Improving and Integrating Therapeutic Supports for Children Living in Residential Care

By

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Paper submitted in partial fulfillment of the requirements for the degree of

Master of Counselling
In the
Division of Arts and Sciences

City University
of Seattle
2024

This paper is accepted as conforming to the required standard.

December 12, 2024

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Abstract

The purpose of this capstone research is to understand how therapeutic interventions can be strengthened within therapeutic residential care. Children living in therapeutic residential facilities often experience significant mental health and behavioural challenges. Two forms of evidence-based treatment within therapeutic residential settings are program models, which encompass the entire life space of the child (e.g., physical environment, staff, peers, education, recreation), and client-specific therapies (e.g., cognitive behavioural therapy, dialectical behavioural therapy, or motivational interviewing). The literature review explored the current evidence base for program models and client-specific therapies in residential care settings. The findings from the literature review reflect that both program models and client-specific therapies are effective in producing positive outcomes for children and youth. However, many of the studies that support the evidence base for residential care treatments lack rigour and quality. This research also identified the methodological implications of the current evidence base and makes recommendations for both future research and clinical practice. The recommendations derived from the findings of the literature review include 1) the use of trans-diagnostic group therapy in therapeutic residential care settings; 2) including residential care staff in supporting therapeutic interventions where appropriate; 3) implementing standardized intake and outcome measures in care settings; and 4) integrating positive gains made during therapy into the broader milieu environment.

Keywords: Therapeutic residential care, evidence-based practice, general systems theory, client-specific therapy, ecological program model

Acknowledgements

I would like to acknowledge the guidance and support of the many instructors at City University who shaped my counselling practice. Dr. Davis Tharayil supervised this capstone project and helped shape its current form.

My fellow classmates offered their continual support over the last three years, and I am thankful for their friendship. I would also like to thank my practicum supervisor for his wisdom and generous support, and the site manager at WJW Counselling, who agreed to take me on as a student at the last minute. These two individuals provided me with many opportunities to learn and grow.

I would like to thank my parents for their unconditional love and support, and for providing so much free childcare. Finally, I want to acknowledge my wife, who first encouraged me to explore the human services field, and who has supported my master's in counselling journey. Without her encouragement, guidance, support, patience, and love, none of this would have been possible.

Dedication

This paper is dedicated to the staff of Oakhill Ranch, and more importantly to the children and youth I have had the privilege of caring for there. To the former, you gave me opportunity, knowledge, support, and friendship. To the latter, you showed me the power of resilience, compassion, empathy, and love– I deeply thank all of you.

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Chapter 1: Introduction

Therapeutic Residential Care (TRC) is one of the most restrictive and intensive therapeutic environments into which children and youth may be placed (Herbell et al., 2022). Children and youth who are referred to residential care typically have significant behavioural and mental health challenges (Harder & Knorth, 2015). These challenges make it hard for these clients to successfully live and thrive in less restrictive placement types like group care or foster care (James, 2011). Most children and youth referred to TRC have had involvement with the child welfare system (Schutte et al., 2023). Access to TRC typically occurs after repeated failures of other levels of intervention in the child welfare system (Whittaker et al., 2015) and is often considered a last option for treatment (Yeheskel et al., 2019). Children entering TRC often have multiple comorbid mental health issues, challenging behaviours, and have experienced abuse, neglect or violence (Yeheskel et al., 2020; Schutte et al., 2023). Many clients in TRC also have a history of substance use or self-harm behaviours (Yeheskel et al., 2020; Schutte et al., 2023). Children living in TRC settings are more likely to experience poorer psychosocial outcomes when compared to peers living in more conventional home environments (Galvin et al., 2022) or peers in the general population (Cameron et al., 2018).

The efficacy of TRC is disputed. Long-term outcome studies have shown that children who have resided in TRC care have poorer health outcomes, employment, and educational opportunities than the general population (Eriksson et al., 2024). A recent scoping review on the short-term outcomes of TRC has also disputed the efficacy of TRC. While there are numerous studies that demonstrate a variety of positive gains delivered by TRC, a definitive conclusion that TRC delivers positive outcomes to clients remains difficult (Eriksson et al., 2024). Some

evidence suggests that most children experience short-term benefits from residential care regardless of the reason for being placed there (Rau et al., 2020).

Attempts to explore the specific mechanisms that produce change within TRC settings have also yielded inconclusive results. There is little consensus on the exact practices, policies, and interventions that bring about positive outcomes for youth and children in therapeutic residential care (Lanier et al., 2020; James et al., 2017; Harder & Knorth, 2015). This is partly due to the difficulties in assessing and comparing the wide variety of measures, populations, and TRC settings from one study to another (Lanier et al., 2020; Eriksson et al., 2024). However, there is a consensus that children require healthy relationships in the context of safe and secure environments in order to thrive (Sellers et al, 2020; Bath & Seita, 2018; Perry, 2009).

The efficacy of TRC has been challenged (Whittaker et al., 2016; Anglin, 2018). A 2003 consensus statement from the Stockholm International Conference on Children and Residential Care declared that "institutional" care, which was used as a synonym for TRC (Anglin, 2008), produces negative outcomes for children living in these settings (Stockholm Declaration, 2003). More recently, the United States Senate Committee on Finance released a damning report on youth residential treatment in the United States. The conclusion of the report was that state-funded residential treatment facilities lack necessary government oversight and regulation, and that these facilities have a net negative effect on children (Senate Committee on Finance, 2024). The Association of Children's Residential Care (ACRC), an international organization of residential care providers dedicated to upholding quality standards of care and treatment in TRC, have argued the report's findings are narrow in scope and erroneously applied to all residential treatment facilities (ACRC, 2024). TRC settings are expensive to run, and some authors have questioned whether the high costs justify their existence (e.g., Yeheskel et al., 2020).

