Kris Nelson Community-Based Research Program

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The Struggle: A Review of Common and Evidence-Based Practices in Shelter Care, Residential Treatment, and Day Treatment for Youth

Prepared in partnership with
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Abstract

Higher placements for youth face a unique challenge: developing a flexible, evidence-based intervention system for a particularly high-risk population. Common themes in the lives of these youth include complex trauma, self-harm, conduct problems, and lack of developmentally-appropriate social skills. A number of practices are reviewed in the present study, including models for the treatment milieu, specific intervention procedures, models of therapy, and measures to assess children’s mental health outcomes. The review revealed that a number of evidence-based practices are available for this population, but appropriate models should be chosen depending on the characteristics (i.e. age, presenting problem) of the population.

Integration of multiple evidence-based practices is recommended in order to best serve youth, and continuous evaluation of said practices and exploration of further practices is likely necessary in order to achieve and maintain improved program outcomes. Common themes within these models is the need for a social-emotional curriculum, trauma-informed care, a relationship-based system, adequate staff and system supports, use of reinforcement, reduction of punishment, preventative practice, a data driven system, and including input from youth. In accountability measures, the Child and Adolescent Needs and Strengths Assessment Tool (CANS) seemed to be the most cost-effective, least time-intensive measure while retaining strong psychometric properties. This report was prepared for St. Joseph’s Home for Children in Minneapolis (a division of Catholic Charities of St. Paul and Minneapolis) and its emergency shelter, residential treatment, and day treatment programs, with support from the University of Minnesota Center for Urban and Regional Affairs.
Introduction

It is no secret that child welfare in the United States is in a constant state of crisis. Even more so, oft-forgotten higher placements such as congregate care and day treatment settings for youth tend to maintain a state of “survival mode”. St. Joseph’s Home for Children in Minneapolis is no different - staff interviews indicated high levels of burnout, turnover, and inadequate program supplies. With maintaining the status quo already being so difficult in higher placements due to these factors; it is understandable why comprehensive changes in interventions may be infrequent and difficult to implement. The purpose of the present project was to conduct a literature review of practices in congregate care and day treatment settings in order to recommend potential new practices to Catholic Charities of St. Paul and Minneapolis as a part of their strategic envisioning process for St. Joseph’s Home for Children.

St. Joseph’s Home for Children offers three different types of services for youth: emergency shelter care, residential treatment, and day treatment. The presenting concerns of individuals in these programs varies, but the most common theme is trauma, specifically complex trauma. Other presenting problems include, but are not limited to emotional and behavioral problems, attention deficit and hyperactivity, dissociation, suicidality, and psychotic symptoms.

Emergency shelter care is offered for youths aged 6-17 who have been displaced and are seeking another placement. The stay is typically between 30 and 90 days, and there are two units: one for youth aged 6-12, and one for youth aged 12-17. One psychotherapist serves both the units, and direct-care staff offer 24-hour supervision and assist with implementation of activities and daily routines. Residential treatment is offered for children of the same ages, with three units; one for ages 6-11, one for ages 12-14, and one for ages 15-17. Each unit has its own program manager and psychotherapist (trained in Trauma-Focused Cognitive Behavioral Therapy or TF-CBT, an evidence-based practice), with direct care staff offering similar supervision to shelter. Youth in residential treatment attend a school on-site that is implemented in partnership with Minneapolis Public Schools. Both the emergency shelter and residential treatment currently use a restorative-type intervention where clients who engage in challenging behavior are moved from being “on green” to “on yellow” or “on red” depending on the severity of the offense. Clients must then complete a “restorative”, a sheet where they reflect on the incident and what could have been done differently in order to regain their “green” status. Creative processing and restoration is encouraged beyond this sheet, but often is not completed due to time constraints.

Day treatment is located at a different site than the other programs. Services are offered for youth who are aged approximately 6-13. Three classrooms each serve less than ten students each. Therapists at day treatment are also trained in Trauma-Focused Cognitive Behavioral Therapy. Half days of school are offered with the other half of the day being mental health treatment. Skills-based groups are offered twice daily and group therapy is conducted once daily; used in
the classroom is the “Zones of Regulation” as outlined in Kuypers & Winner (2011). Students are encouraged to express their emotions in accordance to a color, red being agitated or emotional, yellow being in an elevated or anxious state, green being ready to learn, and blue being sad or lethargic. Students typically stay in the day treatment program for about one year before discharge.

**Literature review**

A number of different scholarly resources were tapped for the purposes of this project. Searches were made using PsycINFO, Google Scholar, PubMed, and the University of Minnesota Libraries’ MCAT system. Also searched were evidence-based clearinghouses that have rated interventions that would be relevant for this population, including the California Evidence-Based Clearinghouse for Child Welfare (CEBC), and the National Registry of Evidence-Based Programs and Practices (NREPP). Other regional and national organizations were identified during the review and interview process with models of care that were also included in the present study. The goal of these steps was to identify intervention strategies, treatment models, frameworks, outcome measures, and therapeutic techniques that could be helpful to serve youth who are currently placed in shelter care, residential treatment, and day treatment. Despite being an underfunded and under-attended to setting, there are a myriad of practices identified that could be implemented. The practices were divided into three categories; milieu, specific interventions, and psychotherapy. The treatment milieu is defined as an overarching or comprehensive theme towards interaction and intervention with youth. Specific interventions include training programs and in-depth methodologies on how to interact with youth. Psychotherapy is primarily treatments that would be administered by a licensed mental health professional. The focus of the research on accountability measures was on comprehensive instruments that measure a child’s overall level of functioning, and its ability to predict outcomes post-discharge (predictive validity).

**Overview**

Research on similar programs to St. Joseph’s Home for Children has yielded a variety of findings. Of the three, residential care was by far the most researched. There is a body of literature supporting modest, but significant effects for youth in residential treatment (Souverein, Van der Helm, & Stams 2013; Hair 2005; Frensch & Cameron 2002; Preyde et al. 2011), despite evidence for peer contagion (Robst, Armstrong, & Dollard 2011). Several studies have been conducted comparing residential care with treatment foster care. One review suggested that there is only minimal evidence for treatment foster care as a more effective treatment than residential care (Curtis, Alexander, & Lunghofer 2001), but others argue that the two simply serve different populations, and that comparison between the two is meaningless (Baker et al. 2007). Comparisons have also been made from residential care to intensive in-home treatment (Preyde
et al. 2011, Barth et al. 2007). Preyde et al. (2011) asserts that the two also serve different populations, and that both improve outcomes. Barth et al. (2007) asserts that in-home treatment has better outcomes than residential care, and that intensive in-home treatment is preferred due to its properties as a less restrictive setting. However, it is worth noting that Preyde et al. (2011) incorporates evidence-based practices into their residential such as cognitive-behavioral therapy (CBT), whereas Barth et al. (2007) used the Re-ED model in its residential treatment group, which has a limited evidence base according to literature reviews (James 2011). Despite the high costs of residential care, more than one study seems to suggest that on occasion there is no other option for youth (Baker et al. 2007, Preyde et al. 2011), with others suggesting that other options should be considered first before residential placement (Barth et al. 2007). Another common theme was the uncertainty of consequences following closure of residential treatment, with the concern of some youth not receiving appropriate services (Baker et al. 2007, Barth et al. 2007).

