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Residential Treatment Centres and Group Homes

What Works and What Doesn't Work

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What Works and What Doesn't Work

Definitions:

The terms, residential treatment centre and group homes, refer to types of setting within the continuum of placement for people with special needs. The full continuum ranges from least intrusive and least support to highest level of intrusion and support, accordingly: (Martin, 2000; Curtis, 2001; Farmer, Burns, Dubs, & Thompson 2002; Frensch, & Cameron, 2002; Libby, Coen, Price, Silverman & Orton, 2005)

- (1) *Receiving Homes: (RH)* families who will take children on short notice for limited periods of time, while long term alternatives are considered
- (2) *Customary care or Kinship care: (KC)* full time nurturing and protection of children by their relatives, members of their tribes or clans, godparents, stepparents or other adults who have a kinship bond with the child
- (3) *Regular (non-kin) foster care: (FC)* full time nurturing, structure, socialization and guidance in the home of a non-kin
- (4) *Specialized or Treatment Foster Care: (TFC)* full time nurturing, structure, socialization and guidance in the home of a non-kin PLUS the foster parents are recruited, trained, reimbursed and under contract to care for children with special needs
- (5) *Family Group Care: (FGC)* full time nurturing, structure, socialization and guidance in the home of a non-kin with five or more children not of common parentage PLUS the foster parents are recruited, trained, reimbursed and under contract to care for children with special needs PLUS the foster parents are provided with special supports, such as a homemaker or child and youth workers on shift. Often the house is owned by the agency and the foster parents "live-in".

- (6) *Fully Staffed Group Care: (GC)* community based residential homes, in which the direct care of children placed is provided by child and youth workers organized on a shift-work basis. The shifts can be rotating block shifts (e.g. 3 days 4 days off) or based on shifts of 8 hours per day, 40 hours per week, covering a 24 hour cycle, 365 days of the year.
- (7) *Residential Treatment Centre: (RTC)* a system of care, in which several fully staffed group homes or a large campus with staffed residential units are managed under a common clinical supervisory structure, including day treatment or “on-site classrooms” and a clinical support unit (offering multi-disciplinary assessment, psychotherapy, family therapy and/or psychotropic medication).
- (8) *Psychiatric hospital and secure treatment units: (PH/ST)* institutions with wards (either contained within a hospital facility or in cottages on the hospital grounds), containing all of the ingredients of a residential treatment centre, but with the additional capacity to certify a young person as a danger to self and others and hold him/her in a locked room or ward.
- (9) *Correctional Facilities: (CF)* locked facilities to which youth are sent by court order as a consequence of criminal misconduct

The full continuum operates in almost every country in the world for children and youth in need of substitute care by the state or with special needs affecting their emotional, behavioural, developmental, mental or physical health. A similar continuum, without the foster care component, can be seen for adults with special needs such as mental illness, substance abuse disorder and developmental disability.

1.0 The Purpose of this Paper:

The purpose of this paper is to review the literature, especially, systematic reviews, meta-analyses and mega-analyses of the literature, on outcomes, evidence-based practice and evidence based treatment for residential treatment centres and group homes. The specific research questions are listed below.

1.1 Research Questions:

- (1) What are the outcomes for children and youth placed in Residential Treatment Centres (RTC) and staffed group homes (GC) compared with other types of placements on the continuum of care
- (2) How does service delivery change in agencies if RTC and GC adopt evidence-based *practices*
- (3) What is evidence-based *treatment* and are there EBTs that have been implemented within a settings such as RTC and GC
- (4) What are the practices or interventions operated by staff in RTC or GC that contribute to good outcomes for children and youth (i.e.) the *active ingredients* of effective service
- (5) What are the interventions as well as systemic problems with such agencies that contribute to bad outcomes for children and youth (i.e.) *iatrogenic effects*
- (6) What are the characteristics of children, youth and families, or their problems that would make RTC or GC an appropriate choice (level of care) in favour of less intrusive settings such as treatment foster care
- (7) What do prominent authors in the literature summarizing outcomes for children and youth in RTC and GC recommend in the best interests of children placed

1.2 Search process

Four electronic bibliographic databases (Psychinfo, ERIC, Sociological abstracts and the Applied Social Sciences Index) were searched using phrases such as evidence based treatment, evidence based practice, outcome evaluation, residential treatment centre and group care. In addition, the reading lists from course curricula for child and youth workers were reviewed. Hundreds of articles were reviewed at the abstract level and certain articles were reviewed in full text.

The next section is a review of outcomes for children and youth with mental health issues (including psychiatric disorders, behaviour problems and emotional problems, such as attachment difficulties and trauma related issues) across the continuum of placement types, based on the best research evidence available.

2.0 Outcomes for Children and Youth

2.1 Kinship Care and Regular Foster Care

Sinclair, Wilson, & Gibbs (2005) conducted an extensive qualitative and quantitative *pre-post* study of 596 children randomly selected from those living in regular foster care in seven local jurisdictions across England, including two foster care agencies within the city of London itself. An average of 14 months separated the two data collection periods. The informants were: foster parents, child's case worker, family case worker and children over the age of 5 years. In addition, 24 cases were selected for detailed case study (13 cases were previously identified as "gone well" and 11 cases had "done less well").

One half of the children were ages 11 and older and a quarter of these had been first admitted when under 5 years of age. Within the 11 to 15 year old age group, there were 2.9 discrete episodes of being in and out of care and 27% of these older children had experienced five or more placements. There is considerable instability in the lives of children in regular foster care. The vast majority of these children were admitted to care because of abuse or neglect (63%) followed by parental rejection of child (21%). The child's behaviour was a reason for admission in 3% of cases. The social workers identified "treatment" as one of the goals of placement in 2% of cases. The primary goals of placement were *long term placement in the foster parents' home* (38%) or *transfer to an adoption placement* (11%).

Changes over the 14 months of the study period were measured. The study examined the interrelationships between (a) *improvement* in behaviour, social competence, attachment and functioning, (b) negative placement disruptions and placement changes that were made for positive reasons, (c) foster parents' acceptance or rejection of the child, (d) the impact of other children in the foster family, (e) the services and support of social workers assigned to the foster home or the child and (f) foster parent characteristics: including age, training etc.

The study by Sinclair et al concludes that foster parents can be successful in offering stability, acceptance and care to all types of children including disturbed children. However, being a disturbed child in regular foster care places the child at risk of being rejected. Secondly, there is very little improvement for the disturbed child in his behaviour or global adjustment no matter how committed his foster parent is to ensuring placement stability, even when enhanced with psychotherapy and support.

These findings have been replicated by Reifsteck (2005) with 208 children and numerous studies reviewed by Paul Steinhauer (1991) and Judith Martin (2000). It should be noted that regular foster care was never intended as a treatment for children with a psychiatric diagnosis.

In a recent systematic review of psychosocial treatment for children in foster care (including regular and treatment foster care), Racusin, Maerlender, Jr. , Sengupta, Isquith & Straus,Martha (2005) concluded:

“In sum, a large number of the nearly one-half million children in foster care at any one time have histories of adversity and demonstrate high rates of behavioral and psychiatric difficulties. These problems do not dissipate by adulthood; rather, these children are at significant risk for a broad spectrum of adverse functional outcomes, including poor academic achievement, un/under-employment, homelessness, chronic mental health problems, unintended pregnancies, substance abuse, and antisocial behaviors. The negative outcomes appear to be associated with a combination of the lingering effects of adversity preceding out-of-home placement, demographic factors, poor response to interventions during foster care, and premature transition to adulthood and independent living before attaining necessary adaptive skills.” (p. 204)

It also appears that the clinical profile of children in regular (non-kin) foster care is identical to children placed in kinship care (McMillen, Zima, Scott, Auslander, Munson, Ollie, Spitznagel, 2005).

2.2 Treatment Foster Care

Multidimensional treatment foster care is an implementation of treatment foster care that is evidence-based. The principle researchers behind this model have published information on the nature of the treatment process. (Fisher & Chamberlain, 2000).

Case workers have low caseloads (10 to 12 children each); the foster parents measure behaviour and consult with clinical staff on a daily basis; the parent daily report (PDR) lists the child's response to a predetermined list of behavioural targets, the number of points earned or taken away in response to the child's behaviour.

Areas Targeted By Multidimensional Treatment Foster Care:

- Reinforce normal and prosocial behaviours
- Provide the youth with close supervision
- Closely monitor peer associations
- Specify clear and consistent limits and follow through on rule violations with nonviolent consequences
- Encourage youth to develop positive work habits and academic skills
- Support family members to increase the effectiveness of their parenting skills
- Decrease conflict between family members
- Teach youth new skills for forming relationships with positive peers and for bonding with adult mentors and role models.

In addition to the foster parents, the treatment team includes behaviour support specialists (who work one-on-one with the young person in applied behavioural analysis), youth therapists (who advocate for the youth), family therapists, consulting psychiatrists, PDR callers, and case managers/clinical team supervisors. Many MTFC youth enter the program with multiple diagnoses that include disruptive behaviour disorders such as conduct disorder and attention-deficit disorder, as well as posttraumatic stress disorder, depression, dysthymia, bipolar disorder, and obsessive-compulsive disorder. Often, along with these diagnoses come complex medication regimens that have developed as the youth has transitioned from one setting to another. The consulting psychiatrist reviews the diagnosis, manages the medications and makes recommendations for dealing with comorbid illness.

The results of outcome studies prior to the year 2000 were reviewed. The outcomes observed on three occasions (discharge, one year and two years later) for the random controlled trial of 79 boys with serious delinquency showed the MTFC group had few arrests, fewer runaways and less self-reported delinquency than a control group placed in one of 11 group homes in Oregon State. At the two year point, the MTFC group were more likely to have jobs, better relationships with their families, practiced safe sex and used drugs less frequently. Outcomes related to the comorbid psychiatric conditions were not reported; there was no information about emotional adjustment or relationship patterns. The MTFC program in Oregon, which is well represented in the EBT literature, is a small program with less than 50 children being treated. There are, however, thousands of children in treatment foster care across North America. Reddy and Pfeiffer (1997) examined studies covering a wide range of TFC programs. They found that treatment foster care produced large positive effects on increasing placement permanency and children's social skills. Medium positive effects were found in reducing behaviour problems, improving psychological adjustment, and reducing restrictiveness of postdischarge placement. Although, there were few investigations which collected data both at time of program completion and follow-up, precluding a test of the durability and generalizability of treatment foster care outcomes.

James & Meezan (2002) also reviewed the literature on treatment foster care outcomes across many different programs. They concluded that (a) treatment foster care (TFC) is delivered with such variability that conclusions about its effectiveness are difficult to draw; (b) many variables in the child's ecology that potentially confound the effects of the intervention remain unexamined; and (c) service impacts have been defined narrowly.

2.3 Family Group Care

The literature on outcomes in family-based group care is focussed almost entirely on the “teaching family model” which is listed by many authors as an evidence-based treatment (US Surgeon General, 1999, page 177). The teaching family model is a derivative of the research at Achievement Place. The components of the Teaching Family Model: (Field, 2004) are:

- (1) a token economy type motivational system where points are exchanged for privileges
- (2) a focus on teaching youth social skills from a standardized skills curriculum
- (3) an emphasis on normalization, including having youth involved in the maintenance of the home (e.g., cooking, cleaning, and other chores) and participation in sports, and
- (4) a system of self-government in which youth take partial responsibility for the establishment and maintenance of house rules.

Frensch and Cameron (2002) reviewed several studies of the *teaching family model*. There are over 250 programs across Canada and the USA offering the teaching family model. Most of the published research is on Achievement Place located in Lawrence, Kansas and Father Flanagan’s Boys Home in Boys Town, Nebraska. The literature reports modest effectiveness of the teaching family model on educational progress. They reported more Boys Town residents (83%) had graduated from high school than residents of a comparison sample (69%) in two group homes operated on a different treatment approach. In an examination of 13 Achievement Place homes and 9 comparison group homes, there was evidence of in-program change, but little evidence for the maintenance of post-program change on other indicators of success. In a comparison of the number of youth involved in recorded criminal offences, the only significant advantage for Achievement Place homes over comparison group homes occurred while residents were in treatment.