With regards to indigenous communities, the child welfare system in Canada is burdened by the harm created by structural discriminatory policies like the Canadian residential school system (Rand, 2011). Some authors have argued that the child welfare system in Canada is a perpetuation of colonial policies that continue to remove indigenous children from families (Ball & Benoit-Jansson, 2023; Rand, 2011). Indigenous children are overrepresented in the child welfare system in Canada, and the Canadian government has made efforts to reduce the number of children in care (Government of Canada, 2024). In the context of these circumstances, TRC in Canada is faced with unique challenges to demonstrate cultural competency, reduce indigenous overrepresentation, and work with other community supports and services to deliver positive outcomes to children in care (Gharabaghi, 2019).

As the pressures mentioned above suggest, TRC facilities have come under increasing criticism in recent years (Eriksson et al., 2024; Gutterswijk et al., 2020; Sen et al., 2024; Whittaker et al., 2016). TRC settings are under increasing pressure to demonstrate efficacy so their existence can continue to be justified as a treatment setting (Yeheskel et al., 2020).

The adoption of evidence-based practices within TRC settings is one way the field has attempted to remain accountable and produce best outcomes for clients (James, 2015). EBPs involve the purposeful use of scientific evidence to inform practices. In the context of psychotherapy, EBPs also take into account individual client characteristics including culture and client treatment choices (American Psychological Association, 2021).

James and colleagues (2017) argue that to help assess the efficacy of EBP treatments a distinction needs to be made in residential treatment research between milieu-program models, and “client-specific” therapeutic interventions (p. 5). One way to conceptualize how these two treatment factors work in TRC is to think of the program models as providing *care* to residents

(i.e., environmental supports and stability) and the client-specific therapeutic interventions as the *treatment* for specific mental health challenges (Harder et al., 2018).

Research Problem

There is little research exploring how exactly CSTs work within program models. In addition to this, there is little research that explores or assesses the efficacy of CSTs within TRCs (James et al., 2017). Incorporating EBPs into TRC settings uncritically and without testing could negatively impact clients (Daly et al., 2018; Lee & McMillen, 2017). Researching the efficacy of EBPs within TRC settings is an important area of study because it has the potential to improve short and long-term outcomes for this population (E.g., McCredie et al., 2017; Klodnick et al., 2020; Dimitropoulos et al., 2023). While there is evidence to show that evidence-based therapeutic treatments are effective with children and youth who experience mental health challenges (Weisz et al., 2017), it is possible that the gains made in individual therapy are not carried over or reinforced in the TRC milieu environment.

A failure to research and understand how CSTs and other therapeutic interventions are implemented in TRC settings could at best result in the ineffective implementation of EBPs and not achieve the desired outcomes for clients. It may be possible that some CSTs could contraindicate the treatment of the program model, and vice versa. At its worst, a failure to understand the implementation of CSTs in TRC settings could result in harm to clients.

The populations affected by this research question include the children and youth living in TRC care. As mentioned above, this population experiences significant behavioural and mental health challenges, and has poorer outcomes compared to populations of children living in care and the general child and youth population (Galvin et al., 2022; Cameron et al., 2018).

Children with severe mental health challenges are less likely to be successful in normal home environments and are more likely to experience longer stays in TRC (Akin & McDonald, 2018).

Other important populations affected by this research question include the biological and foster parents of children living in TRC care. Parenting children with significant mental health challenges can be highly stressful and present an additional burden to families with multiple challenges in other life domains (Karjalainen et al., 2019). Increasing the efficacy of treatment of children with severe mental health challenges can reduce the stress that parents and caregivers experience when children return home from more restrictive forms of care (Karjalainen et al., 2019).

A third population affected by this research question includes frontline TRC staff (e.g., Child and Youth Care Workers (CYCWs)) who interact with this population daily. Working with challenging populations of children and youth can be stressful for frontline staff (Santos et al., 2023). CYCWs working in TRC settings often experience emotional fatigue and burnout. Furthermore, CYCWs who work with children and youth with severe mental health and behavioural challenges are themselves likely to experience mental health issues (Santos et al., 2023). Increasing the efficacy of therapeutic treatment may decrease the frequency and intensity of challenging behaviours that CYCWs help manage (Cosgrove et al., 2022). This could result in better outcomes for youths and could also decrease burnout and emotional fatigue amongst CYCWs.

Evidence for the problem of understanding the adoption of EBPs into TRC care is represented in the academic literature (e.g., Herbell et al., 2022; James, 2015; James et al., 2017; Graaf et al., 2021; Lee & McMillen, 2017; Ringle et al., 2019; Whittaker, 2017). Some of the research on this problem has explored: the distribution of EBPs in TRC care across the United

States (Herbell et al. 2022); what is currently known about the efficacy of program models and CSTs in TRC (James, 2015); the factors and barriers that affect implementation of EBPs in TRC (James et al., 2017); the implications to practitioners and researchers for incorporating EBPs into organizations that offer wrap-around supports to children and youth (Graaf et al., 2021); the ways in which EBPs can be implemented into TRC care (Lee & McMillen, 2017); and the attitudes that care providers have towards implementing EBPs into TRC care (Ringle et al., 2019).

With respect to the above concerns and questions, the research problem this paper is attempting to answer is: how can evidence-based therapeutic interventions in TRC settings be strengthened and integrated into the broader milieu environment?

Justification

This study is justified for several reasons. Firstly, the evidence-base for TRC is not conclusive. Children and youth in government care are vulnerable. Placing the most challenging young people from this population into a setting where efficacy of treatment is not totally clear, has the potential to cause harm. Yet, TRC continues to be considered a necessary setting into which children with severe behavioural and mental health challenges are placed. More research into how to improve the efficacy of TRC needs to be done to protect and serve this population better. This is in accordance with principle's I and II of the Code of Ethics for Canadian Psychologists, which states that psychologists must respect the moral rights of all people and that psychologists must avoid doing harm (Canadian Psychological Association, 2017). This research project aspires to contribute to a knowledge base that seeks to increase the efficacy of treatment for children and youth living in TRC settings.

This study is also justified because children and youth in TRC are vulnerable and often unable to give consent to live in these settings due to their minor status (CPA, 2017). Therefore, the burden to demonstrate efficacy of treatment is important given the vulnerability of this group and the severity of mental health challenges this population faces.