Day treatment and alternative education settings have a moderate amount of research surrounding them. More research seems to be needed to specifically address themes of trauma in these settings. Research generally supports the effectiveness of day treatment (Grizenko 1997, Lakusta et al. 2012), specifically the half-day model when compared to standard education settings for high-needs students (Robinson 2000). Hughes & Adera (2006) recommend a number of models used across the US for practice in day treatment and alternative education settings. These include an adaptation of the Teaching-Family Model used in Boys Town, Nebraska, the Life Space Crisis Intervention, Positive Behavioral Interventions and Supports, and the Re-ED model (Re-education of Emotionally Disturbed Children). Hughes & Adera (2006) also asserts that evidence-based practices are needed for use in day treatment settings in order to ensure the efficacy of interventions.

There is a particular dearth of research on emergency shelter care for youth. Leon et al. (2016) examined the characteristics of populations entering and leaving shelter care. It also recommended further study on shelter care, as well as examining the role of work culture and the potential for increased and earlier intensive case management services, while working with families if possible. Only a handful of literature exists on shelter care, with a significant portion of it being outdated (Koehn et al. 2001, Hurn et al. 1991, Segal & Schwartz 1987, Litrownik et al. 1999, Hurley et al. 2006), and even fewer reporting meaningful outcome data (Hurley et al. 2006, Koehn et al. 2001). Nevertheless, the consensus among the literature was that longer shelter stays are a poor outcome (Koehn et al. 2001, Leon et al. 2016). Even so, alternatives to shelter care focusing on expedited placement such as the 23-hour assessment center (later outlined in this paper) suggest that shelter care is still an often-used next placement for youth, likely due to a lack of other available placements (Payne 2014). Given this, it seems that shelter care is a necessary piece of the child welfare system; even if the literature has nothing that would meet the traditional criteria for an “evidence-based practice”, generalizations from other settings can hopefully be made, such as in the MYSTC model examined in Hurley et al. (2006).
Wraparound approach to child welfare

Amidst the mixed research on residential care and the limited literature on shelter care, calls have been made to move towards a more comprehensive and preventative model for youth in care through wraparound services (Wisconsin Department of Health Services 2016, Bruns et al. 2013). The wraparound approach is a team-based partnership usually put together by a care coordinator, consisting of representatives from many domains of the youth’s life, including community members, teachers, family members, and mental health professionals. The team goes through four phases in the wraparound process: engagement and team preparation, creating a plan, implementation of the plan, and then transitioning out of the wraparound process (Ferguson 2006). Strengths of the wraparound approach include its use as a preventative practice for at-risk youth and families, encouragement of placement in less restrictive settings, and its tendency towards natural as opposed to artificial supports. In many cases it has proven to have support in terms of practice-based evidence, but may not meet rigorous research standards as an evidence-based practice (Walter & Petr 2011). This has been confirmed by meta-analyses (Suter & Bruns 2009). Nevertheless, it has been rated as a “promising” practice with “high” relevance to the child welfare population (California Department of Social Services 2016). Wraparound can be used in any number of settings, including residential care, schools, or community care, which supports the diversity of its implementation. Others have voiced opinions supporting wraparound services as an alternative to out-of-home care, including foster care and more restrictive settings (Tierney 2016). Considering the overload that child welfare often experiences, using wraparound services as a preventative practice could not only ease the load of child welfare, but possibly produce better outcomes for all at-risk youth; through preventing the separation from the child and the family in the first place, relationships are maintained and continuity of care is achieved. Despite this, some research suggests that in-home care through wraparound will not prevent all out-of-home placements, only serve a different population (Preyde et al. 2011). Even so, it remains an alternative to traditional modalities of care.

Models for the treatment milieu

Positive Behavioral Interventions and Supports (PBIS) is a three-tiered system that has been commonly implemented in US schools. The first tier involves preventative practices such as clear expectations, a token economy, and regular reinforcement of appropriate behavior for all youth. The second tier focuses on at-risk youth whose needs are not being met by the tier-one interventions; it may involve increased check-ins or skills training. The third tier is meant for youth who have not responded to tiers one and two, and involves conducting a functional behavior assessment and individualized planning in order to address challenging behavior. (Horner, Sugai, & Anderson 2010). In particular, PBIS emphasizes the importance of being analytical and using data in order to make informed decisions within an organization. (Scheuermann et al. 2015). Previous research has indicated that it can be successfully
implemented in higher placements (Kalke, Glanton, & Cristalli 2007, James et al. 2015), but that adjustments may be needed from the default framework (Scheuermann et al. 2015). Calls have been made to implement the PBIS framework into more restrictive settings such as residential or day treatment (Lampron & Gonsoulin 2013). An important consideration when working with PBIS is the cultural concern of what is “appropriate behavior” to reinforce (Wilson 2015). This can be addressed potentially through either cultural competency training in staff, or a culturally-responsive PBIS model such as is outlined in Bal, Thorius, & Kozleski (2012). Although boasting a strong evidence base in the school system, more research needs to be done on its use in higher placements, including in residential and day treatment settings, as the higher placement literature on PBIS focuses on the juvenile justice setting (Scheuermann et al. 2015, Lampron & Gonsoulin 2013). Implementing PBIS may be a gradual process, and some staff may not be on board with motivating clients with “extrinsic” factors, as opposed to improving “intrinsic” motivation. There is little, if any empirical validation for PBIS in residential treatment or shelter care in particular (Kalke, Glanton, & Cristalli 2007). It may, however, be more appropriate for a day treatment setting as it has been researched extensively in school-like environments.

Compared to some other models, PBIS implementation could occur with relatively limited changes to existing organizational structures. Training through PBIS is available through the Minnesota Department of Education as a part of a 2-year training cohort, free of charge. It is important to note that they reference “alternative schools”, so perhaps shelter and residential treatment may not be applicable to this 2-year training (Minnesota Department of Education, personal communication, August 9th, 2016).

Another framework for potential use in organizations like St. Joseph’s Home for Children is Conscious Discipline®. As a social-emotional learning curriculum, it uses a “brain state model”, prioritizing the needs of youth, and emphasizes that staff need to use skills such as acceptance and authenticity in order to develop successful relationships with youth. It also emphasizes that youth should learn about emotion management, assertiveness, and that actions have consequences. It focuses on the use of everyday events, as opposed to external curricula, to teach youth. (Bailey 2015). The NREPP rated Conscious Discipline® as having effective outcomes on social learning and promising outcomes on academic achievement, based on one study for preschool aged youth (Substance Abuse and Mental Health Services Administration 2016).