As the case with many “evidence-based treatments” there is evidence of a positive difference in outcome for the *teaching family model* over other “generic group homes”, but the outcomes tested are limited and there are questions about how much these findings can be generalized over time and from one site to the next. Quoting from Frensch and Cameron:

“Studies of the effectiveness of this model appear to support modest in-program gains, particularly in the area of educational progress. However, the teaching family model appears to fall short in the long-term maintenance of in-program effects and in the post-treatment reduction of delinquent and criminal behaviour.” (Frensch and Cameron, 2002, page 331)

2.4 Staffed Group Care:

There are no articles on the outcomes for children in family group care compared with children treated in fully staff operated community based group homes. However, there are studies that have examined differences in treatment approach (behaviourism versus non-behavioural) and comparing group care to treatment foster care.

In general, the US Surgeon General has observed that “there is a dearth of research on the effectiveness of therapeutic group home programs targeted towards the emotionally disturbed adolescent” (US Surgeon General, 1999, page 177). The US Surgeon General cited a dissertation study on the outcomes of 20 adolescents treated in a group home compared with a matched sample of 20 adolescents who were not treated. This study concluded that after 18 months, 90% of the treated group had fair or good functioning compared with 45% of the untreated group. “The treated group achieved a significant decrease in psychopathology, while the untreated group did not.” (US Surgeon General, 1999, page 178).

The vast majority of outcome research in staffed group care is targeted at services to young offenders. Grietens and Hellinckx (2004) conducted a *mega-analysis* of all other meta-analyses of research in relation to criminal misconduct and recidivism. The article by Grietens and Hellinckx reviewed 857 published articles. One of the largest meta-analysis by Garret concerned 8,076 young people in correctional institutions (90 studies) and community group homes (21 studies) compared with 4,979 in a control group. The researchers narrowed the data to only those studies with a high quality research design. Under conditions of best science, the results demonstrate that different treatment approaches are all somewhat effective in reducing recidivism. Specifically, group homes using a *psychodynamic approach* produced a 17% decline in recidivism, a 30% decline for *behavioural programs* and a 32% decline for programs based on *enhancement of life skills*.

When the studies were grouped according to theoretical orientation of programs, Garrett found that treatment based on behavioral theory produced the greatest amount of positive change across delinquent types and outcome measures including psychological adjustment, recidivism, community adjustment, and academic improvement. Cognitive-behavioural interventions, family therapy, and wilderness programs also yielded large positive changes

Frensch and Cameron completed a systematic review of outcome studies in both “family based group care” and residential treatment centres. They concluded:

“Parental involvement and family support during treatment is consistently and significantly related to children and youth’s within treatment progress and the ability to successfully adapt to the community following discharge. This was common to outcome

studies for both group homes and residential treatment centres." (Frensch and Cameron, 2002, page 335).

Another systematic review of group care by Curtis, Alexander & Lunghofer (2001) came to the same conclusion, but added one more critical ingredient, *educational support*.

2.5 Residential Treatment Centres

There are many more outcome studies and more varied designs evaluating the effect of residential treatment centres (RTCs). RTCs are defined as offering a system of care with group living and robust clinical support. The systematic review of outcome studies in residential treatment by Frensch and Cameron (2002), found a significant effect of *family involvement in treatment* on positive outcomes for children and youth. Conversely, the number of family problems at admission, such as abuse, mental illness, and divorce, was negatively associated with follow up measures of home and school adjustment.

The findings from a composite of studies found that generalization of treatment gains after discharge from treatment was dependent on factors such as:

- (1) parents made contact with their children and the residential staff during treatment
- (2) contacts made by parents were more positive in nature.
- (3) there was a reduction of stress and an increase of support in a child's post-treatment environment
- (4) after-care services were used by the youth and his family post discharge
- (5) prior to discharge there were significant *within-treatment improvements* in child's self esteem, level of present and risk of future of antisocial behaviour and decreased risk of substance abuse

Hoagwood and Cunningham (1992), who are prominent authors in the evidence based treatment literature, conducted an outcome study of 114 emotional disturbed residents. The children studied were admitted because of *severe behavioural problems* (violence, assaultiveness, and serious suicide attempts), *family functioning* (neglect, concern for family's safety, and sexual abuse), and *school performance* such as persistent school failure. Overall:

- (1) In 63% of the cases, either no or minimal progress had been made in treatment or the student was discharged with a negative outcome.
- (2) Twenty-five percent of students had a positive outcome status of being discharged back into school or into school-related vocational training

- (3) 11% of students were still in placement with substantial treatment progress.

Hoagwood and Cunningham found that a positive outcome was more likely to occur if: (a) a student was discharged prior to 15 months and (b) community-based services were available to support the transition of a student from residential placement into the community. (reviewed in Frensch and Cameron, 2002, page 333)

Lyons, Terry, Martinovich, Peterson & Bouska (2001) conducted an outcome study of 285 adolescents over a two year period. The youth were placed in one of seven residential treatment centres. Results suggest that while adolescents tended to improve overall during the course of their stays, there was considerable variation in which symptoms improved and which did not. Two symptoms actually became reliably worse with treatment. In addition, significant variation in outcomes was demonstrated across sites, with adolescents in one site getting reliably worse during the course of residential treatment.

The primary *diagnosis-related groups* that were treated were:

- post-traumatic stress disorder (PTSD, 27%)
- attention-deficit hyperactivity disorder (ADHD, 21%)
- depressive spectrum disorder (17%)
- oppositional-defiant disorder (ODD, 11%)
- bipolar disorder (7%)
- psychotic disorder (6%)
- conduct disorder (2%), and
- adjustment disorder (1%).

The Acuity of Psychiatric Illness—Child and Adolescent Version (CAPI, Lyons, 1998) was used to monitor various aspects of psychiatric illness during each review period. The CAPI is composed of 20 anchored ratings (0 to 3) of items in four domains: *High Risk Behaviors* (e.g., aggressiveness, suicidality, self-mutilation), *Symptoms* (e.g., depression, anxiety, impulsivity, reality assessment); *Functioning* (e.g., educational, family, peer, and self-care functioning) and *System Support* (e.g., parental supervision, safety).

The findings were as follows:

- (1) improvement in self-mutilation and aggression towards people
- (2) clearly reliable improvement in suicidal ideation/gesture
- (3) Aggression towards Objects (kicking a chair in anger, damage to buildings) failed to show any response to residential treatment for the full sample

- (4) no site demonstrated improvement exceeding that found in other sites
- (5) children and adolescents placed in one particular site were significantly less disturbed but these children and adolescents became reliably worse over the course of their residential stay.
- (6) RTC may be somewhat more effective with PTSD and emotional disorders rather than ADHD and behavioural disorders.

The research within residential treatment centres provides more detail than can be seen in the outcome studies on group homes. The research on community based group homes is almost entirely about juvenile delinquents adjudicated to a group home placement as their consequence. Moreover, the outcome domain, *recidivism*, is widely reported to the exclusion of other possible outcomes, such as school performance, social functioning, symptom relief, etc.

In contrast, the research on RTCs cover a range of diagnostic groupings and outcomes (including functioning, academic success, symptom relief and change in problem behaviours).

2.6 Psychiatric Hospitals

This is the most intensive and restrictive level of care for treatment purposes. According to Wong (1999), there are relatively few empirical studies demonstrating the therapeutic benefit of psychiatric hospital for treating serious behavioural disorders. There have been some outcome evaluations of psychiatric hospitals, and the overall conclusions is that such facilities do achieve *within-treatment* changes for youth with most severe mental health crisis, including suicide attempts and severe depression, severe aggression, schizophrenia and psychoses. Kazdin (1989) investigated 324 children receiving 2 to 3 months of psychiatric inpatient care. Kazdin found statistically significant improvements on almost all clinical measures, including indicators of aggressive and hostile behaviour, at 1 month and 1 year follow-up assessments.

Wong (1999) conducted an outcome evaluation of behaviour modification treatment (token economy) in a psychiatric hospital setting where young people remained on average for 60 weeks. The conclusion showed that clients improved very slowly but to a clinically significant degree on serious behaviour problems that were the basis of their hospitalization in the first place. All but one youth (diagnosed with schizophrenia) improved significantly and were able to be discharged to less restrictive settings.

2.7 Correctional Facilities

Correctional facilities have been the subject of extensive evaluations over many decades. Grietens & Hellinck (2004) re-analyzed the databases of 10 large meta-analyses of young offenders in residential treatment (group homes, RTC and correctional facilities). The most comprehensive meta-analysis of treatment for delinquency was conducted by Lipsey (1992) and Lipsey and Wilson (1998). In this analysis, nearly 400 treatment programs were included, in which about 40,000 juveniles participated. The authors made a distinction between treatment effects for institutionalized (83 studies) and noninstitutionalized offenders (117 studies). The mean effect size was a 10% reduction in recidivism but there was great variation in outcomes across the 200 studies. Sixty-four percent (64%) of studies showed a reduction in recidivism and 36% showed an increase in recidivism. Lipsey analyzed the differences in offender characteristics, setting, treatment approach and legal sanctions. They found that program type was the key variable in explaining differences in outcomes; specifically behavioural programs were much more successful. Lipsey's meta-analysis was grouped with additional studies (Dowden & Andrews, 2000). They found that programs based solely on legal sanctions (whether it was Probation or a correctional institution) produced a 2 percent increase in recidivism.

“The successful programs significantly more often included a sound theoretical model, multifaceted treatment, role-playing, modeling, and social-cognitive skills training. Further, successful programs included attention for the need principle (Andrews et al., 1990). This means that treatment targets were matched to the specific criminogenic needs of the offenders, and for the responsivity principle (Andrews et al., 1990), this means that the styles and modes of treatment were attuned to the learning styles and abilities of the offenders. “

“This review of metaanalyses on the treatment effects for residentially cared juvenile offenders .. produced an average reduction of recidivism by about 9%” (Grietens & Hellinck, 2004, page 410).

2.8 Conclusions about outcomes across the continuum

Positive lifespan outcomes have been demonstrated for children across the continuum of care from kinship care to residential treatment centres and psychiatric hospitals. Positive outcomes – in particular, reduced recidivism – have been demonstrated even within correctional facilities and within community based group homes for delinquents. The *nothing works* doctrine first articulated by Martinson (1974) has been completely repudiated (Ross & Gendreau, 1980; Grietens & Hellinck, 2004) This does not mean that *everything works for everybody*; there are different outcomes depending on the following:

- (a) **Severe family-based risk:** (i.e.) the parents are dangerous or disturbed as well;

Seriously disturbed parents do not adversely affect the child's *within-treatment* gains, but these problems do adversely affect successful adjustment (i.e. generalization of treatment effects) post discharge.

- (b) **Severe developmental risk:** (i.e.) the child is significantly emotionally disturbed or delinquent

- i. in contrast with a child who has suffered from misfortune and maltreatment but who is otherwise normal, developmentally, – except for his misery and lack of structure and opportunities in life

Children with established developmental risk (emotionally disturbed or delinquent) do not get better in regular foster care or kinship care. These children require treatment and many (but not all) change for the better with treatment.

- (c) **the nature of the child's special needs** (psychiatric, learning, behaviour, family-based, etc.)

The nature of the child's special needs must be matched to the areas targeted by the treatment program to produce positive outcomes. In general, most disturbed children need special educational support. Many need intensive supervision and special attention to ensure that they feel safe both in the placement resource and the community.

- (d) **the nature of the daily program** (behavioural methods, therapeutic alliance, developmental competency and skill building)

Children with dangerous or self destructive behaviour respond best to behavioural treatment methods; finally, emotionally disturbed and/or traumatized children need sensitive, relationship building care. Research has shown that different treatment methods achieve different outcomes and that seriously disturbed children have multiple issues to deal with (emotional, behavioural, educational, chemical) and they need multi-modal (i.e. multi-method) treatment across all social situations (multi-systemic).

- (e) **the level of care** (i.e. intensity or adult-child ratios and type of resource from family homes to staffed community group homes and residential treatment)

More intensive interventions (on condition that the child is not low-risk of having or developing emotional and behavioural disorders) produce more and better outcomes. Even the exemplar program for multidimensional treatment foster care, which is evidence based, is much more intensive than any other treatment foster care program (i.e. low caseloads, multiple and varied support staff, daily clinical direction for every child, multi-disciplinary clinical support).

