplomate would have a Bachelors Degree and three years of experience working with children with behavioral disorders. Finally, at a level five, a TSS Diplomate II would be considered an Associate Level BSC with three years of experience plus certification in Applied Behavior Analysis through the Pennsylvania Training Network (p. 155).

Following those educational and experience requirements, the pay scale proposed by Cautilli and Rosenwasser (2001) varies widely, as well. At a level one, the TSS Aide would get paid $16/hr, at a level two, the TSS Associate would get paid $26/hr, at a level three, the TSS Full would get $30/hr, a level four TSS Diplomate would get $32/hr, and a level five TSS Diplomate II would be getting $35/hr in wages (p. 156). This varies

widely from the current $11/hr-$14.50/hr starting rate for TSS workers at the initial start. If the pay scale was aligned more properly with Cautilli and Rossenwasser (2001), there would likely be more organization, satisfaction, and clarity for TSS workers, which in turn would lead to a higher retention rates among behavioral health agencies.

Limitations

In terms of limitations, this was not a longitudinal study so there is no way to follow up on whether the TSS clients did in fact engage in delinquent behavior. The lack of finding out if juveniles become delinquent in the future is a large limitation, namely because this study took the TSS workers' opinions, rather than facts regarding their attempts at preventing juvenile delinquency. If more time was permitted, the co-investigator could conduct a longitudinal study to determine whether the prevention of juvenile delinquency was in fact related to wraparound services.

The sample size for this study could be expanded, as well. The sample size of fifteen was extremely small for this study, and while it was a benefit that the co-investigator knew everyone who participated due to working with them in the past, the results would prove to be more accurate if the sample size was larger by at least a dozen more people. While the co-investigator reached out and communicated to all fifteen respondents, only twelve filled out both the informed consent form and questionnaire. There was one respondent who filled out the informed consent form but not the questionnaire, one respondent who agreed to participate in the survey and never responded or filled out the informed consent form or questionnaire, and one respondent who agreed to participate in the survey but the next day withdrew due to feeling uncomfortable with the process. If there was a larger sample size, there would likely be

more completed surveys to help the co-investigator better determine the relation between wraparound services and juvenile delinquency, according to Therapeutic Staff Support.

Another limitation was time constraints. The informed consent form was to be filled out and mailed back to the co-investigator within a week, and the questionnaire was to be filled out and mailed back to the co-investigator within two weeks. Multiple respondents told the co-investigator they would need longer than two weeks to fill out the questionnaire due to its length and their schedules. Some respondents may have been confused and there may have been a lack of clarification regarding the wording of the questions.

Finally, the last limitation the co-investigator encountered was the method for distributing the surveys to respondents. After initially sending out the informed consent forms, only nine respondents communicated they had received them. The other respondents told the co-investigator they never received the forms. Out of the nine who had received them, only five were successfully mailed back to the co-investigator, with the other four communicating to the co-investigator that they had also mailed them out (yet the co-investigator never received them). After receiving all of the informed consent forms, the co-investigator then mailed out all the questionnaires, with seven people communicating they received them and the remaining respondents communicating they never received them. After all respondents successfully received the questionnaires, the co-investigator then received twelve questionnaires back via mail service between five days and four weeks.

Future Research

In terms of future research recommendations, there are a few things that could be done differently, had I been given the chance to cultivate this study. I would expand on the survey instrument questions, include a larger sample size and even the possibility of in person interviews with the capability to ask follow up questions, would provide more meaningful data.

For future research, I would also be extremely interested in the delinquency rate for juveniles within wraparound services and to see where TSS workers do in fact help prevent delinquency rates due to the interventions and rapport they use and build with their clients. At a minimum, I would measure the delinquency rate of juveniles within wraparound services for a year to understand whether there is a pattern among the two. Ideally, I would measure the delinquency rate of juveniles within wraparound services for approximately five years to get an in depth perception of the connection, if there is one. Finally, I would not limit myself to the small geographic area of Western Pennsylvania. To secure a more generalizable finding, I would like to conduct a survey that would include respondents from differing regions around Northeast Ohio, to see if opinions differed with respect to those who do similar jobs as TSS workers in Pennsylvania.

Appendices

Appendix A

Questionnaire

1. For a 5 year old child with autism and ADHD who has just started services in the school setting, what resources do you think would work best?

2. How would you intervene with a 10 year old client who is a danger to others (hitting, kicking, biting, throwing objects), has autism, and is nonverbal in the school setting?

3. How would you go about building a professional relationship with a client who is 17 years of age, has PTSD, and lives with a foster family in the home/community setting?

4. What is your highest level of education?
Associates Degree Bachelors Degree Masters Degree Doctoral Degree

5. How many training hours are you required to complete annually?
0-10 11-20 21-30 31-40 41-50

6. How long have you been working as a Therapeutic Staff Support (TSS)?

7. How many clients have you worked with total since beginning as a TSS?

8. What is your favorite part about working as a TSS; least favorite part? Explain.

9. What do you do in order to build a professional relationship with your clients?

10. What do you feel are the most valuable resources to provide children with in order to help them achieve a successful future? Explain.

11. How much impact do you feel you have in preventing juvenile delinquency among your clients?
Little impact Average impact Great impact

12. Of the home/community clients, on average what percentage do you believe has turned out to be juvenile delinquents?
0% 25% 50% 75% 100%

Appendix B

Informed Consent Form

Dear (sir or madam):

We are conducting a study to determine the relationship between Therapeutic Staff Support workers and their clients. In this study, you will be asked to answer (10) questions. Your participation should take about (15) minutes.

There are no risks to you.

All information will be handled in a strictly confidential manner, so that no one will able to identify you when the results are recorded/reported.

In order to assure anonymity, please do not identify yourself in any way when answering these (10) questions.

Your participation in this study is totally voluntary and you may withdraw at any time without negative consequences. If you wish to withdraw at any time during the study, simply contact the co-investigator of the study.

Please feel free to contact Kristen Verina, B.A. or Dr. Christopher Bellas, Ph.D. at XXX or XXX if you have any questions about the study. Or, for other questions, contact the Director of Grants and Sponsored Programs at YSU XXX.

I understand the study described above and have been given a copy of the description as outlined above. I am 18 years of age or older and I agree to participate.

_____

Signature of Participant Date

Appendix C

IRB Approval

Youngstown
STATE UNIVERSITY

One University Plaza, Youngstown, Ohio 44555
Office of Research
330.941.2377
www.ysu.edu

April 8, 2018

Dr. Christopher Bellas, Principal Investigator
Ms. Kristen Verina, Co-investigator
Department of Criminal Justice & Forensic Sciences
UNIVERSITY

RE: HSRC PROTOCOL NUMBER: 153-2018
TITLE: The Perception of Therapeutic Staff Support Interventions with Children & Its Possible Impact on Future Delinquency

Dear Dr. Bellas and Ms. Verina:

The Institutional Review Board has reviewed the abovementioned protocol and determined that it is exempt from full committee review based on a DHHS Category 3 exemption.

Any changes in your research activity should be promptly reported to the Institutional Review Board and may not be initiated without IRB approval except where necessary to eliminate hazard to human subjects. Any unanticipated problems involving risks to subjects should also be promptly reported to the IRB.

The IRB would like to extend its best wishes to you in the conduct of this study.

Sincerely,

Mr. Michael A. Hripko
Associate Vice President for Research
Authorized Institutional Official

MAH:cc

c: Attorney Patricia Wagner, Chair
Department of Criminal Justice & Forensic Sciences

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