Although training options for Conscious Discipline® are very flexible, the research that has primarly been examined is either distributed either through their website or by the author of the Conscious Discipline® book. The study examined by the NREPP is an unpublished manuscript, and furthermore, said study was done in the schools, so it is unclear whether it is generalizable to a residential, shelter, or day treatment setting. Nevertheless, Conscious Discipline® has been implemented in many organizations with success despite a lack of a rigid empirical base; demonstrating anecdotal and practice-based evidence as is given on the Conscious Discipline® website (Loving Guidance Inc. 2015).
Developed by local Minnesota professional Dr. Anne Gearerity, the Developmental Repair model is a comprehensive modality for the therapeutic milieu. It was developed and is currently used at the Washburn Center for Children (a day treatment center) in Minneapolis. It is a comprehensive, trauma-informed curriculum for “very at risk” youth between the ages of 3 years and 9. It emphasizes the roles of self-awareness, environmental influences, relationships with adults, and the mind-body connection. It takes the philosophy that children can succeed if given the proper chances and guidance, even in the face of complex and significant trauma. Using a model called the “arousal curve” to understand dysregulation in children, it states that when the opportunity to learn is missed, dysregulation and behavior problems will continue to exacerbate. Gearity (2009) not only outlines the model, but also emphasizes the research that it is based on, including the limitations of behavioral models, as well as trauma and attachment theories. Although based on research, this model has not been evaluated by peer-reviewed studies. However, in the manual it does emphasize the use of evidence-based and promising practices. It is notable to mention that this model in particular does not emphasize working with families as much as other models. Implementation at St. Joseph’s Home for Children may require more resources, however, as the model would likely need to be adapted to serve children who are older. Formal training procedures in Developmental Repair are not set, and would require consultation with experts in the model such as Dr. Anne Gearerity.

Attachment, Regulation, and Competency (ARC) as described in Kinniburgh et al. (2005) attempts to tackle complex trauma in youth of all ages. To address attachment issues, they outline methods to improve the caregiver relationship; including routines, caregiver emotional intelligence, and use of praise. Youth are taught emotional management skills, and are given opportunities to show their strengths and mastery, in addition to the ability to practice and evaluate their own outcomes. Some research has demonstrated that ARC is effective in a trauma-informed system with TF-CBT (Bartlett et al. 2015). It has also been implemented in a number of residential facilities for youth in the US (James et al. 2015). Although it is not cleared by evidence-based clearinghouses, it has preliminary research support and is based in previous research including attachment theory and psychoeducational techniques. The research surrounding ARC has primarily been around residential (Hodgdon et al. 2013) and child welfare populations (Bartlett et al. 2015), both times involving youth who have experienced complex trauma. Implementation of ARC as a comprehensive model in particular would be a way to address themes of trauma across multiple domains of practice. Training is customized to meet the needs of the organization; typically, it is a one-year process that involves a half-day needs assessment, two-day foundational training, and monthly consultation calls with a system implementation team. After the initial training process, organizations are expected to maintain the model themselves. The cost of this training process was estimated to be between $18,000 and $22,000. There are fidelity measures for this model, available upon request. (Margaret Blaustein, personal communication, August 10th, 2016).
Positive Peer Culture (PPC) is a program that emphasizes youth taking responsibility and engaging with each other in order to increase prosocial behavior. It is designed primarily for youth 11 and older. The program is meant to last 6-9 months. It revolves around holding 45-90 minute sessions 5 times a week in order to create a community among youth. It emphasizes 4 separate needs of young people: belonging (being a part of a community or a group greater than yourself), independence (the ability to have some say in their own life), generosity (giving back to others within or outside the group), and mastery (knowledge of competence and self-efficacy) (Laursen 2010). A recent literature review of practices in residential treatment identified PPC as “supported” by research under the criteria for the California Evidence-Based Clearinghouse for Child Welfare (CEBC) (James 2011). However, it was also noted that much of the supporting research is for the related program EQUIP, designed specifically for delinquent youth. This is likely why the relevance to the child welfare population is rated as “medium” by the CEBC (California Department of Social Services 2016). Training is available for this model through CF Learning under the designation “Cultures of Respect”. Cost for a 2-day training is $4,500 plus travel and materials expenses. Additional consultation for implementation is available post-training, but may cost extra (CF Learning 2016). Strengths of this model include applicability across domains of service, its relatively broad evidence base, and the simplicity of its implementation. However, recent literature reviews reveal that it is not broadly used in residential treatment (James et al. 2015). It also lacks a parent component, and some believe it may not appropriate for youth who have experienced maltreatment, and should only be used with youth with emotional or behavioral disorders (James 2011).

Risking Connection® is a type of trauma-informed training emphasizing three primary deficits due to trauma - attachment, self-capacity and regulation, while emphasizing the role of biology in trauma (such as neurochemistry). Its framework for relationship building includes respect, information, connection, and hope (“RICH” relationships). Preliminary research suggests that training in this program improves staff beliefs towards trauma-informed care in a residential setting (Brown, Baker, & Wilcox 2012). However, no outcome studies have been conducted and it is not rated by the CEBC. (California Department of Social Services 2016) Costs, however, are relatively flexible, with 90-day access to online training being $65, and the cost of a class being approximately $595. Although the website claims to use evidence-based practices such as DBT and EMDR, it is unclear to what extent these practices are included within the trainings, especially considering the specialized training often needed for such practices. (Sidran Institute 2015). Although difficult to justify investing in a program with such a small evidence base, some residential treatment centers have elected to train in the Risking Connection® model (James et al. 2015).

The Neurosequential Model of Therapeutics (by Dr. Bruce Perry) takes a neurodevelopmental approach to the treatment of trauma in youth. A key facet of this model is the concept that youth who have experienced trauma may not be have enough cognitive resources in order to undergo
treatments such as Dialectical Behavior Therapy or Trauma-Focused Cognitive Behavioral Therapy. Instead, this approach focuses on mindfulness-based interventions such as deep breathing or meditation for those who are stuck in this “survival mode”, and then interventions such as TF-CBT for those who have adapted cognitively (Perry & Hambrick 2008). It includes metrics to measure levels of functioning according to this framework that are to be used as a supplement to, but not in place of, other assessment metrics. Following a train-the-trainer (TTT) model, the cost of implementation of this framework averages to about $7,000 per trainer (ChildTrauma Academy 2013). Though touted as an evidence-based practice, no randomized control trials have been conducted to evaluate NMT. Preliminary research evidence suggests effectiveness, however it is unclear whether the results are generalizable outside of a preschool population (Barfield et al. 2012). Implementation would be simple through the TTT model, but outside involvement to maintain fidelity seems to be minimal post-training.