3.0 Implementation of Evidence-based Practice

This section describes what is evidence-based *practice* and how it could be implemented in staffed group care and residential treatment centres. The following quotes which are cited in Whittaker (2006) and in the *KE Glossary* (2005) describe evidence based practice

“Evidence-based social work is the mindful and systematic identification, analysis, evaluation, and synthesis of practice effectiveness as a primary part of an integrative and collaborative process concerning the selection and application of service to members of target client groups. The evidence-based decision-making process includes consideration of professional ethics and experience as well as the personal and cultural values and judgments of consumers. (Cournoyer, 2004, p. 4).

“Evidence-based practice indicates an approach to decision making which is transparent, accountable, and based on a careful consideration of the most compelling evidence we have about the effects of particular interventions on the welfare of individuals, groups, and communities” (Macdonald, 2001, p. xviii).

“The conscientious, explicit and judicious use of current best evidence in making decisions about the care of [clients]” (Sackett, Richardson, Rosenberg, & Haynes, 1997, p. 2).

“We use the term evidence-based practice to describe practices (e.g., outcome management, intake screening, outcome measurement, program evaluation), whereas the term evidence-based treatment (EBT) refers specifically to empirically supported interventions. Placing the client’s benefits first, evidence-based practitioners adopt a process of lifelong learning that involves continually posing specific questions of direct practical importance to clients, searching objectively and efficiently for the current best evidence relative to each question, and taking appropriate action guided by evidence. In

children's mental health services, the term evidence-based practice (EBP) refers to a body of scientific knowledge about service practices, including referral, assessment, outcome management/assessment, quality improvement practices, and case management." (Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001).

"It also refers to scientific knowledge about the impact of clinical treatments or services on the mental health problems of infants, children, and adolescents. The knowledge base results from the application of scientific methods that examine the impact of specific practices on outcomes. EBP denotes the quality, robustness, or validity of scientific evidence as it applies to these issues." (Barwick, et. al, 2005 'Knowledge Transfer & Implementation of Evidence-Based Practice in Children's Mental Health, Children's Mental Health Ontario, Toronto)

Child & Youth Workers in management positions promote evidence-based practices within their programs by attending to four principles:

- (1) *being scholarly*: reading the current literature and consciously relating their professional opinions to the source (theory or research)
- (2) *evaluating the literature*: deciding through a critical process if the literature or ideas from a training seminar meet the standards of good science and are worthy of affecting practice
- (3) *applying new ideas*: taking information about best practice or new knowledge from current research and improving the way service under their management is delivered
- (4) *sharing the knowledge*: disseminating the information learned about best practice to staff and colleagues

Guidelines to assist in the implementation of each of the principles follows.

3.1 Being Scholarly

Staying up to date with current literature by reading the best journals in your profession is a criterion of competent management; Ontario government officials actively promote this standard and evaluate agencies against it. (Rettinger, 2006)

3.1-a Journals

The articles in this review of the literature on child & youth work and residential treatment were published in the following journals:

American Journal of Orthopsychiatry
American Psychologist
Behavioural Interventions

Child and Adolescent Psychiatric Clinics of North America
Child and Family Social Work
Child & Youth Care Forum
Children and Youth Services Review
Child Psychiatry and Human Development
Clinical Case Studies
Clinical Psychology: Science and Practice
International Journal of Social Welfare
Journal of Abnormal Child Psychology
Journal of Behavioural Education
Journal of Child and Family Studies
Journal of Child & Youth Care
Journal of Clinical Child Psychology
Journal of Consulting and Clinical Psychology
Journal of Emotional and Behavioral Disorders
Professional Psychology: Research and Practice
Psychiatric Services
Research in Social Work Practice
Residential Treatment for Children and Youth
Social Services Review

3.1-b Websites

Ollendick & Davis (2004) recommend a *4s strategy* for obtaining information from the web.

- 1) *System sources*: These are frequently updated summaries of results of high-quality systematic reviews of original research articles.
 - a. The British Medical Journal provides this type of information at one of its speciality sites: www.clinicalevidence.org.
 - b. The National Institute of Mental Health is a US government website See: <http://www.nimh.nih.gov/>
 - c. The Centre of Knowledge on Healthy Child Development at McMaster University set up in honour of Dr. Dan Offord. The site provide evidence based information on anxiety, mood disorders, depression and behaviour problems. The page on behaviour problems can be found at: http://www.knowledge.offordcentre.com/behaviour/cd/summaries/cd_evidence_02.html

- d. The Provincial Centre of Excellence for Children and Youth Mental Health in Ontario provides a library of articles supporting evidence based practices and evidence based treatment, including systematic reviews of the literature. See: http://www.onthepoint-childandyouthmentalhealth.ca/index_e.htm
 - e. The American Psychological Association's special site on evidence based treatments for children and youth contained information on anxiety, depression, ADHD and oppositional defiant behaviour problems. See: <http://www.effectivechildtherapy.com/>
- 2) *Synopses*: These are structured abstracts of high-quality systematic reviews of original research articles.
- a. The British Medical Journal provides another speciality site for this type of information at www.ebmh.bmjournals.com.
 - b. The Centre for Evidence based mental health is based in the United Kingdom and provides extensive information on the latest research in child and adolescent psychiatry. See: <http://cebmh.warne.ox.ac.uk/cebmh/>
- 3) *Synthesis*: high-quality systematic reviews of original research articles.
- a. A good example of this is the Cochran library at www.update-software.com/abstracts/mainindex.htm
 - b. The American Association of Child and Adolescent Psychiatry publishes "practice parameters" for different disorders. This is very useful if you have a client with a specific psychiatric diagnosis. See: <http://www.aacap.org/index.wv>
- 4) *Studies*: the original source study for the levels above. In order to locate the source articles, the reader needs access to electronic databases, such as Psychinfo. You can view PsycARTICLES and PsycCHAPTERS abstracts for no charge, and pay just \$11.95 for each full-text article you want to read, save or print. See: <http://psycinfo.apa.org/psycarticles/search>

3.2 Evaluating the Literature

Many people use google to find the latest information on children with mental health issues or on residential treatment. This often links the user to bad science and worse advice. It is much safer to search inside of reputable web sites, such as the one listed above.

Systematic reviews of the literature published in reputable journals, such as the ones listed above, provide a synopsis of published research in a particular area, such as residential treatment, treatment foster care, etc. over many years. The authors generally screen the articles according to declared criteria, such as scientific merit. The findings from several studies can be grouped in a common statistic, referred to as *the treatment effect* or the *mean effect size*, which is the change in the average score on admission and discharge divided by the pooled standard deviation. The degree of improvement of an experimental treatment over a control group (either a group which gets no intervention or treatment as usual) can be stated as an *effect size*. An effect size that is less than 0.3 is considered small; effect sizes in the range of 0.3 to 0.5 is considered medium and anything that is greater than 0.5 is considered large.

Another way to answer the question of *what works* is to account for: (a) the proportion of children who drop out of treatment, (b) the percentage who improve (i.e. responders) and the % who did not improve or even became worse and (c) the % who broke down after discharge and were placed in a higher level of care. (Connor, Miller, Cunningham & Melloni, 2002). It is critical to ask the effectiveness question in both ways since an experimental treatment may obtain better outcomes in terms of average scores, but at the cost of high drop-out rates or a high proportion of low grade responders. They only look good *on average* because of a small number of super-responders who push the averages up. A recent meta-analysis of evidence based treatments for phobia, anxiety and depression (Westen & Morrison, 2001) found that *less than 1/3rd of candidates* for the "efficacy trials" were accepted. Moreover, many did not complete the experimental treatment and were dropped from the study. Of those who completed (74% of depressed patients to 86% of panic disorders), 1/2 of the patients who completed the experimental treatment improved. Westen & Morrison (2001) conclude:

"With patients that improved, there was a substantial reduction in symptomatology, but depressed and anxious patients continued to experience a clinical significant level of symptoms on discharge. On follow-up two years after a course of EBT, roughly 1/4 of carefully screened patients with major depression, who are not suicidal and do not abuse alcohol or other drugs, can expect to improve and remain improved 2 years later. By any standards, it is difficult to construe these data as evidence for the hypothesis that these treatments show genuine efficacy for the treatment of depressive disorder." Page 886

Evidence based treatment is still in its scientific infancy and the whole story is sometimes clouded by the enthusiasm of the proponents to the treatment. We must always ask: (1) what types of children (disorders and problems) were shown to improve; (2) what types and what percentage of children did not improve; and (3) what does the word "improve" mean.

3.3 Applying new ideas

Raising the standard of service is a great challenge to professional child and youth workers with management responsibility. It is especially difficult because there are large numbers of direct care givers in staffed group homes and residential treatment centres who are not specifically trained in child and youth work.

The strategies than a treatment organization must do to fully implement an evidence based practice standard are as follows: (Chambless et al., 1996)

- (1) Articulate strategies to change practitioner behaviour in line with theory-based practice, accreditation standards, internal outcome data or new findings from basic research – with an emphasis on strategies for:
 - a. dissemination of the information to the staff and
 - b. acceptance of the new paradigms.
- (2) Deliberately change organizational behaviour by monitoring and reinforcing the fidelity of implementation
- (3) Deconstruct the treatment environment to identify core potencies and recognize counter productive elements
- (4) Have a system of uniform therapist training and a system to ensure therapist adherence to planned procedures,

In order to implement evidence based practice, agencies require a comprehensive plan to bring out the desired changes. In order to make a plan, the child and youth manager must be have good information (through observation and supervision) about current patterns of interaction between workers and clients; this needs to be broken down into positive therapeutic activities that are linked in the literature to good outcomes (e.g. evidence of competent behavioural treatment capability when dealing with dangerous or self destructive behaviour). It is also wise to identify staff/client interaction that is counter therapeutic and known to produce bad outcomes (e.g. restraining children for the purpose of “bonding” to them).

The plan should reinforce positive staff interactions and treatment capacity and monitor and stop bad practice. It is also important to set up a program of *capacity building*, in which staff are trained, supervised and rewarded to learn new treatment approaches that are more appropriate to the needs of the clients according to the scholarly reviews. Please see section, [8.0 Best Practice Recommendations for GC and RTC](#), for a discussion of best practice in residential treatment today.

3.4 Disseminating the Information

This means that management must share the knowledge gained from scholarly reviews to the front line staff using a variety of innovative ways to communicate including: (a) designated time at the regular staff meeting and (b) creating a logic model of your program as it should be and having the staff read and discuss it (Whitaker, 2004). Please see section [8.3 increasing the uptake of EBP in group care and RTC](#) for more details on preparing a logic model.

Clinical supervision is a critical opportunity to monitor and assess the fit between the front line practice and evidence-based practice; regular and timely supervision is essential to teach and reinforce best practice. The relationship between the supervisor and the front line staff can be a means to support staff in an emotionally demanding and stressful job; the supervisor-relationship can be used to model interpersonal and communication skills that staff must use with the children. Finally the supervisory relationship provides a means to prevent and manage the symptoms of burn out. Front line burn out is a source of iatrogenic effects or unintended bad outcomes for children in placement.

4.0 Evidence based Treatment

Evidence based *treatment* is much more narrowly defined than evidence based *practice*. Evidence based treatment concerns a set of interventions that meet certain conditions, specifically:

“Treatment is identified as evidence-based if:

- a) Treatment has been compared with either a no-treatment control group or some other intervention (e.g. treatment as usual or TAU)
- b) Two or more random controlled studies attest the effects of intervention
- c) The studies include replication of findings beyond the original investigators
- d) The patient sample has been well specified (inclusion and exclusion criteria) and perhaps diagnosis
- e) Treatment manuals are used for the intervention” (Kazdin, 2005, p. 14)

Although the definition is quite clear, there is considerable disagreement about which “treatments” belong on the list (Ollendick & Thompson, 2004). Miller, Sweben & Johnson (2005) examined 10 systematic reviews of evidence based treatments for substance abuse in youth or adults; they found that some treatments are found on most lists of EBTs whereas others appear on only one or two so that in the end no single list

of evidence based treatments by the most prominent research groups are identical. There at least 150 different treatment packages that meet the criteria of evidence based treatment. (Malik, Beutler, Alimohamed, Gallagher-Thompson & Thompson, 2003).

