

Elements of Effective Practice for Children and Youth Served by Therapeutic Residential Care

Research Brief

MARCH 2016

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Abstract

Child welfare values include serving children in the least restrictive settings with the most effective interventions. Group homes and residential treatment centers, as restrictive living environments, have been challenged to better define their intervention models and the youth they are best suited to serve. They have been asked to “right size” lengths of stay and to involve family members more extensively in treatment. Further, they have been asked to do more than manage problem behaviors, including helping youth to heal and to learn skills for managing their emotions and behaviors that they can use in the community. Lastly, child welfare has been tasked with conducting more extensive evaluation studies.

The focus described above is important because as of September 30, 2014, about 14% of all children placed in out-of-home care in the United States (56,188 children) were in some form of congregate care. Specifically, 415,129 children were in out-of-home care, with 23,233 (6%) placed in group homes and 32,955 (8%) placed in residential treatment centers and other institutions of some kind. These are “high end and high cost” settings.

This research brief summarizes applicable research that identifies key elements of effective practice that are based on the needs of children and youth referred to therapeutic residential care (TRC). It also describes how certain interventions and broader systems reforms, when implemented together, can help ensure that the right service, at the right dosage and at the right time are provided — and for the shortest amount of time necessary — to achieve key therapeutic and permanency planning outcomes. Our review found a range of interventions, many of which can be delivered in two to six months. It also found a lack of rigorous research for many TRC interventions that could (1) provide key information to help guide the field in which interventions are especially effective for addressing specific youth treatment needs, (2) identify what kinds of intervention sequencing might be needed for certain groups of youth, and (3) enable these interventions to be more fully rated by various practice registries.

Introduction

Background

Historically, group homes and residential treatment centers have been an important but controversial part of the child welfare continuum of services. As of September 30, 2014, 415,129 youth were in out-of-home care, with 23,233 (6%) placed in group homes and 32,955 (8%) placed in residential treatment centers and other institutions of some kind. This is 14% (56,188) of all youth placed in out-of-home care.¹

Frequently, some or all of these facilities, including shelter care and juvenile justice facilities, are referred to as “congregate care.” For example, there are only two categories in the Adoption and Foster Care Analysis and Reporting System (AFCARS) that combine to form the congregate care placement option: group home and institution. In AFCARS, group homes are licensed or approved homes providing 24-hour care for children in a setting that generally has seven to 12 children. An institution is a child care facility operated by a public or private agency that provides 24-hour care and/or treatment for children who require separation from their own homes and a group living experience. These facilities may include child care institutions, residential treatment facilities and maternity homes.²

A 30-year history of research on group care has included research on populations and programs characterizing different levels of programs as described above. For the purposes of this paper we believe that summarizing this aggregate research is useful to provide context for a more nuanced discussion about effective elements of practice for services that are most accurately referred to as therapeutic residential centers (TRC) or residential treatment/group care. By TRC, we mean group homes serving seven or more children, residential treatment centers, and psychiatric residential treatment facilities (see discussion below for additional details).

As illustrated in Figure 1, states vary substantially in how extensively they use congregate care and for which groups of children and youth. Some feel that TRC and other forms of congregate care were developed and “entrenched” during a time when child welfare practice ideology and interventions were very different. So, it is an industry that delivers a product that is no longer required at the same scale and was not adequately efficacy-tested.³

Many states are focusing on more carefully using this form of care, including some as part of their Title IV-E waiver (e.g., Arizona, Delaware, Massachusetts, Rhode Island, and West Virginia). Group homes and residential treatment centers have been challenged to better define and standardize their intervention models and the youth they are best suited to serve. They have been asked to “right size” lengths of stay, involve family members more extensively in treatment, help youth learn skills for managing their

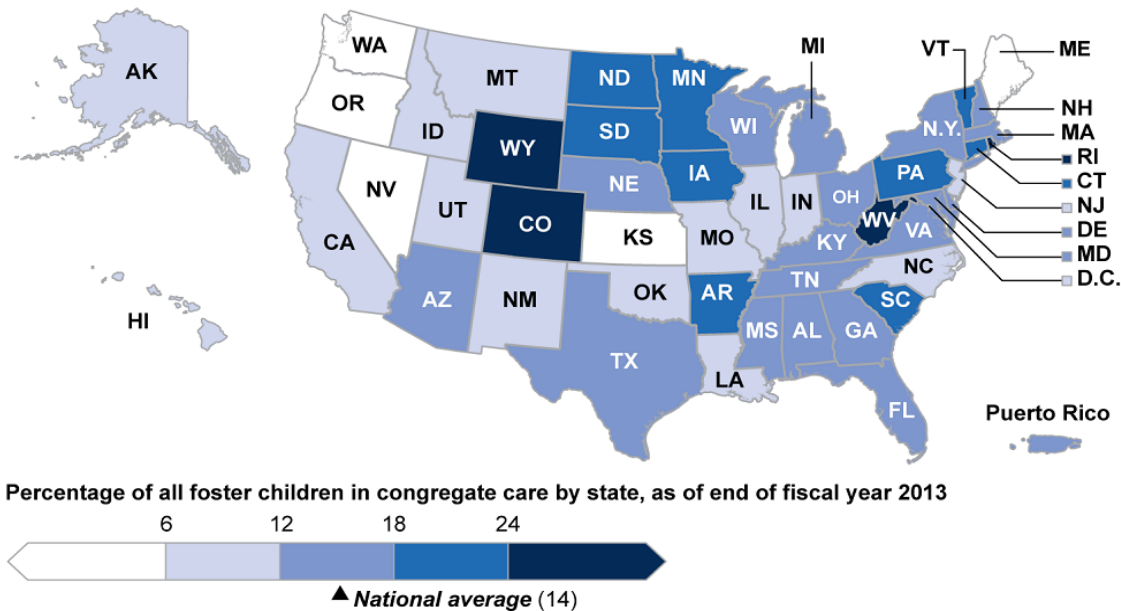
emotions and behaviors that they can use in the community, and conduct more extensive evaluation studies.⁴ This is a call to be more specific and targeted in order to better meet the needs of the children, youth, and families that receive services at this level of care.

The group-care field has responded by improving many aspects of intervention design, implementation, staff development, and evaluation, including providing more after-care services — support services that follow youth into the community transition.⁵ But there is not yet consensus on transformation, and, as with any systems change, these agencies will need a method of funding to support these transformations. In addition, states are working to determine what kinds of program models, funding mechanisms, and performance monitoring will make those reforms possible.⁶ Both the rate of use and length of time in care have decreased in many states.

There has been a significant decrease in the percentage of children placed in congregate care settings in the past decade (34% from 2004 to 2013), and this reduction is at a greater rate than the overall foster care population (21%).⁷ According to the most recent data available, children spend an average of eight months in congregate care (34% spent more than nine months). While these trends suggest that child welfare practice is moving toward more limited use of congregate care, the depth of improvement is not consistent across states, and some cohorts of children and youth have fared better than others.⁸

After the next section on statistics of the population that is in care, rather than “congregate care,” we will use a more precise term for these services and centers: **therapeutic residential care (TRC)**. As mentioned before, this term refers to group homes serving seven or more children, residential treatment centers, and psychiatric residential treatment facilities (PRTFs). PRTFs provide non-acute inpatient facility care for recipients who have a mental illness and/or substance abuse/dependency and need 24-hour supervision and specialized interventions.⁹ We will not focus on shelter care because it is designed to serve as temporary housing for children and it has few

Figure 1. Children in Congregate Care (Sept. 30, 2013)¹⁰



Source: GAO analysis of data states reported to HHS. | GAO-16-85

therapeutic components, and because some states intend to significantly reduce shelter care by using other strategies to care for children in crisis situations. Psychiatric hospital programs will also not be a focus because they are a very intense and restrictive use of group care, limited to a very small group of youth with acute and severe problems. The paper also does not focus on secure detention and other forms of juvenile corrections placements (see Table 1).

Table 1. Distinction between Congregate Care and Therapeutic Residential Care (TRC)

Congregate Care		
Therapeutic Residential Care (TRC)		Other Forms of Congregate Care
Group Homes	Other Forms of TRC	
<ul style="list-style-type: none"> Group homes serving seven or more children 	<ul style="list-style-type: none"> Residential treatment centers Psychiatric residential treatment facilities (PRTFs). 	<ul style="list-style-type: none"> Shelter care Psychiatric hospital programs Secure detention and other forms of juvenile corrections placements.

After a general introduction and statistics on who is served at this level of care, this research brief summarizes key elements of effective practice that are based on the characteristics and needs of children and youth referred to therapeutic residential care. It



also describes effective TRC interventions — encompassing child welfare values related to less-restrictive and community-based services — including serving the most appropriate youth, with the most appropriate interventions, for the shortest amount of time necessary to achieve key therapeutic and permanency planning goals.

We begin with a national overview of who is being served in the broader group of services known as congregate care, including the behavioral health profiles and treatment needs of those children and adolescents. Despite a paucity of research, we then focus on describing what interventions (including their duration, age range, dosage, and sequencing) are associated with effective services for different constellations of youth needs. There are ample data to indicate that youth proceed to group care for reasons not entirely nor exclusively consistent with their social and emotional needs. This is intended to help suggest what might be ideal lengths of stay for certain groups, recognizing that every family is unique. The research brief closes with a summary of some of the key components that have been identified as needed for improvement of TRC.

What do we know about who is being served in congregate care?

Data limitations

Before reporting some of the key characteristics of youth served in TRC and the broader programs of congregate care, we will highlight a few of the major data limitations in this program area. First, there are limitations in the clinical diagnoses of youth placed in these programs in that case records occasionally do not include the proper data. Second, there are little comparable data in relation to the demographic characteristics of the families of origin of the young people who are served by TRC programs. Yet in designing TRC programs for specific populations, it is important to have demographic data for the families of the young people to be served, as well as for the young people themselves.¹¹ Finally, there is little information about the trauma/risk behavior trajectories and adequacy of interventions utilized prior to entry of these youth into this higher level of care.

Youth characteristics

Using the National Child Traumatic Stress Network data set, Briggs et al. studied a sample of 11,076 children who had experienced at least one traumatic event (Mean \bar{X} age: 10.6 years). Compared to youth not in residential treatment (undefined), youth in residential care were significantly more likely to have suffered all eight trauma types: physical abuse (55% vs. 30%), sexual abuse (40% vs. 24%), emotional abuse (68% vs. 37%), domestic violence (58% vs. 49%), traumatic loss/bereavement (62% vs. 50%), school violence (20% vs. 12%), community violence (31% vs. 16%), and to have an

impaired caregiver (60% vs. 40%).¹² The children served in residential treatment had greater functional impairment in all eight of the functional impairment areas they had examined (behavior, academic, attachment, running away, substance abuse, self-injury, suicidality, criminal activity).¹³ In a recent landmark study, the U.S. Children's Bureau compiled a core set of statistics to describe the youth being served in various forms of congregate care (including shelter care and maternity homes).¹⁴

Using descriptive statistics and limited logistic regression analyses to better understand the children who experience time in congregate care, we found that children with a DSMII diagnosis,¹⁵ behavioral health issues, or clinical disabilities other than a DSM diagnosis made up a significant proportion of those children who, at some point during their time in foster care, experienced time in a congregate care setting. Using this "Clinical Disabilities" information¹⁶ and the "Child Behavior Problem (CBP)" as a circumstance associated with the child's removal and placement into foster care, we developed four mutually exclusive subgroups for analyses: Subgroup 1 (No Clinical Indicators), Subgroup 2 (DSM Indicator), Subgroup 3 (CBP Indicator), and Subgroup 4 (Disability Indicator).¹⁷ (See Figure 2 for the percentage in each group.)

Figure 2. Cohort Trends in Congregate Care Use

Three cohorts of youth were followed for five years from the time they entered foster care for the first time in FFY 2006, 2007, and 2008 [and] were examined using our four-subgroup divisions. Of those who experienced some time in congregate care, on average about 41% were in Subgroup 1 (No Clinical Indicators), 20% in Subgroup 2 (DSM Indicator), 32% in Subgroup 3 (CBP Indicator), and 7% in Subgroup 4 (Disability Indicator). Given these similarities among cohorts, additional congregate care analyses only are reported for the most recent cohort (children and youth followed from 2008 to 2013).

The majority of the children in the 2008 cohort did not spend long periods of time in a congregate care setting. Thirty-six percent spent 60 days or less in congregate care; 5% spent 61 to 90 days; and an additional 35% spent 91 days to one year in that setting. Close to one-quarter (24%) spent more than one year in congregate care. On average, they spent nine months in a congregate care setting (close to the average of eight months seen below); more than one-third (34%) spent more than nine months.¹⁸

The field should pay close attention to the youth who had clinical indicators because these are the children/youth/families who are most likely to need specific types of services in TRC and step-down. The 41% with no clinical indicators illuminates the reality that many youth in group care arrive and are served with an incomplete understanding/articulation of their needs, strengths, and, consequently, progress. Any

problem-solving endeavor like youth treatment is set up for failure if the problem is poorly defined.¹⁹

Point in Time (PIT) analyses enabled the Children’s Bureau to see how congregate care is being used for all children in care on September 30, 2013 (i.e., the last day of the federal fiscal year [FFY] 2013). They used those analyses to answer the question, “What is the difference between children who do and do not experience congregate care?”

They found that:

- Children in congregate care settings are almost 3 times as likely to have a DSM diagnosis compared to children in other settings. (Note that this is not wholly unexpected because a DSM diagnosis is required for payment in most of these congregate care settings.)
- Children in congregate care settings are more than 6 times more likely than children in other settings to have “child behavior problem” as a reason for removal from home. (Briggs et al. defined behavior problems as including violent, aggressive, destructive, dangerous, or illegal behaviors at school, home, or in the community.²⁰)
- On average, children spent a cumulative amount of eight months in a congregate care setting compared to an average time in a particular placement type of 11 months for children in other settings.²¹
- The overall time in foster care was longer for children who spent some time in congregate care, with an average of 28 months compared to 21 months total time in foster care.²²

The PIT analyses can over-represent youth who have been in care for longer time periods and youth who enter care toward the end of the federal fiscal year. Therefore, the Children’s Bureau followed three cohorts of youth for five years from the time they entered foster care for the first time in FFY 2006, 2007, and 2008. This allowed for a better understanding of how many “new” entries into congregate care occur in a given year. (See above, including Figure 2.)

The Children’s Bureau also examined groups of youth by age and found that:

- Children 12 years and younger composed an unexpectedly high percentage (31%) of children who experienced a congregate care setting. This needs careful examination.
- Use of congregate care varies by state (see Figure 1), and additional information on state practices, policies, and state-specific definitions of congregate care would provide important missing information. Twenty-one states had percentages of children 12 and younger in congregate care that were above the national average of 31%. States ranged from 6% to 69% of the 2008 cohort who were age 12 or younger and who experienced a congregate care episode.²³

These differences confirm the importance of common definitions and clear assessments to determine the most appropriate and effective level of service need for children and youth served by child welfare services, especially for higher levels of care. For children ages 13 years and older, the second and third findings below were surprising to many observers and are concerning:

- Of the approximately 51,000 children age 13 years and older who entered foster care in 2008, about half (25,535) entered congregate care at some point. These older youth represent 69% of the children in congregate care.
- Among those youth, more than 4 in 10 entered due to a reported behavior problem and no other clinical or mental health condition.
- About one-quarter (24%) entered a congregate care setting as their first placement.²⁴

This last finding is worth considering carefully. Does “first placement” mean the same thing as a first service response? Can we discern what proportion of those “first placements” were the result of careful treatment planning versus system inertia (i.e., not doing anything until things escalate to a point where out-of-home care is required — and then choosing group care because a bed was available and/or there was a shortage of regular or treatment foster homes)? This touches on the issue of residential placement as a “last resort,” as opposed to a purposeful and carefully timed treatment of choice.²⁵

Sub-group differences in services and outcomes

As with most service populations, it is important to understand sub-group differences:

- Subgroup differences also are apparent in the time children spend in congregate care. For children and youth with no clinical indicators, 21% spent one week or less compared to only 4% of the children with a DSM diagnosis and 12% with a behavior problem only. One in five children (20%) with a behavior problem and 38% of children with a DSM diagnosis spent more than one year in a congregate care setting compared to those children with no clinical indicators (19%) and children with disabilities (30%).²⁶
- Across all subgroups, most children leave out-of-home care to a permanent placement. However, more children with a behavior problem exited to permanency (72%) and fewer emancipated (15%) than children in any of the other subgroups. More of the children with behavior problems (6%) also were transferred to another agency following discharge from foster care compared to children in the other three subgroups, which may indicate a move to juvenile justice, another state, or another behavioral health system.

- Overall, results indicate that children with a DSM diagnosis and behavior problem indicators may experience a need for higher levels of care than other children in congregate care (or they may need more targeted and effective interventions). Children with a DSM diagnosis were more likely to have congregate care as a subsequent placement, be previously adopted, and have three or more placement moves compared to the other subgroups. Children with a behavior problem indicator were more likely to enter congregate care as their first placement, have only one or two placement moves, and exit to permanency. These children also were more likely to re-enter care and be transferred to another agency, which may indicate a need for longer-term stabilization in an alternate setting.²⁷

That more than one in five children with no clinical indicators (21%) spent one week or less in congregate care is puzzling unless these were children for which there was an acute behavioral crisis that could be resolved quickly. But in those situations, a 24-hour in-home crisis services team with wraparound services as a back-up likely would be less traumatic and more cost-effective. Similarly concerning is why nearly equal proportions of children with no clinical indicators (19%) and those with a behavior problem (20%) spent more than one year in congregate care. These findings imply that inequities may exist in the group care system and that any conclusions about what would be effective services for certain kinds of children are premature until these dynamics are understood better, including who is served and why.

There is some research indicating that a worrisome proportion of youth enter TRC directly, without other less restrictive treatment efforts being tried first.²⁸ In a few cases, this may be appropriate rather than having the child “fail up” into higher and higher levels of care instead of being placed in the most appropriate level of care at the outset. For most children, however, we should be focusing on helping to serve them successfully, in less restrictive (and less costly) settings.