Some areas in California have elected to take a different approach to shelter care; Payne (2014) names it the 23-hour assessment center. This model revolves around finding another placement for all youth who arrive within 23 hours and 59 minutes; in a sense, it is an intake center where assessments and case management are given a focus in order to minimize the time spent in a shelter. Often, 23-hour assessment centers partner with outside organizations in order to staff and fund their day-to-day staffing and equipment needs. A separate room is used when youth are approaching their time limit, or for one reason or another would require a different placement sooner instead of later (Lee 2004). Because the center does not count as a residential placement as youth do not stay over 24 hours typically (and there are no bedrooms), it is licensed differently than other placements. There is an emphasis on being data driven, and finding the best placement for each youth. However, placements frequently become shelter care, as opposed to foster care or residential treatment. Other youth (such as individuals with juvenile justice involvement or emotional or behavioral disorders) are simply turned away from the assessment center, or receive expedited placement (Payne 2014). The assessment center model does not require training, but would require significant internal restructuring from a shelter care model.

Radically different than most models of residential treatment, the Teaching-Family Model (TFM) centers on hiring a heavily vetted live-in couple to act as “family-teachers” to the youth in residential treatment. These individuals receive intensive training, supervision, and consultation from former family-teachers, and are supplemented by direct-care staff. They are also offered training for their own professional development, with potential upward mobility being offered as well. Shared governance with youth is also emphasized, who evaluate the program through interviews and surveys as a supplement to standard reviews from administration. In lieu of punitive measures, the model emphasizes reinforcing appropriate behavior. Direct-care staff support is also emphasized, citing a relation between burnout and support for punitive measures, as well as the documented negative effects of punishment (Daly & Dowd 1992, Lambert et al. 2010, Riesel et al. 2012). The Teaching-Family Model has been researched extensively, but is
only rated as “promising” by the California Evidence Based Clearinghouse for Child Welfare (James 2011). Despite this, outcome studies from the Teaching-Family Model tend to show positive results (Lee & Thompson 2008). Its child welfare relevance is rated as “high” by the CEBC, indicating much of the research has been validated in both residential treatment and juvenile justice settings (California Department of Social Services, 2016). There is also an adaptation of TFM specifically designed for shelter care called “Managing Youth in Short Term Care” (MYSTC), but has not been researched extensively (Hurley et al. 2006). Despite strengths in research and methodology, the organizational change required to move towards the Teaching-Family Model is quite comprehensive and expensive; estimates have been as high as $20,000 and also require more changes in staffing than other models (Washington State Institute for Public Policy 2015).

The Stop-Gap Model of residential treatment, on the other hand, is based on the premise that the focus should be primarily on the impending discharge of the youth, and in doing so, tends to de-emphasize the role of the therapeutic relationship. Designed primarily for youth with emotional and behavioral disorders, it involves individual behavior planning through “naturalistic functional assessment” (as opposed to a traditional functional behavior assessment), as well as skills training (primarily anger and social skills), and a unique, case-management heavy modality. A token economy with a response cost component is also typically used, along with parent training (McCurdy & McIntyre 2004). Some studies have shown promising results for the Stop-Gap model (McCurdy & McIntyre 2004, Zakriski, Wright, & Parad 2006), and it has received notable mentions in literature reviews (James 2011). However, it has not been widely implemented in residential treatment (James 2015). There is a Stop-Gap adaptation used in a summer program that resembles the length of shelter care, where placements last approximately 45 days; although, research is limited not only on the efficacy of this program but also on its generalizability to a shelter setting (Zakriski, Wright, & Parad 2006). Implementing this model would require extensive outside involvement, including $25,000 in first-year costs (Barry McCurdy, personal communication, August 2nd 2016). The discharge and generalizability-focused pieces of this model are particularly appealing, with some concerns about a de-emphasis on relationships. Although it would be ideal to get every youth new placements sooner rather than later, this is often not decided by the home, and is dependent on external factors. It is possible that this model may seem more appropriate for shelter care than residential, with its heavy emphasis on discharge. (McCurdy & McIntyre 2004).

Among models of trauma-informed care specifically, the Sanctuary® model as described in Bloom (2005) is quite notable. It is a comprehensive, holistic approach designed for youth residential treatment. It outlines guiding principles including non-violence, emotional intelligence, inquiry, social learning, shared governance, open communication, social responsibility, and growth/change. It also involves a specific framework called “SELF” (safety, emotion management, loss, and future) to discuss trauma. Staff and youth are both encouraged to
use this framework. Frequent community meetings are also emphasized (Bloom 2005). The Sanctuary® model is rated as having “promising” research evidence by the CEBC (James 2011). Some studies have encouraged the integration of the Sanctuary® model as a piece of trauma-informed care among other evidence-based practices (See, Restorative Healing Model, Park et al. 2008). The Sanctuary® model represents many current trends, including shared governance, safety plans, and psychoeducation to both youth and parents. However, the population examined in peer-reviewed articles is limited to youth 12 and older in residential treatment (Rivard et al. 2005). This makes it unclear if the practice is generalizable to younger clients, shelter clients, or day treatment settings. However, under CEBC criteria, it is the only system-level trauma treatment practice with at least promising research evidence (California Department of Social Services 2016). Implementation of the Sanctuary® model would likely be costly, considering the prices of the similar system-wide Stop-Gap and ARC models (Sanctuary representatives did not respond to communication). The process would likely take up to 3 years and involve 15 hours of training for all staff each year after a comprehensive needs assessment of the organization. It would also involve being a part of the Sanctuary® network, a professional community of homes that use the model (Esaki et al. 2013).

Specific intervention strategies

The restorative justice (RJ) approach to discipline has received attention in recent literature and practice, especially in the context of children’s residential treatment. (Littlechild 2009, Park et al. 2008). RJ interventions can include family group conferencing, victim-offender mediation (VOM), and community conferencing (Park et al. 2008). The concept behind RJ practice is to have both parties involved in the incident come together with a mediator and have a dialogue about the offense. Both parties express their perspective on the event, and discuss what potential reparations may be needed in order to maintain the relationship. (Artello et al. 2015). Meta-analyses have shown that participants in VOM may be only 70% as likely to re-offend as non-participants, and support the use of restorative practices in general (Nugent, Williams, & Umbreit 2004; Latimer, Dowden, & Muise 2005). Training on restorative practices is available from a number of sources, including the International Institute for Restorative Practices (IIRP), who charge $1,800 for a train-the-trainer (TTT) model where a staff within an organization becomes an expert on the practice, and trains other staff on the practice. Fidelity to the model is strongly encouraged, but fidelity monitoring procedures are not outlined on the IIRP website (International Institute of Restorative Practices 2016). It is worth noting that victim-offender mediation (VOM) in particular has a strong evidence base. Unfortunately, most studies focus on the juvenile justice population and not populations in group care or day treatment. This has not deterred some organizations from implementing VOM in their curriculum, however (Park et al. 2008). Training materials and manuals are available online for VOM (Umbreit & Lewis 2015).
Widely used across the US is Aggression Replacement Training, or ART (James et al. 2015). ART is a 10 week, group-based intervention for youth who present with aggressive behaviors, including individuals with oppositional defiant disorder and conduct disorder. It is based on three components; skillstreaming (or structured learning), anger control training, and moral education. Skillstreaming is a curriculum of social and emotional learning, with an emphasis on management and plans to deal with stress and anger. Anger control training teaches skills such as identifying triggers and cues, and how to use reminders and reducers in order to remain in control once triggered via self-evaluation. The moral education component is based off of the moral stages described in the classic Kohlberg (1973), and involves presenting a series of moral dilemmas and having a discussion surrounding them. A curriculum is outlined in Glick and Goldstein (1987), with a more recent version in text also being available. Calls have been made to integrate ART into curricula for youth who have experienced trauma (Amendola & Oliver 2013). The CEBC rates it as a “promising practice”, with a relevance to child welfare as “medium”, and the Office of Juvenile Justice and Delinquency Prevention rates it as “effective”. It is the third most-used practice in all of residential treatment (James et al. 2015). Despite this evidence base and usage, some studies have criticized the ART literature as not having rigorous enough methodology (Brännström et al. 2016). In addition, it is a program primarily designed for adolescents, limiting generalizability to younger populations. Research samples have included youth in runaway shelters, residential treatment, and juvenile justice populations. (California Department of Social Services 2016). However, considering the limited research base, it is unclear whether it is functional as a social-emotional curriculum in a trauma-informed environment as a standalone, as opposed to simply a treatment for aggression and conduct issues. Perhaps this is why it has been implemented alongside other evidence-based practices in other systems (James et al. 2015, Park et al. 2008). The cost to train a trainer in ART is $2,500, but two trainers are recommended for implementation (EpisCenter 2015). A limitation is that if only one individual is presenting with aggressions, the purpose of ART is defeated as it is a group exercise; although, it could also be used simply as a social-emotional curriculum.