4.1 EBT's based on a prevention models

There are several effective primary prevention models, many of which are variations of *Parent Management Training* (PMT) including Incredible Years Parenting Program (IYPP) by Webster-Stratton and the 3Ps program. "The field of evidence based parent management training programs is "vast" covering various types of clinical issues and client characteristics with some commonalities (behaviourism) and differences. "Despite the differences, the results are positive." (Kazdin & Weisz, 1998) Other prevention programs, such as *I can problem solve* (ICPS) by Shure (research Press), are based on *Problem Solving Skills Training* (PSST).

The prevention programs are based on 10-12 week sessions of 1-2 hours duration in groups of 5 to 15 youth. The curricula, however, has been implemented by child and youth workers in group homes and residential treatment centres as a component of their daily program. The description of the active ingredients of PSST (as deconstructed by Kazdin & Weisz, 1998) is similar to the process of running a daily program in a group home or treatment by child & youth worker. (Libby, Coen, Price, Silverman & Orton, 2005; Vollmer, 2005; Ward, 2004; Trieschman, Bredtro & Whittaker, 1969, chapter 2 on engaging the child and chapter 3 on play and structured tasks).

- "Start with how children approach situations especially their thoughts
- Teach children a step-by-step approach to solve interpersonal problems
- Foster prosocial behaviour through modelling and reinforcement
- Employ structured tasks involving games, academic activities and stories
- Identify and express verbally the *child's otherwise unspoken self-talk*
- Teach the child the sequence of different examples of self talk that lead to particular problems
- Provide cues that prompt the child to apply his newly taught skills to the immediate situation
- Provide feedback and praise to reinforce correct use of skills
- Employ modeling, practice, role playing, reinforcement and mild punishment such as loss of points or token" (active ingredients of PSST according to Kazdin & Weisz, 1998)

4.2 EBT's based on time-limited counselling sessions

A second class of evidenced based treatments can be described as time-limited counselling employing interventions such as: (a) cognitive behavioural therapy, tailored to reduce symptoms of Post Traumatic Stress Syndrome in specific populations such as sexually abused girls (Target & Fonagy, 2005) and (b) cognitive behavioural therapy for depression aimed at depressogenic thoughts in combination with drugs and/or interpersonal therapy (Target & Fonagy, 2005). There are several combinations of time-limited evidence based treatments for different diagnostic groups. However, these are treatment models that are implemented in a clinic setting and in the physician's office. Children in group care and residential treatment often obtain these services *as an adjunct* to the residential program (Breland-Noble, Farmer, Dubs, Potter & Burns, 2005). These researchers studied the type of services used by 304 youth, 184 in TFC and 120 youth in group homes. The youth were similar on clinical and demographic dimensions. Their findings were as follows:

“In both settings, nearly all youth received case management, mental health specialty treatment, and some intervention in school. Inpatient psychiatric care, school guidance counselors/psychologists, special educational classes, and vocational services did not differ by placement type. ... On the other hand, group home youth were more likely than TFC youth to serve time in a detention facility; have a probation officer ; work with a psychologist, psychiatrist, or therapist; visit an emergency room; and attend a special school” (Breland-Noble, Farmer, Dubs, Potter & Burns, 2005, p. 173).

“The current work suggests that such residential placements operate within an extensive system of care for serving youth. Youth in these settings receive a wide variety of services beyond their residential placement. Some of these (e.g., outpatient therapy and case management) are so common that they may be seen as part of the ‘bundle’ that comprises such residential treatment.” (Ibid, page 178)

Breland-Noble, et al concludes that it is very difficult to disentangle the positive and negative (iatrogenic) effects of the adjunct services. Indeed, Breland et al conclude that the negative outcomes in group care for delinquents may be the result of their involvement in the correctional system (courts, probation officers, etc.) which is occurring at the same time as the group care is provided.

4.3 EBT's for seriously emotionally and behaviourally disturbed

A recent systematic review of the literature on effective prevention and treatment for child mental health (Weisz, Sandler, Durlak & Anton, 2005) found that the following treatment settings are poorly represented in the evidence based treatment interventions: (1) primary care clinics, (2) day treatment programs, (3) residential facilities, (4) family courts and (5) inpatient units. There are several disorders for which there is little

evidence of effective treatments: (a) eating disorders, (b) youth sex offenders, (c) suicidal youth and (d) teenagers with ADHD. There are more than 100 diagnostic categories in the DSM and evidence-based treatment covers a small percentage of these.

“In addition, comorbidity in youth is very common and only four programs aimed primarily at young offenders and substance abuse address a range of comorbid problems in the model: MST, MTFC, functional family therapy and multidimensional family therapy.

“Almost all EBTs related to time limited brief therapy and very few address enhanced therapy (for difficult cases) and continuing care (for chronic cases). Moreover, the vast majority of time limited therapies are variants of cognitive-behavioural interventions; conversely non-behavioural approaches (psychodynamic, client-centred, eclectic) represent between 18% and 26% of studies sampled. This is true despite the fact that “nonbehavioural approaches are more representative of the treatment models most widely used in clinical practice.” (Weisz, Sandler, Durlak & Anton, 2005, Page 639)

There are four *non-residential* evidence based treatments that have demonstrated efficacy with seriously disturbed adolescents: (*Community Treatment ... 2002*)

- (1) *Multi-systemic Therapy (MST)*: This is a form of family therapy in which the content of the intervention (marital or family therapy, parent training, behavioural and cognitive approaches, supportive therapy and case management) are combined to fit the clinical picture; MST is effective according to Target & Fonagy (2005), but it also depends on an intact and willing family.

MST meets the criteria of EBT according to Burns & Hoagwood (2002) and several other reviews referenced in this paper, including Target & Fonagy (2005). However, outside of the tight circle of researchers dealing with youth mental health, MST is not highly visible. In a review of ten separate lists of EBTs for substance abuse by the seven most prominent research groups in the field, MST appeared on only one list. (Miller, Sweben & Johnson, 2005). A treatment manual has been prepared for MST and the treatment is associated with rigorous protocols for ensuring compliance with the model.

- (2) *Intensive Case Management (ICM)*: to mobilize, coordinate and maintain an array of services and resources to meet the needs of individuals over time (Evans & Armstrong, 2002, page 41). Different models of case management have been tested; where properly implemented with appropriate caseloads, intensive case management is effective in reducing symptoms and improving social adaptation of the youth. The

functions of case management are: assessment, service planning, service implementation, service coordination, monitoring & evaluation and advocacy.

Intensive case management meets the criteria of evidence based treatment according to Burns & Hoagwood (2002). It is also a component of multisystemic therapy and the defining functions of ICM are similar to the definition of evidence based practice. There is no manual or protocol for testing compliance with the model. As noted in the introduction to section 4.0, no expert group agrees on which treatments belong on the list of EBTs and which do not. ICM does not appear on several recent reviews of EBTs for youth by Target & Fonagy (2005). In a review of ten separate lists of EBTs by the seven most prominent research groups in the substance abuse field, ICM appeared on only one list. (Miller, Sweben & Johnson, 2005).

- (3) *Wraparound*: Wraparound is a “definable planning process that results in a unique set of community services and natural supports that are individualized for a child and family to achieve a positive set of outcomes” (Burchard, Bruns & Burchard, 2002, page 69). The process of developing the plan requires the involvement of the family and a variety of community agencies. Wraparound has been deconstructed and adapted to treatment foster care (Marsenich, 2002). Wraparound, however, is not nearly as manualized as MST (Bruns, 2004). Indeed, Bruns has proposed a “wraparound index” to assist agencies to monitor and maintain the fidelity of implementation. VanDenBerg, & Grealish, (1998) have published a training manual for wraparound programs. Wraparound is not mentioned in Target & Fonagy (2005) recent review of EBTs; Burns & Hoagwood (2002) feature Wraparound on their list of community based treatments for youth with serious emotional and behavioural disorders.

The research evidence in support of Wraparound is based on a retrospective quasi-single case design (without experimental manipulation in the style of an ABABA design), several pre-post outcome studies and two quasi-experimental designs without a comparison group. In other words, the research evidence in support of wraparound has the same standard of evidence as research in group care and residential treatment centres.

- (4) *Pharmacological Interventions*: Psychoactive medications have a high quality of scientific evidence in support of their impact on the symptoms of children diagnosed with ADHD, anxiety, depression, bipolar disorder, schizophrenia and epilepsy. In most cases where medication is prescribed, complementary treatment (most often CBT) is considered crucial to achieve satisfactory clinical outcomes. (Target & Fonagy, 2005). During four months in 2001, a National Institute of Mental Health study found that 67% of youth in treatment foster care and 77% of youth in group care had been prescribed at least one psychotropic drug. Youth in group homes were more likely to take more than one psychotropic drug (Breland-Noble, Elbogen, Farmer, Dubs, Wagner & Burns, 2002).

4.4 Do bona-fide treatments work

Wampold et al (2002) re-analyzed a highly regarded meta-analysis (Gloaguen et al.,1998) of treatment for depression which found that cognitive behavioural treatment was superior to other therapies. *Other therapies* were defined as psychotherapies without distinct cognitive or behavioral components.

Gloaguen et al. (1998) found the effects these treatments were heterogeneous, indicating these comparisons were creating unexplained variance in the outcomes. The re-analysis by Wampold et al (2002) was designed to investigate the source of heterogeneity in the CT/ other therapies comparisons. Wampold et al split the "other therapies" group into bona fide therapies and non bona fide therapies. The criteria of bona fide therapies are:

- (1) the therapist was trained to provide the therapy and was either enrolled in or held a graduate degree in the relevant field
- (2) the therapist developed a relationship based on face-to-face meetings with the patients and was individualized for the patient (i.e. did not involve a standard protocol delivered rigidly to each client)
- (3) treatment contained psychologically valid components, as evidenced by at least two of the following four conditions:
 - a. a citation was made to an established school or approach to therapy
 - b. a description of the therapy was contained in the article and the description contained a reference to a psychological process, such as operant conditioning

- c. a manual for the treatment existed and was used to guide the delivery of treatment
- d. the active ingredients of the treatment were identified and citations provided for these ingredients

Cognitive Behavioural treatment and the bona fide therapies (non-cognitive and non-behavioural) were *all equally effective* in reducing depressive symptoms. (Wampold, Minami, Baskin & Tierney, 2002). Some of these bona fide treatments are now identified as evidence based treatments in other reviews (Roth & Fonagy, 2005)

- Focused effective therapy
- Interpersonal psychotherapy (IPT)
- Brief relational/interpersonal psychotherapy
- Brief psychodynamic
- Interpersonal process group (Yalom)
- Short term psychotherapy
- Interpersonal therapy
- Psychodynamic interpersonal psychotherapy
- Psychodynamic
- Brief Psychodynamic Therapy

The bona fide treatments listed above are described in negative terms (non-behavioural and non-cognitive). In positive terms, these treatments are • derivations of psycho-dynamic theories of personality, • focus on relationships with the client to produce the desired changes and • include both group and individual modalities. The specific therapies mentioned are all defined as short-term counselling delivered by Masters or PhD trained therapists in a clinic setting.

4.5 Evidence based treatment practiced by Child & Youth Workers

It has been clearly established in the literature cited above that there are no evidence based treatments that apply to the daily programs delivered by child and youth workers in residential care. However, the bona-fide treatments listed above and at least five evidence-based treatments have been *deconstructed and adapted* to the day-by-day practice of child and youth workers:

- (a) PSST or problem solving skills training (Kazdin & Weisz, 1998)
- (b) cognitive behavioural therapy (see the Creighton Youth Services manual)

- (c) behavioural modification¹ (Wong, 1999)
- (d) Aggression Replacement Training (Goldstein & Glick, 1987) which was originally designed for a correctional institution and
- (e) Wraparound (see Bruns, Burchard, Suter, Leverentz-Brady & Force, 2004 for a review of compliance to treatment protocols with wraparound).