This perspective is reinforced by National Survey of Child and Adolescent Well-Being (NSCAW II) Child Behavior Checklist data analyzed recently by Chapin Hall and the Chadwick Center when they examined three sub-groups in that data set in terms of youth who: (1) remained in their own homes; (2) were placed in non-congregate care out-of-home settings (such as kinship or traditional foster care); and (3) those in congregate care. When the CBCL results were examined using detailed congregate care subgroups (see Figure 3), the data show:

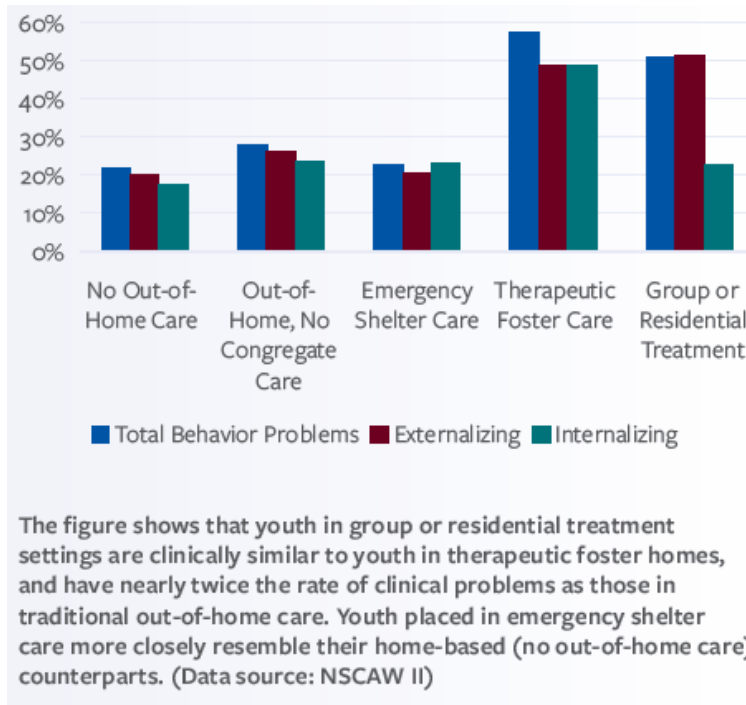
“...that youth placed in emergency shelter care more closely resemble their home-based counterparts in terms of mental health need, and youth in congregate care settings are clinically similar to youth in therapeutic

foster homes. These findings suggest potential levers for achieving reductions. First, the lower level of clinical problems among youth experiencing emergency shelter care paired with the frequency of congregate care as first placement among this group suggests the need for front door *strategies that build capacity for initial home-based placements*. Second, the comparable clinical profiles among congregate care and therapeutic foster care youth suggest the *potential for intensive intervention provided in home-based settings that are prepared to support and address the needs of youth with complex and challenging diagnostic profiles as either an alternative to the use of congregate care altogether or as a back door, step-down approach.*²⁹

In addition, these researchers found that youth with internalizing problems, such as depression or anxiety, are more likely to be placed in therapeutic foster homes than congregate care settings. *“This suggests that investments in interventions focused on stabilizing affect and behavior, de-escalating conflict, and promoting mindfulness and stress reduction could be used to make more home-based placements available to youth with externalizing behaviors.”*³⁰

Other research has uncovered patterns in the characteristics of children who tend to stay for longer periods of time in TRC. For example, Baker et al. and Glisson et al. found that mental health issues were associated with a slower rate of discharge. Baker et al. also found that prior placement history, legal status (being under protection for child abuse or neglect or voluntary entry), and parental incarceration were also associated with longer stays.³¹ In contrast, short lengths of stay due to runaway behavior were significantly associated with youth who were older (14 to 17 years of age), and who had prior substance abuse history. These data imply different characteristics of youth with different service needs. The issues are: what are the needs of specific children and youth, and why is a particular setting considered the most effective for youth with these needs?

Figure 3. Percent of Youth above the CBCL Clinical Cut Point by Placement Type



Source: Chadwick Center and Chapin Hall. (2016). *Using evidence to accelerate the safe and effective reduction of congregate care for youth involved with child welfare*. San Diego, CA & Chicago, IL, p.4. Reprinted with permission.

Summary

Some congregate care and TRC literature suggests a need to re-examine both the utilization of TRC and the specific services provided. National data indicate the majority of youth served in congregate care settings (69%) are adolescents, while a concerning 31% are under the age of 13 years. Furthermore, for 1 in 4 youth, congregate care is a first placement, and 41% have no clinical indicators, which suggests that this level of care is not needed. However, data also suggest that youth who are referred to congregate care are 3 times more likely to have a DSM-V classification and 6 times more likely to have behavior problems than youth referred to lower levels of care in the community. These identified problems do not, however, automatically equate to the need for congregate care. While these data suggest that congregate care facilities are serving youth with higher level psycho-social and behavioral concerns, it is not clear whether, with certain kinds of community-based services, at least some of these youth could be served in their communities. Too few states have developed assessment-based specific criteria for use of TRC and then measured youth outcomes to see if the criteria were effective.³²

Questions about level and type of care needed are especially relevant when cohort analyses reveal that 4 out of 6 youth served in these facilities do not have any clinical

indicators recorded in their case file, and so for those children congregate care is being used to address behavior problems. Some worry that the condition of many of these youth do not warrant this level of care. In a recent paper, Chapin Hall and the Chadwick center caution that youth placed in congregate care are "... more likely (to) have externalizing problems (suggesting that strategies for serving these youth in home-based setting(s) should focus on preparing those homes to respond by de-escalating difficult behaviors)."³³

A serious dilemma may be evident here: Is congregate care an industry developed for a child welfare system that is unable to appropriately balance children's need for family and community with agency need to assure child safety? Has this resulted in the use of congregate care expertise in housing and caring for children difficult to manage in other settings, but generally without sufficient modern child welfare system consideration and funding for the potency of relationships, community, and belonging as healing agents for children?³⁴ Had these children/youth with significant trauma and behavioral issues been identified and served earlier could they have been effectively served in less restrictive and more community-based settings?

Therapeutic residential care interventions

TRC outcomes research

A number of studies have shown positive effects of TRC, including improvements in child behavior, and reductions in trauma symptoms, and increased optimism, life satisfaction and other emotional health improvements while in care and during 3- to 12-month follow-up periods.³⁵ For example, the Boys Town studies have been consistently strong and positive in most respects, including a recent study of the Family Home Model that showed continuing effects post-treatment.³⁶ Two California studies of other models also demonstrated treatment effects: one study of 8,933 children found that when properly assessed and placed into the appropriate level (intensity) of care upon entry, the majority of children exit the residential care system altogether, and return home or to home-like settings sooner and at a lower cost. Furthermore, in this particular study, high-level (intensive) residential therapeutic care programs achieved the greatest placement stability, with reduced placement stability with less intensive TRC.³⁷ This is an important finding because placement stability is associated with more positive outcomes for children placed in out-of-home care.³⁸ A more recent study of TRC in four California counties as part of a services reform project provided preliminary evidence of improvement in behavioral functioning and more youth stepping down to less restrictive placements.³⁹

Finally, a recent analysis of the Midwest Study data of youth in foster care as they aged out of care found that when a wide range of demographic and life experience variables

were controlled for, the only outcome differences between youth who had been in foster care without residential treatment experience and those with residential treatment experience was not being in the labor force in the past 12 months and not owning a car. The researchers commented:

Youth who enter residential care are likely to be more troubled and have more problematic histories and experiences than youth placed in other out-of-home settings. The drastic reduction in statistical significance that was observed in the second set of regression models once these characteristics were accounted for suggests that it is these characteristics, and not just the residential care setting per se, that contribute to the bleak outcomes observed later in life. This represents both an opportunity for and places an onus on the future of residential care. Knowing that more troubled children will enter these settings, and that their time in placement could potentially solidify or disrupt the trajectories toward unfavorable outcomes, more intentional and data-driven approaches to residential care are called for.⁴⁰

As mentioned in the introduction, while there is clearly evidence of effective programming in general, the models studied and the rigor of the evaluations vary significantly. For example, there has been an under-investment in intervention design, service quality monitoring, and outcomes research in TRC. The field needs intervention studies using randomly selected control groups, rigorous quasi-experimental designs, and longitudinal outcome studies that use common measures across studies.⁴¹ With those limitations in mind and with some study exceptions,⁴² it appears that although many youth improve in some areas of functioning during the course of TRC, gains are frequently lost after their return to the community. Further, improvement during the course of treatment has not been a reliable predictor of long-term outcomes.⁴³ However, the likelihood of maintaining some gains after discharge can be increased by at least three factors (“common elements of treatment”):

1. Involving the resident’s family in the treatment process before discharge (for example, in family therapy).
2. Achieving stability in the place where the child or youth goes to live after discharge.
3. Ensuring that aftercare support for the child or youth and their families is available.⁴⁴

In the upcoming sections we summarize key treatment goals and principles of TRC, along with what interventions have been used and the level of evidence for them.

Assessment

Intervention selection is made possible, in part, by a careful multi-dimensional assessment. As illustrated in Figure 4, this involves the use of multi-dimensional child

and family assessments that consider strengths, needs, risk, and safety factors and what strategies could address those needs. There are practical functional assessment measures and screening tools that can assist with this process. There are many elements of the multi-dimensional assessment where the family and other members have an important role. But there are some aspects of the assessment that need to be conducted by a professionally trained person, such as administering and reviewing the scores from a trauma, depression, or substance abuse screen or a behavioral functioning rating assessment. So one member of the child and family team should be a trained professional who conducts some aspects of the assessment.

Figure 4. Key Assessment Domains for Child Assessment in Child and Family Social Services



Source: Pecora, P.J. (2015). *Assessment: Ensuring That Children Receive the Right Services at the Right Time from High Quality Providers*. Presentation for the National Association for Children’s Behavioral Health conference, Baltimore, July 16, 2015.

Treatment principles

While there has been no formal concurrence or agreement, the following treatment principles and areas of clinical focus appear to be important for high-quality TRC, as highlighted by early studies of TRC and the United States General Accounting Office 1994 study:

- Individualize child-specific treatment to address trauma and risk behavior in residential settings as well as step-down community services.
- Help youth learn skills for managing their emotions and behaviors that they can use in the community (adaptation skills).⁴⁵



- Address other areas of child functioning, such as social/peer, academic, and life skills, including community linkages upon transition.
- Support a trauma-centered therapeutic milieu and positive working relationships between staff and youth.⁴⁶
- Minimize lengths of stay, whenever possible, including the use of brief repeatable TRC episodes, if needed.⁴⁷
- Collaborate with others to facilitate the achievement of legal and emotional permanency, including carefully approaching discharge/transition planning with permanency in mind.
- Integrate family while youth is in residence as well as part of step-down planning; with the child's case manager, identify and link the child to a caring adult who will be there for the child after treatment.⁴⁸
- Provide timely aftercare/post-permanency services to the family as needed, including treatment foster care.

The National Child Traumatic Stress Network (NCTSN) study of those served in TRC and the Knoverek et al. and Underwood et al. reviews highlight the need to address specific areas of treatment: reduced mental health symptoms, aggressive behaviors, cognitive distortions leading to delinquent behavior, cognition impairment, complex trauma, criminal activity, deviant sexual fantasies (applicable to a very small proportion of youth), disassociation, running away, substance abuse, suicidality and other forms of self-injury; elimination of trauma re-victimization; improved attitude, self-concept, self-esteem/self-worth, academic achievement, affect regulation, and attachment; and improved readiness to live in the community.⁴⁹

In a 24/7 environment child care workers can be powerful members of a treatment team because they manage the living environment, including crucial times of the day such as early morning and bedtime. But these staff need specialized training and coaching to do that well, as emphasized by a book about “the other 23 hours” and the CARE approach.⁵⁰

Trauma-informed care

All areas of child welfare and behavioral health services (not just TRC) should more fully implement trauma-informed care approaches, including those addressing trauma caused by system factors such as poorly handled initial child placement, maltreatment by foster parents, and **complex trauma** (see Figure 5). Typically, complex trauma exposure involves the simultaneous or sequential (long-term) occurrence of child maltreatment; it may include psychological maltreatment, neglect, physical and sexual abuse, poly-victimizations,⁵¹ and witnessing domestic violence. Complex trauma is associated with:

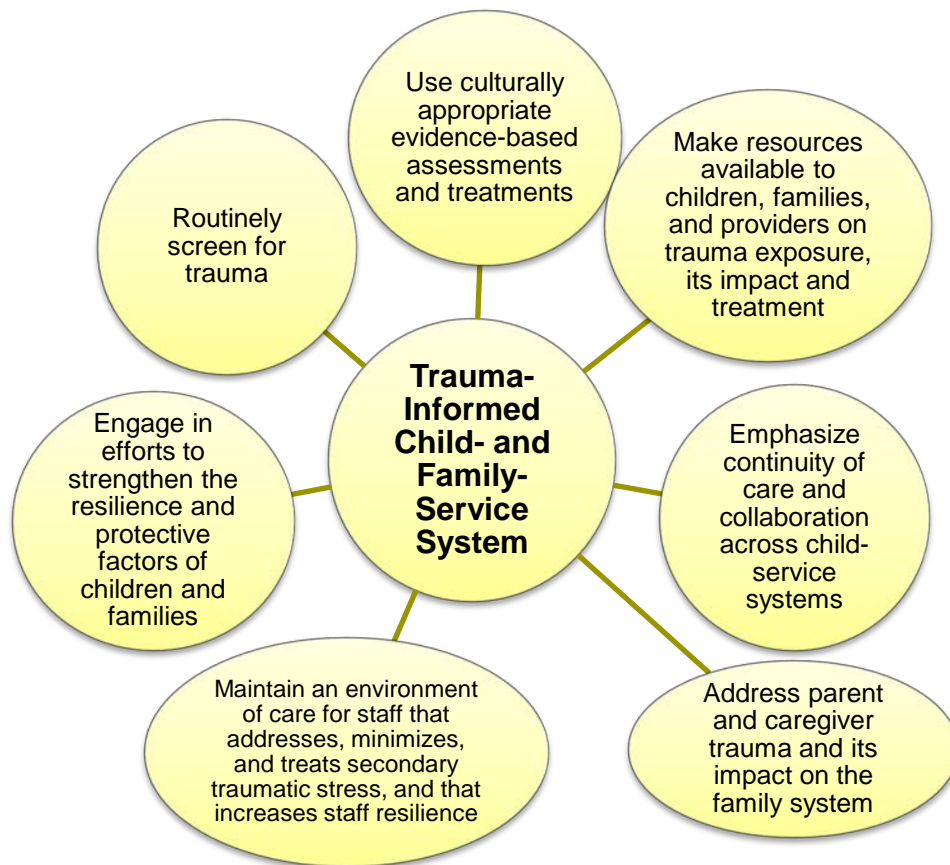
- Chronic exposure
- Early childhood occurrence, and
- Occurrence within the child's primary caregiving system and/or social environment.

Exposure to these initial traumatic experiences, the resulting emotional dysregulation, and the loss of safety, direction, and the ability to detect or respond to danger cues may impact a child's development over time and can lead to subsequent or repeated trauma exposure in adolescence and adulthood without supports that might buffer the negative effects.⁵² Cook et al., Herman, and others have noted that individuals who suffered severe, long-lasting, interpersonal trauma, especially in early life, frequently suffer from symptoms that span the domains of attachment, biology, affect regulation, disassociation, behavior, cognition, and self-concept, including:

- Increased propensity to seek out experiences and relationships that mirror their original trauma.
- Severe difficulties in controlling emotions and regulating moods.
- Identity problems, including the loss of a coherent sense of self.
- Marked inability to develop trusting relationships.
- Sometimes, adoption of the perpetrator's belief system.⁵³



Figure 5. Elements of a Trauma-Informed Child- and Family-Service System According to the National Child Traumatic Stress Network



Source: National Child Traumatic Stress Network (NCTSN) (undated). *What is a Trauma-Informed Child- and Family-Service System?* Accessed online on 8/31/2015 at <http://nctsn.org/resources/topics/creating-trauma-informed-systems>

These consequences of exposure to traumatic experiences suggest a need for comprehensive assessment, not just of the presenting problem, but of youth experiences across time. This kind of assessment will more accurately reflect youth trauma and risk behaviors, as well as the service array needed to address identified needs. In addition to offering targeted services based on youth need, services targeting caregiver need and further examination of the provision of these services at the community level to prevent the need for a higher level of care, or to support successful transition back to the community, should be considered.



Furthermore, some youth may go on to mistreat others, while others may be compelled to seek out relationships with others who mistreat them in a similar way to their original abuser.⁵⁴ Thus TRC programs that serve traumatized children and youth should be first and foremost a “sanctuary,” with an abundance of environmental and relational safeguards to prevent further re-traumatization and to help youth build on their strengths and any positive social networks.⁵⁵ The interventions also must build (or rebuild) child and caregiver self-regulation skills, and the secure attuned relationships between children and caregivers necessary for children to have the safety needed for traumatic memory desensitization and reintegration of identity.⁵⁶ Significant treatment challenges exist, however, as summarized by Sigrid James:

First, most current available trauma treatments have been developed for the individual or group therapy context. Residential treatment, by nature, is ongoing 24 hours a day, 7 days a week, 365 days a year and cuts across all contexts through which youth move (e.g., school, milieu, social, and clinical), and therefore a circumscribed trauma treatment (i.e., one that is delivered only via individual or group therapy sessions) is less likely to be effective. Additionally, the most commonly used trauma treatment for youth, Trauma Focused Cognitive Behavioral Therapy (TF-CBT), is contraindicated for youth who: (a) [have] current self-harm or suicidal behaviors (a common problem for many youth in residential care), (b) lack a family system that can provide empathic support during trauma processing (youth in residential care often have unstable family connections, if any at all), and/or (c) are at risk for further trauma exposure (youth in residential care are at increased risk for victimization due to higher rates of run-away behaviors).

A second barrier is that, given limited resources and high need to establish safety, most residential treatment facilities prioritize training for line staff in management of “problem behaviors” over trauma-informed practices. Risky behaviors such as self-harm, suicidal, and run-away that contribute to the youth’s placement and often continue beyond admission are necessarily a focus of intervention. However, the very behavior management techniques and safety procedures that are designed to reduce unsafe behavior (i.e., use of restraint) are triggering for traumatized youth, leading to increased dysregulation and reactivity. This paradox points to a need to integrate trauma-informed approaches in the milieu that go beyond individual or group therapy because milieu staff are often on the “front lines” in helping youth to manage the high levels of dysregulation that lead to reactive aggression, self-harm and run-away behaviors.⁵⁷

As might be expected, as child trauma exposure increases, so does the need for more extensive and potentially more complicated treatment. Underlying PTSD may be masked by various coping mechanisms that are interpreted as anti-social “conduct disorders” and treated with the wrong medications or interventions.⁵⁸ Because of these challenges, some recommend that a more comprehensive “over-arching trauma-informed” treatment approach be used that can be taught to the full range of TRC and related staff, such as administrators, clinicians, and residential counselors, and be flexible enough to be applied across contexts (e.g., school, therapeutic, and milieu). Creating a trauma-informed therapeutic milieu that extends beyond the individual therapy hour is critical for traumatized youth who require ongoing support in their day-to-day interactions with the world. But forming intimate, mutually respectful, limber, and gratifying relationships is next to impossible for youth relating to shift staff and intermittent individual clinical sessions during a TRC stay. Thus most forms of TRC have limited ability to deliver the corrective experience of relational healing as we understand it.⁵⁹

Because negative memories of traumatized youth can be triggered by being around other traumatized youth, consider placing children in treatment foster care or with family or others who can “demonstrate their ability and commitment to keeping all residents safe, minimizing youths’ exposure to chaos and inappropriate intimacy, and providing secure containment when youth are triggered.”⁶⁰ In addition, TRC programs need to pay attention to the special treatment issues that lesbian, gay, bisexual and transgender (LGBT)⁶¹ and latency-aged youth face.⁶²

While the level of research evidence for these strategies varies, interventions focused on emotion regulation, sensorimotor techniques, expressive therapies, dyadic therapies, family therapy, and trauma memory processing (narration of trauma memory) are especially relevant and are included in Table 2 and Appendix A. For example, **self-regulation enhancement** is the ability to deploy several psychobiological competencies to achieve an “allostatic” (homeostasis-promoting) balance in body state, psychological state, and relationship to the physical and interpersonal environment — drawing from both executive function and emotion regulation capacities.⁶³ These skills are acquired through social learning (modeling proactive behaviors by observing others) and reinforcement (being motivated to engage in positive self-regulation through specific consequences).⁶⁴ Some interventions for increasing self-regulation include the PAX Good Behavior Game and SPARCS, which are summarized in Table 2. These are sometimes part of a larger organizational culture approach.