Another commonly-used practice in residential treatment is Collaborative Problem Solving (CPS). As a caregiver training program, it is designed as a team-based model between youth and adults to approach and resolve issues. In lieu of training parents, it has also been used to train direct-care staff (Greene, Ablon, & Martin 2006; Holmes, Stokes, & Gathright 2014). As opposed to using a directive (“Plan A”), or free-range (“Plan C”) approach, CPS emphasizes the use of a middle ground, “Plan B”, a collaborative approach. It uses three steps; the first is displaying empathy for the youth’s concern. The second is to define the problem, including the child’s presenting concern, with the third being an invitation to the child to help solve the problem. This model asserts that youth acting out is the result of cognitive deficits, specifically in flexibility, frustration tolerance, and problem solving. Preliminary research suggests the effectiveness of the CPS intervention (Johnson et al. 2012). Its widespread use across residential facilities for youth is notable; however, it remains unrated by evidence-based clearinghouses.
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(James et al. 2015). Despite its use in residential treatment, studies have primarily focused on inpatient hospitals (Greene, Ablon, & Martin 2006; Holmes, Stokes, & Gathright 2014) or non-US samples (Johnson et al. 2012). Training is available through the organization Think:Kids, through a train-the-trainer model for $2,000. The process is intensive, and requires a number of fidelity measures in order to ensure proper training is completed (Think:Kids 2016). Despite the fact that CPS could use more evidence, the collaborative model represents many current trends in the literature and across other models outlined in this review. With its promising evidence and widespread use, it may be a good practice in higher placements for youth. However, its heavy cognitive side may be more difficult to use with younger children, in addition to its relatively limited research base.

In terms of reactive programs, Life Space Crisis Intervention (LSCI) is another practice with a promising evidence base. It involves first draining off the emotions of the youth, emphasizing de-escalation and respecting their space. The intervention moves on to create a timeline of events and define the central issue. Meaningful insight is given by the adult, skills to manage the situation in the future are taught, and a debriefing is given before the youth re-joins the group (Long, Wood, & Fecser 2001). Research evidence suggests the effectiveness of LSCI (D’Oosterlinck et al. 2008, Soenen et al. 2014), and it is rated as “promising” by the CEBC, with a relevance rating of “medium” to child welfare. Research has been primarily focused on school settings and youth presenting with emotional and behavioral disorders (California Department of Social Services, 2016). Enrolling in the online course individually costs $200, but presumably, discounted prices for large-group trainings are available but not listed on the website. Most trainings last about five days, but shorter trainings are available. (LSCI Institute 2016). Although some research evidence supports the use of LSCI, additional randomized controlled trials could be done, especially in US samples, considering most samples have been European (D’Oosterlinck et al. 2008, Soenen et al. 2014). In addition, many facilities already have de-escalation and holds procedures in place; and a second de-escalation technique may be difficult to justify financially amongst other organizational changes.

Managing and Adapting Practice (MAP), a framework offered by PracticeWise, LLC, outlines a plethora of evidence-supported interventions in a searchable database, each to be used depending on the presenting concern. Frequent use of positive verbal reinforcement is emphasized in most interventions, and its flexible framework allows for individualization. However, it includes punishment-based interventions such as timeout (Chorpita, Daleiden & Collins 2014), when current literature focuses on the reduction of seclusion (Huckshorn et al. 2005, Caldwell et al. 2014, Green-Hennessy & Hennessy 2015). Despite this, the level of individualization in the MAP model is a strength that is hard to ignore. Although many interventions within the MAP system are supported by evidence, the MAP system as a whole has minimal research support, limited to a case study (Chorpita, Daleiden, & Collins 2014), and some calls for its integration into a wraparound approach (Bruns et al. 2013). An annual subscription to MAP, including
practitioner guides, is approximately $205. Electing to use this model comes with obvious strengths in the ability to customize treatment for each youth, its evidence-based procedures, and its cost-effective nature. A limitation of MAP is the lack of comprehensive training (especially for the interventions used, it simply outlines the procedure).

Models of psychotherapy

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an evidence-based practice that is commonly used in residential treatment facilities (James et al. 2015). It revolves around the use of psychoeducation and mindfulness, followed by the development of a trauma narrative as well as in-vivo exposure. Meta-analyses suggest that TF-CBT is effective (de Arellano et al. 2014). However, the cognitive nature of the practice limits its generalizability to younger individuals, and its commonplace use in residential treatment means that the trauma narrative may already have been completed by the time someone has been admitted to a residential treatment center. In some cases, it seems that TF-CBT is certainly a good practice, but not necessarily sufficient.

Commonly cited as another evidence-based treatment for trauma is Eye Movement Desensitization and Reprocessing (EMDR). The underlying philosophy of EMDR is that trauma overwhmels the brain, and activates maladaptive neural pathways (the “adaptive information processing model”). It involves a number of steps, including standard history, assessment, and relationship building. EMDR then begins the process of desensitization, where the client focuses on a traumatic memory, while moving his or her eyes back and forth (following the therapist’s finger) for about a minute. Once this process has been mastered, a more adaptive cognition is paired with that process, and then bodily sensations of stress are also paired with that procedure. There is closure and evaluation at the end of each session (Shapiro, 2001). EMDR has been deemed efficacious in children according to meta-analyses (Rodenburg et al. 2009). The CEBC also rates it as a “well-supported” intervention (California Department of Social Services 2016). In addition, there is an adaptation of EMDR integrating play therapy outlined in books such as Tinker & Wilson (1999). Research has been done on its use in children as young as four (although more research needs to be done with younger populations), with many studies also demonstrating its effectiveness in three sessions or less (de Roos et al. 2011, Wesselman et al. 2012). However, despite the evidence base for this treatment, the concept of having a therapist move his or her finger in one’s field of vision in order to treat trauma has little face validity. Youth in particular may perceive it as “ridiculous”. Training in EMDR costs $890 or more per therapist, and usually consists of two spaced-out weekends (with supervision in between them), in addition to licensure fees (Trauma Recovery 2016).

