# Correlation between Group Home Caregiver Gender and Organization Outcomes

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**ABSTRACT—** ***When agencies such as the Child Protection Services, Department of Probation or Child Welfare Services place children in out-of-home care, there seems to be incidents where clients are not afforded adequate protection. Children and youths are further injured and a cycle of maltreatment by caregivers working at these care agencies starts. System-generated trauma from stressful and emotionally overwhelming experiences such as multiple placements, frequent changes in schools, and peer groups has called for the research of studies leading to evidenced-based practices that prove effective in the treatment of this population. The purpose of this quantitative research is to explore the correlation between caregiver gender and adolescents' trauma related behaviors in nine group homes. Independent t-test procedures were conducted to determine the mean differences between genders. A two tailed significance level of .05 was specified. The findings revealed that gender was significantly related to trauma related behaviors. Male staff members reported experiencing more client aggressive behaviors than female staff members. It is recommended that further study be conducted on group homes to understand how organization characteristics impact client successes while in out-of-home treatment and care***.

**Keywords—** Group home, trauma informed care, rate classification level, Likert scale, Ordinal scale, ANOVA, Chi-Square test, correlation analysis, regression analysis.

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## 1. INTRODUCTION

Hurley [1] recognized the changing mental health needs of youths admitted to residential group home care (Hurley, 2009). Research of the literature suggests that the mental health needs of youths that enter into residential group home care have increased in relation to psychiatric diagnoses, being prescribed two or more psychotropic medications, and using alcohol or drugs. Youths in the general population, have a lifetime rate of mental health problems of 15% to 20% [2] [3] [4]. Comparatively, 47%-93% of youths in residential group care have a diagnosed mental health problem [5] [6] [7]. Furthermore, 30%-60% of youths in residential group care have dual mental health diagnoses [7] [8] [9], as stated in [1]. 35%-75% of youths in residential group care are prescribed psychotropic medication [5] [10] [11]. Youths in residential group care are at risk for other mental health problems as 20%-68% have issues with substance abuse [7] [8] [9] [11], as stated in [1], and 30% report suicidal behaviors [5] [7] [8]. It is also reported that 47% had been the victim of abuse or neglect behaviors [5] [7] [8]. From the late 1980s to the late 1990s, about 28% of American youth continued to score in the clinical borderline range on the Child Behavior Checklist total score [12]; however, 60% to 85% of youth in residential care have scored in the clinically significant range on emotional or behavioral assessment scales such as the Child Behavior Checklist and the Global Assessment of Functioning [13], as stated in [1] [5] [7].

As funding resources continue to decrease and state and local networks require more intense and shorter placement durations, service organizations are increasingly stepping down youths into less restrictive settings more frequently. Consequently, Hurley et al. [1] postulate the use of residential group homes for youths who are not successful in less restrictive settings, and youths with more difficult and complex mental health issues are stepping up to residential group homes from failed prior placements in less restrictive settings. The trend since 1982 was towards utilizing community-based group homes with behavioral modification treatment programs aimed at the individual child or youth first, then, towards reunifying the child with her family.

Foster family care homes were the state's secondary source for care services with over 8400 licensed foster care homes in 2003, and by 2008 there are barely over 7300. This figure is more than just a trend. A recent legislation was signed deferring children back into Intensive Treatment Foster Care Programs as an alternative to group home placement. As a result, group homes have reduced in numbers at a rapid rate. Further, County Children Foster Care Agencies are reducing the number of placements into county group homes. Orange County Children Services in Southern California has reduced their child placements into group homes from an estimated 160 to less than 60 child placement contracts. Nationally, there has been a paradigm shift from solely individual focused treatments towards the inclusion of family and community-based treatments. As a reforming principle and activity, the Child Welfare System has merged with mental and behavioral health systems to provide "wraparound" services [14]. These wraparound services within the context of the residential child care system, extends services to the child's family.

In order for youth and their families to receive community-based wraparound services, there needs to be an issue of "medical necessity" for them to qualify. Clinicians often describe reasons for services from a medical orientation to the exclusiveness of social, economic, and other non-medical issues of their clients. The family is defined as the core of the community, thus, treatment services need to be done within the community and focus on strengthening the family as a unit. Therefore, utilizing group homes alone does not address the problems associated with abuse, neglect, and emotional distress issues simply because they do not reach deep enough into the community with their treatment services. Group home services do not treat or support the treatment of families of the clients they serve.