Related to these cautions and suggestions is the idea that trauma is often processed in nonverbal realms.⁶⁵ This is why the interventions mentioned above and those below need to be considered, in addition to cognitive behavior therapy (CBT; see Table 2 and Appendix A). For example:

- Integrate *CBT with Structured Sensory Intervention for Traumatized Children, Adolescents and Parents – At-risk Adjudicated Treatment Program (SITCAP-ART)* to address both the implicit, sensory memories and the explicit memories.⁶⁶
- Combine *Dialectical Behavior Therapy (DBT)* and *Eye Movement Desensitization and Reprocessing (EMDR)* treatments for adolescents within a TRC setting to address trauma and resulting conditions.⁶⁷

Finally, note that neglect is what brings the largest number of children into foster care, and when accompanied by other forms of trauma, the effects of neglect can be complicated to treat. Griffith and others caution, for example, that individuals with a history of neglect may not be a good fit for narrative processing interventions that focus on a discrete traumatic event because neglect is rarely a single event.⁶⁸ While certain TRC models such as the Sanctuary Model address this issue more comprehensively, all TRC and other child welfare programs should incorporate trauma treatment principles. The next section presents information to help answer this question: What are the most effective interventions for treating certain kinds of youth needs, including the duration of that intervention?

Program models and interventions that are effective or relevant for therapeutic residential treatment and group care

Program models: Seven TRC models have received some scrutiny:

1. Menninger Clinic Residential Treatment Program Model
2. Multifunctional Treatment in Residential and Community Settings (MultifunC)
3. Positive Peer Culture (PPC)
4. Re-ED
5. Teaching Family Model (TFM)
6. The Sanctuary Model
7. The Stop-Gap Model

These models (and references) are described in Appendix A. Comparing these models in relation to the needs of youth and their families must be done with caution. For example, James made some thoughtful observations about a set of TRC models she reviewed:

Comparing the models to each other in their utility for group care settings is not straightforward. All models target youth considered to be “troubled” or “at risk.” However, while PPC, TFM, Stop-Gap and Re-ED appear to be particularly equipped to deal with youth who exhibit externalizing behavior problems, the Sanctuary® Model places explicit emphasis on

addressing trauma within a safe and supporting milieu. PPC and the Sanctuary® Model are intended for use with adolescents whereas the age range for TFM, Stop-Gap and Re-ED extends to younger ages. None of the models have race/ethnicity or maltreatment type specifications. All models are described as short-term programs with stays ranging from 3 months to about 1 year. Emphasis on group treatment varies across the models: PPC and Re-ED rely heavily on (almost) daily structured group meetings. TFM and Stop-Gap may utilize a group format, but rely on groups to a lesser degree. The Sanctuary® Model is not specifically designed with a group component, but is more milieu-oriented. A major criticism of group care has been its lack of connection and involvement with the youth's biological family (Barth, 2005). All models except for PPC include a parent component. However, we do not know at this time how consistently this aspect is implemented in each model.

Unfortunately, research on group care models remains in early developmental stages and prohibits identification of essential or core ingredients. However, there are a few treatment components in some of the models that are unique, and determining their role in the effectiveness of the model would deserve further investigation. For instance, a distinguishing factor of the TFM model is the use of Teaching Parents who live with about six to eight youths in small therapeutic group home units. As such TFM homes tend to bear more resemblance with treatment foster homes than with larger group care facilities, which traditionally rely on shift staff. Given the stronger evidence for treatment foster care (in particular Multidimensional Treatment Foster Care) (Chamberlain, 2002), this is a feature that makes the TFM particularly promising. Small therapeutic group care settings have been described as a realistic alternative for difficult-to-manage youth when treatment foster care is not available (Burns et al., 1999). In contrast, PPC's emphasis on peer culture raises concerns in light of prior research on iatrogenic effects (e.g., Dishion et al., 1999).⁶⁹

James Whittaker also has concerns: "I have more faith in a whole cloth approach where we start with a set of principles, change theory, structure and then select a limited array of key interventions to implement it This seems to me more consistent with what successful non-TRC EBP's such as Multi-systemic Therapy and Multi-Dimensional Treatment Foster Care have done, than simply an approach that aggregates ever greater numbers of EBP's in a residential setting."⁷⁰

Specific interventions or elements of effective practice: Based on a review of the literature and selected conversations with experts from the U.S. and overseas, the following interventions are highlighted as effective or relevant for therapeutic residential treatment and group home care. For each intervention, we cite the problem area addressed, age range, and the length of treatment. We also indicate how each of these interventions was rated by the California Evidence-Based Clearinghouse for Child Welfare (CEBC) according to their established criteria using the three highest levels of effectiveness for the CEBC classification system:⁷¹

1. **Well-Supported by Research Evidence:** Sample criteria include multiple-site replication and at least two randomized control trials (RCTs) in different usual care or practice settings that have found the practice to be superior to an appropriate comparison practice. The RCTs have been reported in published peer-reviewed literature. (Marked with three asterisks in Appendix A.)
2. **Supported by Research Evidence:** Sample criteria include at least one RCT in usual care or a practice setting that has found the practice to be superior to an appropriate comparison practice. The RCT has been reported in published peer-reviewed literature. In at least one RCT, the practice has shown to have a sustained effect at least one year beyond the end of treatment. (Marked with two asterisks in Appendix A.)
3. **Promising Research Evidence:** Sample criteria include at least one study utilizing some form of comparison (e.g., untreated group, placebo group, matched wait list) that has established the practice's benefit over the comparison, or found it to be equal to or better than an appropriate comparison practice. In at least one study, the practice had a sustained effect for at least six months beyond the end of treatment. (Marked with one asterisk in Appendix A.)

For some intervention ratings, we drew from the Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Effective Programs (NREP), where the quality of the research studies reviewed is rated on a 4-point scale, the "BLUEPRINTS" intervention registry, or the Office of Juvenile Justice and Delinquency Prevention (OJJDP).⁷² Interventions that were not able to be rated due to a lack of evaluation data are marked as such (NR: Not able to be rated). In some cases, the evidence base for the effectiveness of a particular intervention within a TRC environment is sparse, so we rely on the research evidence indicating that the intervention is effective for a particular problem or area of functioning that youth in TRC typically have, and various meta-analyses that have reported intervention effect sizes.⁷³ Brief descriptions of each of these interventions are included in Appendix A. Recent reviews by James and her colleagues have highlighted many of the same interventions.⁷⁴ A list of youth skill domain areas and intervention types that are recommended for them are contained in Appendix B.

With the exception of Multi-Systemic Therapy (MST) for sexual aggression or the more general MST intervention used to help facilitate family reunification,⁷⁵ we did not include interventions that use a home-based or in-home intervention strategy or are focused on attachment issues in children ages birth to 5 because nearly all children in that age range can and should be provided for in an outpatient, birth family, kinship family or treatment foster home setting. These home and community-based interventions include programs such as Circle of Security Parenting (COS-P), Cognitive Behavioral Intervention for Trauma in Schools (CBITS), Coping Power Program, imagery rehearsal therapy, life story intervention, Parent-Child Interaction Therapy (PCIT), Parent Management Training – Oregon Model (PMTO), Positive Parenting Program (“Triple P”), prolonged exposure therapy for adolescents, Problem-Solving Skills Training (PSST), Promoting Alternative Thinking Strategies (PATHS), risk reduction through family therapy, Seeking Safety, The Incredible Years (IY), the 3-5-7 Model, therapist web-assisted treatment, trauma-focused art therapy,⁷⁶ and Treatment Foster Care Oregon-Adolescents (TFCO). Some of these programs were recently highlighted as effective “disruptive behavior treatments” for youth with externalizing behaviors.⁷⁷

Expressive therapies, while under-researched, are important to consider:

Practitioners of expressive therapies know that people also have different expressive styles — one individual may be more visual, another more tactile, and so forth. When therapists are able to include these various expressive capacities in their work with clients, they can more fully enhance each person’s abilities to communicate effectively and authentically. Activities such as drawing, drumming, creative movement, and play permit individuals of all ages to express their thoughts and feelings in a manner that is different than strictly verbal means and have unique properties as interventions.⁷⁸

Successful treatment may therefore depend on the use of non-talk therapies like activities that engage proprioception (the sense of the relative position of neighboring parts of the body and strength of effort being employed in movement)⁷⁹ and restorative vestibular mechanisms (many of which can be provided in outpatient as well as TRC settings):

Activities that engage proprioception enable the child to determine the position of their bodies relative to their environment, such as opportunities to run, skip, jump, and hop. Other activities such as rocking, swinging or other rhythmic movement stimulate the vestibular mechanism and enhance spatial awareness of the child’s body (Kranowitz and Miller 2006). While there has been no empirical research on the use of sensorimotor techniques (Ogden and Minton

2000), patterned and repetitive activities such as yoga, music, body movement, and balance can provide sensory input facilitating brain development and self-regulation skills for children (Perry 2009; van der Kolk 2006). Changing intensity and pace can help emotional and physical regulation. Warner, Koomar, Lary, and Cook (2013) articulate the use of sensory integration for children in residential treatment centers, including the creation and use of sensory rooms, hiring Occupational Therapists to provide services to the children as well as serve as consultants to multidisciplinary staff, and incorporating sensorimotor techniques in trauma psychotherapy which can include expressive therapies.⁸⁰

This array of interventions offers the TRC field a holistic approach to intervention with the ability to focus on managing youth behavior as well as addressing underlying traumas based on their exposures. Yet caution needs to be exercised in using Table 2 and the longer reference table in Appendix A because the intervention must be tailored to the needs of that child and his or her family. An intervention designed for one treatment stage or setting may not be appropriate for another. For example, Real Life Heroes (RLH) was specifically developed to help traumatized children who were not improving with cognitive behavioral therapies and other trauma-informed interventions that focused primarily on the child's development of self-regulation skills and desensitization to traumatic memories and reminders. RLH was also developed "to provide trauma-informed treatment for children who did not meet the criteria for other treatment models, including children who had not yet disclosed primary traumatic experiences, and children living in placement programs who lacked safe, non-offending caregivers who were able and willing to participate in trauma therapy."⁸¹

Similarly, a recent study compared the use of TF-CBT with minimal applied behavior analysis (ABA) approaches combined with minimal individualized intensive behavioral interventions (IBI) and skill building services with a control group that received ABA and IBI more extensively. The researchers found that TF-CBT was not as effective for children ages 12 to 17 with cognitive disabilities.⁸² While a table of TRC model effect sizes is included in Appendix C as just one example of the kinds of effect size data available, more effect size data is needed for specific interventions and specific sub-populations.

Client-specific interventions are often narrowly focused on particular problems and may be an "add-on" to a larger group home model approach that also should be chosen carefully.⁸³ In addition, the TRC interventions table in Appendix A lists the number of required sessions and their duration. Many of these interventions focus not on the "other 23 hours" but on time-limited individual or group clinical interventions. Essentially, these clinical models are "add-ons" that will be ineffective if the group living environment is

unstable. Little information is provided about how these interventions might be integrated and reinforced in a powerful group living environment. Without such integration and reinforcement in this environment, the effectiveness of these interventions is likely to be significantly reduced. Added to this concern is how the child care workers, who can be powerful creators and managers of the therapeutic milieu, will be involved in these clinical interventions that are likely to be delivered by clinical psychologists or social workers.⁸⁴ Thus, some worry that neither current funding nor program operations seem conducive to efficiently installing any of these interventions (and if the program is to be truly child-need guided, more than one of the interventions may need to be available). So we might identify one or more relevant interventions but it may not be practical to implement what is actually needed for a comprehensive approach.⁸⁵

Behavior management: Because so many youth enter TRC with one or more behavioral problems, behavioral treatment and related interventions appear to be essential components for TRC, as well as in other community-based educational or treatment settings. For example, ABA approaches with IBI typically include “repeated behavioral trials using backward behavioral chaining, discrete manipulation of variables, antecedent manipulations, positive reinforcement, compliance training, simple correction, extinction, teaching to specific adaptive skills, and over-correction, among other behaviorally based interventions.”⁸⁶ Focused ABA interventions are:

...generally more time-limited in nature because they are designed to address specific behavior deceleration concerns including aggression, self-injury, disruptive behavior, pica, and other challenging behaviors. Individuals with such problem behaviors often meet criteria for certain psychiatric diagnoses, such as ‘Disruptive Behavior Disorder’ or ‘Stereotypic Movement Disorder with Self-Injurious Behavior.’ ABA-based treatment of these problems involves first conducting a functional behavioral assessment to identify the variables controlling problem behavior (i.e., the causes of the behavior). Then, this assessment information is used to guide the development of individualized treatment(s). Typically, function-based treatments involve altering the environment to minimize problem behavior, establishing and reinforcing adaptive behaviors, and withholding reinforcement for problem behavior. Focused interventions can also address other concerns such as anxiety and skills deficits (i.e., social skills and self-care deficits).⁸⁷

Cognitive behavioral interventions are one of the most well-researched ways to address dysfunctional ways of coping with anxiety or depression and can take effect in a relatively few number of sessions.⁸⁸ But Kendall-Tackett cautions that there is at least one study that shows that if there is hyperactivation of the hypothalamic-pituitary-adrenal (HPA) axis, psychotherapy may be less effective. In that study the 29 hospitalized

patients had increased levels of urinary-free cortisol at baseline. This condition, hypercortisolmia, may cause impaired cognitive functioning, which may have made it difficult for the patients to participate in the cognitive therapy. In this situation antidepressants or other methods may be needed to decrease the elevated HPA functioning.⁸⁹ These data again confirm the need for comprehensive assessment to determine not only appropriate level of care, but the specific type of targeted interventions for individual youth as well as across groups of youth.

Considering core ingredients

Table 2 presents program models and interventions that appear to be effective or relevant for therapeutic residential treatment and group care. It includes two sections: (1) program models that include case management and a collection of services/interventions and (2) interventions that are organized according to their level of evidence. But some are rarely provided by TRC programs, and considering these in relation to the needs of youth and their families must be done with caution. In addition, the evidence base for many interventions is sparse; consequently the evidence rating is not based on an extensive research base. Finally, *research synthesis* is often not undertaken in child welfare. “It is not wise to base policy and practice on single studies or a handful of selected studies. Don’t we want decisions to be made based on entire bodies of evidence? Synthesis is an important role for intermediaries, but few intermediaries truly really understand the problems and methods of research synthesis.”⁹⁰



Table 2. Program models and interventions that appear to be effective or relevant for therapeutic residential treatment and group care

TRC Program Models	
Supported	<ul style="list-style-type: none"> • Positive Peer Culture (PPC)
Promising	<ul style="list-style-type: none"> • Boys Town Family Home ProgramSM and Teaching Family Model (TFM) • The Sanctuary Model • The Stop-Gap Model
Not Able to Be Rated Because of Insufficient Research Evidence At This Time	<ul style="list-style-type: none"> • Menninger Clinic Residential Treatment Program Model (RTAP) • Multifunctional Treatment in Residential and Community Settings (MultifunC) • Re-ED (originally called Re-Education of Children with Emotional Disturbance)
TRC Interventions (CEBC, Blueprints, OJJDP or SAMHSA NREP Ratings)	
Well-Supported	
<ul style="list-style-type: none"> • Attachment Biobehavioral Catch-up (ABC) • Cognitive Behavioral therapy (CBT) • Cognitive Processing Therapy • Coping Cat • Ecologically-Based Family Therapy 	<ul style="list-style-type: none"> • Eye movement desensitization and reprocessing (EMDR) • Multisystemic Therapy (MST) for Youth with Problem Sexual Behavior • PAX Good Behavior Game (PAX GBG) • Trauma-Focused Cognitive Behavioral Therapy
Supported	
<ul style="list-style-type: none"> • Adolescent Community Reinforcement Approach • Aggression Replacement Therapy (ART)^(OJJDP rated it as effective) • Brief Strategic Family Therapy • Cognitive Behavioral Therapy (CBT) for Adolescent Depression^(NREP rating 3.4-3.7) • Dialectical Behavior Therapy (DBT) • Ecologically-Based Family Therapy 	<ul style="list-style-type: none"> • Functional Family Therapy • Moral Reconciliation Therapy ^(NREP ratings 1.9-2.0) • Structured Sensory Intervention for Traumatized Children, Adolescents and Parents – At-risk Adjudicated Treatment Program (SITCAP-ART)^(NREP 2.5 rating) • Trauma Affect Regulation: Guide for Education and Therapy (TARGET)^(NREP ratings 3.0 - 3.2)
Promising	
<ul style="list-style-type: none"> • Anger Replacement Training[®] (ART[®]) 	<ul style="list-style-type: none"> • Residential Student Assist Program (RSAP) ^(OJJDP rated it as effective)



<ul style="list-style-type: none"> • Adolescent Coping with Depression^(NREP ratings: 3.6 – 3.8) • Interpersonal Psychotherapy for Depressed Adolescents (IPT-A) 	<ul style="list-style-type: none"> • Solution-Focused Brief Therapy (SFBT)^(OJJDP rated it as promising) • Theraplay
<p>Not Able to Be Rated Because of Insufficient Research Evidence At This Time</p>	
<ul style="list-style-type: none"> • Anger Management Group Treatment Model • Applied Behavior Analysis (ABA) approaches with Individualized Intensive Behavioral Interventions (IBI) • Attachment, Regulation and Competency (ARC) • Biofeedback and Neurofeedback • Complex Trauma Treatment • Equine Therapy • Focused ABA interventions 	<ul style="list-style-type: none"> • Music Therapy • Real Life Heroes • Sensorimotor techniques • Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) • Therapeutic Crisis Intervention (TCI) • Trauma Systems Therapy (TST) • Trust-Based Relational Intervention (TBRI®) Therapeutic Camp

Group counseling and other forms of group work

While not listed specifically in the Table 2 list of program models and interventions, various forms of group work can be a powerful but under-recognized treatment modality.⁹¹ For example, Underwood et al. describe one approach to sequencing process and psycho-educational groups. (See Table 3.) These are not different from treatment approaches that are community-based — which underlies the importance of coordination of service approaches while in TRC and when transitioning back to the community.

Table 3. Sequence of core process group activities and core psycho-educational group activities

Sequence of core process groups	Sequence of core psycho-educational groups
Treatment Stage I Cognitive distortions Victim awareness	Treatment Stage I Emotions management Healthy boundaries
Treatment Stage II Empathy development Problem-solving and social skills Managing mental health	Treatment Stage II Sex education Understanding mental health
Treatment Stage III Personal victimization	Treatment Stage III Violence prevention Sexual harassment



Sequence of core process groups	Sequence of core psycho-educational groups
Substance education and dependence Mood management Treatment Stage IV Arousal reconditioning and disclosure Grooming behaviors Relapse prevention	Treatment Stage IV Thinking errors Community reintegration Electives Relationship skills Family parenting Spirituality Peer associations Acculturation

Source: Underwood, L. A., Barretti, L., Storms, T. L., Safonte-Strumolo, N. (2004). A review of clinical characteristics and residential treatments for adolescent delinquents with mental health disorders: A promising residential program. *Trauma, Violence, & Abuse*, 5(3), 199-242. Table 6: Page 227. Copyright ©2004 by SAGE Publications, Inc. Reprinted by permission of SAGE Publications, Inc.