James et al. (2015) cites Dialectical Behavior Therapy (DBT) as the most-used practice in residential treatment for youth. DBT revolves around the concept of radical acceptance of oneself (based in Zen philosophy), in addition to more conventional cognitive approaches. It is
commonly cited as a treatment for individuals presenting with borderline personality traits, suicidality, and self-harm. A standard program lasts 12 months, including individual and group skills sessions. It is worth noting that DBT is specifically designed to combat emotional dysregulation. (Little, Butler, & Fowler 2010). The NREPP rates DBT as a good practice, rating at an average score of 3.4 on a 4-point scale (Substance Abuse and Mental Health Services Administration 2016). Although clearly efficacious for treating self-harm, most studies applicable to youth have been done only on self-harm in adolescents (Wasser et al. 2008; Little, Butler, & Fowler 2010). It is especially unclear whether DBT is generalizable to elementary-age children due to its cognitive components; or if it is generalizable to treat other presenting problems due to the unilateral focus of the research on DBT and self-harm. However, adaptations for both residential treatment and younger populations have been made, although they are not extensively researched (Perepletchikova & Goodman 2014; Little, Butler & Fowler 2010). Training is offered through the developer's institute, but is quite expensive; usually $10,000 or more (Linehan Institute, personal communication, August 2nd 2016). However, other organizations, (such as DBT Associates located in Fridley, Minnesota) offer less intensive and more cost-effective trainings. For example, a DBT weekend training costs $250 (DBT Associates 2009). Although DBT may not specifically address the trauma that individuals in higher placements may face, it remains a good practice to treat self-harm and emotional dysregulation in adolescents.

Motivational Interviewing (MI) is a therapeutic practice that has its roots in the person-centered tradition. The goal of MI is to create change from within an individual to correct a presenting problem they have and are willing to do something about (drinking, smoking, self-harm, bad parenting, etc.). The first step is to express empathy for the client’s situation and build a rapport. The second is to work on developing a discrepancy between the client’s behavior and their cognitions about it. Resistance is to be met with understanding and normalized, not opposed. Through this process, the client is to develop self-efficacy towards individual change. Meta-analyses indicate the efficacy of MI (Lundahl et al. 2010). It is rated as a “well-supported” practice by the CEBC with a “medium” relevance to child welfare, due to the lack of literature on youth and a focus on treatment of adult substance abuse (California Department of Social Services 2016). Some studies have been done in exploring the use of MI outside the substance abuse treatment domains (Kamen 2009), but more research needs to be done to clearly state that this is an evidence-based treatment for youth outside of the substance abuse domain. Despite this, some residential treatment centers for youth have elected to implement MI in their programming (James et al. 2015). There seems to be a stronger research base in using MI to improve parenting practices than with children and adolescents (Lundahl et al. 2010). Training in MI is relatively cost-effective, running about $150 per individual. It depends based on the trainer solicited, but there are many to choose from in the US (MINT 2016). Although clearly an evidence-based and cost-effective practice in mental health, it is unclear whether it is generalizable to children and youth, outside of its applicability for parents.
The Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC) resembles its counterpart, Managing and Adapting Practice (also owned by PracticeWise, LLC). In this case, individualization is encouraged through a flowchart to determine what practice to use with the child. It is designed for use with youth between the ages of 6 and 13. Preliminary research evidence has suggested the effectiveness of MATCH-ADTC (Chorpita et al. 2013, Weisz et al. 2012). However, both of these studies were done by the developers of the MATCH-ADTC program. Limitations included the predominantly male samples, and the limited age range of 6-13. Nevertheless, the NREPP rated the program as effective in treating emotional disturbances, and promising in treating externalizing behaviors and general functioning (Substance Abuse and Mental Health Services Administration 2016).

The full range of protocols in MATCH-ADTC is unclear from the research, but appears to include psychoeducational and cognitive-behavioral approaches. Buying the online manual costs $75, and there seems to be little external support offered in terms of implementation (PracticeWise 2012). On the other hand, this means that MATCH-ADTC is relatively cost-effective and easy to implement. However, fidelity to the interventions may be difficult to maintain without external support. Its versatility with elementary-aged children is notable, considering the challenges to find similar evidence-based interventions for that population.

**Accountability measures**

Under law, many children’s mental health treatment centers are required to administer the Strengths and Difficulties Questionnaire (SDQ). The instrument has 25 questions and has predictive validity of DSM-V diagnoses (He et al. 2013). Other research has suggested that different measures may have stronger psychometrics for outcome assessment, likely due to the relatively low number of items on the SDQ (Achenbach et al. 2008). A recent literature review on child welfare outcome measures did not include the SDQ (Rosanbalm et al. 2016).

The Child and Adolescent Functional Assessment Scale (CAFAS) is a commonly used outcome measure for treatment outcomes in higher placements. It measures eight domains of functioning: school/work, home, community, behavior towards others, substance use, thinking, emotions, and self-injury. It was initially designed for youth with mental health needs, and has been validated in a residential treatment environment (Hodges & Wong 1996). The CAFAS has been shown to have strong predictive validity and relatively good psychometric properties. It costs $3 to administer, and $400 annually to access an online entry and access database. Alternatively, the paper version could be used exclusively for a reduced monetary cost. The manual suggests it may take 10 minutes to complete once familiar with the instrument, but a 30 minute structured interview tool is also included; hence, it may take extra time to complete. Its sensitivity to change is notable; however, it is not designed to detect quick or immediate change. It is recommended to use the CAFAS to assess the last 30 days of functioning after 3 months of treatment. The CAFAS is not designed to detect quick or immediate change in clients.
This is relatively expensive compared to other measures. Some have expressed psychometric concerns about the CAFAS in terms of its content and construct validity, despite its established predictive validity (Bates 2001). Its strong predictive validity for future behaviors does, however, make the CAFAS a strong tool to evaluate mental health outcomes, however, despite the resources required to administer it. Concern about its construct and content validity should also be noted if assessing outcomes.