Significance of the Study

This study is significant because it explores how therapeutic benefits can be maximized for children living in TRC. By reviewing the literature on outcomes produced by program models, CSTs, and models for integration, this research shows how TRC could be optimized to produce better outcomes for children and youth. A potential outcome of this research is a better understanding for how to improve therapeutic supports in TRC. This would benefit the lives of clients living in these facilities by improving their mental health, decreasing the amount of time in TRC care, and increasing their rate of success in less restrictive environments.

This research project is also significant because it is, based on a current review of the academic literature, one of the few attempts to examine how GST might be applied to the optimization of therapy in TRC. Recent research on the application of GST in the mental health field has explored mental health treatment pathway optimization (Katrakazas et al., 2020; Johnson, 2019) and treating addictions in adults living in residential care (Jason & Bobak, 2022). A literature search for GST and residential treatment for children yielded only one result (e.g., Hans, 1992). While the application of systems-thinking within family therapy has a long history (Becvar et al., 2024) and has been used in organization management for a similarly long time (e.g., Kast & Rosenweig, 1972), its specific application to residential care for children and youth does not appear well-researched. Analyzing the relationships between systems that operate

within TRC could be an area of future research. This could have the potential to improve the delivery of therapeutic supports and improve client outcomes in TRC settings.

This study will connect to the existing literature on the topic of TRC and therapeutic supports by exploring how program models and CSTs both contribute to positive outcomes for clients in TRC, and by exploring how the integration of positive gains made in CST can be integrated into the milieu treatment environment. The efficacy of CSTs within the general child and youth population (i.e., therapy) appears to be supported by the literature (Weisz et al., 2017). Changing the contexts in which therapy occurs (i.e., from a community setting to a TRC setting) could have implications for the efficacy of therapy. This paper will explore and clarify the existing research on the use of evidence-based therapeutic interventions within TRC environments.

The positive consequences of completing this study could include the improved mental health of children and youth living in residential care (McCredie et al., 2017; Klodnick et al., 2021; Cosgrove et al., 2022), placement stability (Cosgrove et al., 2022), reduced duration of stay in TRC (Chambers et al., 2016), the possibility of reduced operational costs (Carlucci et al., 2021), and increased intake and treatment efficiency (Kaasbøll et al., 2022).

Theoretical Framework

A general systems theoretical approach is adopted in this study to help explore and understand how the relationships between different systems within TRCs interact and influence each other to produce measurable outcomes. General Systems Theory (GST), developed by Ludwig von Bertanlaffy, posits that processes in the environment, whether they are geological, biological, psychological, or social organizational, can be understood as systems with a unique array of components which drive the system (Bertanlaffy, 1967; Katrakazas et al., 2020;

Johnson, 2019). GST is related to the integration and analysis of all the parts a system requires to function including information, subsystems, structure, information inputs, internal processes, and the integration of each of these parts into the system (Kast & Rosenzweig, 1972).

Adopting a GST approach to examining the integration of CSTs and program models allows for the comparison and analysis of two systems within TRC. According to GST, these two systems are themselves components (or subsystems) of the broader TRC system. If the purpose of TRC is to help children in care return to less-restrictive care-environments and to achieve thriving, then examining how the components of TRC work to produce this outcome is an important part of improving the performance and outcomes of TRC. A GST theoretical framework will allow for a comparison and analysis of the efficacy of two systems within TRC, and to seek ways to understand how these two systems can be better integrated for the purposes of improving client outcomes.

Definition of Key Terms

The following defined terms are important in helping the reader to understand this research.

***Evidence-based practice*:** Evidence-based practice (EBP) is the intentional and purposeful use of up-to-date research and expert consensus to deliver and guide decision and policy. In the psychology and counselling fields, evidence-based practices are used to provide clients with the best-informed treatments for the purposes of improving their health and well-being (American Psychological Association, 2021). In the context of residential care, EBPs often refer to practices that have been tested and researched outside of TRC settings (James, 2017). EBPs in TRC are used with the purpose and intent to improve positive outcomes for children and youth living in these settings (Graaf et al., 2021).

Therapeutic Residential Care: Therapeutic residential care is a treatment setting for children and youth living outside of a home environment where every domain of the setting is oriented towards the treatment, care, and growth, of the client (Whittaker et al., 2015). TRC ideally considers the total ecology of the child's life and needs. The living environment is purposefully designed to foster stability, safety, education, protection, treatment, and healthy interpersonal relationships. This is done with the collaborative participation of other community organizations and invested partners, as well as with the family of the client (Whittaker et al., 2016).

Client-Specific Therapy: Client-Specific Therapies (CSTs) are additional therapeutic interventions (e.g., dyadic therapy) that are deployed within TRC settings. CSTs consider the personal characteristics and attributes of the individual and seek to address challenges and symptoms unique to the client (James et al., 2017). Examples of CSTs could be therapeutic modalities like Dialectical Behavioural Therapy (DBT), Cognitive Behavioural Therapy (CBT), and Aggression Replacement Training (ART) (James et al., 2017).

Program Model: Program models are a treatment intervention that encompass all domains of the child's life. Program models often have a theory of change, a philosophy of treatment, and comprehensive supports that include psychoeducation, case management, psychotherapy, education, and family involvement (James, 2017). They consider the physical environment, daily structure, education, routines, interpersonal relationships, extracurricular community opportunities, and family relationships to create an ecologically oriented life space that fosters stability, safety, and development (James, 2017; Holden, 2023).

Integration: Integration is the combination of diverse subsystem elements into a single realized overarching system where substituent components work towards the demands of the overarching system (Rajabalinejad et al., 2020). Integration within clinical treatment settings describes the

useful interactions between systems within the treatment setting for purposes of improving outcomes for clients (Jason & Bobak, 2023).

Researchers Reflexivity and Positionality

According to Olmos-Vega at al. (2022), researcher reflexivity is the conscious disclosure and continuous reflection of how researcher biases and perspectives influence the course of research. Researcher subjectivity has both positive and negative influences, and the exploration and disclosure of researcher biases is necessary to help illuminate researcher blind spots and attend to issues of power and inequality in the research. Through reflexive disclosure and discussion of my own subjectivity, I hope to give the reader a better understanding of my own approach and position relative to the current topic.