Summary

Unfortunately, evidence regarding the effectiveness of congregate care and the subset of TRC programs is limited. Research that is available is mixed: some studies show limited improvements in functioning, and these improvements are not necessarily retained upon re-entry into the community and/or sustained long-term. Other research documents improvements while in care. Two studies of children in California found that when properly assessed and placed into the appropriate level of care at the outset, the majority of children exit the residential care system altogether, and return home or to home-like settings sooner and at a lower cost.

However, other research suggests that additional service components could improve outcomes, including increased family involvement and after-care supports that include promotion of stable placements when a child/youth returns to the community. Reviews of TRC services have identified treatment goals, principles of practice and effective clinical approaches to interventions that may likely boost positive outcomes. These reviews underscore the value of an increased focus on trauma-informed care, utilizing models such as the one developed by the NCTSN, a model that can be applied to both TRC services as well as community-based services. The research focusing on treating special issues for latency age youth appears to be a promising approach; services address issues earlier rather than later. But we need more trials of community-based interventions to determine if more of the TRC youth could be served as effectively or more effectively in their communities — with the most troubled youth placed in short-term inpatient treatment, with follow-up coordinated step-down services in the community.



The research on effective interventions that can be used more broadly than as just part of TRC appears more promising, especially since these services can be used in residential as well as community-based settings. It is interesting to note that the interventions that are considered “well-supported” primarily focus on clinical level anxiety and depression (Attachment Biobehavioral Catch-up [ABC], CBT, Coping CAT, and eye movement desensitization and reprocessing [EMDR]), while two promising programs focus on posttraumatic stress disorder (PTSD) (EMDR and TF-CBT). About half of the “supported” interventions focus on mental health issues, and the others focus on risk behaviors. An interesting question is whether there is a match between needs and services for the children/youth assigned to different facilities that offer different service interventions — for example, are youth with behavior problems assigned to programs that have interventions that effectively address behavior problems?

Components necessary for refining therapeutic residential care

Reform components and external supports

Much of previous work cited in this brief has spanned both congregate care and the more specific TRC programs. As highlighted by Ainsworth, James, Whittaker and others, we are suggesting that refinements be made in the terminology for this area, and will now focus on issues related more to TRC.⁹² A number of policy-makers are calling for TRC to be reserved for the short-term treatment of acute emotional and behavioral health problems to enable stability in subsequent community-based settings.⁹³ Program and legislative reform provisions for therapeutic residential treatment and group care must be comprehensive because reductions in the use of residential treatment and group home care are dependent upon other system reforms and services. These reforms go beyond the walls of TRC agencies. For example, the reforms in California, Connecticut and Tennessee took more than five years to plan and implement to obtain some initial success. Based on conversations with many colleagues, including those invited to a recent forum at the Children’s Defense Fund, we identified what some of those other reforms should be:

1. Understanding your community’s data — who is being placed in specific types of TRC and other forms of congregate care, including emergency shelter care? For whom is congregate care being used as a first placement and *why*? Are there differences in utilization patterns by type of child functioning or problem areas? What kinds of transfers are occurring in terms of moves from birth family care to TRC or from foster family care to TRCs? A number of experts caution that strategies to address each of these uses of TRC and other forms of congregate care may be distinctly different.⁹⁴ And failure to consider “down-stream” implementation side-effects and barriers



may undermine the best-intentioned reform efforts if foster parents or essential after-care services become overwhelmed.⁹⁵

2. Increasing the availability of “up-stream” community-based prevention services, including in-home parent coaching and interventions for families in crisis such as Functional Family Therapy (FFT), Intensive Home-Based Services, and Multi-Systemic Treatment (MST).
3. Improving multi-dimensional assessment for intervention targeting (Figure 4).
4. Using multi-disciplinary teams and team decision-making to carefully assess child needs and make child placement decisions. (Team meetings that are co-led by families can more accurately specify what needs to be addressed and the clinical interventions that may be needed.⁹⁶ The placement type for the child is *not* what the conversation should lead with, but should be a logical step *after* a careful assessment and consideration of a child’s needs has been made.)
5. Improving kinship care licensing by offering rent deposits, house modifications, transportation supports, and other strategies to ensure timely availability of relative caregivers. Provide those kinship parents with the clinical supports they need to parent effectively if the child’s needs outstrip current kin caregiver skill levels.
6. Expanding the supply of treatment foster homes, including those involving kinship caregivers.
7. Reinforcing the philosophy that children belong with families, and shift workers are never sufficient — even if a child is “safe” and “stable.”
8. Setting aggressive targets for reducing the number of children placed in shelter care and TRC by shortening length of stay whenever clinically possible. Related to this is distinguishing dosage and intensity from length of treatment or level of restrictiveness. For example, length of stay is not a substitute for providing the right overall dosage or intensity of an intervention.⁹⁷
9. Providing foster parent supports, as well as interventions designed to prevent a child’s behavior problems from escalating, such as FFT, HOMEBUILDERS, MST or Project KEEP, because some youth escalate into TRC after a placement disruption.
10. Refining the array of clinical interventions in TRC to better meet the needs of the children, including careful use of psychotropic medications.
11. Offering financial incentives and support to help TRC agencies make the transition to becoming providers of aggressive family finding, wraparound,

family team decision-making, youth emancipation, respite and other key services.

12. Using refined performance metrics and redesigned performance-based contracting fiscal incentives to achieve the reform targets.
13. Making assertive permanency planning efforts if a child is placed in TRC. (See below.)
14. Training juvenile court judges about key values and the most effective community and TRC strategies, because some judges order TRC or other forms of congregate care placements without full consideration of other options. And often the presiding or superior court judge cannot influence the outlying (and often rotating) county judges.
15. Providing more timely aftercare services from TRC staff for parents, families, relatives, and other caregivers *after* reunification, and for adoptive families. (A small but significant proportion of youth served in TRC are from adoptive and kinship care families — and more work is needed to create supportive pathways for leaving care.)⁹⁸

In addition, the Youth Law Center, based on a national study, recently observed that a majority of states and the District of Columbia have some kind of restriction in the use of shelter care, TRC and other congregate care facilities, although the types of limitations vary. Restrictions can be imposed by statute, regulation, or sub-regulatory policy or guidance, and can be included in licensing, placement, and funding criteria. Types of restrictions include:

- Absolute prohibition on placement of children under a specified age in certain types of settings.
- Prohibition on placement of children under a specified age with defined exceptions.
- Enhanced admission criteria or facility requirements for children under a specified age.
- Required justification, for example, based on the clinical needs of the child.
- Prior supervisory or departmental approval.
- Case plans and placement criteria that specify purpose of placement, length of stay, and regular review.
- Mandate to close facilities or limit capacity of non-family placements.
- Explicit funding restrictions.
- Limitation on approval of rates for additional facilities or additional capacity.⁹⁹

The next sections highlight a few of these reforms.

Assertive permanency planning

If a child is placed in any kind of out-of-home care (including TRC), assertive permanency planning efforts need to be made. These could include Family Finding, Permanency Roundtables (first implemented in Georgia¹⁰⁰), and Expedited Permanency Meetings.¹⁰¹ This is part of what should be a more assertive focus on helping youth prepare for the transition from TRC to a less restrictive and more permanent living situation.¹⁰²

Use of refined data and performance metrics for planning

Along with the data needed to better understand who is being served in these systems, a variety of key performance metrics should be monitored, preferably using trend or entry cohort data that are tracked over time. First, it is important to distinguish between shelter care facilities (which are intended to be used for short-term non-therapeutic living situations) and neighborhood-based group homes, residential treatment centers and psychiatric hospitalizations. Second, be clear about whether juvenile justice-referred youth and private-pay youth are included in the data. Third, some youth may be served on tribal reservation-based facilities, and those youth may or may not be counted — or only counted in terms of state payments to the tribal nations.¹⁰³ Fourth, note whether youth placed by the child welfare agency in an out-of-state group care facility are counted. Fifth, more sophisticated analyses of demographic, child needs, service, and outcome data can be useful — including geo-mapping parent locations of the youth placed in relation to where the facilities are (at least by county), survival analyses of youth served, cluster analyses and latent class analyses of the types of youth served for more refined intervention planning,¹⁰⁴ and multivariate logistical regression of what factors are most predictive of successful group care treatment.¹⁰⁵

Summary

Experts in TRC interventions and models have identified evidence that supports the potential for community-based services, including CBITS, FFT, HOMEBUILDERS, MST and other programs that target key traumas and risk behaviors identified for youth with higher needs. Based on the characteristics of the population of children served by TRCs, all programs should include therapeutic elements to address social, emotional and behavioral management issues for children and youth served in these programs. Also important in the discussion about TRC components of practice is an understanding of the larger service context within which TRC services exist.

Understanding and addressing these larger contextual issues can only improve the likelihood that TRC services, as an integrated part of an overall service system, will improve the outcomes for children and youth served by child welfare systems. Of particular importance is the need for comprehensive assessments to identify individual youth and family needs, as well as providing information on an aggregate level to assist

in planning the number of types of services needed. More targeted services, a philosophy of permanency for all youth, and use of assessment data to inform the development of service approaches can only increase the likely effectiveness of these programs.

Conclusions

This research brief summarized current data on congregate care use, characteristics of youth currently served, and key elements of effective practice that are based on the needs of children and youth referred to therapeutic residential treatment and group home care. A key contribution of the brief is the recommendation about being more specific with language — specifically, using the term Therapeutic Residential Care for a subset of programs clustered within Congregate Care. This paper tried to address these two key questions for TRC:

- What are the characteristics and needs of youth who would most appropriately be served in TRC?
- What interventions are associated with effective TRC services?

This brief also described how certain interventions and broader systems reforms, when implemented together, can help ensure that the right youth are served in TRC, with the most appropriate interventions, and for the shortest amount of time necessary to achieve therapeutic and permanency planning goals. Important concerns are being raised about the consistency, quality and effectiveness of TRC services and they need to be thoughtfully addressed. For example, Libby, et al., in a study of TRC services in Colorado that did not include a case file review (an important limitation), found that it appeared that, regardless of case type, over the course of a week most youth are together and are engaged in similar activities for similar periods of time. According to these authors, this belies the idea of “within RTC” specialization, duration and sequencing by major case types:

This begs the value question: if a given RTC [Residential Treatment Care] takes two young people, for example, of low and high severities and associated low and high relative case (payment) rates, but yet does not vary the service mix, what does the higher rate reflect? Our table might suggest only medication management and intense supervision. This might suggest that a Child Welfare system should think about RTC specialization at the provider (RTC) level and not treat all beds as uniformly interchangeable. Another cost implication is that in the current reimbursement rates, in Colorado held suppressed for a decade, there are not enough resources to realistically implement specialised [sic] services by case type.¹⁰⁶

A clear understanding of the population served by TRC programs raises the possibility of these programs being designed for population sub-groups to address specific special needs or problems (i.e., more targeted programs). At present it is all too common to find programs with mixed youth populations because of the practice of accepting all referrals, regardless of their marginal suitability, to keep a high bed occupancy rate. To change this practice would, however, mean that programs would have to be encouraged and remunerated for holding open beds in TRC programs as is recommended for treatment foster homes, and to have a small but sufficient array of interventions to meet the needs of a specialized group of youth that they intend to serve.¹⁰⁷ By shortening overall length of stay and improving targeting of who to serve in TRC, funds should be freed up to pay for high-quality targeted interventions.

Our review found a range of interventions, many of which can be delivered in two to six months. But we also found a lack of rigorous outcomes research for many interventions that would (1) provide key information to help guide the field in which interventions are especially effective for addressing which youth treatment needs, and (2) enable the interventions to be more fully rated by various practice registries.¹⁰⁸ Stated another way, while an array of promising and experience-informed interventions are available, we need more research that better specifies which interventions are most effective for which youth needs, and how to best sequence and combine them.



Appendix A: Brief summaries of interventions that can be used as part of an effective approach to therapeutic residential treatment and group care

Evidence Level Legend:

* Promising

** Supported by some research evidence.

*** Well-supported by research evidence.

NR: Not rated for level of research evidence at this time.

Program Model or Intervention	Problem or Skill Area Addressed	Ages	Treatment Duration
PROGRAM MODEL			
<p>Boys Town Family Home ProgramSM and Teaching Family Model (TFM)* The TFM was first implemented in 1967 with the opening of a group home for delinquent youth as the Achievement Place Research Project at Kansas University. The TFM is best known because of its utilization at Boys Town (formerly Father Flanagan's Boys Town).</p> <p>Boys Town uses an advanced and updated adaptation of the TFM, called the Boys Town Family Home Model.¹⁰⁹ With this model, family-style living and other program elements, while clearly specified, are experienced by youth and families as a natural, family-focused living arrangement rather than a prescriptive curriculum. Trained married couples, called Family Teachers, live with children 24 hours per day. They implement the intervention strategies with youth and are the primary contact for the child's family. This model is more similar to treatment foster care than to traditional residential care. This is characterized by clearly defined goals, integrated support systems, and a set of core elements, which include:</p> <ul style="list-style-type: none"> • Teaching skills • Building healthy relationships • Supporting religion and faith • Creating a positive family environment • Promoting self-determination¹¹⁰ 	<p>Typical problems that youth have upon entering TRC, including aggression and depression</p>	<p>0-17</p>	<p>12-18 months</p>

Program Model or Intervention	Problem or Skill Area Addressed	Ages	Treatment Duration
PROGRAM MODEL			
<p>Menninger Clinic Residential Treatment Program Model.* This intensive short-term model of TRC focused on these intervention components, besides careful use of medication:</p> <ul style="list-style-type: none"> • Seek out and then involve family members more extensively in treatment • Establish positive working relationships in a trauma-centered organizational milieu with the staff youth spend the most amount of time with — the child care workers¹¹¹ • Help youth learn skills for managing their emotions and behaviors that they can use in the community (adaptational skills) • Involvement in community activities (whenever possible) • Provision of timely after-care/post-permanency services to the family as they need it¹¹² 	<p>Typical problems that youth have upon entering TRC, including aggression and depression</p>	<p>Not specified</p>	<p>N/A: overall program model, median program duration is 3-4 months</p>
<p>Multifunctional Treatment in Residential and Community Settings (MultifunC)^{NR} This model is based on “The Risk principle,” which predicts that residential treatment and other intensive interventions work best for high-risk youths, that is, youths with many risk factors. The Responsivity principle makes a distinction between general and specific responsivity. General responsivity implies that well-structured programs based on cognitive behavior theory and social learning theory are more effective than other approaches if the program targets risk factors such as social skills deficits, poor anger management and antisocial attitudes.</p> <p>Some of the evidence-based practices that have been incorporated into the model include motivational interviewing; behavioral contingency management; social skills training; aggression replacement training (ART); problem solving; parent management training; and ecological intervention.</p> <p>Promising practices that have also been incorporated into the program include youth and family engagement and</p>	<p>Serious behavior problems</p>	<p>Not specified</p>	<p>TRC: About 6 months.</p> <p>Integrated aftercare: 4-5 months</p> <p>Total: 10–12 months.</p>



Program Model or Intervention	Problem or Skill Area Addressed	Ages	Treatment Duration
PROGRAM MODEL			
<p>involvement; staged treatment progressing from an emphasis on daily routines and structure to logical and natural consequences applied in the youth's home environment; treatment progress monitoring; aftercare support in family, school and peer settings; and ongoing quality improvement, training and support.</p> <p>The treatment process is organized in two main parts. The first takes place within the institution and the other takes place in the home environment (aftercare). It has been implemented in Norway, Sweden and Denmark; quasi-experimental studies were to be completed by 2015.¹¹³</p>			
<p>Positive Peer Culture (PPC)** The PPC treatment model was developed by Vorrath and Brendtro in response to the failure of conventional treatment approaches to effectively deal with negative peer pressure among troubled youth.¹¹⁴ "It is grounded in theories of social psychology and argues that social context is a powerful determinant of thoughts and behaviors. As such, PPC aims to transform a negative peer context into a positive peer culture, in which adult authority is deemphasized. Group norms that reinforce mutual responsibility, prosocial attitudes and social concern are fostered through the development of trust and respect. The model assumes that as youth become more committed to caring for others, hurtful behaviors are replaced by prosocial and responsible behaviors, and self-worth is increased."¹¹⁵</p>	<p>Typical problems that youth have upon entering TRC, including aggression and depression</p>	<p>12-17</p>	<p>90-minute group meetings five times per week for 6-9 months</p>
<p>Re-ED (originally called Re-Education of Children with Emotional Disturbance)^{NR} Re-ED is an ecological competence approach to helping troubled children and youth and their families entering child serving systems.¹¹⁶ "This philosophy-based approach has refined its beliefs and practice since the early 1960s. Re-ED signified a change in service paradigm for youth, emphasizing a strength-based approach, an ecological orientation, a focus on competence and learning, an emphasis on relationship-building and the development of a culture of questioning and informed or data-driven decision-making. Re-ED was originally implemented and tested in short-</p>	<p>Typical problems that youth have upon entering TRC, including aggression and depression</p>	<p>0-22</p>	<p>Group sessions one to several times per day lasting one hour or less for 4-6 months</p>



Program Model or Intervention	Problem or Skill Area Addressed	Ages	Treatment Duration
PROGRAM MODEL			
term residential treatment programs as well as public school support services programs. ¹¹⁷			
Sanctuary model of a trauma-informed treatment culture* This program is not a client-specific intervention, but a full-system approach that targets the entire organization with the intention of improving client care and outcomes. Originally developed by Sandra Bloom in the context of a short-term acute inpatient psychiatric setting, the focus is to create a trauma-informed and trauma-sensitive environment in which specific trauma-focused interventions can be effectively implemented. ¹¹⁸	Anxiety, depression, PTSD	12-20	N/A: overall program model
Stop Gap Model* The Stop-Gap model, introduced by McCurdy and McIntyre, ¹¹⁹ re-conceptualizes group care as a short-term arrangement aimed at stabilizing youth sufficiently for discharge to a lower level community-based treatment. It incorporates evidence-based practices within a three-tiered approach (i.e., environment-based, intensive, and discharge related) of service delivery for group care settings. The two-fold goal of the Stop-Gap model is to interrupt the youth's downward spiral imposed by increasingly disruptive behavior and prepare the post-discharge environment for the youth's timely reintegration. The Stop-Gap model recognizes the importance of community-based service delivery approach while providing intensive and short-term support for youths with the most challenging behaviors. ¹²⁰	Disruptive behavior disorders (Conduct Disorder [CD], Oppositional Defiant Disorder [ODD], and attention-deficit hyperactivity disorder [ADHD])	6-17	90 days to one year
INTERVENTION (CEBC OR SAMHSA NREP RATING)			
Adolescent Coping with Depression (CWD-A)** ^(NREP ratings: 3.6-3.8) The CWD-A course is a cognitive behavioral group intervention that targets specific problems typically experienced by depressed adolescents. Each participant receives a workbook that provides structured learning tasks, short quizzes, and homework forms. To encourage generalization of skills to everyday situations, adolescents are given homework assignments that are reviewed at the beginning of the subsequent session. ¹²¹	Anxiety, discomfort, irrational/negative thoughts, limited experiences of pleasant activities, poor social skills	13-17	16 two-hour sessions are conducted over an 8-week period for mixed-gender groups of up to 10 adolescents
Adolescent Community Reinforcement Approach (A-CRA)** A-CRA is a behavioral intervention that seeks to	Substance abuse issues	12-22	Once per week for 50-