Typically, group homes are child-centered that focus strictly on their clients. In 2002, nearly 80% of all children in placement were placed at group homes. In 2006, less than 55% of all children in placement were placed at group homes [15]. Nationally, child welfare agencies receive nearly 500,000 reports of maltreatment calls a month with over three million each year being accepted for evaluation and nearly one million cases are opened for child welfare intervention annually [16] [17] [18]. In California, reports show that on any given day 131,000 children and youth are involved in the Child Welfare System [19]. Nearly 40,000 of these youths receive emergency services and other forms of assistance to help keep the family together safely, and another 42,000 live in foster homes, relative homes, and residential care facilities [19]. This research focuses on this sector and its residential care facilities.

Caregiving workers are instrumental in the success of out-of-home children and youths because they are almost always the foremost point of contact on a rotating 24 hour basis. Basically, they are the therapeutic parents and are expected to maintain the care of youths when the youths are not in therapy. Youth interactions with caregiving workers often mirror the interactions with their parents, and a result of such an ongoing relationship is that the care workers may experience the same feelings as parents of these youths that are diagnosed with Disruptive Behaviors Disorder. These emotions range from frustration and annoyance to sympathy and warmth [20]. Therefore, it is important for caregiving workers to be capable of recognizing problematic interaction patterns and to respond appropriately utilizing a strength-based milieu, thus breaking the negative interaction cycles which led to the initial placement, and create space for the child to change [21].

Care workers tended to create connections with youth in creative ways [22], which allowed them to correct behaviors in the frame of a relationship; however, these methods were not based solely on their training or procedures. According to [23], in order for positive relationships to form and changes to occur, care workers need a clear idea about what to do and how to do it. Therefore, it is clear that care workers would benefit from increased training and further monitoring on how to successfully change behavior patterns.

The questions then become: are residential facilities prepared to 1) understand the nature of the clients served; 2) become organizationally ready to meet the service needs of out-of-home placed clients; and 3) understand to what degree does the perception of organizational, group, and individual factors influence service performances? This is clearly an indication that youths are increasingly possessing greater and more complex mental health issues (Hurley et al. 2009). The number of out of home placed children has increased dramatically since the 1980s [24]. LeBlanc [24] cites research indicating that in 1985, an estimated 276,000 children were in out-of-home home care, and by 1993 that number had risen to 449,000, and up to 542,000 children by 2001. Though the child welfare system prefers to treat troubled youths within what are known as "systems of care" (which focus on treating youth at their homes rather in out-of-home placements) a substantial number of enrolled children experience out-of-home care while involved in such systems [25].

## 2. RESEARCH PROBLEM STATEMENT

The development of healthy and supportive relationships between children and caregivers in a group care setting precedes a child's reunification with parents or being selected for a lower level of care. Clearly, a child's disruptive behavior may inhibit them from functioning in healthy relationships with caregivers and ultimately lead to the occurrence of multiple placements. Thus, it is the function of the group home care giver to help youth manage their response to caretakers and thus relearn how to trust caregivers to meet their needs [22] [26]. It has been argued that out-of-home placement successes should be moderated by how well maltreated children can manage relationships with caregivers.

Available research attempt to study a specific set of factors to identify the causal relationship between two or more sets of variables [18] [25] [27] [28] [29], such as family, child, or community factors to suggest some directional strength among the variables. For instance, family risk factors (e.g., substance abuse, criminality, or domestic violence) or child/youth risk factors (e.g., behavior, child abuse, emotional stability, or age). These do show some significance among variables or predictive relationships towards out-of-home placement frequencies, but they often fall short in addressing similar accuracies on out-of-home placements themselves and placement outcomes [18] [25] [27] [29]. Data is available showing what children and youth in out-of- home placements apparently need in terms of services, but research often falls short in identifying the quality of service outcomes or even addressing organizational key success factors needed to facilitate high service outcomes (e.g., decision making processes, proper organizational alignment between organization, group and individual levels, quality employee recruitment, retention efforts, and employee training and development). Therefore, if there is a gap between understanding client needs and providing quality services, the answer lies in securing proper organizational alignment and service fit. Thus, the organization must become aware of the clients' needs before such awareness can be passed down throughout the organization to the individual level where, with such awareness, workers can began to address proper client needs.

This paper addresses the research question: What is the relationship between staff gender and frequency of client absence without official leave (AWOLs), negative client/staff interactions and client aggressive behavior? The independent variable is the gender and trauma-related behavior (AWOL, negative client/staff interactions, client aggressive behavior, and outbursts) are the dependent variable.