Commonly used in assessing children’s mental health outcomes is the Achenbach System of Empirically Based Assessments (ASEBA). It consists of the Child Behavior Checklist (CBCL), Youth Self-Report (YSR), and the Teacher Report Form (TRF). Each inventory includes about 100 items, and each can take about 10 minutes to complete. Compared to other measures, it has lower inter-rater reliability, likely due to the fact that different parties are completing the different forms of the ASEBA. It has otherwise strong psychometrics and is widely used (Rosanbalm et al. 2016, Achenbach et al. 2008). Considering the length of the ASEBA with three forms, another option is simply to use the Child Behavior Checklist. It has been validated with good psychometric properties, but may struggle with differential diagnosis (Gomez & Vance 2014). Although Rosanbalm et al. 2016 cites the cost of the ASEBA to be 60 cents per administration, the ASEBA website cites the cost of 50 CBCL forms alone as $30 (60 cents per administration). If the entire ASEBA is administered, administrative support may be needed as it is a lengthy instrument that may be difficult for staff to administer within time constraints (Rosanbalm et al. 2016). Otherwise, the ASEBA and the CBCL are both widely used and empirically-based instruments to assess outcomes in children’s mental health.

Perhaps the most cost-effective option for assessing outcomes in children’s mental health is the Child and Adolescent Needs and Strengths Assessment Tool (CANS). The CANS form for mental health has 47 items, with the comprehensive form having 131 items. It presents with strong reliability and validity evidence (although evidence for convergent validity is limited), and can be administered by a bachelor’s level staff or higher. Like the CAFAS, it is not designed to detect quick or immediate change, but will detect changes of long-term clinical significance (Rosanbalm et al. 2016). A $10 per person certification is recommended for use, but the tool is open-sourced and free to access; in fact, there are many different CANS forms available to browse (Holliday 2012). The state of Wisconsin recently started a wraparound approach initiative to their child welfare services and included the CANS as their recommended outcome measure (Wisconsin Department of Health Services 2016). Considering its strong psychometric properties and cost-effective nature, the CANS should be strongly considered as an option for youth mental health outcome measurement.
Applicability to programs

Shelter care, residential treatment, and day treatment are all very different contexts for youth to be in. Common to youth in all of these environments is the theme of trauma. Considering the threat of re-traumatization of youth in these environments, a universal, trauma-informed model is likely necessary. Considering that studies on the Sanctuary® model have been primarily conducted on adolescents (Rivard et al. 2005), the only universal model across these three domains would be ARC. Also notable is that ARC specifically addresses complex trauma; despite this, its research base remains relatively lacking despite some evidence and its already-present usage in residential treatment centers (Hodgdon et al. 2013, James et al. 2015). PBIS is another such model that may be applicable across shelter, residential, and day treatment settings, with more evidence to support its implementation (Horner, Sugai, & Anderson 2010). However, literature to support its implementation in higher placements is limited. It does not specifically address trauma-informed care, but its concept of tier one prevention is certainly preferred to reactive practices where re-traumatization is a concern. Restorative justice is also a universal approach applicable to these three domains. Its relatively inexpensive train-the-trainer approach is far more cost-effective than full implementation of the ARC model. Furthermore, manuals such as Umbreit & Lewis (2015) exist allowing for cost-effective implementation of interventions (even if there may be fidelity concerns). It is worth noting that restorative justice is a broad approach, and does not address trauma specifically. It has been used in some settings as a supplement to trauma-informed care (Park et al. 2008).

Other interventions outlined earlier deserve special note for applicability across shelter, residential, and day settings. Collaborative Problem Solving (CPS) is one such approach. As a parent/caregiver training program that can also be used by direct-care staff, it already has a wide range of applicability, with a promising team-based mindset when it comes to adult/youth interaction. Its widespread implementation suggests practice-based evidence, but no clearinghouse has rated it as an evidence-based practice (James et al. 2015). Another intervention outlined earlier that may be applicable across all settings is Motivational Interviewing (MI). Although not typically used with younger populations, it has been used on adolescents and parents with success, often in three sessions or less (Lundahl et al. 2010). Training in MI is also available for direct-care staff, despite its roots as a therapeutic modality. Another added bonus is the underlying theme of a person-centered, humanistic philosophy within MI - which revolves around quickly building rapport by expressing empathy and being present with the client. That philosophy could also improve work with younger clients who may not be able to go through the MI process through relationship building. As far as therapy goes, it is worth considering that DBT is the most used practice in residential treatment according to one literature review (James et al. 2015). It is also potentially a treatment that could be applicable across all domains (although it is unclear if meaningful results could be achieved in short-term shelter care), as staff interviews at St. Joseph’s Home for Children revealed that informal DBT work is common
among some therapists. Investing in formal training for this would only improve fidelity of implementation; and considering training options such as DBT Associates (for $250), investment may not be costly. It is however worth noting that the literature on DBT primarily focuses on self-harm and borderline traits; and may be more applicable to adolescents than to younger children, further limiting its generalizability.

Considering the relative dearth of peer reviewed studies on emergency shelter care, staff working there face a unique challenge in terms of implementation of evidence-based practice (Leon et al. 2016). However, there is an adaptation of the Teaching Family Model, called Managing Youth in Short-Term Care (MYSTC). It focuses on individualized assessment for seven days after admission, skills training, a token economy, and equipping staff to be successful with youth. In one study, a 40 hour training session in the MYSTC model resulted in improved critical incidence rates and staff experience survey scores. It is worth noting however, that the runaway rates increased in this particular study (Hurley et al. 2006). In Zakriski, Wright, & Parad (2006), a 45-day summer program adaptation of the Stop-Gap Model is outlined, which could be adaptable to short-term shelter care. The interventions were targeted specifically for individuals who had aggressive behaviors, internalizing behaviors, or social skills deficits. It is unclear, though, if the summer program could be adaptable to the 30-90 day stay in short-term shelter care, or if all clients in short-term shelter care would benefit from the program. There is also even less empirical evidence on this 45-day model as opposed to the full Stop-Gap model.

Although not designed for short-term shelter care, the Sanctuary® and ARC models, if implemented system-wide, could establish a culture of trauma-informed care. Also notable is the short-term success of therapies such as MI and EMDR. Although either modality may take longer than three sessions, research does suggest that both MI and EMDR can achieve success sooner than practices such as TF-CBT (Lundahl et al. 2010, de Arellano et al. 2015, Rodenburg 2009). If shelter stays are 30-90 days long, weekly sessions (totaling 4-12 sessions) could help to make significant clinical progress.

Residential treatment faces the challenges of longer-term stays and a high-needs population of youth presenting with externalizing and internalizing symptoms. To address these challenges, a number of models outlined in this paper may be appropriate. The Teaching-Family Model, though requiring radical change in terms of organizational structure, is incredibly promising for residential treatment due to its reinforcement-oriented, relationship-based, and data-driven framework. It is also used by one of the most well-known residential treatment facilities in the US, Boys Town in Nebraska. Despite its strengths, it is not necessarily a model designed for trauma-informed care. The Sanctuary® model is, however, a trauma-informed model that was designed for residential treatment, albeit only validated for adolescents. Positive Peer Culture also offers a 6-9 month program that, although also only empirically validated for adolescents, may coincide well with the needs of a residential program (James 2011). Considering the work
of Wesselman et al. (2012) of EMDR with younger populations, it could also be used with children who may be too young for the cognitive portions of TF-CBT.