Program Model or Intervention	Problem or Skill Area Addressed	Ages	Treatment Duration
PROGRAM MODEL			
<p>increase the family, social, and educational/vocational reinforcers of an adolescent to support recovery from substance abuse and dependence. The manual outlines an outpatient program that targets youth 12-22 years old with Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), cannabis, alcohol, and/or other substance use disorders. A-CRA also has been implemented in intensive outpatient and residential treatment settings and the adult model, Community Reinforcement Approach (CRA), has been found effective with adults. A-CRA includes guidelines for three types of sessions: adolescents alone, caregivers alone, and adolescents and caregivers together. According to the adolescent's needs and self-assessment of happiness in multiple areas of functioning, therapists choose from among 17 A-CRA procedures that address, for example, problem-solving skills to cope with stressors, communication skills, and participation in positive social and recreational activities with the goal of improving life satisfaction and eliminating substance use problems.¹²²</p>			90 minutes for three months.
<p>Aggression Replacement Training*® (ART®) This is a cognitive-behavioral intervention to help children and adolescents improve social skill competence and moral reasoning, better manage anger, and reduce aggressive behavior. The program specifically targets chronically aggressive children and adolescents ages 12-17. The program consists of 10 weeks (30 sessions) of intervention training, and is divided into three components — social skills training, anger-control training, and training in moral reasoning. Clients attend a one-hour session in each of these components each week. Incremental learning, reinforcement techniques, and guided group discussions enhance skill acquisition, and reinforce the lessons in the curriculum.¹²³</p>	Chronic aggression	12-17	10 weeks (30 sessions)
<p>Anger Management Group Treatment Model^{NR} The Anger Management Group Treatment Model is a combined cognitive-behavioral therapy (CBT) approach that employs relaxation, cognitive, and communication skills interventions. Participants draw on these different interventions to develop individualized anger control plans. Key components of the anger management</p>	Anger, aggression	6-18	One meeting a week for 1.5 hours for 12 weeks in groups (shorter duration if



Program Model or Intervention	Problem or Skill Area Addressed	Ages	Treatment Duration
PROGRAM MODEL			
treatment are monitoring anger through the use of cues and developing cognitive-behavioral strategies in the form of anger control plans. ¹²⁴			offered as individual treatment)
<p>Applied Behavior Analysis (ABA) approaches with individualized Intensive Behavioral Interventions (IBI) <small>NR</small> (This approach can include a functional behavior analysis). ABA with IBI typically includes “repeated behavioral trials using backward behavioral chaining, discrete manipulation of variables, antecedent manipulations, positive reinforcement, compliance training, simple correction, extinction, teaching to specific adaptive skills, and over-correction, among other behaviorally based interventions.”¹²⁵</p> <p><i>Focused ABA interventions</i> are “generally more time-limited in nature because they are designed to address specific behavior deceleration concerns including aggression, self-injury, disruptive behavior, pica, and other challenging behaviors. Individuals with such problem behavior often meet criteria for certain psychiatric diagnoses, such as “Disruptive Behavior Disorder” or “Stereotypic Movement Disorder with Self-Injurious Behavior.” ABA-based treatment of these problems involves first conducting a functional behavioral assessment to identify the variables controlling problem behavior (i.e., the cause of the behavior). Then, this assessment information is used to guide the development of an individualized treatment(s). Typically, function-based treatments involve altering the environment to minimize problem behavior, establishing and reinforcing adaptive behaviors, and withholding reinforcement for problem behavior. Focused interventions can also address other concerns such as anxiety and skills deficits (i.e., social skills and self-care deficits).”¹²⁶</p>	Physical aggression, sexual aggression, verbal aggression, tantrums, self-injurious behaviors, autism-related dysfunctional behaviors	Not specified	Three times per week (duration was not specified)
<p>Attachment Biobehavioral Catch-up (ABC)^{***} ABC is designed to help parents improve their nurturing behaviors so that their infants can develop more secure and emotionally positive relationships with their caregivers. The first intervention component helps caregivers to re-interpret children’s behavioral signals so that they provide nurturance even when it is not elicited.</p>	Attachment insecurities, emotional dysregulation in terms of forming relationships.	0-2	10 one-hour sessions



Program Model or Intervention	Problem or Skill Area Addressed	Ages	Treatment Duration
PROGRAM MODEL			
<p>The second intervention component helps caregivers provide a responsive, predictable environment that enhances young children's behavioral and regulatory capabilities.¹²⁷</p>			
<p>Attachment, Regulation and Competency (ARC)^{NR} Adopts a systems-level approach to addressing the regulatory capacities of complexly traumatized youth in residential treatment settings. ARC is a framework for intervention with youth and families who have experienced multiple and/or prolonged traumatic stress. ARC identifies three core domains that are frequently impacted among traumatized youth, and which are relevant to future resiliency: attachment, self-regulation, and competency. The three domains are broken down into 10 building blocks for intervention with a manualized but flexible treatment approach.¹²⁸</p>	Attachment, anxiety	2-21	Can range from 12 to more than 52 sessions ¹²⁹
<p>Biofeedback and Neurofeedback^{NR} Biofeedback and neurofeedback are treatment techniques in which people are trained to improve their health by using signals from their own bodies that are measured by a machine. One area of utilization is when psychologists and other therapists use it to help tense and anxious clients learn to relax. Biofeedback is most often based on measurements of blood pressure, brain waves (EEG), breathing, heart rate, muscle tension, skin conductivity of electricity, and skin temperature. By watching these measurements, you can learn how to change these functions by relaxing or by holding pleasant images in your mind. Biofeedback and neurofeedback are ideal approaches for those individuals seeking complementary and alternative medicine (CAM) therapies.¹³⁰</p>	Anxiety, constipation, insomnia, tension and migraine headaches	6-adult	Varies
<p>Brief Strategic Family Therapy (BSFT)^{**} BSFT is a brief intervention used to treat adolescent drug use that occurs with other problem behaviors. These co-occurring problem behaviors include conduct problems at home and at school, oppositional behavior, delinquency, associating with antisocial peers, aggressive and violent behavior, and risky sexual behavior. BSFT is based on three basic principles: First, BSFT is a family systems approach. Second, patterns of interaction in the family influence the</p>	Adolescent drug use co-occurring with other problem behaviors such as conduct problems at home and at school, oppositional behavior, delinquency, associating with antisocial peers,	12-18	8 to 24 sessions (total duration was not specified)

Program Model or Intervention	Problem or Skill Area Addressed	Ages	Treatment Duration
PROGRAM MODEL			
<p>behavior of each family member. The role of the BSFT counselor is to identify the patterns of family interaction that are associated with the adolescent's behavior problems. Third, plan interventions that carefully target and provide practical ways to change those patterns of interaction that are directly linked to the adolescent's drug use and other problem behaviors.¹³¹</p>	<p>aggressive/violent behavior, and risky sexual behavior.</p>		
<p>Cognitive Behavioral Therapy (CBT)^{***} CBT is a time-limited, evidence-based psychotherapy for treating anxiety disorders and major depressive disorders. It is "an intervention for ameliorating distressing feelings, disturbing behavior, and the dysfunctional thoughts from which they spring. Improvements in target symptoms, such as anxiety and depression, are mediated through identifying and disputing the automatic thoughts that generate those feelings. Behavioral techniques, such as skills training and role-playing, are well-established ways of addressing phobias and posttraumatic reactions. These techniques also help patients develop coping mechanisms for managing the thoughts and feelings identified during the intervention."¹³² Several types of CBT have been highlighted as helpful for child welfare: remote CBT for anxious children, individual CBT for anxious children, parent CBT for anxious children, CBT for depressed adolescents, and trauma-focused CBT.¹³³</p>	<p>Anxiety, depression</p>	<p>13-25</p>	<p>12 to 16 weekly sessions</p>
<p>Cognitive Behavioral Therapy (CBT) for Adolescent Depression^{**}(NREP rating 3.4-3.7) This is a developmental adaptation of the classic cognitive therapy model developed by Aaron Beck and colleagues. CBT emphasizes collaborative empiricism, the importance of socializing patients to the cognitive therapy model, and the monitoring and modification of automatic thoughts, assumptions, and beliefs.¹³⁴</p>	<p>Depression</p>	<p>13-25</p>	<p>12 to 16 weekly sessions</p>
<p>Cognitive Processing Therapy (CPT)^{***} Developed originally for use with rape and crime victims, CPT begins with the trauma memory and focuses on feelings, beliefs, and thoughts that directly emanated from the traumatic event. The therapist then helps the clients examine whether the trauma appeared to disrupt or confirm beliefs prior to this experience, and how much the clients have</p>	<p>Trauma symptoms, including depression, anxiety, guilt/shame, or anger</p>	<p>Older adolescents and adults</p>	<p>One-on-one: 1-2 sessions per week totaling 12 sessions (50 minutes per session),</p>



Program Model or Intervention	Problem or Skill Area Addressed	Ages	Treatment Duration
PROGRAM MODEL			
<p>over-generalized (over-accommodated) from the event to their beliefs about themselves and the world. Clients are then taught to challenge their own self-statements using a Socratic style of therapy (leading clients to understand their reasoning processes and beliefs through questions), and to modify their extreme beliefs to bring them into balance. CPT can be conducted individually or in groups where the written trauma account is completed in an individual session.¹³⁵</p>			<p>Group: weekly 90-minute sessions for about 12 weeks</p>
<p>Complex Trauma Treatment^{NR} (requires a combination of interventions such as TF-CBT and others) Cook et al. highlight six core components of intervention:</p> <ol style="list-style-type: none"> 1. <i>Safety</i>: The installation and enhancement of internal and environmental safety. 2. <i>Self-regulation</i>: Enhancement of the capacity to modulate arousal and restore equilibrium following dysregulation across domains of affect, behavior, physiology, cognition (including redirection of dissociative states of consciousness), interpersonal relatedness and self-attribution. 3. <i>Self-reflective information processing</i>: Development of the ability to effectively engage attentional processes and executive functioning in the service of construction of self-narratives, reflection on past and present experience, anticipation and planning, and decision making. 4. <i>Traumatic experiences integration</i>: The transformation, incorporation, or resolution of traumatic memories, reminders and associated psychiatric sequelae into a non-debilitating, productive, and fulfilling existence through such therapeutic strategies as meaning-making, traumatic memory containment or processing, remembrance and mourning of the traumatic loss, symptom management and development of coping skills, and cultivation of present-oriented thinking and behavior. 5. <i>Relational engagement</i>: The repair, restoration or creation of effective working models of attachment, and the application of these models to current interpersonal relationships, including the therapeutic alliance, with emphasis on 	<p>Anxiety, trauma</p>	<p>Not specified</p>	<p>Not specified</p>



Program Model or Intervention	Problem or Skill Area Addressed	Ages	Treatment Duration
PROGRAM MODEL			
<p>development of such critical interpersonal skills as assertiveness, cooperation, perspective-taking, boundaries and limit-setting, reciprocity, social empathy, and the capacity for physical and emotional intimacy.</p> <p>6. <i>Positive affect enhancement</i>: The enhancement of self-worth, esteem and positive self-appraisal through the cultivation of personal creativity, imagination, future orientation, achievement, competence, mastery-seeking, community-building and the capacity to experience pleasure.¹³⁶</p>			
<p>Coping Cat*** Coping Cat is a cognitive-behavioral treatment for children with anxiety. The program incorporates four components:</p> <ul style="list-style-type: none"> • Recognizing and understanding emotional and physical reactions to anxiety • Clarifying thoughts and feelings in anxious situations • Developing plans for effective coping • Evaluating performance and giving self-reinforcement¹³⁷ <p>The computer-assisted intervention, Camp Cope-a-Lot, is 12 sessions with less than half of the sessions requiring professional time.</p>	Anxiety	7-17	Weekly 50-minute sessions for four months
<p>Dialectical Behavior Therapy (DBT)** DBT is a mindfulness- and acceptance-based cognitive-behavioral therapy adapted for treating people with severe, complex, hard-to-treat multi-diagnostic conditions, in particular borderline personality disorder (BPD). Standard comprehensive DBT comprises four components:</p> <ol style="list-style-type: none"> 1. Individual therapy (about 60 minutes/week) 2. Group educational skills training (about 120 minutes/week) 3. Team meeting (about 90 minutes/week) 4. Unscheduled telephone calls (average duration about 6 minutes) 	Borderline personality disorder (BPD) and substance abuse	18-25	About six months



Program Model or Intervention	Problem or Skill Area Addressed	Ages	Treatment Duration
PROGRAM MODEL			
<p>DBT for Substance Abusers was developed by Dr. Linehan and colleagues to treat individuals with co-occurring substance use disorders and BPD.¹³⁸ DBT was found effective as a precursor for treating trauma in sexually abused young women,¹³⁹ and for reducing PTSD symptoms.¹⁴⁰</p>			
<p>Ecologically-Based Family Therapy (EBFT)** EBFT addresses multiple ecological systems and originated from the therapeutic work with substance-abusing adolescents who have run away from home. The treatment was developed to address immediate needs, to resolve the crisis of running away, and to facilitate emotional re-connection through communication and problem-solving skills among family members. Family interaction is a necessary target of the therapeutic techniques. Therapy relies on understanding the individual, interpersonal, and environmental context as well as the unique resources and needs of the family and its members. The intervention includes family systems techniques such as reframes, re-labels, and relational interpretations; communication skills training; and conflict resolution, but also therapeutic case management in which systems outside the family are directly targeted. The model includes 12 home-based (or office-based) family therapy sessions and 2-4 individual HIV prevention sessions.¹⁴¹</p>	Substance abuse	12-17	About 12-16 weeks
<p>Equine Therapy^{NR} Equine Therapy is the discipline of using horses as a means to provide metaphoric experiences in order to promote emotional growth. The horses provide a way for troubled youth to react when they are otherwise therapy resistant. Equine therapists will usually teach many lessons on ways in which horses learn, react, and follow instructions related to the lives of youth themselves.¹⁴² Studies have been done to show the effects of building relationships with animals and horses.</p> <p>Endorphins are released into the body and decrease chemicals that cause stress and arousal when sessions with horses are experienced by troubled youth. Troubled teens are typically in a state of aggression, defiance, or anger. Using horse therapy with these teens helps</p>	ADHD, anxiety disorders, autism, behavioral difficulties, boundaries, communication, depression, impulse control, isolation, mood disorders, personality disorders, PTSD, receptive or expressive language disorders, schizophrenia, self-efficacy, social skills, trust	13 -21	Not specified

Program Model or Intervention	Problem or Skill Area Addressed	Ages	Treatment Duration
PROGRAM MODEL			
maintain a constant and healthy chemical balance. ¹⁴³ Hippotherapy is an approved treatment tool by professional physical, occupational, and speech therapy associations. ¹⁴⁴			
Eye movement desensitization and reprocessing (EMDR) ^{***} EMDR is based on Adaptive Information Processing theory and involves eight phases of psychotherapy that integrate psychodynamic, cognitive behavioral, interpersonal, experiential, and body-centered therapies ¹⁴⁵	Anxiety, behavior problems, fear, phobias, posttraumatic stress and posttraumatic stress disorder (PTSD)	2-17	One 50- or 90-minute session per week for 3-12 weeks
Functional Family Therapy (FFT) ^{**} FFT is an evidence-based family counseling intervention targeted toward youth-family conflict areas, such as physical or verbal aggression, and other behavioral or emotional problems. While FFT is increasingly being used in child welfare, the vast majority of FFT studies are based on programs targeted toward high risk youth who have had previous contact with the juvenile justice system or who are at risk of delinquency. A clinician meets in the home with the youth and his or her family to progressively build protective factors against delinquency while mitigating risk factors. The intermediate program goals focus on improving interpersonal relationships between family members and then building those skills in extra-family relationships. ¹⁴⁶	Youth-family conflict areas, such as physical or verbal aggression, and other behavioral or emotional problems	11-18	12- 14 sessions over 3-4 months ¹⁴⁷
Interpersonal Psychotherapy for Depressed Adolescents (IPT-A) [*] IPT-A is a time-limited, manualized psychosocial treatment for depression in adolescents and adults. IPT-A is defined in a treatment manual that was adapted to address the developmental needs of adolescents and their families. IPT-A is an outpatient treatment designed for adolescents with mild to moderate depression severity. It is not indicated for adolescents who are acutely suicidal or homicidal, psychotic, bipolar, or mentally retarded, or for adolescents who are actively abusing substances. ¹⁴⁸	Communication, problem-solving	12-18	Weekly 50-minute sessions for 3-4 months
Integrated Treatment of Complex Trauma (ITCT) ^{NR} ITCT is based on developmentally appropriate, culturally adapted approaches that can be applied in multiple	Anxiety, depression, posttraumatic stress,	2-21	16-36 sessions



Program Model or Intervention	Problem or Skill Area Addressed	Ages	Treatment Duration
PROGRAM MODEL			
<p>settings, such as outpatient clinic, school, hospital and inpatient, and involves collaboration with multiple community agencies. Treatment follows standardized protocols involving empirically based interventions for complex trauma and includes multiple treatment modalities: cognitive therapy, exposure therapy, play therapy, and relational treatment in individual and group therapy. Specific collateral and family therapy approaches are also integrated into treatment.¹⁴⁹</p>	<p>attachment disturbance, chronic negative relational schema, behavioral and affect dysregulation, interpersonal difficulties, and identity-related issues.¹⁵⁰</p>		
<p>Moral Reconciliation Therapy (MRT)** (NREP ratings 1.9-2.0) MRT is a systematic treatment strategy that seeks to decrease recidivism among juvenile and adult criminal offenders by increasing moral reasoning. Its cognitive-behavioral approach combines elements from a variety of psychological traditions to progressively address ego, social, moral, and positive behavioral growth. MRT takes the form of group and individual counseling using structured group exercises and prescribed homework assignments. The MRT workbook is structured around 16 objectively defined steps (units) focusing on seven basic treatment issues: confrontation of beliefs, attitudes, and behaviors; assessment of current relationships; reinforcement of positive behavior and habits; positive identity formation; enhancement of self-concept; decrease in hedonism and development of frustration tolerance; and development of higher stages of moral reasoning.¹⁵¹</p>	<p>Moral reasoning</p>	<p>13-55</p>	<p>Groups meet once or twice weekly for 3-6 months</p>
<p>Multisystemic Therapy for Youth with Problem Sexual Behavior*** A juvenile sex offender treatment program to reduce criminal and antisocial behavior, especially problem sexual behavior, by providing intensive family therapy services in the youth's natural environment.¹⁵²</p>	<p>Criminal and antisocial behavior, especially problem sexual behavior</p>	<p>10-17 (CEBC) 12-18 (Blueprints)</p>	<p>5-7 months</p>
<p>Music Therapy^{NR} Music Therapy is the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional. Music is used within a therapeutic relationship to address physical, emotional, cognitive, and social needs of individuals. It can include creating, singing, moving to, and/or listening to music. Through musical involvement in the therapeutic context, clients' abilities are strengthened and transferred to other</p>	<p>Physical, emotional, cognitive, and social needs</p>	<p>1-adult</p>	<p>Not specified</p>