In the field of residential care, child and youth workers have engaged in a process of deconstructing several existing evidence based treatments developed for prevention or clinic based psychotherapy, selecting parts that are implementable in group living and adapting them into a process of intervention. The process itself is controversial; according to the strict definition of evidence based treatment, the intervention must be delivered faithfully and in full compliance with the manual. Therefore, adaptations of *prevention and clinic based* EBTs in residential care are not evidence based. Several prominent researchers have tested the hypothesis that deconstructing and adapting the EBT destroys its relationship to outcomes or treatment efficacy. The results are equivocal; treatment adherence to the manualized version of the EBT's have been shown in some studies to be better than the adaptation (Lipsey & Wilson, 1993; Perepletchikova & Kazdin, 2005; Weisz, Jenson-Doss & Hawley, 2006) and in other studies, there is no difference (Perepletchikova & Kazdin, 2005). Moreover, two different manualized versions of cognitive behavioural therapy (which constitute two separate evidence based treatments) have been shown to be essentially the same treatment process in direct studies of the therapist-patient interaction (Malik, Beutler, Alimohamed, Gallagher-Thompson & Thompson, 2003), which suggests that the exemplar version of CBT can be deconstructed and re-assembled with demonstrably positive outcomes.

In other words, child and youth workers *may be* implementing evidence based treatment when they deconstruct, re-assemble and adapt the exemplar treatment to residential care even though the treatment protocol was originally *delivered in and structured for* a clinic context or a prevention program.

¹ Formal behavioural modification has been implemented in Multi-dimensional Treatment Foster Care and Residential Treatment Centres; however, in these instances, the behaviour modification intervention is supervised daily by either Masters' level behavioural therapists or Ph.D.s. The child and youth worker is following a tightly controlled script and is part of the team conducting the treatment. In every group home and treatment centre, child & youth workers apply behavioural techniques (such as behaviour charts, consequences) and principles (Social learning theory) in managing behaviour. In the later sense, such treatment activity has been called a *deconstruction and adaptation* of an evidence based treatment.

A significant part of the daily care provided by child and youth workers has not been evaluated through random controlled trials and single case designs. Indeed, many aspects of child and youth work cannot be traced back to an exemplar treatment that was evidence based. This includes the use of teachable moments, engaging the youth in a relationship, managing aggressive and non-compliant behaviour (apart from a token economy) and providing rehabilitative social activities. This fact has led to a lack of respect for child and youth workers, group homes and residential treatment centres (Whittaker, 2004) and efforts to change practices in group care or the RTC setting so that it was clearly evidence based (McCurdy & McIntyre, 2004; Whittaker, 2004; Whittaker, Greene, Blum, Blum, Scott & Savas, 2006).

The *lack of evidence* of the efficacy of child and youth work and the subsequent *lack of respect* has led to restrictions on the use of group care and funding limitations (Ainsworth & Hansen, 2005; Whittaker, 2004). This cycle of anti-group home policy and funding cuts is also unscientific and has been shown to cause significant harm (Ainsworth & Hansen, 2005). It is unscientific according to Roth & Fonagy, in *What Works for Whom* (2005)

Absence of evidence is not the same thing as evidence of ineffectiveness.

5.0 Active Ingredients

This section deals with the question: What are the practices or interventions operated by staff in RTC or GC that contribute to good outcomes for children and youth (i.e.) the *active ingredients* of effective service. The research which identifies the active ingredients is based for the most part on pre-post outcome studies. This type of research means that we cannot prove the causal connection between intervention and outcome. We can, however, identify interventions that are *correlated* with specific outcomes; in other words, we can find *connections and contributions*.

5.1 group homes and residential treatment centres

In a systematic review of outcome evaluations of group care and residential treatment centres between 1993 and 2003, Heather Hair (2005) concluded that positive outcomes can occur in these models if the treatment is *multimodal, holistic and ecological* in approach.

Heather Hair (2005) found that the crucial phase of treatment for ensuring the durability of changes was in the last few months before discharge and in the six months after discharge.

Heather Hair's review of studies found correlations between positive outcomes for children (*within-treatment* improvement in emotional and behavioural improvements and *continuation of gains* after discharge) and the following conditions. References are cited wherever these correlations are reported in other systematic reviews.

- (1) supportive family involvement throughout treatment**
 - a. also found in the systematic review by Frensch & Cameron (2002)
 - b. in comparison between TFC and GC by Curtis et al, (2001)
- (2) quality of life in the discharge placement (especially stability)**
 - a. discharge placement is positive, stable, and supportive (Frensch & Cameron, 2002)
 - b. there is less stress and more social support in the families (Frensch & Cameron, 2002; Curtis et al, 2001)
 - c. there is comprehensive discharge planning (Curtis et al, 2001)
- (3) easily available aftercare services including advocacy for school and/or gainful employment**
 - a. after care services are used (Frensch & Cameron, 2002)
 - b. there is a supportive community network (Curtis et al, 2001)
- (4) Shorter lengths of stay in group care or RTC (6-9 months for children with less severe psychopathology)**
 - a. Less than 15 months for youth with severe mental health issues (Hoagwood & Cunningham, 1993)
- (5) academic success during treatment**
 - a. educational support before and after discharge (Curtis et al, 2001)
- (6) successful program completion before discharge especially for delinquents**
- (7) the residential program philosophy is ecological (embracing multiple social systems)**
- (8) staff training and supervision is a priority in the facility**
- (9) the therapist-client relationship is valued and nurtured**

- a. in qualitative studies, young people state that relationships with their direct care giving staff are among the most positive aspects of their residential experience (Little, Kohm & Thompson, 2005)

The most consistent ingredient in positive outcomes with children in residential treatment is outside the treatment facility altogether.

“Clearly, offering families community-based services that facilitate the transition of children and youth back into the community and work to support the maintenance of within treatment gains is vital to the long-term success of residential treatment.”
(Frensch & Cameron, 2002)

5.2 Treatment Foster Care

The active ingredients in Multi-dimensional Treatment Foster Care (MTFC) in comparison with TAU (i.e. treatment as usual) in group homes were found to be (a) *better adult-child relationships* as defined by: • firm limit setting and control over coercive behaviour by youth, • close supervision of youth especially in community and • more frequent positive interaction between youth and adults and (b) *less time in the company of other delinquent peers*. (Eddy & Chamberlain, 2000). This finding by the research leaders of MTFC raises a question about whether or not other versions of treatment foster care that are not based on a token economy could in fact be equally effective by attending to the active ingredients through other methods.

5.3 establishing a therapeutic relationship

Outcome studies have identified personal attributes of good therapists and in-session activities that positively influence the therapeutic alliance from a broad range of psychotherapy perspectives (Ackerman & Hilsenroth, 2003). It is widely recognized that the therapeutic alliance is critical for good outcomes in youth, to prevent drop-outs and relapse and to increase compliance with the treatment regime. (Weisz, Jenson-Doss & Hawley, 2006) The establishment of positive relationships with adults in the treatment environment has also been demonstrated to positively affect outcomes (Jesness, 1975; Solnick, Braukmann, Bedlington, Kirigin, & Wolf, 1981) - cited in Handwerk, Field & Friman, 2000. Treatment providers who are effective at providing positive attention, praise, and supervision while minimizing criticism, and negative attention are most successful (Feldman et al., 1983; Gold & Osgood, 1992).

The active ingredients in promoting a therapeutic alliance are:

- “communicating a sense of hope for patients to achieve their goals,
- “noting patient progress toward goals,
- “understanding, accepting, and respecting patients,

- “being open-minded and enthusiastic,
- “referring to common experiences between the patient and therapist,
- “conveying a feeling of working together in a shared effort against the patient’s anguish, (also identified in Anglin, 2002)
- “communicating a trust in the patient’s growing ability to use what has been learned in treatment, as well as
- “facilitating the use of healthy defences and supportive activities. “ (Ackerman & Hilsenroth, 2003)

5.4 treating disorders of behaviour and emotions day by day

There are a number of techniques and principles of intervention that are common to group homes assessed by referring agencies as “well functioning”. These qualities have been documented during qualitative program evaluations (Anglin, 2002) and are apparent in accreditation standards. These qualities apply to all types of treatment oriented placements from treatment foster care to residential treatment centres. The techniques and principles are as follows:

- responding to pain and pain based behaviour, developing a sense of normality. (Anglin, 2002, page 55)
- “One of the observed characteristics of staff in a “well functioning” home is a sensitivity to the need to respond effectively to both the residents behaviour and their own anxieties” (ibid, pg.55)
- High quality standards of practice when interacting with youth, specifically:
 - “listening and responding with respect
 - communicating a framework for understanding
 - building rapport and relationship
 - establishing structure, routine, and expectations
 - inspiring commitment
 - offering emotional and developmental support
 - challenging thinking and action
 - sharing power and decision making
 - respecting personal space and time
 - discovering and uncovering potential, and
 - providing resources” (ibid, pg. 57; also similar language used to describe C&YW interventions in Fewster & Garfat, 1998)

- Emotional pain must be owned, named and understood in it's developmental context, and put within a personal story (note relationship to *narrative therapy*, a bona fide treatment) that can lead to a desired future (ibid, pg. 111)
- Providing effective behavioural management of children exhibiting risk sexual behaviour, specifically: (Farmer & Pollock, 2003)
 - Intensive supervision of clients (an active ingredient of MTFC):
 - keeping in eyesight of adult care givers at all times
 - rules for where child is allowed to go
 - extra supervision in the community
 - briefing other children about how to keep themselves safe/not to keep secrets
 - plans for who will and will not "deal" with the child (e.g. is female or male worker better to deal with bedtime routines?)
 - alarm/motion detectors
 - supervision of contact with family members.
 - adequate sex education, specifically:
 - knowledge of their developing bodies
 - contraception
 - safe sex
 - sexual health
 - appropriate relationships
 - what is appropriate for them to know at their age, etc. to address the disadvantage of their being highly sexualized without having the knowledge or development to accompany their actions.
 - modification of inappropriate sexual behaviour, by
 - redirection of masturbation to an appropriate setting
 - teaching/modeling boundaries as a care giver
 - teaching young people how to give affection in appropriate ways
 - educating young people on critical gaps in information about sexuality that may be related to their lack of inhibition
 - talking openly with youth about sexual issues/behaviours.

- therapeutic attention to the needs of the child which underlie the behaviour. The needs often present in children with sexual behaviour problems include:
 - the need to talk about their past (it would be helpful if carers told the children upon arrival that they knew some of the things about them and would be there to talk at anytime the child needed to)
 - the need for adjunct psychotherapy
 - non-sexualized nurturing interactions especially at bedtimes and other special occasions

6.0 Iatrogenic Effects

Several studies (summarized below) identified *enhanced risk* for some types of children in residential care and *unintended bad outcomes* with certain types of interventions (aka *iatrogenic effects*):

- grouping teenagers with varying degree of antisocial conduct and attitudes leads to “delinquency training” or a counter culture in which the best intentions of staff are undermined by anti-authority talk, (Little, Kohm & Thompson, 2005; Poulin, Dishion & Burraston, 2001).
- In a meta-analysis of treatment studies (largely group residential care) with juvenile delinquents, Lipsey (1992) reported that 29% of reviewed experiments resulted in negative effects (i.e., better outcomes for the control condition).
- Negative attention-forcing behaviour is highly resistant to change because, to a child of limited skills who desires the recognition of others, even reprimands serve as rewards, because they are reinforced by the amusement of peers from whom attention is sought. (Bandura, 1973, page 293)
- “Longitudinal studies repeatedly show that association with deviant peers is the strongest correlate of escalation in problem behaviors in adolescence (Dishion & Loeber, 1985; Elliot et al., 1985; Patterson & Dishion, 1985). “ (quoted in Poulin, Dishion & Burraston, 2001, page 221)
- a “pattern of non-confiding peer relationships” in group living as opposed to children raised in a family home (Little, Kohm & Thompson, 2005)
- a much higher risk that children in group living arrangement will suffer from bullying and sexual abuse (Little, Kohm & Thompson, 2005)
- Positive peer culture (Vorrath & Brendtro, 1985) is a set of group interventions that are used both in school programs and in residential settings mostly with

juvenile delinquents. The agent of change is a group process in which the young people are assisted to reinforce each other on positive social behaviour. In several outcome and longitudinal studies, different versions of this approach have proven to increase delinquency not decrease it. (Poulin, Dishion & Burraston, 2001).