## 3. RESEARCH METHODOLOGY

In this quantitative research an empirical methodology was used in which data was gathered in numeric form [30]. This was a correlational research, which is empirically descriptive in nature and the independent variables in this type of study are ones that cannot be manipulated, or should not be manipulated, thus allowing for little to no control over the independent variables [31]. This study investigated employees' gender as they correlate to group home client occurrences of AWOL, negative client/staff interactions, outbursts, and aggressive behaviors, which are factors referred to as "trauma related behaviors". This study attempted to determine whether, and to what degree, a relationship exist between these variables. This study was a correlational study which described the organizational characteristics of selected California group home residential child care organizations. Specifically, this population included residential treatment facilities or group homes that have been issued a license from the California Community Care Licensing and included nine California residential facilities for children and youth. The selected California residential facilities are similar in that they are all regulated by Title 22, Chapter 5 of the California Code of Group Homes Regulations, and are licensed to provide care and housing to up to six male children and youth between the ages of 13 to 18. Furthermore, the facilities are in the rate classification level (RCL) 11. Monthly revenue for this RCL is $43,656. Group home rates range from 1 thru 14, with rate classification 14 being the highest rate and defines the amount of revenue allotted for the care of children and youth. The higher the rate classification of a group home, the higher the group home revenue used for food, clothing, shelter, daily supervision, school supplies, a child's personal incidentals, liability insurance with respect to a child, and reasonable travel to the child's home for visitation. For this study, only group homes rated at level 11 were selected on the basis that behaviors within this range are considered homogeneous to congregate care facilities. The selected residential facilities all provide 24/7 monitoring, supervision, safety, education, mental, and healthcare services. The facilities all provide medication management, group, individual, and family therapy, recreation, and independent living skills training. The treatment models all utilize an eclectic cognitive behavioral framework guided by attachment and developmental theories and are required to utilize strength based frameworks, and each unit employs between seven to twelve workers per shift.

Participants for this study were selected from a sample of selected licensed California residential child care organizations. Participants consisted of licensed administrators, facility managers/supervisors, and child care workers/staff who are employed by three group home organizations located in San Bernardino County, three in Riverside County, and three group homes in Los Angeles County. The purpose for selecting such a broad range of participants was to solicit diversity among child care workers. Data indicating measures of trauma related behaviors was collected, coded, and analyzed from group home archival incident reports for the periods of no later than six months prior to the study, and from surveys pertaining to staff perceptions from 100% percent selected group home care worker participants, administrators and supervisors who volunteered to participate in the study. Archival data was coded to express the following data values: run away; client/staff negative interactions; client's aggressive behavior; and client outbursts.

The primary means of gathering information to explore relationship correlations that may affect trauma related behaviors in group homes consisted of questionnaires from caregivers and management personnel. A questionnaire was used in this study. Surveys were used to collect data from selected participants. Specifically, questionnaires were used to collect descriptive data from selected participants and required each participant to complete the survey for the demographical information. Additional data included whether or not they received trauma related care training at the group home that they are currently working at, or if they have received trauma informed training at all. All group home

employees were solicited to participate in the study. Informed consent forms indicated that by participating in the study and completing the survey questionnaires and returning to the researcher on site constituted participants consent to participate.

The Likert Scale is commonly used in survey research. It is usually used to measure respondents' attitudes by asking the extent to which they agree or disagree with a particular question or statement. A typical scale may be "Strongly Agree, Agree, Not Sure/Undecided, Disagree, and Strongly Disagree." In this study respondents were asked to select an answer from among a list of closed-ended questions. Closed-ended questions were chosen in this study because they provide a greater uniformity of responses and are more easily processed [32] [33]. To lessen the possibility of respondents misinterpreting questions, an instruction sheet was added instructing the respondent to select the one best answer. Important issues considered were:

- Raw data was made ready for analysis by coding the responses. In this study, responses were coded as Strongly Agree=1, Agree= 2, Neutral= 3, Disagree= 4, and Strongly Disagree=5.
- In this study the Likert scale was coded on the ordinal scale. It tells us that the people with the higher-numbered responses are more likely not to have trauma informed care training.
- Analyze the Likert scale data with descriptive statistics. With Likert scale data, the best measure to use is the mode, or the most frequent response. In this study, the distribution of responses was displayed in a graphic.
- Inferential statistics were used to test the hypothesis. Though the best one depends on the nature of the study and the questions to answer, a popular approach is to analyze responses using ANOVA techniques. In this study the responses of trauma related behaviors among gender, education, experience, and perception as the independent variables were analyzed.
- Survey data was further simplified by combining the four response categories (Strongly Agree, Agree, Disagree, Strongly Disagree) into two nominal categories, such as agree/disagree, accept/reject, etc. In this study, the chi square was used to analyze responses.