My interest in this topic has been influenced by my own experiences working as a CYCW at a therapeutic residential care facility in the Edmonton area. Through my professional journey working with children who experience significant behavioural problems, difficulties in daily functioning, and who grapple with the lasting effects of trauma and abuse, I have become interested in how best to deliver mental health supports to children living in TRC. As a white, privileged, and male staff member, my experiences are undoubtedly different from those youths I work with who are racially, culturally, and gender diverse. This capstone research topic comes from a staff and management-oriented perspective, rather than from a ground-up child-centered perspective. Exploring the child perspective of mental health supports in TRC would be a useful topic for future research to provide balance to the perspective presented here, and I acknowledge that this is a limitation of this research project.

The facility I work in uses Cornell University's Children and Residential Experiences (CARE) program model, and I have been trained in this model and use it daily when I work in

my capacity as a Child and Youth Care Worker (CYCW). During my research into various program models, I found that the CARE model was often cited as one of the few program models with an evidence base. My own experiences with the CARE model have the potential to introduce subjectivity bias into this study. While I subjectively feel that CARE is an efficacious model to help treat children in TRC, I hypothesize that my own experiences have caused me to be more critical of the CARE model than of other program models. Readers should consider how my subjectivity bias may affect the representation of the research. Precautions taken to prevent the introduction of bias in this project include a review of all statements made about CARE, and ensuring these statements are connected to the evidence represented in the literature, and not my own subjective feelings.

I also acknowledge the overrepresentation of indigenous children in government care (Government of Canada, 2024) and recognize that a large gap in the current study is a failure to meaningfully explore the perspectives and needs of indigenous children living in government care. My own experiences working as a CYCW affirm that, while indigenous engagement and education is an important component of my own work as a CYCW, incorporating indigenous culture into the program milieu in a daily and meaningful way was challenging, and this task often fell on indigenous staff or indigenous cultural liaisons. In addition, my research and my practices are likely to contain blind spots where certain cultural perspectives have not been considered. As a researcher and CYCW, I continue to look for opportunities to decolonize my own practices and increase my cultural competency.

Overview

This first chapter has provided some background information and context to help frame discussions about TRC research that occurs in the following chapters. A brief overview of the

behavioural and mental health challenges experienced by clients living in TRC, as well as some of the challenges faced in TRC settings has also been explored. The research problem, theoretical framework, justification and significance of the study, and some definitions have been discussed in this chapter.

Chapter two explores the literature review methods used in this research project and discusses the methodological strengths and weaknesses of some of the articles used in this paper. The purpose of this is to identify the impact that each research approach has on the findings from the literature review. Chapter three contains the literature review that discusses the current state of research on TRC program models, CSTs, and the use of GST in mental health. This chapter also includes descriptions of qualitative themes derived from the literature review, and the implications for the current state of integrating CSTs and program models in TRC settings.

The fourth chapter discusses the applications of the findings from the literature review. The applications of the research on therapeutic interventions within TRC are discussed in terms of their contributions to clinical applications, the current scientific knowledge base, well-being to society, and cultural and diversity implications.

Chapter five discusses the conclusions and recommendations derived from the literature review and chapter four. The recommendations for clinical practice, and the implications of these recommendations on clinical applications and future research are included in this chapter.

Chapter 2: Methods

The following section explores both the procedures used to conduct the current literature review and a methodological critique of the studies used in the literature review. The intent of the methodological critique is to identify the limitations that might have impacted the findings of those studies as well as the interpretations of the findings.

The problem statement that has structured the current exploration of literature is: how can the gains made in clinical therapeutic interventions in TRC settings be strengthened and integrated into the daily program-milieu environment in which children and youth live?

Literature Search Process

The initial research for this literature review began with using a variety of search terms to discover the dominant keys words used in the field of therapeutic residential care research. Initial search terms included: “psychotherapy in residential care”; “mental health supports in residential care”; “mental health supports in congregate care for children”; “mental health supports for children living in campus-based treatment facilities”; “evidence-based practices in residential care for children” and “psychotherapy and children living in residential care.” The initial searches were conducted using the City University online digital library search function. This initial search yielded 7 key articles that discussed the variety of therapeutic supports used in residential care. These preliminary articles included: James et al.’s (2017) review of evidence-based practices in TRC settings in the United States; James’ (2011) review of program models in TRC settings; Whittaker et al.’s (2016) “A Consensus Statement of the International Work Group on Therapeutic Residential Care”; Whittaker’s (2017) introduction and overview of key perspectives and articles on Evidence-Based Practices in TRC; Hansen et al.’s (2021) exploration of the effect of wait times on parents seeking residential services for their children;

Whittaker et al.'s (2015) edited volume on a range of articles about incorporating evidence-based practices into TRC; and Jacob and Lesage's (2019) analysis of the public cost of residential mental health services (including addictions treatment) in Alberta. By making note of the keywords used by these articles, a more refined search was conducted. In addition to this, several of these preliminary articles came from the journal *Residential Treatment for Children and Youth*. Subsequent searches for additional articles were made using this journal's internal online search function. Additional searches using similar terms were conducted using the PsycINFO and PubMed Central online databases.

The preliminary articles allowed for a refinement of search terms. Several authors (e.g., James et al., 2017; Whittaker et al., 2016) observed that "residential care" had many names in different contexts and countries. Additional terms for residential care include: "congregate care", "Out of Home Care (OoHC)", "campus-based care", "group care", and "campus-based treatment programs." The following Boolean phrase was used to reflect the variety of search terms revealed in the 7 preliminary articles: {(["CBT"] OR ["DBT"] OR ["Trauma-informed therapy"] OR ["Acceptance and Commitment Therapy"] OR ["Evidence based"]) AND [("residential care") OR ("in-patient care") OR ("residential treatment") OR ("out of home care") OR ("congregate care") OR ("campus-based care")] AND [("children") OR ("youth") OR ("teenagers")]}. Using pure Boolean search logic yielded no results and the search had to be modified to use City University of Seattle's advanced search function to replicate the Boolean-type search phrase.