- A random sample of children placed in regular foster care was studied in England. Within the 11 to 15 year old age group, there were 2.9 discrete episodes of being in and out of care and 27% of these older children had experienced five or more placements. (Sinclair, Wilson & Gibbs, 2005, page 140)
- Rejection by the foster parent is primarily predicted by the difficulty of the child (behaviour, attachment, development) (ibid, p.195)
- Rejection by the foster parents was correlated with deterioration in self-confidence domain, behaviour in social situations and emotional ties (ibid, p.226)
- There is little evidence that children in foster care grew less disturbed or that their attachment scores improved (ibid, p.228)
- Experiencing multiple placements (4 or more) doubles the risk of delinquency adjudications for male victims of child abuse². (Ryan & Testa, 2005) Note, this effect was not found among female victims of child abuse who experienced multiple placements.
- "Many foster children feel more humiliated and ashamed of being in foster care than they do about having been abused by their parent" (Martin, 2000, p. 113)

Throughout the continuum of care, children in the CAS care or placed in custody under Youth Criminal Justice Act can be harmed by the services provided on their behalf; as an unintended outcome of service, these children can develop serious emotional and behavioural problems and graduate as unsuccessful, under-educated, emotionally disturbed young adults.

6.1 Preventing iatrogenic effects

The iatrogenic effects of placements across the continuum of care are well known and considerable research has been dedicated to principles of service and specific interventions that protect children in care from these bad outcomes.

² from 11% of males victims who remained in their own homes to 23% who were admitted and experienced multiple placements. This was from a large scale longitudinal study in Chicago involving nearly 20,000 youth who were victims of child abuse.

Systematic reviews of numerous outcomes studies have identified program qualities that appear to prevent a significant percentage of the aforementioned iatrogenic effects (Ross & Gendreau, 1980; Handwerk, Field, & Firman, 2000; Grietens & Hellinck, 2004; Rhule, 2005). Their reviews found that:

- The assumption that group care will be ineffective because of exposure to negative peer group is unwarranted because there are group programs that achieve positive outcomes, suggesting that program models are the determining factor which can offset negative peer influence. (Handwerk et al, 2000)
- The use of behavioural treatment techniques (Lipsey, 1992) such as token economies (Wong, 1999) and functional behavioural assessments (Field, Nash, Handwerk & Friman, 2004) have been effective in stopping the counter-culture or process of *delinquency training* within the treatment group.
- Treatment providers who are effective at providing positive attention, praise, and supervision while minimizing criticism, and negative attention are most successful (Feldman et al., 1983; Gold & Osgood, 192).
- Conducting risk assessment of referrals to group care and ensuring that young people who are at low-risk of future offending are screened out of intensive group-based interventions (Dowden & Andrews, 2000)
- Minimizing contact of clients who have diagnosis of antisocial conduct disorder with other youth of a similar diagnosis (Poulin, Dishion & Burraston, 2001)
- Grietens and Hellinckx (2004) review of 12 meta-analyses of treatments for conduct disorder found that the successful programs significantly more often included a sound theoretical model, multifaceted treatment, role-playing, modeling and social-cognitive skills training.
- Further, successful programs included attention for *the need principle* (Andrews et al., 1990). This means that treatment targets were matched to the specific criminogenic needs of the offenders.
- Successful programs also attended to *the responsivity principle* (Andrews et al., 1990); this means that the styles and modes of treatment were attuned to the learning styles and abilities of the offenders.
- Successful programs, whether focused on the rehabilitation of either academic or behavioural difficulties, or both, always focus on treatment rather than discipline. Programs with no success were the discipline focused ones (Gifford-Smith, Dodge, Dishion & McCord, 2000).

7.0 Criteria for a Best Match to staffed residential care

This section looks at the question of what are the characteristics of children, youth and families, or their problems that would make RTC or GC an appropriate choice (level of care) in favour of less intrusive settings such as treatment foster care. There are four principles that address issues of best match: risk, need, general responsiveness and specific responsiveness. Before examining the criteria of best match, section 7.1 deals with the current practice:

7.1 Current practice in matching

Mark Courtney's study (1998) analyzed data from the "level of care" study conducted in California in 1991. This was a study of preferred placements, not actual placements, of placing workers in 10 agencies. The "age" of the child at the time of placement makes a difference in choice of group care only; each additional year in the child's age increased the likelihood of placement in group care by 1.208. If the child has one or more disabilities (e.g. developmental, medical or physical) than the odds of placement in group care increased by 2.091. If the child had a history of placement in treatment setting, the odds of being placed in group care increased by three fold (2.985). The most powerful reason (odds increased by 4.910) for choosing group care were externalizing behaviour problems (e.g. aggression and antisocial conduct) .

In terms of choosing treatment foster care over regular foster care, age made no difference. Children of African American identity were 2.661 times more likely to be placed in TFC. The child's externalizing behaviour was once again the most powerful reason (odds of choice for TFC over regular foster care increase by 3.178) but by a lesser margin than the choice for group care where the odds increased by five times. A history of prior placement in treatment settings was the second most powerful reason for choosing TFC over regular foster care (2.745).

The availability of parents to participate in the child's life and the child's gender had no impact on decisions about placement. A child's level of internalizing problems (withdrawn, anxious, depressed) had a much weaker relationship on the choice for treatment in group care (odds increased by 2.439) or in treatment foster care (1.893).

In conclusion, the preferences of placing workers is consistent and, for the most part, has good face validity. There are no outcomes studies that have validated these rules of matching children to treatment foster versus group care. (Curtis, Alexander & Lunghofer, 2001). Curtis et al (2001) who reviewed comparison between TFC and group care had these major findings:

- (1) Numerous studies across two decades using standardized measures, such as the CBCL, have demonstrated that children in residential group care are very disturbed emotionally and behaviourally.
- (2) In various studies, significant differences have been observed in abuse histories, with physically abused children more likely to go to TFC and sexually abused children more likely to go to group care.
- (3) There are few differences in psychiatric symptoms and behaviour problems between children in TFC versus group care.
- (4) The exceptions are: (a) children with histories of AWOL problems are more likely to be in group care; (b) females in group care were more likely to have substance abuse problems and runaway behaviour.

Handwerk, Friman, Mott & Stairs (1998) examined the relationship between program restrictiveness and youth behavior problems. A key concept in the continuum-of-care model is matching the restrictiveness of treatment to the level of youth behaviour problems. Restrictiveness refers to the degree that treatment and setting constrains choices and limits freedoms of patients. Only a few investigators have examined this relationship, and the findings have been equivocal. Extending Handwerk's initial study of the relationship between youth behaviour problems and program restrictiveness, the researchers examined the relationship across seven programs spanning the continuum of care: parent training program, outpatient clinic, family preservation program, treatment foster care, residential group home, acute-care shelter, and inpatient psychiatric hospital. Results indicated a high level of correspondence between restrictiveness and youth behaviour problems, with the least restrictive programs serving children with fewer behaviour problems and highly restrictive programs serving children with more behaviour problems.

Hussey & Guo (2005) conducted a study on length of stay in child residential treatment. This study examined the impact of a variety of factors on length of stay in RTC: child's psychiatric symptoms, behaviour problems, parental psychopathology, placement history and demographic variables (age, gender, ethnicity). The findings indicate that higher levels of child psychopathology and child's behaviour problems increased length of stay at a consistent and steady rate. This was expected and confirmed.

With the degree of behaviour and psychiatric problems held constant, other factors emerged had a significant impact on length of stay. These other factors were: (a) *child's ethnicity*: being of African Americans ethnicity increased the length of stay by 44%; (b) *age of entry*: each increase of one year in the child's age on admission, reduced the length of stay by 30%; (c) *child medication status*: children taking medications

increased length of stay by 62%; (d) *parental substance abuse*: Parental alcohol abuse reduced length of stay by 183%. The last finding was counter-intuitive, but the authors suggest that placing workers may move these children out of treatment and into foster care (rather than discharge home) because of a hopeless home situation.

There appears to be a sound body of research evidence that placement decisions across the continuum of care make good sense or have face validity.

Additional research has identified the principles of best match for levels of care and placement type: *risk, need, general responsivity* and *specific responsivity*.

7.2 the risk principle

Dowden and Andrews (2000) first identified *the risk principle* in matching youth with antisocial conduct disorder to the proper level of care, intensity and duration of intervention. The risk principle means that higher levels of service should be allocated to the higher risk cases; additionally, if a specific program tends to “over-intervene” with low risk cases, the program has minimal or even negative impact, relative to delinquency. This is a narrow definition of risk, referring only to the probability of future violent recidivism. In their meta-analysis of correctional treatments, Dowden & Andrews (2002) found that the programs which matched their interventions according to the risk principle achieved a reduction in recidivism of 12% compared with only 3% for programs that did not match their individual treatment plans in this way.

The risk principle makes common sense and is reflected in service principles embedded in the Child & Family Service Act of Ontario, especially the principle of least intrusive intervention. In practice, however, it has been difficult to monitor and verify this principle in action. Researchers obtain a distorted picture of “why” children are placed in different settings (different levels of care, group vs foster, treatment versus not) by observing the characteristics (behaviour, emotional disturbance) of children placed in a range of settings at one point in time. There are four reasons for the confusion:

- (1) *Clinical changes within-placement*: The behaviour that led to the child's placement may be very different than the behaviour observed after some time in the placement. A cross sectional study of children at one time in range of placement types cannot observe how the child changes in terms of his risk and needs from admission to whatever point the cross sectional review assesses the population. Since the average length of stay varies significantly by placement type, the law of averages will not fix up the distortion.

- (2) *Preferred versus actual placement:* Children do not always get access to the most appropriate placement; as a result, some children will be over placed and others under placed; although in one study of this problem, the “overwhelming majority of the children received the preferred placement eventually”. (Courtney, 1998) In anecdotal evidence, almost all placing workers will recall children who did not receive the preferred level of care.
- (3) *Movement between different levels of care:* Over time children move from lower to higher levels of care and then back to lower levels. Aspects of their clinical profile seldom if ever change (including family history, academic ability, psychiatric diagnosis, history of behaviour problems). If these variables are used to describe the child at different points in the continuum of care, the population of children in different placement types may look the same across the continuum.
- (4) *Poor responders often break down:* Approximately 30% of youth will not respond to the most appropriate treatment intervention; these young people tend to break down in placements. Such youth may require re-admission to care after a discharge from RTC. Some youth move upwards in the level of care sequentially over time as a result of placement breakdowns. These non-responders by definition undermine the apparent effectiveness of whatever placement or treatment service they receive at the time of the study. Many service providers – including those testing evidence based treatments – improve their image of “effectiveness” by screening out non-responders at the beginning of service.

Outcome studies have identified the profile of children and youth who are most likely to succeed - the flip side of the non-responders (Connor, Miller, Cunningham & Melloni, 2002). Connor et al (2002) describe the *reliable responders to RTC* in this way:

- Youths who have less severe dysfunction
- better personal and social adjustment
- an acute (as opposed to a chronic) onset of problems
- greater academic ability
- an absence of associated learning problems, and
- a greater capacity for interpersonal relationships (Erker, Searight, Amanat, & White, 1993; Wells, 1991).
- higher rates of anxiety and depression and lower rates of conduct problems (Hooper et al., 2000; Joshi & Rosenberg, 1997).

The list of *reliable responders to treatment foster care* is almost identical (Redding, Fried & Britner, 2000). The children who do best in TFC have:

- fewer emotional and behavioural problems
- fewer prior placements and less time spent in institutions before their first foster placement
- fewer prior negative placement outcomes
- good relationships with their foster family
- a degree of control over the frequency and type of visitation with their biological family.

If placement agencies select only the reliable responders for admission, a gap of unmet needs in the community will emerge, since many children and youth who are most in need of mental health services have the opposite qualities to the items on the good responders list. (Kazdin, 1995).