Program Model or Intervention	Problem or Skill Area Addressed	Ages	Treatment Duration
PROGRAM MODEL			
<p>areas of their lives. Music therapy also provides avenues for communication that can be helpful to those who find it difficult to express themselves in words.¹⁵³</p>			
<p>PAX Good Behavior Game (PAX GBG)^{***} PAX GBG is an environmental intervention used in the classroom with young children to create an environment that is conducive to learning. The intervention is designed to reduce off-task behavior, increase attentiveness, and decrease aggressive and disruptive behavior and shy and withdrawn behavior.¹⁵⁴</p>	Physical and verbal aggression	6-12	Less than 6 months with games played weekly or more ¹⁵⁵
<p>Real Life Heroes (RLH)^{NR} Focuses on promoting safety, helping children understand the impact of trauma, improving affect regulation and coping, and repairing attachments to caregivers. RLH engages children and caregivers to rebuild (or build) emotionally supportive relationships, develop self-regulation and co-regulation skills, reduce traumatic stress reactions, and integrate a positive self-image through conjoint life story work. RLH includes psycho-education, a life story workbook, multi-modal creative arts, “youth power plans” and a toolkit to help practitioners implement National Child Traumatic Stress Network recommended components of treatment for Complex PTSD as a child and family transition from residential treatment to home and community-based programs. This is one of a small number of interventions evaluated within residential settings.¹⁵⁶</p> <p>RLH may differ from other trauma treatment models in its focus on the developmental needs of children ages 6–12 (as well as adolescents functioning at a latency-level in terms of their social, emotional or cognitive development), and it may be unique in its prioritization of treatment for guilt and shame associated with high risk behaviors (e.g. self-abuse, aggressiveness) that can lead to placement in residential treatment programs.¹⁵⁷</p>	Affect regulation, aggressiveness, coping, guilt, repairing attachments to caregivers, self-abuse, trauma	6-18	6-10 months (weekly 30- to 90-minute sessions, typically 25-40 sessions, but can be reduced to meet program constraints or extended as needed)
<p>Residential Student Assist Program (RSAP) (OJJDP rated it as effective) RSAP is designed to prevent and reduce alcohol and other drug (AOD) use among high-risk multi-problem youth who have been placed voluntarily or involuntarily in a residential child care facility (e.g., foster care facility, treatment center for adolescents with mental health</p>	Difficulties with alcohol, tobacco, or illegal drugs	12-18	20-24 weeks



Program Model or Intervention	Problem or Skill Area Addressed	Ages	Treatment Duration
PROGRAM MODEL			
<p>problems, juvenile correctional facility). Based on the Employee Assistance Program (EAP) model, the intervention focuses on wellness and addresses factors that hinder adolescents from being free from AOD use, such as emotional problems and mental disabilities, parental abuse and neglect, and parental substance abuse. The program is delivered in residential facilities by Master's-level counselors who use a combination of strategies, including assessment of each youth entering the facility, an eight-session prevention education series, group and/or individual counseling for youth who have chemically dependent parents and/or are using substances, and referral to substance abuse treatment programs. These services are fully integrated into the adolescent's overall experience at the residential facility. The counselors also conduct facility-wide awareness activities, provide training and consultation on AOD prevention to facility staff, and lead a task force for staff and one for residents, both of which aim to change the facility's culture and norms around substance use and facilitate referrals to the program.¹⁵⁸</p>			
<p>Seeking Safety for Adolescents* Seeking Safety for Adolescents is a present-focused, coping skills therapy to help people attain safety from trauma and/or substance abuse. The treatment is available as a book, providing both client handouts and clinician guidelines. The treatment may be conducted in group or individual format for adolescents (both females and males) in various settings (e.g., outpatient, inpatient, residential, home care, and schools). Seeking Safety for Adolescents consists of 25 topics that can be conducted in any order and number. Examples of topics are Safety, Asking for Help, Setting Boundaries in Relationships, Healthy Relationships, Community Resources, Compassion, Creating Meaning, Discovery, Recovery Thinking, Taking Good Care of Yourself, Commitment, Coping with Triggers, Self-Nurturing, Red and Green Flags, and Life Choices.¹⁵⁹</p>	<p>Substance abuse, trauma</p>	<p>12-17</p>	<p>1-1.5 hours per week for 3-6 months</p>
<p>Sensorimotor techniques^{NR} Children who have experienced early childhood trauma can have difficulty assimilating sensory input from their environment, which can result in emotional dysregulation. Children in</p>	<p>Emotional dysregulation and behavior problems</p>	<p>0-18</p>	<p>Varies by intervention</p>



Program Model or Intervention	Problem or Skill Area Addressed	Ages	Treatment Duration
PROGRAM MODEL			
<p>residential care often initially are unable to use information received through the senses to function effectively in daily life and have difficulty reading verbal and nonverbal cues from the environment. Sensorimotor techniques enhance a child’s attunement to their own body. Tactile experiences can be especially beneficial. The use of rice or sand for hiding small toys can be soothing for children as they move their hands through the coarse material searching for hidden toys.¹⁶⁰ Physical activities can target proprioception and vestibular experiences.¹⁶¹</p>			
<p>Solution-Focused Brief Therapy (SFBT)* (OJJDP rated as promising) Solution-Focused Brief Therapy minimizes emphasis on past failings and problems, and instead focuses on clients’ strengths, and previous and future successes. There is a focus on working from the client’s understanding of her/his concern/situation and what the client might want to be different. The basic tenets include:</p> <ul style="list-style-type: none"> • It is based on solution-building rather than problem-solving. • The therapeutic focus should be on the client’s desired future rather than on past problems or current conflicts. • Clients are encouraged to increase the frequency of current useful behaviors. • No problem happens all the time. There are exceptions — that is, times when the problem could have happened but didn’t — that can be used by the client and therapist to co-construct solutions. • Therapists help clients find alternatives to current undesired patterns of behavior, cognition, and interaction that are within the clients’ repertoire or can be co-constructed by therapists and clients as such. • Differing from skill-building and behavior therapy interventions, the model assumes that solution behaviors already exist for clients. • It is asserted that small increments of change lead to large increments of change. 	<p>Internalizing disorders and behavior problems</p>	<p>Youth and adults</p>	<p>Less than one year</p>

Program Model or Intervention	Problem or Skill Area Addressed	Ages	Treatment Duration
PROGRAM MODEL			
<ul style="list-style-type: none"> • Clients' solutions are not necessarily <i>directly</i> related to any identified problem by either the client or the therapist. • The conversational skills required of the therapist to invite the client to build solutions are different from those needed to diagnose and treat client problems.¹⁶² <p>Solution-focused interventions engage the client in a "conversation of change" that is conducive to the solution-building process. In this conversation, the solution-focused practitioner invites the client to be the "expert of change." Collaboratively, the solution-focused practitioner and the client co-construct a desirable future that does not contain the problem.¹⁶³</p>			
<p>Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)^{NR} SPARCS is a present-focused, manually guided group treatment. It is specifically designed to improve the emotional, social, academic, and behavioral functioning of adolescents exposed to chronic interpersonal trauma (such as ongoing physical abuse) and/or separate types of trauma (e.g., community violence, sexual assault). The curriculum was designed to address the needs of adolescents who may still be living with ongoing stress and may be experiencing problems in several areas of functioning. This can include difficulties with affect regulation and impulsivity, self-perception, relationships, somatization, dissociation, numbing and avoidance, and struggles with their own purpose and meaning in life, as well as worldviews that make it difficult for them to see a future for themselves.¹⁶⁴</p>	Anxiety, verbal and physical aggression, depression	12-18	16 sessions (4 months if sessions are weekly)
<p>Structured Sensory Intervention for Traumatized Children, Adolescents and Parents – At-risk Adjudicated Treatment Program (SITCAP-ART)^{**}(NREP 2.5 rating) SITCAP-ART is a modification of Structured Sensory Intervention for Traumatized Children, Adolescents and Parents. It is based on structured sensory therapy — integrating sensory-based activities and cognitive-reframing strategies. "The approach is grounded in the understanding that trauma is a sensory experience; traumatic memories are experienced at a</p>	Youth with symptoms of posttraumatic stress disorder and other mental health-related responses to trauma who are on probation for delinquent acts, and who may also be at risk of dropping out of school, substance	13-25	75-minute sessions are typically delivered over 10-12 weeks



Program Model or Intervention	Problem or Skill Area Addressed	Ages	Treatment Duration
PROGRAM MODEL			
<p>sensory level and must be reactivated in a safe environment in order to be moderated and tolerated with a sense of power and feeling of safety. The program provides structured activities for externalizing these traumatic memories in concrete and narrative forms. Discussions about the traumatic experience, along with sensory-based activities such as drawing, imagery, and relaxation, enable the adolescent to create language (called a trauma narrative) for his or her experience. Cognitive reframing strategies are then used to improve resiliency and help the adolescent begin to manage and make sense of the traumatic experience. It is offered in outpatient and residential treatment settings.”¹⁶⁵</p>	<p>abuse, and mental health issues</p>		
<p>Therapeutic Crisis Intervention (TCI)^{NR} TCI is a “holding” technique to proactively restrain violent youth behavior. At TCI’s core lies the principle that successful resolution of a child’s crisis depends on the environment’s (the care organization) and the individual’s (the care worker) therapeutic and developmentally appropriate response. The TCI system teaches and supports strategies for care workers at all levels of the organization to:</p> <ul style="list-style-type: none"> • Assess children’s aggressive behaviors as expressions of needs • Monitor their own levels of arousal • Use non-coercive, non-aggressive environmental and behavioral strategies and interventions that de-escalate the crisis and that lead to the child’s own emotional self-regulation and growth • Use physical interventions only as a safety intervention that contains a child’s acute aggression and violence¹⁶⁶ 	<p>Aggressive behavior, violent behavior toward themselves or others, or physical structures</p>	<p>Not specified</p>	<p>On an as-needed basis</p>
<p>Theraplay[*] Theraplay is a structured play therapy for children and their parents. Its goal is to enhance attachment, self-esteem, trust in others, and joyful engagement. The sessions are designed to be fun, physical, personal, and interactive, as well as to replicate natural, healthy interactions between parents and young children. Because of its focus on attachment and</p>	<p>Attachment, behavior and interpersonal problems resulting from learning disabilities, temper tantrums, phobias, difficulty socializing and making friends, overactive-</p>	<p>0-18</p>	<p>Approximately 1.5 years (30- to 45-minute sessions weekly for 18-24 weeks and then</p>



Program Model or Intervention	Problem or Skill Area Addressed	Ages	Treatment Duration
PROGRAM MODEL			
<p>relationship development, Theraplay has been used for many years with foster and adoptive families.¹⁶⁷</p>	<p>aggressive behavior, self-esteem, trust in others, withdrawn or depressed behavior, developmental delays, and pervasive developmental disorders</p>		<p>four follow-up sessions; weekly sessions are shorter for younger children)</p>
<p>Trauma Affect Regulation: Guide for Education and Therapy (TARGET)**(NREP ratings 3.0 - 3.2) TARGET is an educational and therapeutic intervention for the prevention and treatment of traumatic stress disorders. TARGET teaches a seven-step sequence of skills, the FREEDOM Steps, designed to enable participants to understand and gain control of trauma-related reactions triggered by current daily life stressors.</p> <p>TARGET uses the FREEDOM steps to help participants recognize and purposefully utilize their personal strengths when experiencing stress reactions in their current lives. TARGET thus both empowers and challenges trauma survivors, and the professionals working with them, to become highly focused and mindful, to make good decisions, and to build healthy relationships.¹⁶⁸</p>	<p>Anxiety, depression, PTSD, shame, grief</p>	<p>10 +</p>	<p>10-12 sessions</p>

Program Model or Intervention	Problem or Skill Area Addressed	Ages	Treatment Duration
PROGRAM MODEL			
<p>Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)** TF-CBT is a conjoint child and parent psychotherapy approach for children and adolescents who are experiencing significant emotional and behavioral difficulties related to traumatic life events. It has mostly been used and evaluated with youth who were sexually abused or exposed to domestic violence.</p> <p>TF-CBT can also benefit children with depression, anxiety, shame, and/or grief related to their trauma.¹⁶⁹ This psychotherapy model includes parent and child individual and joint sessions in several modules that combine trauma-sensitive interventions with CBT. TF-CBT aims to (1) improve child and parent knowledge and skills related to processing the trauma; (2) manage distressing thoughts, feelings, and behaviors; and (3) enhance safety, parenting skills, and family communication.¹⁷⁰</p>	Anxiety, depression, PTSD	4-18	12-16 weeks of treatment (once a week; 60- to 90-minute sessions)
<p>Trauma Systems Therapy (TST)^{NR} TST is both a clinical model for the treatment of child traumatic stress as well as an organizational model that provides a framework for the coordinated provision of appropriate services. The primary clinical innovation that encapsulates TST is the concept of the trauma system. Bound exclusively by a traumatized child’s emotion regulation capacity and his/her social environment (which can also include the system of care), the trauma system is the focus of the approach. The four primary service modules within TST are: (1) home- and community-based care; (2) outpatient, skills-based psychotherapy; (3) psychopharmacology; and (4) services advocacy.¹⁷¹</p>	Anxiety, depression, PTSD	6-19	Depends on the TRC ¹⁷²
<p>Trust-Based Relational Intervention Therapeutic Camp (TBRI®)^{NR} TBRI® is a holistic approach that is multidisciplinary, flexible, attachment-centered, and challenging. It is a trauma-informed intervention that is specifically designed for children who come from “hard places,” such as maltreatment, abuse, neglect, multiple home placements, and violence. TBRI® consists of three sets of harmonious principles: connecting, empowering, and correcting. These principles have been used in homes, schools, orphanages, residential treatment</p>	Attachment disturbances due to maltreatment, abuse, neglect, multiple home placements, and violence	1-18	Approximately 6-8 hours a day for 2-5 weeks (either 4 or 5 days/per week) in a camp setting. Follow-up



Program Model or Intervention	Problem or Skill Area Addressed	Ages	Treatment Duration
PROGRAM MODEL			
<p>centers, and other environments. They are designed for use with children and youth of all ages and risk levels. By helping caregivers understand what should have happened in early development, TBRI® principles guide children and youth back to their natural developmental trajectory.¹⁷³</p>			<p>sessions continue as needed. May be able to be easily modified for use in TRC.</p>



Appendix B: Skill domain areas and intervention types that are recommended for them

Skill Domain Learned	Content Domain	Modality Description	Goals
Cognitive distortions	Psychoeducation group; individual counseling	Interventions that involve recognizing unstable thinking patterns, reasoning, and logic that may contribute to hurtful behaviors to promote emerging social skills and choose more responsible thinking and behavior	Improved prosocial and coping skills; reduced cognitive distortions
Empathy development and victim awareness	Process group; individual counseling	Interventions that encourage empathy, taking responsibility for hurtful behaviors, for using denial and minimization, and developing an understanding of victimizing behaviors and its effect on victims, including themselves, to improve victim awareness	Improved prosocial and coping skills; reduced aggression; reduced deviant sexual fantasies
Mood management	Process group; individual counseling; medication management	Interventions that provide knowledge, behavioral strategies, management of anger, and use of medication and understanding emotions through practice to promote prosocial coping techniques	Improved prosocial and coping skills; reduced mental health symptoms
Social skills and problem solving	Process group; individual counseling	Interventions that emphasize communication and relationship skills, emotional awareness, and capacity for growth and development using previously learned coping and social skills to improve problem solving and coping strategies	Improved prosocial and coping skills; reduced aggression
Personal victimization	Psychoeducation group; individual counseling	Interventions that address individual's own victimization experiences, dynamics of their mental illness, identify triggers for mental and behavioral acting out, and adapt coping strategies for difficult interpersonal situations to decrease trauma revictimization	Reduced trauma revictimization; improved quality of life
Healthy boundaries	Psychoeducation group; individual counseling	Interventions that emphasize appropriate physical and emotional boundaries that increase knowledge of the individuality of others to decrease inappropriate touches and verbal discussions	Reduced deviant sexual arousal; reduced aggression



Skill Domain Learned	Content Domain	Modality Description	Goals
Relapse prevention	Process group; individual counseling	Interventions that identify and target feelings, thoughts, and behaviors that could lead to relapse; explore hurtful patterns; and integrate learned principles and concepts of previous treatment components to improve behavioral coping responses	Improved community readiness; reduced recidivism; improve placement stability
Community reintegration	Process group; individual counseling	Interventions that emphasize transitioning, community reintegration, and aftercare plans with collaboration of families and referral agencies to improve community readjustment	Improved community readiness; reduced recidivism
Family interventions	Psychoeducation group; individual counseling	Interventions that include family counseling, education, parenting, telephone consultations and so forth to improve family boundaries, trust, monitoring, and reintegration	Improved quality of life; improved family structure and monitoring
Substance dependence and education (12 steps)	Psychoeducation group; individual counseling	Interventions that emphasize education and awareness of the impact of substances, the addiction process, management, and abstinence to eliminate the use of substances	Improved quality of life; improved family structure and monitoring; reduced aggression
Mental health management	Psychoeducation group; individual counseling; medication management	Interventions that emphasize mental health symptoms and how to manage them by using medication and decreasing irrational thoughts and beliefs to improve awareness of emotional and behavioral triggers and crisis behavior	Reduced mental health symptoms; improved quality of life; improved placement stability
Sex education	Psychoeducation group; individual counseling	Interventions that emphasize appropriate sexual boundaries, behaviors, fantasies, contact, behaviors, and sexually transmitted diseases to eliminate deviant sexual fantasies and thinking errors	Reduced aggression; improved family structure and monitoring; improved community readiness
Violence prevention	Psychoeducation group; individual counseling	Interventions that emphasize use of nonviolent responses to conflict to eliminate precursors leading to hurtful and criminal behaviors	Reduced aggression; reduced trauma revictimization; improved community readiness
Arousal reconditioning (disclosure)	Process group; individual counseling	Interventions that emphasize appropriate arousal states, arousal patterns, disclosure of sexual interests, and types of individuals most aroused	Eliminate deviant arousal patterns

Skill Domain Learned	Content Domain	Modality Description	Goals
Grooming behavior	Process group; individual counseling	Interventions that emphasize prosocial behaviors, sexual boundaries, and fantasies	Decrease inappropriate sexual conduct

Source: Underwood, L. A., Barretti, L., Storms, T. L., Safonte-Strumolo, N. (2004). A Review of Clinical Characteristics and Residential Treatments for Adolescent Delinquents with Mental Health Disorders: A Promising Residential Program. *Trauma, Violence, & Abuse* Vol. 5(3) pp. 199-242. Table 5: Pages 225-226. Copyright © 2004 by SAGE Publications, Inc. Reprinted by permission of SAGE Publications, Inc.



Appendix C: Effect sizes obtained when certain group care models were compared with treatment foster care

Source: Lee, B. R., Bright, C. L., Svoboda, D. V., Fakunmoju, S., & Barth, R. P. (2011). Outcomes of group care for youth: A review of comparative studies. *Research on Social Work Practice*, 21(2), 177-189. doi:10.1177/1049731510386243, page 182. Reprinted with permission.