Inclusion and Exclusion Criteria

From the results this search yielded, rough exclusion criteria were imposed– any article that focused on: psychiatric in-patient hospital care; foster care exclusively; patients aged 18

years or over; pharmacological treatments in TRC; or any article that was over 15 years old (unless substantially influential in the history of the development of current literature), was excluded. Inclusion criteria for articles included any article that explored: EBPs in residential care; child quality of life within the context of mental health support delivery in TRC settings; and the efficacy and outcomes of psychotherapy treatments or program models in TRC.

Subsequent ad hoc library and google scholar searches were made when certain knowledge gaps were identified. For example, when more information was needed to explore the prevalence of transdiagnostic therapies in TRC, a more specific search using the search terms "transdiagnostic therapy and residential care" was conducted using the City University of Seattle online library database.

Additional searches for information on General Systems Theory included the search terms: "general systems theory and mental health"; "General Systems Theory and Bertanlaffy"; and "General Systems Theory and Psychology." These searches were conducted using the City University of Seattle online library database and Google Scholar searches.

While the parameters for this capstone project stipulate that only articles written within the past 5 years could be included, a publication date filter was rarely used during the research process. A review of articles older than 5 years was useful in helping to understand the development of the field of research on mental health supports in TRC. For example, James' (2017) review of EBPs in TRC settings was immensely helpful in framing the useful dichotomy of Client Specific Therapies (CSTs) versus TRC program models.

Data Analysis

The types of literature included in the literature review were predominantly peer reviewed journal articles. However, an edited volume on various EBP-related topics in TRC

(Whittaker et al., 2015), a working group consensus statement (Whittaker et al., 2016), policy statements (Koftinoff et al., 2023; Amarbayan et al., 2021), and a child advocacy report (Provincial Advocate for Children and Youth, 2016), were useful auxiliary texts for providing additional background information and context.

A research software application called Zotero was used to organize and collect all sources of information into one place. A Zotero browser plug-in allowed for the quick collection of journal articles. This allowed for much easier recall of previously accessed information and allowed for the creation of tags and keywords to group together literature thematically. This aided in the chapter three thematic grouping process. A digital highlighter function within Zotero facilitated the identification of salient pieces of information. At the beginning of the literature review research process, a digital notepad within Zotero was used to re-frame highlighted pieces of information within each article. However, this process became cumbersome. Instead, a Word document was created that contained the alphabetized bibliographic information from each article. Beneath each article bibliography, a template was used to allow the researcher to input each article's: key themes, findings, study size, study type, researcher paradigm, methods, and data analysis. This allowed for a more in-depth summary of each article beyond tags and keywords.

Selection of Articles

There was an abundance of peer-reviewed journal articles on the topic of how to improve the efficacy of TRC across multiple domains. The core articles selected for the literature review focused on measurable and qualitative positive outcomes produced by TRC program models, therapeutic clinical interventions, and general systems interventions deployed within TRC

settings. Table one below lists articles selected for analysis in the methodological critiquing section (See the appendix for a full list of all articles included for review of literature):

Table 1

List of Selected Studies

Author	**Year**	**Title**	**Journal**	**Type**
Daly et al.	2018	Quality care in therapeutic residential programs: Definition, evidence for effectiveness, and quality standards	*Residential Treatment for Children & Youth*	Qualitative
Dimitropoulos et al.	2023	A qualitative study on the implementation of a transdiagnostic cognitive behavioral therapy for children in a child welfare residential treatment program	*Child Abuse & Neglect*	Qualitative
Farmer et al.	2017(a)	Would we know it if we saw it? Assessing quality of care in group homes for youth	*Journal of Emotional and Behavioral Disorders*	Mixed-methods
Harder	2018	Residential care and cure: Achieving enduring behavior change with youth by using a self-determination, common factors and motivational interviewing approach	*Residential Treatment for Children & Youth*	Qualitative
Holden & Sellers	2019	An evidence-based program model for facilitating therapeutic responses to pain-based behavior in residential care	*International Journal of Child, Youth & Family Studies*	Quantitative
James et al.	2017	The implementation of evidence-based practices in residential care: Outcomes, processes, and barriers	*Journal of Emotional and Behavioral Disorders*	Mixed-methods
Joiner & Buttell	2018	Investigating the usefulness of trauma-focused cognitive	*Journal of Evidence-*	Quantitative

		behavioral therapy in adolescent residential care	*Informed Social Work*	
Kaasbøll et al.	2022	Interagency collaboration for early identification and follow-up of mental health problems in residential youth care: Evaluation of a collaboration model	*Nordic Social Work Research*	Qualitative
Klodnick et al.	2021	Adapting dialectical behavior therapy for young adults diagnosed with serious mental health conditions in residential care: A feasibility study	*Residential Treatment for Children & Youth*	Mixed-methods
Taussig et al.	2019	A positive youth development approach to improving mental health outcomes for maltreated children in foster care: Replication and extension of an RCT of the fostering healthy futures program	*American Journal of Community Psychology*	Quantitative

Methodological Strengths and Limitations

The following section presents a critical analysis of the various methods used in the above articles.

Quantitative & Mixed Methods Studies

Of the 23 core articles used in the literature review section of this capstone project, eight studies used a quantitative design. Quantitative designs are used to understand and analyze complex relationships between multiple variables. Notable advantages of quantitative methods include the ability to analyze trends from large sample sizes, being time efficient, potentially producing generalizable results, and easier replication of results by other researchers (Taherdoorst, 2022).

The strengths of the quantitative approaches in this literature review include the use of numerical quantitative data to understand what therapeutic interventions and program models have measurable effects on what populations of children living in TRC. This information may be particularly useful for TRC facilities seeking information on which EBPs to adopt in order to improve outcomes.

The mixed-methods studies reviewed here (e.g., Dimitropoulos et al., 2023; Klodnick et al., 2021) are especially useful because they provide both a statistical understanding of the efficacy of certain interventions while also allowing participants to voice the meanings they have derived from their experiences.