Rutter and Sandberg (1985) state that children who are at risk for developing enduring serious mental health or behavioural problems are recognizable through the application of four criteria:

- {a} Certain behavioural symptoms are much more predictive of bad outcomes than others. The two strongest predictors are poor peer relationships and hyperactivity/inattention
- {b} Disorders that are more pervasive over situations are more persistent over time. In other words moderate problems in school, at home and in the community is more serious (risky) than even more serious problems in one place, such as school.
- {c} Disorders associated with a wide range of emotional or behavioral difficulties are worse than a single symptom or narrow range of problems. Co-morbidity is far more predictive of bad outcomes than any single disorder.
- {d} Problems out of keeping with normal developmental trends usually have a worse outcome than those problems that are severe exaggerations of age-appropriate phenomena.

The criteria by Rutter & Sandberg, which is based on research evidence from the field of developmental psychopathology, can be used for implementing the risk principle in matching the child to the proper intensity of intervention and level of care.

7.2-a measuring risk

The term *risk* refers to the percentage probability of specific bad outcomes in the future. Examples of specific bad outcomes include: (a) violence by a parent directed at the children, (b) violent recidivism by offenders or mentally ill patients with a history of violence, (c) a youth developing into a serious, persistent criminal offender, (d) a youth developing the full clinical criteria for a serious mental illness, such as bipolar disorder and (e) a depressed youth committing suicide. The rules for making predictions of this type are well known. They are as follows: (Webster, Harris, Rice, Cormier & Quinsey, 1994)

- (1) predictions about violence in the near term are much more accurate
- (2) predictions about violence within the same context in which the predictor data is collected is much more accurate
- (3) when left to their own devices, clinicians display wide variation in predicting ability; the variation is not due to profession, or apparent skill and experience.
- (4) for clinicians, errors in estimating the base rate of violence for a class of individuals (for example women) produces serious prediction errors. Knowledge of base rates for the class of individuals under study is the most crucial piece of information necessary for optimum prediction.
- (5) actuarial methods are significantly more exact than the psychiatrist opinion of dangerousness alone

“Indeed, several studies have found significant bias (experienced forensic staff consistently underrated the dangerousness of women and good looking men); moreover, the forensic staff had much more confidence in their predictions than the data warrants. All of them tend to look at the “public” cases of obvious failures in predictions as evidence that they in hindsight would never have made such a failure to identify dangerousness. Yet they would and do.” (Webster et al, 1994, page)

The rules about predicting violence apply equally to predicting a worsening clinical condition. Webster et al developed the *violence prediction scheme*, an actuarial instrument for use in forensic assessment units. Similar instruments exist for predicting violence with serious, persistent young offenders (*Youth Level of Service* by Hoge & Andrews) and measuring suicidality among depressed teenagers (*Inventory of suicide orientation – 30* by Kowalchuk & King). These instruments are already in use to

determine the level of care and degree of program restrictiveness for the relevant population and bad outcome.

The relevant risk question for deciding placement in group care and residential treatment centre is as follows: *is the child on a pathway to developing serious social, emotional and behavioural problems such that he or she will not be able to manage the transition to independent adulthood successfully.* An actuarial solution (protocols and instruments) for answering this question has been developed in prevention research studies. (August, 1995; Brandenburg, 1990; Lochman, 1995; Loeber, 1990; Loeber, 1987 & Loeber, 1984). The protocol involves *multi-stage classification of risk*, specifically measure the presence of pre-morbid or gateway conditions of emotional and behaviour disorder and then measure the catalytic risk factors that amplify the pre-morbid conditions or protect the youngster from getting worse. The set of instruments have *multiple informants* (parents, youth and clinician observation) and *multiple domains* (behaviour, emotions, thoughts, social adaptation, parental stress, history of adversity and attachment).

In child welfare, Martha Dore (1999) recommended similar instruments be used for all children at some point in their history of state care, because between 30% and 60% of children in CAS care have diagnosable disorders.

7.3 the Need Principle

The need principle was identified by Dowden & Andrews (2000) in their meta-analysis of correctional treatments for violent offenders. They found that programs which attended to the need principle (as defined below) achieved a reduction in recidivism of 22% compared to a 1% increase in recidivism from programs that offered "one size fits all" and did not alter their program to deal with the characteristics of the offender that were promoting the violent behaviour.

The need principle focuses specifically on offender needs and classifies them into two separate categories. The first category, criminogenic needs, are defined as dynamic risk factors that, when changed, are associated with reduced levels of criminal activity (Andrews and Bonta 1998; Andrews, Bonta, and Hoge 1990; Andrews et al. 1990). Examples of criminogenic needs include antisocial attitudes, antisocial feelings, chemical dependencies, and poor parental affective and supervision skills. The second category, termed noncriminogenic needs, are also dynamic, but changes in these particular need areas are not associated with subsequent reductions in criminal activity. Examples of noncriminogenic needs include level of self-esteem, focusing on vague emotional/personal problems unrelated to criminal activity or increasing the cohesiveness of antisocial peer groups.

The need principle provides important information regarding the types of offender needs that should be targeted within a correctional treatment program. More specifically, the need principle states that if the end goal of treatment is reduced recidivism, then the criminogenic needs of offenders must be targeted. Although the need principle recognizes that targeting noncriminogenic needs of offenders may also be important for reasons other than reducing recidivism, it warns that targeting these areas should not be expected to reduce reoffending. Therefore, when public protection is a goal of correctional programming, programs should predominantly focus on targeting criminogenic as opposed to noncriminogenic needs.

The same logic model could apply to any other emotional and behavioural problem presented by the young person. The impact of the need principle on matching to TFC, group care and residential treatment is that the specific content and program flexibility of the placement is a critical factor in selecting a service that will get the best outcomes. In implementing *the need principle*, the program's ability to target the specific needs of the young person may be as important or more important than the type of placement (TFC, group care, etc.) and level of care.

The need principle refers to a narrow definition of needs – the needs which drive the primary clinical or social problem. A full set of all possible needs within this narrow definition are found in the field of developmental psychopathology.

An instrument, such as the *Looking After Children* scale, originally developed in England and implemented in Ontario, identifies basic human (e.g. good physical health) and special needs (e.g. remedial education) which the child needs for his well being. Working with placements to meet this type of need is dealt under the principle of *specific responsivity*. See [7.5 the Specific Responsivity Principle](#).

7.3-a Measuring pathogenesis needs

A full clinical assessment is required to measure needs in this narrow sense of the word: the needs which drive (give genesis to) the pathological situation which necessitates treatment. The meta-analysis of treatments for violent young offenders found that treatment programs which targeted the criminogenic needs of the young person achieved a reduction in recidivism of 22% compared to a 1% *increase* in recidivism for programs that do not (Dowden & Andrews, 2000)

The instruments and guidelines for assessing young people in order to identify the targets of intervention often start with generic clinical inquiries and branch out into very specific assessment instruments. Practice guidelines written for specific groups of children (victims of sexual abuse, traumatized by violence, depression, conduct disorder, autism) generally include details for how to identify the *genesis* needs.

For example, the International Society for the Study of Dissociation has published guidelines for the assessment and treatment of children and adolescents with dissociative disorders secondary to trauma (Silberg, 2003). There are many factors that are critical in the genesis of emotional and behavioural disturbance. One need is paramount and a considerable amount of early work in residential treatment is dedicated to this need.

“Achievement of physical safety is a primary goal that supersedes any other therapeutic work... If the child is regressing in therapy, the therapist should... evaluate safety in the environment, evaluate possible stressors (court testimony, visitations, too much focus on traumatic events)” (Silberg, 2003, page 7)

Other needs/targets of intervention are also important including: • helping the child to achieve a sense of cohesiveness about his affects, cognition and related behaviour, • desensitize traumatic memories • correct learned attitudes towards life resulting from traumatic stress and • promote healthy attachments with their caregivers. There are many techniques and interventions, including evidence based treatment, to meet the needs which are specific to and give genesis to dissociative symptoms in children who have been traumatized.

CAS agencies who place children need to be aware of the genesis needs at the origin of the child's disturbance and to place the child where the program has the capacity to meet those needs.

7.4 the General Responsivity Principle

The *general responsivity principle* means tailoring program content to “what works best in general”. When treatment programs are matched to the young person according to the principle of general responsivity, the program achieved a 24% reduction in violent recidivism compared to 4% when the program approach was not matched to the approach that works best in general for delinquents (Dowden & Andrews, 2000). With serious, persistent delinquents, this means providing *Behavioral Treatment* (cognitive behavioral/social learning), as indicated by:

- modeling and reinforcement of pro-social attitudes and behavior;
- graduated practice of new skills;
- role playing; and
- concrete verbal and visual suggestions –give reasons, use prompting, are very clear and explicit

7.4-a Treatment for anxiety:

Anxiety is the most common psychiatric disorder in childhood: dysfunctional anxiety is characterized by a self-perpetuating cycle of elevated biological response to

stress, debilitating cognitions and avoidance of stressful circumstances. Best practice involves: (Kazdin & Weisz, 1998)

- educating the youngster about his “biological stress response” and how his thoughts heighten arousal,
- teaching relaxation skills and
- providing systematic desensitization and exposure linked with modelling.

7.4-b Treatment for depression:

Best practice in treatment has focussed on cognitive models which maintain the depression, including perceptions of self as inadequate, the world as unfair, the future as hopeless, all personal failures as caused by internal, global and intractable deficits and all personal success as caused by good luck due to specific occasional external events. The behavioural models focus on deficits in *coping skills* (interpersonal relationships and social problems solving) and in selecting affect-enhancing activities in the course of daily living (one of the components of *affect regulation*). Best practice techniques involve efforts: (Kazdin & Weisz, 1998)

- to identify and modify depressogenic schemas and biases about the cause of personal success and failure
- skills training to enhance *social interactions* (how to start a conversation or make a friend), *social problem solving* (how to resolve conflict without alienating others) and other competencies relevant to *self esteem* (setting personal performance goals and reaching them).
- Progressive relaxation training to reduce the tension that can undermine enjoyment
- Structured experiences in selecting and engaging mood enhancing activities to increase rates of positive reinforcement

Both of these models of cognitive behavioural treatment interventions (for anxiety and depression) involve (a) peer or therapist modelling, (b) in-session role plays and (c) structured homework assignments. Trauma specific CBT appears to best able to reduce PTSD symptoms in sexually abused girls. (Target & Fonagy, 2005)

7.4-c Treatment for oppositional and aggressive children:

Cognitive processes have been identified which maintain antisocial behaviour in children and adolescents: (a) inability to generate alternative ways to handle social situations and interpersonal problems; (b) deficiency in identifying the means to obtain particular ends, such as making friends; (c) poor grasp of the consequences of their

actions; (d) assuming a hostile intent or other distortions when interpreting the actions of others; (e) little understanding of how others may feel; and (f) little ability to anticipate the effects of their actions – as distinct from the consequences that may flow from harmful effects. (Kazdin & Weisz, 1998)

Best practice include providing *Problem-Solving Skills Training* (PSST) specifically:

- Start with how children approach situations especially their thoughts
- Teach children a step-by-step approach to solve interpersonal problems
- Foster prosocial behaviour through modelling and reinforcement
- Employ structured tasks involving games, academic activities and stories
- Identify and express verbally the *child's otherwise unspoken self-talk*
- Teach the child the sequence of different examples of self talk that lead to particular problems
- Provide cues that prompt the child to apply his newly taught skills to the immediate situation
- Provide feedback and praise to reinforce correct use of skills
- Employ modeling, practice, role playing, reinforcement and mild punishment (loss of points or token)

The best practice for treating young people varies according to the major diagnostic grouping (PTSD, depression, bi-polar, anxiety, autism) and the domain of their dysfunction (family, friends, school, internalizing issues, such as emotional pain and externalizing issues, such as behaviour problems). The references cited in section [3.1-b Websites](#) will provide a resource to identify the specific rules of *general responsivity* that apply to the young person. The capacity of the program and its staff to deliver these treatment models must be matched to the rules of general responsivity.