Study	Ran Away From Placement	Completed Program	Favorable Discharge	Return Home	Legal	Homelike	Formal	Days in	Days in	Days	Criminal	Criminal	Self-Report	Self-Report	Self-Report	Self-Report Index (Property/Felony Crimes)	Constructed	Constructe	Violent	CBCL	Pregnancy	Pregnancy	Homework	Homework	School	
					Involvement in Next 6 Months	Setting 6 Months Later	Placement in Next 6 Months	Lockup in Next 1 Yr	Lockup in Next 2 Years	With Parents in Next 1 Year	Referral Rates Next 1 Year	Referral Rates Next 2 Years	General Delinquency Next 1 Year	General Delinquency Next 2 Years	Delinquency Measure Next 1 Year		Delinquency Measure Next 2 Years	Criminal Records Next 2 Years	Caregiver-Report Delinquency Score	Within Next 1 Year			Within Next 2 Years	Completion 3-6 Months Post-Baseline	Completion Next 1 Year	Attendance Next 1 Year
Chamberlain & Reid, 1998	.55	.80	-	-	-	-	-	.77	-	.45	.71	-	.59	-	.54	.45	-	-	-	-	-	-	-	-	-	-
Chamberlain, Leve, & DeGarmo, 2007	-	-	-	-	-	-	-	.53	.79	-	.45	.42	.20	.04	-	-	.46	.65^a	-	-	-	-	-	-	-	
Eddy & Chamberlain, 2000	-	-	-	-	-	-	-	-	-	-	.61	-	.65	-	-	-	-	-	-	-	-	-	-	-	-	
Eddy, Whaley, & Chamberlain, 2004	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	.53	-	-	-	-	-	-	
Lee & Thompson, 2008	-	-	.46	.31	.04	.15	.94	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Leve & Chamberlain, 2007	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	.58	.63	.55	
Leve, Chamberlain, & Reid, 2005	-	-	-	-	-	-	-	.50	-	-	.38	-	.19	-	-	-	-	-	-	.52	-	-	-	-	-	
Kerr, Leve, & Chamberlain, 2009	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	.14	.36	-	-	-	

Note. Italicized numbers indicate that the outcome favors the group care intervention. Numbers in boldface type indicate a statistically significant difference or association.

^a Reported by the authors.

Appendix C Table References

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 15. The “Diagnostic and Statistical Manual of Mental Disorders (DSM)” is the standard classification of mental disorders used by mental health professionals in the United States.
 16. The AFCARS definition of clinical disabilities includes mental retardation, visually or hearing impaired, physically disabled, emotionally disturbed (DSM diagnosis), and other medical condition requiring special care (e.g., in most cases, these chronic illnesses requiring ongoing medical care). The operationalized AFCARS definition requires that these disabilities be professionally diagnosed.
 17. U.S. Children’s Bureau. (2015). Page ii.
 18. U.S. Children’s Bureau. (2015). Pages ii and iii.
 19. Personal communication, Nadia Sexton, Nov. 5, 2015.
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 21. Length of time was calculated by totaling all time in a particular placement type during the course of a child’s entire first removal episode. This accounts for placement moves and provides a better picture of the actual overall time spent in a setting type.
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 23. U.S. Children’s Bureau. (2015). Page iii.
 24. U.S. Children’s Bureau. (2015). Page iii.
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95. Ainsworth & Hanson (2005). Personal Communication, Bryan Samuels, December 17, 2014.
96. Use of multi-disciplinary teams and team decision-making to carefully assess child needs and make service delivery decisions (when enhanced by training in critical thinking and common errors in assessment/decision-making) has been noted as an essential scientifically supported approach in many fields, including aviation (<http://www.navair.navy.mil/nawctsd/Resources/Library/Acqguide/navipt1.htm>), medicine (http://www1.imperial.ac.uk/cpssq/research_themes_2/cpssq_research_themes/cancer_mdts/), maritime safety, and risk assessment in child protective services. See:
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 - Klein, G. (1998). *Sources of Power: How People Make Decisions*. Boston: The MIT Press.
 - Munro, E. (1999). Common errors of reasoning in child protection work. *Child Abuse & Neglect*, 23(8): 745–758.
 - Munro, E. (2008). *Effective child protection*. (Second Edition.) London: Sage.
 - Turnell A. and Essex S. (2006). *Working 'denied' child abuse: the resolutions approach*. Buckingham: Open University Press.
97. See for example, Chadwick Center and Chapin Hall (2016).
98. For a concise summary of supportive pathways for leaving out of home care see Stein, M. (2015). Supportive pathways for young people leaving care. In Whittaker, J. K., del Valle, J. F. & Holmes, L. (Eds.) (2015). *Therapeutic residential care for children and youth: Developing evidence-based international practice*. London, UK: Jessica Kingsley, pp. 189-200.
99. Youth Law Center. (2015). *State policies on non-foster care settings*. New York City: Author.
100. See <http://www.casey.org/georgia-permanency-roundtables/>
101. Expedited Permanency Meetings were developed by the Annie E. Casey Foundation.
102. Pecora, P.J., Blackwell, D., & Davis, M. (2015). *Implementing Group Care Reform in California: The RBS Case Study*. Seattle: Casey Family Programs. Retrieved May 22, 2015, from <http://www.casey.org/media/rbs-full-report.pdf>. Thompson, R., Wiley, T. A., Lewis, T., English, D. J., Dubowitz, H., Litrownik, A. J., et al. (2012). Links between traumatic experiences and expectations about the future in high risk youth. *Psychological Trauma: Theory, Research, Practice, and Policy*, 4, 293–302.

103. For example, in Montana and other states that use the ROM system, information about American Indian child placements in group care may be available. Personal communication, Susan Smith, Sept. 2, 2015.
104. For examples of cluster analysis in child welfare, see:
- Courtney, M.E., Hook, J.L., & Lee, J.S. (2012). Distinct subgroups of former foster youth during young adulthood: Implications for policy and practice. *Child Care in Practice* 18(4): 409-18.
 - McEwen, E., & Weiner, D.A. (2014). *Strategy for Long Stayers: Cluster Analysis & Practice Implications*. Presentation for the Public Children Services Association of Ohio Metro Strategy Day, Oct. 9, 2013.
105. For multivariate analyses of group care data to predict success, see, for example:
- Hair, H.J. (2005). Outcomes for children and adolescents after residential treatment: A review of research from 1993-2003. *Journal of Child and Family Studies*, 14(4), pp. 551-575.
 - McDowell, D., Ortiz, M.J., Stevenson, A.M., Lichtenstein, C., & Pecora, P. J. (2014). *Final Evaluation Report for the California Residentially Based Services (RBS) Reform Project*. Sacramento, CA: Walter R. McDonald and Associates. Available at: http://c.ymcdn.com/sites/www.cacfs.org/resource/resmgr/Advocacy/RBS_Year_3_Outcomes_Evaluation.pdf
 - U.S. Children's Bureau. (2015). *A national look at the use of congregate care in child welfare*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau.
106. Libby et al. (2012), p. 182. Lyons et al. also found a similar pattern but that study was over 15 years ago. See: Lyons, J. S., Libman-Mintzer, L. N., Kisiel, C. L., & Shallcross, H. (1998). Understanding the mental health needs of children and adolescents in residential treatment. *Professional Psychology: Research and Practice*, 29, 582-587.
107. Personal communication, Frank Ainsworth, Oct. 20, 2015.
108. Many of these limitations have been raised in relation to psychotherapy for children and adolescents. For example, see Schmidt, S., & Schimmelman, B.G. (2013). Evidence-based psychotherapy in children and adolescents: advances, methodological and conceptual limitations, and perspectives. *Eur Child Adolesc Psychiatry*, (22), 265-288.
109. Daly, D. L., & Dowd, T. P. (1992). Characteristics of effective, harm-free environments for children in out-of-home care. *Child Welfare*, 71(6), 487-496. For 12-month follow-up results see Ringle, J.L., Huefner, J. C., James, S., Pick, R., & Thompson, R.W. (2012). 12-month follow-up outcomes for youth departing an integrated residential continuum of care. *Children & Youth Services Review*, (34), 675-679.
110. Abstracted from Thompson, R.W. & Daly, D.L. (2015). The Family Home Program: An Adaptation of the Teaching Family Model at Boys Town. In Whittaker, J. K., del Valle, J. F. & Holmes, L. (Eds.) (2015). *Therapeutic residential care for children and youth: Developing evidence-based international practice*. London, UK: Jessica Kingsley, pp. 113-123. Quote from pp. 115-116.
111. Whittaker, J. K. *The other 23 hours*. New Jersey: Aldine de Gruyter-Transaction.
112. Leichtman, M., Leichtman, M.L., Barber, C., & Neese, D.T. (2001). Effectiveness of intensive short-term residential treatment with severely disturbed adolescents. *American Journal of Orthopsychiatry* 71(2), 227-235.
113. Andreassen, T. (2015). MultifunC: Multifunctional Treatment in Residential and Community Settings. In Whittaker, J. K., del Valle, J. F. & Holmes, L. (Eds.) (2015). *Therapeutic residential care for children and youth: Developing evidence-based international practice*. London, UK: Jessica Kingsley, pp. 100-110. In Norway an outcomes study is being conducted by the University of Tromsø. This study includes about 150 youth and will measure youth outcomes two years after placement. The process was planned to end in 2015, but it has taken longer to include enough youths. So far we only have the one-year results that have been published in a preliminary report in Norwegian. These results indicate that MultifunC succeed in returning the youth to the society (family and ordinary school), while many of the youth in the control group remain in the institutions. (Personal Communication, Tore Andreassen February 11, 2016).
114. Vorrath, H., & Brendtro, L. (1985). *Positive Peer Culture*, 2nd ed.. New York: Aldine (currently Transaction Publishers). Note that the EQUIP program, which is based on PPC as developed by Vorrath and Brendtro, has been evaluated for its effectiveness for youth in juvenile corrections facilities. See:

- Glibbs, J. C., Potter, G. B., & Goldstein, A. R. (1995). *The EQUIP program. Teaching youth to think and act responsibly through a peer helping process*. Champaign, IL: Research Press.
 - Vorrath, H. H., & Brendtro, L. K. (1974). *Positive peer culture*. Chicago, IL: Aldine
115. Caution in interpreting PPC outcomes is necessary: “The limited outcome literature suggests that PPC can be effective with delinquent youth in residential facilities with regard to some outcomes, such as improved self-concept and recidivism.” See James, S. (2011). What works in Group Care? A structured review of treatment outcomes and residential care. *Children and Youth Services Review*, 33, 308-321. Page 311.
116. CEBC summary and rating: Retrieved Sept. 12, 2015, from: <http://www.cebc4cw.org/program/re-ed/>
Also see:
- Cantrell, R., & Cantrell, M. (Eds.). (2007). *Helping troubled children and youth: Continuing evidence for the Re-ED approach*. Memphis, TN: American Re-Education Association.
 - Hobbs, N. (1966). Helping disturbed children: Psychological and ecological strategies. *American Psychologist*, 21, 1105–1115.
117. James (2013), p. 318. For more information about Re-ED see:
- Cantrell, R., & Cantrell, M. (Eds.) (2007). *Helping troubled children and youth: Continuing evidence for the Re-ED approach*. Memphis, TN: American Re-Education Association.
 - Valore, T., Cantrell, R., & Cantrell, M. L. (2006). Competency building in the context of groups. *Reclaiming Children and Youth*, 14(4), 228-235.
 - Freado, M. D. (2010). Measuring the impact of Re-ED. *Reclaiming Children and Youth*, 19(2), 28-31.
118. James (2013), p. 317.
119. McCurdy, B. L., & McIntyre, E. K. (2004). And what about residential ...? Reconceptualizing residential treatment as a stop-gap service for youth with emotional and behavioral disorders. *Behavioral Interventions*, 19, 137–158.
120. The STOP-GAP model is a conceptually compelling approach that to our knowledge has only been tested with one study with promising results. Personal communication, Sigrid James, Nov. 4, 2015.
Stop-Gap information:
- CEBC rating, see <http://www.cebc4cw.org/program/stop-gap/detailed>
 - Barth, R. P. (2005). Residential care: From here to eternity. *International Journal of Social Welfare*, 14, 158-162.
 - James, S., Leslie, L. K., Hurlburt, M. S., Slymen, D. J., Landsverk, J., Davis, I., Mathiesen, S. G., & Zhang, J. (2006). Children in out-of-home care: Entry into intensive or restrictive mental health and residential care placements. *Journal of Emotional and Behavioral Disorders*, 14, 196-208.
 - Zakriski, A. L., Wright, J. C., & Parad, H. W. (2006). Intensive short-term residential treatment: A contextual evaluation of the “stop-gap” model. *The Brown University Child and Adolescent Behavior Letter*, 22(6), 1–6.
121. NREPP Moral Reconciliation Therapy summary retrieved Sept. 20, 2015, from <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=11>. For more information see:
- Deschamps, T. (1998). *MRT: Is it effective in decreasing recidivism rates with young offenders?* Unpublished master's thesis, University of Windsor, Windsor, Ontario, Canada.
 - Little, G. L., Robinson, K. D., & Burnette, K. D. (1991). Treating drug offenders with Moral Reconciliation Therapy: A three-year report. *Psychological Reports*, 69, 1151-1154.
122. For CEBC rating and summary, see <http://www.cebc4cw.org/program/adolescent-community-reinforcement-approach/detailed>
123. For CEBC rating and summary, see: <http://www.cebc4cw.org/program/aggression-replacement-training/>
124. Anger Management Group Treatment Model information:
- For CEBC rating and summary, see: <http://www.cebc4cw.org/program/anger-management-group-treatment-model/detailed>
 - Reilly, P. M., & Shopshire, M. S. (2002). *Anger management for substance abuse and mental health clients: A cognitive behavioral therapy manual*. Retrieved from Substance Abuse and Mental Health Services Administration website: <http://store.samhsa.gov/shin/content/SMA12-4213/SMA12-4213.pdf>
 - Reilly, P. M., Shopshire, M. S., Durazzo, T. C., & Campbell, T. A. (2002). *The anger management for substance abuse and mental health clients: Participant workbook*. Retrieved from Substance

- Abuse and Mental Health Services Administration website:
<http://store.samhsa.gov/shin/content/SMA12-4210/SMA12-4210.pdf>
125. Holstead, J., & Dalton, J. (2013). Utilization of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) for Children With Cognitive Disabilities. *Journal of Public Child Welfare*, 7(5), 536-548, doi: [10.1080/15548732.2013.843495](https://doi.org/10.1080/15548732.2013.843495). Page 540.
 126. Hagopian, L.P., & Hardesty, S.H. (2012). *Applied Behavior Analysis: Overview and Summary of Scientific Support*. The Kennedy Krieger Institute and Johns Hopkins University School of Medicine. Retrieved Sept. 3, 2015, from <http://www.kennedykrieger.org/patient-care/patient-care-programs/inpatient-programs/neurobehavioral-unit-nbu/applied-behavior-analysis>. Note that these interventions are included here as youth with cognitive disabilities and autism spectrum youth are being treated in TRC and some of these techniques appear to be effective. In fact, a recent study found that the combination of TF-CBT with a limited ABA/IBI was not as effective as ABA/IBI services for children placed in a residential treatment center with cognitive and developmental disabilities. (See Holstead, J. & Dalton, 2013 referenced above.)
 127. For more information see:
 - Dozier, M., Dozier, D., & Manni, M. (2002). Recognizing the special needs of infants' and toddlers' foster parents: Development of a relational intervention. *Zero to Three Bulletin*, 22, 7-13.
 - Dozier, M., Lindhiem, O., & Ackerman, J. (2005). Attachment and biobehavioral catch-up. In L. Berlin, Y. Ziv, L. Amaya-Jackson, & M. T. Greenberg (Eds.), *Enhancing early attachments*. New York: Guilford (pp. 178-194).
 128. ARC references include:
 - Founding research center: <http://www.traumacenter.org/research/ascot.php>
 - Hodgdon, H.B., Kinniburgh, K., Gabowitz, D., Blaustein, M.E., Spinazzola, J. (2013) Development and implementation of trauma-informed programming in residential schools using the ARC framework. *Journal of Family Violence*, 28(7). doi:[10.1007/s10896-013-9531-z](https://doi.org/10.1007/s10896-013-9531-z)
 - Homes, C., Levy, M., Smith, A., Pinne, S., & Neese, P. (2015). A model for creating a supportive trauma-informed culture for children in preschool settings. *Journal of Child and Family Studies*. 24(6), 1650-1659. doi: [10.1007/s10826-014-9968-6](https://doi.org/10.1007/s10826-014-9968-6)
 129. NCTSN summary of ARC age limits and number of sessions retrieved Sept. 12, 2015, from http://resources.childhealthcare.org/resources/arc_general.pdf
 130. Biofeedback therapies are "...non-pharmacologic treatments that use scientific instruments to measure, amplify, and feedback physiological information to the patient being monitored. The information assists the patient in gaining self-regulation of the physiological process being monitored. Psychophysiological self-regulation is a primary goal of biofeedback therapies, and feedback of information facilitates learned physiological control, just as feedback facilitates learning of any skill. For example, in the treatment of hypertension, surface electrodes are used to provide the patient with information about skin temperature and muscle tension. The feedback of information from the instrument guides the patient during training as he/she learns to warm the skin (by dilating blood vessels) and relax the muscles. This is generally accompanied by a reduction in blood pressure. In this example, the instrumentation provides physiological information that would otherwise be inaccessible to the patient." Yucha, C., & Gilbert, C. (2004). *Evidence-Based Practice in Biofeedback and Neurofeedback*. Wheat Ridge, CO: Association for Applied Psychophysiology and Biofeedback, p.1. Biofeedback information can be obtained from:
 - <http://psychotherapy.com/bio.html>
 - <https://www.nlm.nih.gov/medlineplus/ency/article/002241.htm>
 - Lake, J., & Moss, D. (2003). QEEG and EEG biofeedback in the diagnosis and treatment of psychiatric neurological disorders: An authentic complementary therapy. *Biofeedback Magazine*, 31 (3).
 - Lumpkin M., & Rakel, D. (2012). Relaxation techniques. In D. Rakel (Ed.), *Integrative Medicine*, 3rd Edition. London: Elsevier.
 - Moss, D., & Kirk, L. (2004). Foreword: Evidence-based practice in biofeedback and neurofeedback. In C. Yucha and C. Gilbert. *Evidence-Based Practice in Biofeedback and Neurofeedback*. Wheat Ridge, CO: Association for Applied Psychophysiology and Biofeedback.
 131. Condensed from description found at <http://archives.drugabuse.gov/TXManuals/BSFT/BSFT2.html> on May 2, 2014. Rating from CEBC: <http://www.cebc4cw.org/program/brief-strategic-family-therapy/>