The majority of the quantitative research designs explored in the literature review used a postpositivist research paradigm. Postpositivism is a research paradigm that assumes knowledge is more concrete and ascertainable through the collection and analysis of data. While the postpositivistic perspective accepts that truth is not absolute (the traditional perspective of positivism), it does assume outcomes are determinable from specific causes (Creswell & Creswell, 2023). That is to say, events and outcomes are the result of certain causes and effects. This is different from a teleological perspective which examines outcomes in terms of their purpose, rather than their causality (Scott, 2022). Postpositivistic perspectives assume that data and evidence, and rational inquiry are the necessary preconditions for the construction of knowledge. Subsequent inquiries and data allow for the continual refining of knowledge as less relevant knowledge is replaced by more relevant knowledge.

The research articles that deployed a postpositivism paradigm explored how adjusting one or more independent variables affected the outcome on the dependent variable. Thus, the researchers using this paradigm explored the effect of a type of treatment like CBT (e.g.,

Cosgrove et al., 2022; Joiner & Buttell, 2018) or DBT (e.g., McCredie et al., 2017; Klodnick et al., 2021) on a variety of outcome measures like symptom reduction (McCredie et al., 2017; Joiner & Buttell, 2018; Taussig et al., 2019), quality of life (Taussig et al., 2019), and adaptive functioning skills (Klodnick et al., 2021; McCredie et al., 2017). The mixed-methods studies (i.e., James et al., 2017; Klodnick et al., 2021; Farmer et al., 2017a) often used a pragmatic paradigm. The quantitative and qualitative knowledge acquired by the researchers through their research had utilitarian potential and could be used to inform future practices and procedures.

Regarding the role of the researcher, researchers who conduct studies with populations that they have pre-existing relationships with (professional or otherwise) can have implications on research outcomes (Creswell & Creswell, 2023) as well as research biases (Trowler, 2011). This can include observer bias where researchers may skew their observations or data depending on the results they expect to see from a population they have pre-existing relationships with (Mahtani et al., 2018), or confirmation bias where researchers draw erroneous conclusions based on the researchers' preconceived ideas about the population (Suzuki & Yamamoto, 2021).

None of the authors who used quantitative or mixed methods approaches in their studies openly disclosed any previous relationships with their sample populations, therefore it is not possible to discuss the role of researcher in the sense that Creswell & Creswell (2023) have defined it.

In any study involving helping professions, there is the potential risk of bias when working closely with other people (Gopal et al., 2021). Confirmation bias and affective bias (e.g., countertransference) are two types of biases at work in helping profession research (Gopal et al., 2021). These biases have the potential to sway outcomes in research. A potential example of this could be found in Holden and Seller's (2019) research into the efficacy of the CARE

program model. Holden is one of the creators of the CARE program model and has written the staff manual for CARE program providers (see Holden, 2023). Though Holden may not be close to the populations in Holden and Seller's study (the authors selected TRC facilities where CARE had not been implemented), the author is invested in the program model, and therefore the potential for omission bias (i.e., ignoring data that could contradict positive results), confirmation bias (i.e., seeing evidence in the data that supports pre-formed conclusions), or overconfidence bias (i.e., overestimating the positive effects of an intervention (Gopal et al., 2021) could be present in the study.

Some articles also included a disclosure statement where authors could state potential conflicts of interest (e.g., Herbell & Ault, 2021; James et al., 2017; Sellers et al., 2020;). Typically, no conflicts of interest were declared when these statements were included. Some conflicts of interest statements were disclosed in funding disclosures. For example, one author in Dimitropoulos et al.'s (2023) study disclosed that they received compensation for offering training in the UP-CBT protocol. The implications of an author receiving paid compensation for training in a certain protocol could be the introduction of financial or confirmatory bias into the study. This author may intentionally or unintentionally misrepresent the results of the study in order to derive future financial benefit. That is, the author may be motivated by financial gain to use the findings of her research to sell more UP-CBT trainings. This could distort the findings of the study.

Sampling in quantitative research can be done either through a random process or a convenience sample, though random sampling (i.e., the random selection of participants within a population to the study) is preferable as this reduces the possibility of bias (Creswell & Creswell, 2023).

Sampling procedures and recruitment varied amongst the quantitative and mixed-methods studies. Some large-scale studies using a survey approach (e.g., Herbell & Ault, 2021; James et al., 2017) involved national or large organizational-level survey data from national regions and populations.

The participants of a few samples in certain quantitative studies were randomly selected (e.g., Taussig et al., 2019). Some studies noted that random sampling was preferable in their studies, but not possible (e.g., Dimitropoulos et al., 2023; McCredie et al., 2017). One mixed-methods (e.g., Klodnick et al., 2021) and one quantitative study used convenience samples (e.g., Joiner & Buttell, 2018). The lack of random samples increases the risk of introducing bias to the study and decreases generalizability to other populations.

The majority of the quantitative studies used for this literature review were conducted in the United States. One mixed-method study was conducted in Canada (i.e., Dimitropoulos et al., 2023). In addition to this, many of the studies were conducted at the state or county level, and some were conducted within one or two TRC facilities. Thus, the geographic limitations of the samples used in these studies may limit generalizability of the findings to other regions.

Two quantitative studies used in this literature review collected information using survey instruments. Both of these studies (e.g., James et al., 2017; Herbell & Ault, 2021) were cross-sectional in that they collected information that was relevant to a specific point in time. Neither study was longitudinal–that is, neither study measured trends across time.

Experimental studies used a variety of measures to collect information to test the cause-and-effect relationship between variables in each study. Data was collected through a variety of instruments pertinent to the measurable objectives of each study. The majority of the instruments

used were valuable and reliable. This increased the credibility of the data of the studies used in this research as well as the findings.

Some authors have concluded that the heterogeneity of outcomes being measured by quantitative research in TRC makes generalizability and comparisons to other TRC research difficult (James et al., 2011; Lanier et al., 2020). In the selection of quantitative articles reviewed in this research project, many of the studies used a wide array of measures to determine positive outcomes ranging from decreased symptomology to frequency of client restraints. The heterogeneity of measures used across studies to assess outcomes for clients in TRC makes it difficult for researchers to compare the results of one study against another. It also makes meta-analysis of the efficacy of TRC very difficult. This adversely impacts the interpretation of the findings of this capstone project because generalizability of the findings from one study to another population may not be possible. However, given the current need for TRC in providing care and housing to high-needs children and youth, there is a general consensus from the TRC field that this research continues to be useful despite its shortcomings (James, 2011; Whittaker, 2017; Galvin et al., 2022).