7.5 the Specific Responsivity Principle

The *specific responsivity principle* means tailoring the program to the individual qualities of the child that affect his/her response to intervention. (Dowden & Andrews, 2000) Some examples are:

- Verbal intelligence
- Cultural background
- Anxiety level
- Motivation to change
- Personal and social awareness

Anglin (2002) identified additional variables that fit within the category of specific responsivity. These are the six reasons that youth in care gave to James Anglin to describe why they preferred group care:

- They feel less conflicted in terms of their loyalty to their family of origin
- Because staff do not own the property, they are less concerned about the damage to property
- They have a diversity of care givers to related to
- Staff get time off to rejuvenate
- The sole purpose of the home is to focus on the youth's needs
- There is an intensity of care not available in other models of care
- There is supervision to support and challenge direct care staff (Anglin, 2002, pg. 98)

The specific responsivity principle uses the information that is specific to the individual child to drive decisions about preferred placement. Some children have strong feelings about the preferred placement (e.g. conflicted about living with another set of parents, wanting to stay in the same school that they were placed in before admission to care, etc.). The results of the focus group with youth as reported by James Anglin illustrates the range of issues that youth think about when faced with a new placement.

Matching at the level of *specific responsivity* is often implemented by the individual program *after* placement and affecting the selection of primary worker, type of community activities, educational supports and techniques for communicating with the youth. Before placement, this level of matching may affect choice of foster care versus group care.

8.0 Best Practice Recommendations for GC and RTC

This section deals with the question: what do prominent authors in the literature summarizing outcomes for children and youth in RTC and GC recommend in the best interests of children placed.

Kazdin's (1995) guidelines for best treatment of young people with serious emotional and behavioural disorders are often not matched in the evidence based research:

- 1) *use an expanded model of assessment*: canvass other areas of the child's functioning beyond rating of his/her symptoms. Specifically, assess social

- functioning and academic performance, parent-child interaction, family stress and marital discord and the child's social context, especially neighbourhood.
- 2) *Match child dysfunction and interventions:* For methodological reasons, research on EBTs are focused on brief, time limited interventions, with the effect evaluated immediately after the intervention. In the real world, children may take years to get better, showing results long after the treatment and some children may need high-strength intervention (intensive and long term). High-strength interventions have been rarely tested in research.
 - 3) *Amenability to treatment:* child, parent, family or therapist factors that may moderate outcome must be considered. [note; in Dowden and Andrews, 2000, reviewed below, this is referred as "Responsivity risk factors"] The child characteristics referred by Kazdin are: •the specific symptoms of the dysfunction, • adaptive skills • and resources. Children who are less amenable to treatment should be given a more concentrated focus or higher dose.
 - 4) *Broad-based treatments:* EBTs focus on a single domain and a single treatment focus; in reality children have many domains requiring intervention. Such children require multiple treatments, conceptualized as "modules" woven into an overall treatment regimen. "Plausible treatment combinations may include individual psychotherapy or cognitively based treatment, school-based reinforcement, family therapy and parent training." (Kazdin, 1995, Page 136)
 - 5) *Ongoing treatment:* for some children the course of maladjustment may be life long. For example, up to 1/3rd or 1/2th of conduct disorder and ADHD continue their dysfunction into adulthood. With such youngsters, the best practice may be either conventional or high-strength treatment – followed by systematic life-long monitoring and treatment as needed, - AKA maintenance therapy

8.1 Before admission to treatment facilities

When the child is first admitted to care, Child Welfare agencies must implement a higher standard of assessment (Leslie, Gordon, Lambros, Premji, Peoples & Gist, 2005). This paper is a review of standards of practice calling for comprehensive assessment of children entering foster care and matching them to interventions based on their needs. Studies have found disproportionately high rates of developmental and mental health problems among children in foster care. These problems can have tragic

and costly sequelae, including frequent placement failures, academic difficulties, increased high school dropout rates, and later delinquency.

Rates of developmental delay and behavioral problems for this population are much higher than those found in the general population. In contrast to the estimated 4% to 10% prevalence of developmental delay among children in the general population, published rates of delay among young children in foster care are reported to be as high as 60%, with 57% exhibiting language delays, 33% showing cognitive problems, 31% displaying gross motor difficulties, and 10% experiencing growth problems. Psychiatric problems are also more common among children in foster care compared with normative samples, even when contrasted with children from similar sociodemographic backgrounds. Studies report as many as 25% to 40% of children younger than the age of 6 years entering out-of-home care have significant behavioural problems, with the majority displaying externalizing behaviors. This greatly exceeds the overall prevalence rate of behavioral issues in the general population of preschoolers, which has been estimated between 3% and 6%.

Ryan & Testa (2005) examined the impact of child maltreatment and placement breakdowns on the risk of delinquency. They studied 18,676 children who were born between 1983 and 1984 and had one substantiated record of child abuse, of which 4,686 were placed.

Their findings were:

- (1) On average, delinquency rates are 47% higher for abused children than for children who were not abused.
- (2) Being admitted to care (i.e. placed) increases delinquency rates for males. Eleven percent (11%) of male victims of child abuse who remain in their own home were charged and convicted of a delinquency, compared to 23% of males who had 4 or more placements during the five year study period.

The data from Ryan & Testa clearly demonstrates the additional risk presented by children who are abused and children who experience multiple placements in care. This reinforces the recommendation of Leslie et al, (2005) that children in CAS care require a higher standard of assessment to identify children requiring treatment.

8.1-a what happens if we do nothing

The use of "no treatment" controls is a scientifically sound way to test the true impact of treatment; it is, however, unethical to deny treatment to children who need it; this makes it difficult to determine, *what happens if we do nothing*. The state of New South Wales in Australia provided a natural experiment to see what happens if there are no group homes or residential treatment centres.

At the turn of the 21st century, Australia embarked on deep funding cuts to group care facilities. In New South Wales, 50% of previously existing group homes have been closed leaving 94% of 27,795 children in CAS care to live in regular foster care or kinship care and 20% of these do not experience a stable placement; there are 1,037 young people (4%) in residential group care. A number of children and young people in the Child Welfare stream have been moved across to the correctional stream. A history of placement in child welfare increases the risk of being arrested and placed in a juvenile justice facility by 15 fold.

Another 1,800 children under 15 years are living in *youth homeless shelters*, while another 17,400 residents of the youth homeless shelters are between 15 years and 19 years of age. The result for child welfare authorities is that a small number of CAS wards are placed in highly staffed, totally unregulated "apartment-like" units for \$1,000 per day. (Ainsworth & Hanson, 2005). Ainsworth & Hanson conclude:

"The dream of no more residential care has gone disastrously wrong. One consequence of the attempt to do without residential care programmes rather than transform into residential education and treatment facilities is that there is a crisis in foster care in NSW ... This crisis has to a large extent been created because many foster carers are exhausted and disillusioned by the placement, or more accurately, misplacement of children and youth who by virtue of unmanageable behaviour should not have been placed in a regular home environment." (Ainsworth & Hanson, 2005, pg. 197)

8.2 Residential Care for serious antisocial conduct disorders

The bad outcomes observed in group care over many decades are primarily observed with programs treating serious antisocial conduct disorders. As discussed above, there are many reasons for the poor outcomes with a population of delinquents: (a) *delinquency training*, where the most devious and antisocial young people recruit less delinquent more vulnerable youngster into the antisocial lifestyle; (b) *providing the wrong treatment approach*; many group homes used a treatment approach that included relationship building, nurturing, empowering and talking through past history. Meta-analysis of the research evidence (Dowden & Andrews, 2000; Lipsey, 1992, Target & Fonagy, 2005) has found that behavioural methods work best with serious behaviour problems and that unfocussed discussion of feelings, empowering and trusting delinquents before they earn it and using a peer mentoring approach escalates problem behaviour. (c) *staying in treatment for too long* leads to resentment and deterioration; and (d) *discharging to the home environment or lower levels of care without proper support*, causes within-treatment gains to disappear.

McCurdy & McIntyre (2004), proposed a package of interventions that could be offered by RTCs that would manage the list of factors contributing to poor results with delinquents. McCurdy & McIntyre (2004) propose a package of evidence based

practices coordinated to immediately lessen or decrease barrier behaviours while simultaneously initiating plans and treatment services intended to help the youth succeed upon return to community: (the article cites references for all EBTs)

1) Environment-based intervention:

- a. Eliminate the barrier behaviour (that prevents the youth from functioning successfully in community) using:
 - i. A token economy
- b. Achieve success in school through academic intervention i.e.:
 - i. treatment for ADHD,
 - ii. a high degree of classroom structure,
 - iii. evidence based teaching (references are specified) such as teaching to mastery, pacing students, direct instruction, etc.
- c. Social skills training (ref Gresham et al, 2001) that emphasizes:
 - i. assessment of strengths and deficits,
 - ii. identifying and addressing specific type of social skill deficit (acquisition, performance or fluency),
 - iii. insuring integrity of implementation and
 - iv. programming for generalization
- d. Problem solving and anger management skills training – especially the use of PSST and AC (Anger Coping program, an EBT developed by Lochman et al)

2) Intensive Intervention if the youth does not respond to environment-based

- a. Functional behavioural assessment (FBA)
- b. Behavioural support plan, specifying:
 - i. Behaviour of concern
 - ii. Preventive antecedent strategies
 - iii. Prosocial alternatives to be taught and reinforced
 - iv. Consequences to reduce problem behaviour
 - v. Crisis intervention plan

3) Discharge-related intervention to prepare the youth and his/her family • to succeed upon reintegration to community, • maintain (generalize) social skills, problem solving skills, anger management skills and • academic success by:

- a. *Intensive case management* (designed to solve the apparently intractable barriers to reintegration to families such as •RTC is in another city, •youth has had multiple placement, •is a ward of the state and •parents have abandoned or abused him)

- b. *Parent Management Training*: of PMT
 - c. *Community Integration*: interventions such as setting up the youth in volunteer jobs with the humane society or a geriatric centre, setting up youth in activities that enables him/her to make friends, etc.
- 4) **Outcome Evaluation**: McCurdy & McIntyre (2004) proposes an evaluation plan that would show that these interventions would achieve their internal process objectives, reduce costs with shorter lengths of stay and achieve its long term goals.

8.3 increasing the uptake of EBP in group care and RTC

James Whittaker a prominent author of many books and journal articles used in the curricula for child and youth workers proposed these measures to improve the standard of practice: (Whittaker, 2004)

- 1) redoubling efforts at parent involvement
- 2) expanding residential respite options
- 3) developing more creative short term residential treatment
- 4) focussing on child well being and family functioning as outcome measures
- 5) studying the limits and potential of family centred service delivery
- 6) developing models of whole family care (e.g. by combining respite at holiday time and skill building for families)
- 7) working to personalize residential care settings and reinforce personal care givers
- 8) examining the potential for co-location of services (e.g. family support and residential care)
- 9) seeking partners and being able to locate residential programs in an overall service network
- 10) conducting longitudinal research to study developmental outcomes for youth in shared care youth who are temporarily placed
- 11) redesigning some group care settings for permanent living and re-examing communal alternatives (e.g. Israeli cluster family care)

Subsequently, Whittaker and others mad these recommendations to transform the industry of residential care: (Whittaker, Greene, Blum, Blum, Scott & Savas, 2006)

- (1) Develop a systems-of-care approach, defined as:
 1. The mental health service system efforts are driven by the needs and preferences of the child and family, and are addressed by a strengths-based approach.
 2. The locus and management of services occur within a multiagency collaborative environment and are grounded in a strong community base.

3. The services offered, the agencies participating, and the programs generated are responsive to cultural context and characteristics.
 - (2) Build a logic model of the program, defined as:
 - a description of the target population, including client or system conditions that led to the need for the program;
 - clearly defined program components and activities (what the program is intending to do with clients);
 - a description (in measurable terms) of what clients will gain after successfully completing the program; and
 - an explanation of why staff believes this service will lead to client gains (the theory behind the program model). (Savas, 1996, p. 39)
 - (3) Create strategic partnerships with Universities and research institutes to identify ways to bring more evidence based practices to agency operations and disseminate the knowledge and evaluate the service
 - (4) In-depth ongoing program evaluation that emphasizes process evaluations in addition to outcome data so that staff can understand how they contribute to the changes.
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