132. Rotter, M., & Carr, A. (2010). *Targeting criminal recidivism in justice-involved people with mental illness: Structured clinical approaches*. Washington, DC: The CMHS National GAINS Center. Retrieved from: <http://gainscenter.samhsa.gov/cms-assets/documents/69181-899513.rottercarr2010.pdf>.
133. Session length: <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=106>. For reviews of traditional CBT interventions, see:
1. Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of cognitive-behavioral therapy: A review of meta-analyses. *Clinical Psychology Review*, 26, 17-31.
 2. Leichsenring, F., & Leibling, E. (2003). The effectiveness of psychodynamic therapy and cognitive behavior therapy in the treatment of personality disorders: A meta-analysis. *American Journal of Psychology*, 160, 1223-1232.
134. Summary and evidence rating abstracted from SANMHSA NREP: <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=106>. Also see:
- Brent, D. A., Holder, D., Kolko, D., Birmaher, B., Baugher, M., Roth, C., et al. (1997). A clinical psychotherapy trial for adolescent depression comparing cognitive, family, and supportive therapy. *Archives of General Psychiatry*, 54, 877-885.
 - Weersing, V. R., Iyengar, S., Kolko, D. J., Birmaher, B., & Brent, D. A. (2006). Effectiveness of cognitive-behavioral therapy for adolescent depression: A benchmarking investigation. *Behavior Therapy*, 37, 36-48.
135. CEBC review and summary retrieved Sept. 30, 2015, from: <http://www.cebc4cw.org/program/cognitive-processing-therapy-cpt/detailed>. See:
- Chard, K. M. (2005). An evaluation of cognitive processing therapy for the treatment of posttraumatic stress disorder related to childhood sexual abuse. *Journal of Consulting and Clinical Psychology*, 73, 965-971.
 - Kelly, K. A., Rizvi, S. L., Monson, C. M., & Resick, P. A. (2009). The impact of sudden gains in cognitive behavioral therapy for posttraumatic stress disorder. *Journal of Traumatic Stress*, 22, 287-293.
 - NREP summary retrieved Sept. 30, 2015, from: <http://nrepp.samhsa.gov/ViewIntervention.aspx?id=386>.
 - Resick, P. A., Williams, L. F., Suvak, M. K., Monson, C. M., & Gradus, J. L. (2012). Longterm outcomes of cognitive-behavioral treatments for posttraumatic stress disorder among female rape survivors. *Journal of Consulting and Clinical Psychology*, 80, 201-210.
136. Cook et al. (2005), p. 394.
137. CEBC review and summary retrieved Sept. 20, 2015, from: <http://www.cebc4cw.org/program/coping-cat/detailed>. See:
- Kendall, P. C., & Hedtke, K. (2006). *Cognitive-behavioral therapy for anxious children: Therapist manual* (3rd ed.). Ardmore, PA: Workbook Publishing.
 - Kendall, P. C., & Hedtke, K. (2006). *Coping Cat workbook*. (2nd ed.). Ardmore, PA: Workbook Publishing.
 - Khanna, M., & Kendall, P. C. (2008). Computer assisted CBT for child anxiety: The Coping Cat CD-ROM. *Cognitive and Behavioral Practice*, 15, 159-165.
138. DBT for Substance Abusers focuses on the following five main objectives: (1) motivating patients to change dysfunctional behaviors, (2) enhancing patient skills, (3) ensuring the new skills are used in daily life, (4) structuring the client's environment, and (5) training and consultation to improve the counselor's skills. For substance abusers, the primary target of the intervention is the substance abuse and specific goals include reducing abuse, alleviating withdrawal symptoms, reducing cravings, and avoiding opportunities and triggers for substance use. Abstracted from:
- Krawitz, R. (2013). *Financial cost-effectiveness of, and other dialectical behavior therapy information, for funders, administrators and providers of services for people with borderline personality disorder*. Waikato District Health Board, Hamilton, New Zealand. Abridged version retrieved from <http://behavioraltech.org/downloads/Financial-Cost-Effectiveness-DBT.pdf>
 - <http://www.wsipp.wa.gov/BenefitCost/Program/339>
 - For ages and duration see SAMHSA NREP summary at: <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=36>
139. An intensive residential treatment adaptation of DBT for women with PTSD associated with childhood sexual abuse was effective for reducing PTSD symptoms. See Harned, M. S., Jackson, S. C.,

- Comtois, K. A., & Linehan, M.M. (2010). Dialectical behavior therapy as a precursor to PTSD treatment for suicidal and/or self-injuring women with borderline personality disorder. *Journal of Traumatic Stress*, 23, 421–429.
140. Steil, R., Dyer, A., Priebe, K., Kleindienst, N., & Bohus, M. (2011). Dialectical behavior therapy for posttraumatic stress disorder related to childhood sexual abuse: A pilot study of an intensive residential treatment program. *Journal of Traumatic Stress*, 24, 102–106.
141. CEBC review and summary retrieved Dec. 9, 2015, from: <http://www.cebc4cw.org/program/ecologically-based-family-therapy/>
142. Summary retrieved Sept. 20, 2015, from <http://www.equine-psychotherapy.com/equine.html>.
143. Retrieved Sept. 20, 2015, from <http://www.equine-psychotherapy.com/troubled-teens.html>.
144. Retrieved Sept. 20, 2015, from <http://nceft.org/about/>. Problems list retrieved, in part, from <http://www.elementsbehavioralhealth.com/addiction-treatment/what-is-equine-assisted-therapy/>.
145. EMDR information:
- CEBC summary and rating: Retrieved Sept. 16, 2015, from: <http://www.cebc4cw.org/program/eye-movement-desensitization-and-reprocessing-for-adults/>
 - Eye Movement Desensitization and Reprocessing Institute, Inc. (2012). *What is EMDR?* Retrieved from <http://www.emdr.com/general-information/what-is-emdr.html>
 - Field, A., & Cottrell, D. (2011). Eye movement desensitization and reprocessing as a therapeutic intervention for traumatized children and adolescents: A systematic review of the evidence for family therapists. *Journal of Family Therapy*, 33(4), 374-388.
 - Soberman, G. B., Greenwald, R., & Rule, D. L. (2002). A controlled study of Eye Movement Desensitization and Reprocessing (EMDR) for boys with conduct problems. *Journal of Aggression, Maltreatment, & Trauma*, 6(1), 217-236.
146. Taxy, S., Liberman, A. M., Roman, J. K., & Downey, M. (2012). *The costs and benefits of Functional Family Therapy for Washington, DC*. Washington, DC: District of Columbia Crime Policy Institute and the Urban Institute. Retrieved from <http://www.urban.org/UploadedPDF/412685-The-Costs-and-Benefits-of-Functional-Family-Therapy-for-Washington-DC.pdf>. For additional information, see <http://www.fftlc.com>.
147. <http://fftlc.com/about-fft-training/clinical-model.html>
148. CEBC summary: <http://www.cebc4cw.org/program/interpersonal-psychotherapy-for-depressed-adolescents/detailed>. or more information:
- Brunstein-Klomek, A., & Mufson, L. (2006). Interpersonal Psychotherapy for Depressed Adolescents. *Child and Adolescent Psychiatric Clinics of North America*, 15, 959-975.
 - Mufson, L. (2010). Interpersonal psychotherapy for depressed adolescents (IPT-A): Extending the reach from academic to community settings. *Child & Adolescent Mental Health*, 15(2), 66-72.
 - Mufson, L., Pollack Dorta, K., Moreau, D., & Weissman, M. M. (2004). *Interpersonal Psychotherapy for Depressed Adolescents* (2nd ed.). Guilford Publications, Inc.: New York.
149. Lanktree, C., & Briere, J. (2008). *Integrative Treatment of Complex Trauma for Children (ITCT-C): A guide for the treatment of multiply-traumatized children aged eight to twelve years*. Child and Adolescent Trauma Program, National Child Traumatic Stress Network. Available from www.johnbriere.com.
150. Anxiety, depression, and posttraumatic stress are addressed earlier in treatment (when possible), in order to increase the capacity to explore more chronic and complex trauma issues later, such as attachment disturbance, chronic negative relational schema, behavioral and affect dysregulation, interpersonal difficulties, and identity-related issues. NCTSN summary sheet for ITCT-C, p. 2.
151. NREPP summary and rating retrieved Sept. 21, 2015, from: <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=34>
152. There is an MST adaptation developed by Eric Trupin at the University of Washington, Department of Psychiatry called MST-FIT. MST-FIT aims to start working with youths and families prior to the youth's release from residential treatment and juvenile correction services. The model is described in the "MST Adaptations" document on the MST website (mstservices.com) and also in this article: Trupin, E. J., Kerns, S. E. U., Walker, S. C., DeRobertis, M. T., & Stewart, D. G. (2011). Family integrated transitions: A promising program for juvenile offenders with co-occurring disorders. *Journal of Child & Adolescent Substance Abuse*, 20, 421-436. FSRC Publication #399. Also, the MST parent organization has standard programs within provider organizations that also provide residential treatment services (Personal communication, Scott W. Henggeler, Nov. 13, 2015) Rating and

Blueprints summary:

<http://www.blueprintsprograms.com/factSheet.php?pid=967d1c50af49565e3ab37a33780edf8a1d2d43ea>

153. Music therapy summary retrieved Sept. 22, 2015, from:
<http://www.musictherapy.org/about/musictherapy/>. For research factsheets, see
<http://www.musictherapy.org/research/factsheets/>.
154. For the Good Behavior Game, see:
- [http://www.nrepp.samhsa.gov/SearchResultsNew.aspx?s=b&q=Self-regulation enhancement](http://www.nrepp.samhsa.gov/SearchResultsNew.aspx?s=b&q=Self-regulation+enhancement)
 - Petras, H., Masyn, K., & Lalongo, N. (2011). The developmental impact of two first grade preventive interventions on aggressive/disruptive behavior in childhood and adolescence: An application of latent transition growth mixture modeling. *Prevention Science*, 12(3), 300-313.
155. "PAX Games start very briefly — a minute or two, increasing in time as students win 12 out of 15 games (or 85%) each week. Eventually, First Graders can "play" the PAX Game for 30 to 45 minutes, vastly increasing fully engaged teaching and learning. Older children can learn to play longer." Pax Game brochure. See <http://goodbehaviorgame.org/>
156. Real Life Heroes references:
- CEBC summary and rating: Retrieved Sept. 12, 2015, from: <http://www.cebc4cw.org/program/real-life-heroes-rlh/detailed>.
 - Kagan, R., Douglas, A., Hornik, J., & Kratz, S. (2008). Real life heroes pilot study: evaluation of a treatment model for children with traumatic stress. *Journal of Child and Adolescent Trauma*, 1, 5–22.
 - Kagan, R., & Spinazzola, J. (2013). Real Life Heroes in residential treatment: Implementation of an integrated model of trauma and resiliency-focused treatment for children and adolescents with complex PTSD. *Journal of Family Violence*, 27(8), 705-715.
157. Kagan, R., & Spinazzola, J. (2013), p. 707.
158. CEBC summary and rating: Retrieved Sept. 12, 2015, from:
<http://www.cebc4cw.org/program/residential-student-assistance-program/>
159. CEBC summary and rating: <http://www.cebc4cw.org/program/seeking-safety-for-adolescents/> Also see:
- Najavits, L. M. (2007). Seeking Safety: An evidence-based model for substance abuse and trauma/PTSD. In K. A. Witkiewitz & G. A. Marlatt (Eds.), *Therapist's guide to evidence-based relapse prevention: Practical resources for the mental health professional* (pp. 141-167). San Diego: Elsevier Press.
 - Najavits, L. M. (2009). Seeking Safety: An implementation guide, in A. Rubin & D. W. Springer, (Eds.), *Substance Abuse Treatment for Youth and Adults: Clinician's Guide to Evidence-Based Practice* (pp. 311-348). John Wiley: Hoboken, NJ.
 - Najavits, L. M. (2002). *Seeking Safety: A treatment manual for PTSD and substance abuse*. New York, NY: Guilford.
160. As cited in Knoverek et al. 2013, p. 658. See:
- Ogden, P., & Minton, K. (2000). One method for processing traumatic memory. *Traumatology*, 6(3), 149–173. doi:10.1177/15347656000600302
 - Perry, B. D. (2009). Examining child maltreatment through a neurodevelopmental lens: clinical application of the neurosequential model of therapeutics. *Journal of Loss and Trauma*, 14, 240–255. doi:10.1080/15325020903004350
161. Activities that engage proprioception enable the child to determine the position of their bodies relative to their environment, such as opportunities to run, skip, jump, and hop. Other activities such as rocking, swinging or other rhythmic movement stimulate the vestibular mechanism and enhance spatial awareness of the child's body (Kranowitz and Miller 2006). While there has been no empirical research on the use of sensorimotor techniques (Ogden and Minton 2000), patterned and repetitive activities such as yoga, music, body movement, and balance can provide sensory input facilitating brain development and self-regulation skills for children (Perry 2009; van der Kolk 2006). Changing intensity and pace can help emotional and physical regulation. Warner, Koomar, Lary, and Cook (2013) articulate the use of sensory integration for children in residential treatment centers, including the creation and use of sensory rooms, hiring Occupational Therapists to provide services to the children as well as serve as consultants to multidisciplinary staff, and incorporating sensorimotor techniques in trauma psychotherapy which can include expressive therapies.

162. Bavelas, Djong, P., Franklin, C. et al. (2013). *Solution Focused Therapy Treatment Manual for Working with Individuals* (2nd Version). Solution Focused Brief Therapy Association, p.2.
163. Lee, M.Y. (2013). Solution-Focused Brief Therapy. *NASW Encyclopedia*. Retrieved Dec. 9, 2015, from <http://socialwork.oxfordre.com/view/10.1093/acrefore/9780199975839.001.0001/acrefore-9780199975839-e-1039>
164. **SPARCS** is based primarily on cognitive-behavioral principles and teaches skills to foster resilience and enhance group members' current strengths. Experiential activities and discussion topics have been specifically developed for use with adolescents, and are designed to capitalize on developmental considerations that are particularly relevant for teenagers (e.g., issues related to autonomy and identity). It should be noted that **SPARCS** is a present-focused intervention, and is not an exposure-based model. Although there is no direct exposure component (e.g., no construction of a trauma narrative), traumas are discussed in the context of how they relate to the adolescents' current behaviors and to their understanding of their problems and difficulties in the here and now. The SPARCS curriculum, which draws from the core components of complex trauma treatment, incorporates techniques from Dialectical Behavioral Therapy (DBT), Trauma and Grief Components Therapy (TGCT), and early versions of Trauma Adaptive Recovery Group Education and Therapy (TARGET). These techniques are utilized with participants throughout many of the group sessions. See:
- CEBC web summary: <http://www.cebc4cw.org/program/structured-psychotherapy-for-adolescents-responding-to-chronic-stress/>
 - Ford, J., Blaustein, M., Habib, M., & Kagan, R. (2013). Developmental trauma therapy models. In J. D. Ford & C. A. Courtois (Eds.), *Treating complex traumatic stress disorders in children and adolescents: Scientific foundations and therapeutic models* (pp. 261-276). New York, NY: Guilford Press.
 - Habib, M., Labruna, V., & Newman, J. (2013). Complex histories and complex presentations: Implementation of a manually-guided group treatment for traumatized adolescents. *Journal of Family Violence*, 28, 717-728.
165. SAMHSA NREP summary and rating retrieved Sept. 12, 2015, from: <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=195> Also see:
- Jacobs, J., & Steele, W. (2007). *Structured sensory intervention for traumatized children, adolescents and parents – At-risk adjudicated adolescent treatment program (SITCAP-ART)*. Grosse Pointe Woods: Trauma and Loss Institute.
 - Raider, M. C., Steele, W., Delillo-Storey, M., Jacobs, J., & Kuban, C. (2008). Structured sensory therapy (SITCAP-ART) for traumatized adjudicated adolescents in residential treatment. *Residential Treatment for Children and Youth*, 25, 167–185.
166. CEBC rating and web summary retrieved Sept. 27, 2015, from: <http://www.cebc4cw.org/program/therapeutic-crisis-intervention/> Also see:
- Britton, M.S., & Rajpurkar, S. (2015). Therapeutic crisis intervention system in residential care for children and youth: Staff knowledge, attitudes, and coping styles. *Children and Youth Services Review*, 56, 1-6.
 - Holden, M. J., et al. (2009). *Therapeutic Crisis Intervention: A Reference Guide*. (6th edition). Ithaca, NY: Cornell University.
 - Nunno, M., Holden, M., & Tollar, A. (2006). Learning from tragedy: A survey of child and adolescent restraint fatalities. *Child Abuse & Neglect: The International Journal*, 30(12), 1333-1342.
167. Theraplay resources:
- CEBC web summary: <http://www.cebc4cw.org/program/theraplay/>
 - Bennett, L., Shiner, S. K., & Ryan, S. (2006). Using Theraplay in shelter settings with mothers and children who have experienced violence in the home. *Journal of Psychosocial Nursing and Mental Health Services*, 44(10), 38-48.
 - Booth, P. B. (2000). Forming an attachment with an adopted toddler using the Theraplay approach. *The Signal. Newsletter of the World Association for Infant Mental Health*, July-Sept, 8(3).
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168. For TARGET information see:
- CEBC web summary: Retrieved Sept. 21, 2015, from: <http://www.cebc4cw.org/program/trauma-affect-regulation-guide-for-education-and-therapy/detailed>

- Courtois, C. A., & Ford, J. D. (2013). *Treating complex trauma: A sequenced relationship-based approach*. New York: Guilford.
 - Ford, J. D., Fallot, R., & Harris, M. (2009). Chapter 20: Group therapy. In C. Courtois & J. D. Ford (Eds.), *Treating complex traumatic stress disorders: An evidence-based guide* (pp. 415-440). New York: Guilford.
 - Ford, J. D., & Russo, E. (2006). Trauma-focused, present-centered, emotional self-regulation approach to integrated treatment for posttraumatic stress and addiction: trauma adaptive recovery group education and therapy (TARGET). *American Journal of Psychotherapy*, 60, 335–355.
 - SAMHSA NREP: <http://nrepp.samhsa.gov/ViewIntervention.aspx?id=258>
 - TARGET website: www.advancedtrauma.com
169. Mannarino, A. P., Cohen, J. A., Runyon, M. K., Deblinger, E., & Steer, R. A. (2012). Trauma-Focused Cognitive-Behavioral Therapy for children sustained impact of treatment 6 and 12 months later. *Child Maltreatment*, 17(3), 231-241.
170. National Child Traumatic Stress Network. (2012). *Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)*. Los Angeles, CA: University of California, Los Angeles. Retrieved from <http://depts.washington.edu/hcsats/PDF/TF-%20CBT/pages/Theoretical%20Perspective/TF-CBT%20fact%20sheet%20therapists.pdf>.
171. For TST information see:
- Brown, A.D., McCauky, Navaka, C.P., & Saxe, G. N., (2013). Trauma systems therapy in residential settings: Improving emotional regulation and the social environment of traumatized children and youth in congregate care. *Journal of Family Violence* 28: 693-7-3.
 - CEBC website: <http://www.cebc4cw.org/program/trauma-systems-therapy-tst/>
 - Saxe, G. N., Ellis, B., & Kaplow, J. B. (2007). *Collaborative treatment of traumatized children and teens: The trauma systems therapy approach*. New York: Guilford Press.
172. “As an organizational model, the intervention is carried out on a universal basis continuously. For a given youth/trauma system, it will depend on the phase of treatment. Ideally, a youth will continue to receive services until they reach phase 5. As services within the child welfare system are often time-limited, phase-based needs may be recommended as follow-up care.” CEBC TST summary: <http://www.cebc4cw.org/program/trauma-systems-therapy-tst/>
173. For TBRI information:
- CEBC web summary and rating: <http://www.cebc4cw.org/program/trust-based-relational-intervention-tbri-therapeutic-camp/detailed>
 - Purvis, K. B., Cross, D. R., Dansereau, D. F., & Parris, S. R. (2013). Trust-based relational intervention (TBRI): A systematic approach to complex developmental trauma. *Child & Youth Services*, 34(4), 1-28.
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