Many of the measures used to collect information during the quantitative analyses have validated construct validity (e.g., Li et al., 2023; Liu et al., 1997; Brown et al., 2022; Wherry & Herrington, 2018). One study did not use data collection measures that had peer-reviewed construct validity. Holden and Sellers (2019) study used self-designed CARE surveys for children and staff that had not been validated. Therefore, the measures of child and staff perspectives towards the CARE program may not be as reliable as other assessment measures that have had their construct validity reviewed and validated.

According to Creswell & Creswell (2023), validity of instruments should be represented by Cronbach's alpha, with an optimal value of between 0.7 and 0.9.

The majority of the measures used by the studies to collect information had been validated. This therefore makes the pretreatment and posttreatment outcomes used in the majority of the experimental studies reliable and trustworthy. Only one article used measures that were not validated (e.g., Holden & Sellers, 2019). Readers of the findings of this capstone project should take caution in making use of these findings for any clinical applications.

Data analysis for the quantitative studies was completed using a variety of methods using analysis of variance (ANOVA) and *t*-tests. *T*-tests (and some variations of *t*-tests including the Wilcoxin-signed rank test) were suitable for analyzing pre-treatment and post-treatment data. ANOVA tests were suitable for determining differences in mean values between pretreatment and posttreatment values while controlling for additional client characteristics.

Statistical analyses like Cohen's *d* and *h* were used to understand the degree of effectiveness of some of the interventions in the experimental studies. For example, Joiner and Buttell (2018) found that the Cohen's *d* value for the impact of the CBT intervention on PTSD values was 0.93, suggesting that the CBT intervention was highly successful at reducing PTSD symptom severity. This has utility in informing the efficacy of using certain therapeutic interventions in TRC settings.

An additional problem that impacts the utility of the information produced in the data analysis was the lack of control groups in many studies (e.g., Holden & Sellers, 2019; Dimitropoulos et al., 2023; Klodnick et al., 2020; and McCredie et al., 2017). The lack of control groups makes it harder to determine which independent variables impacted which dependent variables. When the lack of controls is coupled with lack of random samples, the overall quality

and power of the study is reduced (Galvin et al., 2022a) and it therefore makes it harder to draw conclusions from the results of these studies.

Qualitative Studies

Qualitative research approaches are flexible and allow researchers to adapt their approaches as information and themes emerge from the data (Creswell & Creswell, 2023; Kim et al., 2017). A number of the studies used in the literature review followed a qualitative approach.

While qualitative studies lack generalizability, there is the potential for themes to be generalizable in different contexts as well as within a theoretical framework (Creswell & Creswell, 2023). With this in mind, qualitative research could have the potential to validate certain theoretical approaches that are applied in working with children living in TRCs.

Several qualitative systematic reviews (e.g., Galvin et al., 2022; Lanier et al., 2020; Schutte et al., 2023; Yeheskel et al., 2020) were used in the literature review. The paradigms of these reviews are primarily pragmatic. The authors of the systematic reviews did not work directly with study participants. However, their perspectives leaned towards ensuring that therapeutic interventions and program models deployed within TRC settings are beneficial to clients.

With the exception of one article (Daly et al., 2019), the qualitative articles did not actively disclose their relationships to the study population.

In the broader sense of role of the researcher, two of the qualitative studies (e.g., Kaasbøll et al., 2022; Tørseth & Ådnanes, 2022) disclosed which authors designed the study, conducted interviews, and performed the coding processes.

Only one study (Kaasbøll et al., 2022) indicated that purposive sampling had been used to identify potential participants. Other qualitative studies did not identify their sampling strategy.

Some of the recruitment strategies used included inviting participants directly either by letter (e.g., Tørseth & Ådnanes, 2022) or by telephone and word of mouth (e.g., Kaasbøll et al., 2022). The writer believes that the findings of these qualitative studies are relevant and interpretable.

Data collection for qualitative studies was done via focus groups and interviews (e.g., Kaasbøll et al., 2022; Tørseth and Ådnanes, 2022). Interviews collect rich and detailed amounts of information which helps researchers understand the meaning of an experience (Cresswell & Poth, 2018). However, interviews can be time consuming to conduct, and researchers need to take time to build trust and develop rapport with interviewees. Focus groups are useful when the interactions between participants produces unique discussions of a group experience that could not be captured in a one-on-one interview. A weakness of focus groups is that, during the interview process, one or two individuals may dominate the group's perspective which may sway the data being collected. It can also be logistically difficult to gather a group of people together within a certain space and time. These limitations can impact the findings and their clinical applications.

Data collection in Kaasbøll et al.'s (2020) took place about 6 months after the study was completed. The authors disclosed some concern about the impact that recall bias could have had on the study participants. In a similar vein, Daly and colleagues (2018) discuss their experiences of working with the Florida state Department of Children and Families in narrative form. The work was conducted between 2015 and 2017, but the authors do not disclose whether their narrative discussion is drawn from sources written or collected during that time, or whether the authors are recalling their experiences at the time of writing in 2018. Recall bias could therefore impact the results of their study. Recall bias occurs when a participant's memories or

recollections of an experience may be impacted by the outcomes of that experience. This can impact study findings because the researcher may capture the perceptions of an outcome, rather than perceptions of an experience itself (Prince, 2012).

One of the major strengths of the qualitative approaches reviewed here are that they allow the voices of children living in TRC settings to be heard during data collection and represented in the study data and conclusions. This is important because children living in TRC settings are vulnerable and often do not get to voice their opinions about treatment (Provincial Advocate for Children and Youth, 2016). Children's voices are often left out of medical health research (Hunleth et al., 2022). The data collection process in qualitative research gives voice to child participants and allows them to share perspectives, feelings, insights, and meanings that have the potential to inform theory and practice (Hunleth et al., 2022). This is important because children living in TRC settings are vulnerable and this kind of research can function as advocacy.