Group home administrators provided for a closed room for participants to complete the survey. Further, a survey instrument solicited data from selected participants utilizing a five-item Likert Scale to determine which of the six maltreatment characteristics (1) appearance of affect, (2) difficulty of client/staff interactions, (3) reactivity, (4) emotional outbursts, (5) external behaviors, and (6) aggression, that staff workers and management employees perceive to be present at their respective group home organizations.

Archival data, from incident reports dating back over the previous 18 months, were collected from selected group home organization respondents. The archival data was coded for reported occurrences of resident's: (RA) Run-Away Behaviors; (NCS) Difficulty of Client/Staff Interactions; (CO) Client Outbursts; and, (CAB) Client Aggressive Behaviors. The demographics (i.e., gender, age, average number of years work experience, and average years education level) served as the independent variables, and the archival data, as stated above, served as the dependent variables. Because the present study involved the measurement of occurrences of trauma related behaviors, as described by archival data within incident reports, as they pertain to organizational characteristics (i.e., staff gender, level of education, level of experience, and perceptions of management and staff personnel), a quantitative design was most appropriate because the design allowed the researcher to clarify correlations between group home clients' affective behaviors and caregivers' perceptions and responses to those behaviors. The independent variables were: gender, experience, education, perception, and training, while trauma related behaviors are dependent variables.

## 4. RESULTS AND FINDINGS

The purpose of this quantitative research was to discover and explore any correlation between caregiver gender and adolescents' trauma related behaviors in nine out-of-home care centers. A survey was presented to the participants to ascertain their gender. A data collection tool was used to collect archived data from each group home to count trauma related behaviors experienced and reported by each group home organization. Trauma related behaviors include AWOL, aggressive behavior, negative client/staff interactions, and client outbursts. Descriptive analysis from the survey was used to debrief results of gender and trauma related behaviors. To determine whether the variables were distributed normally, the skewness and kurtosis indices were examined. Per Kline [34], a variable is non-normal if its skewness index (i.e., skewness statistic/SE) is over three and its kurtosis index (i.e., kurtosis statistic/SE) is over 10. To determine whether there were univariate outliers, the variables were standardized. Cases whose standardized values were above the absolute value of 3.29 were categorized as outliers [35]. None of the cases, however, had standardized absolute values above 3.29; therefore, there were no univariate outliers.

**Table 1**
**Frequency and Percentages for Gender**

| | Frequency | Percentage | Valid Percent | Cumulative Percent |
|---|---|---|---|---|
| **Male** | 42 | 48.3 | 48.3 | 48.3 |
| **Female** | 45 | 51.7 | 51.7 | 100 |
| **Total** | 87 | 100 | 100 | |

As shown in Table 1, there were about as many females (51.7%) as there were males (48.3%). The research question sought to determine whether there would be a relationship between gender of the staff member, on the one hand, and frequencies of client AWOLS, negative client/staff interactions, and client aggressive behaviors, on the other. To answer this question, independent t-test procedures were conducted. A two-tailed significance level of .05 was specified. The independent t-test compares the means of two samples. The two should be independent of each other. Furthermore, the dependent variable must be measured on an interval or ratio scale, and the independent variable should have only two discrete levels. In this study, the dependent and independent variables fit this description. The t test is robust and can handle violations of the assumption of a normal distribution [36].

The findings shown in Table 2 reveal that there is a significant relationship between male and female staff members and the number of client aggressive behaviors, $t(85) = 3.14$, $p = .002$. Male staff members reported experiencing more client aggressive behaviors ($M = 20.50$, $SD = 10.88$) than female staff members ($M = 13.40$, $SD = 10.20$). Further findings revealed that there was a significant relationship between male and female staff members and the number of client outbursts, $t(85) = 2.84$, $p = .006$. Male staff members reported experiencing more client outbursts ($M = 13.10$, $SD = 10.90$) than female staff members ($M = 8.73$, $SD = 10.38$). The independent t-test with a two-tailed significance level of .05 findings indicated that gender of the staff member was significantly related to the number of client aggressive behaviors at the .002 level, and client outburst behaviors were found at the .006 level. The findings indicated that male staff members experienced more client aggressive behaviors than female workers with means of 20.50 and 13.40 respectively; this can be explained by perceived gender differences by the clients themselves. Female staff members may be perceived as more nurturing than their counterparts on one hand and the male staff may be perceived as more physically challenging on the other. Based on this it is concluded that there is a significant difference between the frequencies of negative client/staff interactions serviced by male and female workers.