Day treatment for youth also faces challenges including a similar high-needs population to residential treatment, presenting with complex trauma, aggressions, off-task behavior, and more. Considering its similarity to traditional schools (at least when compared to residential and shelter care), day treatment programs could implement PBIS, as it is strongly empirically-validated in the schools. Although, considering the needs of the day treatment population, interventions from tiers two and three of PBIS may be too common and place too much pressure on staff. PBIS also does not emphasize trauma-informed care as it was designed for use in a typical school. To address this theme, use of a trauma-informed framework (ARC, Sanctuary®, or NMT) may be needed. Day treatment at St. Joseph’s Home for Children in particular offers skills groups twice a day. This classroom-style meeting would also be appropriate for group-based interventions such as PPC or ART, depending on the presenting problems and ages of the youth. In younger clients, Developmental Repair may be a more appropriate model as it was designed for youth up to the 3rd grade, and also involves trauma-informed care.

**Interview themes**

Also conducted as a part of the present study were interviews of staff at St. Joseph’s Home for Children. Consistent themes were identified between many of these interviews. Almost every staff interviewed cited turnover as a serious concern, likely due to the role of burnout that results from dealing with aggressive, self-harming, or internalizing behaviors on a regular basis. Some studies have suggested that the ideal youth to staff ratio is 4:1, with no more than ten youth being served in a unit at one time. Given this fact, others assert that that the higher the needs of the youth, the more staff that are needed (Daly & Dowd 1992). The 23-hour assessment center in Alameda County, California, for example, uses a flexible 3:1 youth to staff ratio (Lee 2004).

Another common interview theme in regards to staffing was the idea that the new employee orientation (NEO) does not sufficiently cover trauma, and that it may over-emphasize the role of holds on the unit when preventative practice should be emphasized. Also suggested was that comprehensive training on an overarching theme may be necessary in order to make youth-staff interactions consistent. These concerns could be addressed with person-centered training such as MI or the implementation of a trauma-informed model such as NMT or ARC. The development of intrinsic motivation in youth seemed to be of great concern as well to staff. ART, for example, includes a moral education component to challenge the cognitive abilities of youth and help to develop sets of values (intrinsic motivation); and CPS encourages that same cognitive processing through its collaborative components. Through completion of tasks, “effort justification” (taking pride in your work) could take effect and potentially instill intrinsic motivation in youth.
Concerns specialized to the shelter and residential programs were also present. The building that both are housed in was cited to be outdated by more than one interviewee, with suggestions being made to house both programs in separate buildings. Program supplies were cited to be lacking as well, with gymnasium balls being deflated and art supplies being used up due to insufficient funding. Day treatment has fidgets for youth, which can help to occupy youth during group or activity time, but are not available across all programs. It was suggested by an interviewee that a grant writer for St. Joseph’s Home for Children could help to alleviate monetary issues. It seemed quite common for therapists to participate in case management activities, and especially considering the placement of one therapist in the shelter programs, additional case managers or administrative support may alleviate burnout from therapists and improve service delivery. Also frequently cited was the insufficiency of the current system (red, yellow, green status, with a written reflection required for restoration). Research on restorative practices often focuses on verbal mediation, as opposed to written reflections (Umbreit & Lewis 2015). Finally, the insufficiency of communication between administration and staff was another common theme mentioned in interviews. This issue is perhaps ingrained within the work culture; perhaps regular, community building activities could encourage a more positive work culture.

**Conclusions**

When prompted about higher placements for youth, it is difficult to give a definitive answer as to which one is the “best practice”. Each model has a theoretical basis, a target population, and its own limitations. Many address the need to individualize to the youth, but are not comprehensive enough to address the needs of everyone. This has led to some organizations such as the Woodbourne Center in Baltimore adopting hybrid models such as the “Restorative Healing Model” as outlined in Park et al. (2008). It involves the implementation of three pillars: ART, restorative justice, and trauma-informed care. Although day treatment and shelter care may be different, the components of the Restorative Healing Model can be examined as well; there is a model for the milieu (Sanctuary® is mentioned, but it is not clear if it is actually implemented or a trauma-informed training is simply used), an evidence-based psychotherapy (TF-CBT), a group curriculum (ART), and accountability for youth in restorative justice. These different components could inform what components need to be considered when developing an evidence-informed practice of higher placements for youth. For example, the integration of the ARC trauma-informed framework, usage of TF-CBT and MI, training in VOM and restorative practices, and interventions through MAP would be a comparable, perhaps even more comprehensive approach to treatment.

A number of common themes came up in the literature review between models. Reinforcement as opposed to traditional punishment was heavily emphasized (PBIS, TFM, Sanctuary®, ARC), with the role of timeouts in particular being criticized (TFM, Developmental Repair). Youth-caregiver relationships were paramount in many models, often citing the need to address
attachment difficulties (PPC, TFM, MI, Risking Connection®, Conscious Discipline®). Calls for trauma-informed care were also common, especially as a preventative practice for re-traumatization which may result in worsened outcomes or challenging behavior (Sanctuary®, ARC, Risking Connection®, NMT). Being child-centered was not uncommon (PPC, MI, TFM), with varying levels of autonomy given to youth, from simply a person-centered philosophy, to bottom-up evaluation such as a youth council. Many also emphasized the importance of staff supervision and training - almost giving staff a therapeutic space for expression and processing, as well as professional consultation (TFM, Sanctuary®, Developmental Repair). Being data-driven was emphasized in almost every model; and not just collecting data, but comparing data and determining what works and what does not. Also emphasized was generalization to the outside world in many models, including family and community engagement (TFM, Stop-Gap, PPC, RJ). As far as outcome measures go, it seemed as if most available instruments (ASEBA, CAFAS, CANS, CBCL, SDQ) are not designed to detect quick or immediate change. It would be difficult to assess the efficacy of emergency shelter care outcomes with such measures. However, in the context of residential and day treatment, the CANS stood out as a candidate with strong psychometrics in addition to being cost-effective.

This literature review examined several practices in higher placements for youth. The challenges faced in the different domains at St. Joseph’s Home for Children are each unique; however, common themes of trauma-informed care, relationship building, and a data-driven system can better inform practice. The selection of comprehensive models for the milieu, particularly those with a strong evidence base, can improve service delivery. If supplemented by curricula and interventions such as restorative justice, Collaborative Problem Solving, and Aggression Replacement Training, a truly solid evidence-based program will be in place. Although TF-CBT is an evidence-based practice, on occasion it has proven to be insufficient for the needs of the system at St. Joseph’s Home for Children. Supplementation with other practices such as DBT, EMDR, or MI could improve therapeutic outcomes. It is worth noting that although evidence-based practices can be implemented in these settings, programming will likely need to go through continued evaluation and improvements, as it is unlikely that challenging behaviors will drop to zero upon, during, or after implementation of new programs. Re-examination of the current evidence-based practices and service outcomes should be an on-going process. That, certainly, is the “best practice” to serve youth.
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