**Table 2**
***Mean, Standard Deviation, and Independent t-test Results for Gender and Frequency of Trauma Behavior (N = 87)***

| | Males | | Females | | | |
|---|---|---|---|---|---|---|
| **Variables** | ***M*** | ***SD*** | ***M*** | ***SD*** | ***T*** | |
| **Client AWOLS** | 26.81 | 18.18 | 22.22 | 19.44 | 1.14 | |
| **Negative client/staff interactions** | 29.74 | 15.96 | 23.87 | 16.73 | 1.67 | |
| **Client aggressive behavior** | 20.50 | 10.88 | 13.40 | 10.20 | 3.14 | ** |
| **Client outbursts** | 13.10 | 10.90 | 8.73 | 10.38 | 2.81 | ** |

*p< .05. **p< .01. ***p< .001.

Further, findings reflected group home milieu structures to portray conventional social family patterns of having both parents in a home setting with the father being held in the dominant role as discipliner and controller. As for client outburst findings, male staff again reported experiencing more client outbursts with a significant level at .006 with a mean of 13.10, while females experience of client outbursts on a mean average of only 8.73. This can be explained by viewing client outbursts as signaling behaviors spawned from fear of their physical safety within the milieu or from other youths. Signaling behavior generally indicate distress and a sense of helplessness.

## 5. CONCLUSIONS

This research sought to determine whether there is a relationship between gender of the staff member and frequencies of client AWOLS, negative client/staff interactions, and client aggressive behaviors. To determine this possible relationship independent t-test procedures were conducted. A two-tailed significance level of .05 was specified. The independent t-test compared the means of two samples that were independent of each other. The dependent variable was

measured on an interval or ratio scale, and the independent variable had only two discrete levels. Although the t-test is robust and can handle violations of the assumption of a normal distribution (Cronk 2008), the data in this analysis was normally distributed.

The findings reveal that there is a significant relationship between male and female staff members and the number of client aggressive behaviors, $t(85) = 3.14$, $p = .002$. Male staff members reported experiencing more client aggressive behaviors ($M = 20.50$, $SD = 10.88$) than female staff members ($M = 13.40$, $SD = 10.20$). Further findings revealed that there is a significant relationship between male and female staff members and the number of client outbursts, $t(85) = 2.84$, $p = .006$. Male staff members reported experiencing more client outbursts ($M = 13.10$, $SD = 10.90$) than female staff members ($M = 8.73$, $SD = 10.38$). Based on these results it is concluded that there is a significant difference between the frequencies of negative client/staff interactions serviced by male and female workers.

## 6. FUTURE RESEARCH OPPORTUNITIES

Current work in this area involves research that focus on identifying key internal organizational influences that may cause significant service outcomes within a human service organization. For instance, exploring the impact of workplace stress as a determinant of the way a human service organizations' delivery system functions, and understanding what caregivers do and don't do within human service organizations with a focus on their ability to be empathic, warm, and nonjudgmental.

This study is significant to the current body of literature as it offers discovery of the relational factors youth find important when engaging with residential caregivers. It uncovers how the youth's behavior is impacted due to those exchanges. There exists a growing petition for trauma informed care training in the field of congregate care; the need for further research in this area of care is necessary. Many findings underscored by this research can be a stepping-stone for further examination. This research discloses many possibilities surrounding the usage of group home employee characteristics and training benefits. Following are some suggestions for future research:

- How can group home organizations develop gender specific features that can be leveraged to balance service outcomes; for example, can male caregivers be trained to exhibit a more nurturing role against challenging behaviors when necessary?
- What are the underlying causes behind caregiver's education level which may contribute to their effectiveness in working with troubled children and youths?
- How does the caregiver's work experience contribute to the success and help these children and youths in group homes?
- What are the ethical ramifications facing group home organizations in the face of the practice of forging attachment bonds utilizing trauma informed care practices between caregivers and clients?
- What are the personal ramifications facing caregivers in forging positive attachments with out-of-home placed children and youths?

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