Most qualitative research procedures involved analyzing interviews and identifying common elements using in vivo terms, and then further analyzing and refining the data into codes. These codes were then used by researchers (e.g., Schutte et al., 2023; Tørseth & Ådnanes, 2022; Dimitropoulos et al., 2023) to derive themes from the data. The themes were then organized and structured into a coherent narrative that tells the story of the data. This process is supported by Creswell & Creswell (2023).

With regards to the qualitative systematic reviews, most of the systematic reviews used a brief qualitative description represented in tables with some descriptive statistics to represent their data (e.g., Lanier et al., 2020; Galvin et al., 2022a). Schutte et al. (2023) used a coding process that preserved the regional nature of the articles. This approach allowed the researchers to understand which terms and ideas were most prevalent in which geographic regions.

The systematic reviews were conducted by using a selection of inclusion and exclusion criteria to identify studies related to TRC interventions. A series of exclusion criteria were used to exclude studies not suitable for each systematic review. The remaining articles captured by the inclusion criteria were independently reviewed by researchers to ensure eligibility criteria. Data extraction was completed by researchers and depending on the review, included information like research design, study type, number of participants, gender and age of participants, type of intervention used, outcome measures, length of treatment, therapeutic modalities, and discharge environments. Descriptive statistics were used to discuss aggregated findings where possible. Two systematic reviews adhered to the Preferred Reporting Items for Systematic Reviews (PRISMA) (Galvin et al., 2022a; Lanier et al., 2020).

Strengths of systematic reviews are that they can aggregate large swaths of data in the form of descriptive statistics and qualitative analyses to give the reader a big picture perspective on the state of research. They can tell the reader both what is known about a specific area of research, and what research questions have not yet been asked in that field (Owens, 2021).

Weaknesses of systematic reviews include their retrospective nature and the potential for uncritically including the biases in each reviewed study into the results of the systematic review (Owen, 2021). The systematic reviews used in the literature review were useful in corroborating some evidence found in individual study analyses. For example, many studies did not include random samples. The lack of random samples in TRC research was confirmed by the results of one of the systematic reviews (Lanier et al., 2020). Several authors indicated that conducting a meta-analysis from the reviewed studies was not possible due to the wide array of measures and outcomes used by each study (e.g., Lanier et al., 2020; Schutte et al., 2023).

Summary

The studies reviewed in the literature review used a variety of quantitative, qualitative, and mixed methods studies. The quantitative studies used both survey and experimental designs. They also used a variety of instruments and measures to gather information to in order to answer their research questions. The majority of these measures were validated in the literature, but one study (Holden & Sellers, 2019) used measures that were not validated. Most of the studies did not use random samples due to logistical problems associated with working with children involved in the child welfare system, but two studies did use random samples. *T*-tests and ANOVA tests were used to analyze data and to assess the impact of the independent variable on the dependent variable. Cohen's *d* and *h* were used to understand the degree to which the independent variable impacted the dependent variable.

Regarding the qualitative studies, researchers used a narrative or phenomenological approach. Qualitative researchers used interviews and focus groups to gather data, and this data was then coded and derived to create themes.

Systematic reviews were also used in the literature review and these reviews used inclusion and exclusion criteria to group together relevant studies that addressed the research problem. The systematic reviews were all qualitative in nature. Descriptive statistics and qualitative descriptions were used to aggregate data to answer the research problem.

The authors own research methods included using a scattershot method of search terms to determine what terms identified articles most useful to answer the research problem. Several databases were searched including City University's online catalogue, PSYCinfo, and Pubmed.

Chapter Three: Literature Review

The purpose of this capstone project is to investigate how mental health therapeutic supports can be improved in therapeutic residential care with the purpose of improving outcomes for children living in TRC settings. To explore the issue of how therapeutic supports can be improved in Therapeutic Residential Care (TRC), a review of the existing literature on therapeutic Evidence-Based Practices (EBPs) in TRC will be useful. The findings of the literature review will be presented in this chapter. Ethical considerations, challenges, and limitations of the literature review are discussed at the end of the chapter.

EBP is a broad conceptual category that is guided by conclusions drawn from the data produced by research (Spring et al., 2019). EBPs can be applied to both program models and Client-Specific Therapies (CSTs) in TRC. The academic literature at times conflates EBP applications in both program models and therapy in TRC. For the purposes of this research project, it has been useful to adopt James' (2017) CST and program model dichotomy. Some researchers (e.g., James et al., 2017; Harder et al., 2018) have affirmed the need for this distinction to better determine and isolate which factors produce which outcomes for children and youth living in care.

Client-Specific Therapies (CSTs) in Therapeutic Residential Care

CST is a term used to differentiate the type of clinical treatment a child might receive that is included in the milieu environment. This term is borrowed from James' (2017) term "client-specific EBP" (James, 2017, p. 5). For the purposes of this literature review, a CST includes regular dyadic therapy, or any therapeutic intervention that takes into account the unique characteristics of a child's history or functioning.

The CST interventions reviewed here include: Cognitive Behavioural Therapy (Cosgrove et al., 2022; Joiner & Buttell, 2018; Taussig et al., 2019), Dialectical Behavioural Therapy (Klodnick et al., 2021; McCredie et al., 2017; Masland et al., 2019), and Motivational Interviewing (Eenshuistra et al., 2016). Other therapies like multi-systemic therapy, anger replacement therapy, family therapy, and other EBPs (e.g., telehealth, peer support, case management) were also present in the academic literature. However, they have been excluded from the studies included in this literature review because the therapy and its implementation were not clearly defined or explained in the study. For example, a 2022 study exploring the most commonly used evidence-based practices utilized by 576 TRC facilities in the United States found that three quarters of the facilities polled used family therapy and family psychoeducation (Herbell et al., 2022). However, the study does not explain how the therapies were delivered (either through a CST or a program model). While family therapy is a popular therapeutic modality utilized in TRCs in the United States, there were no studies identifying the delivery of family therapy as a CST. The role of family therapy will be further discussed later in this chapter.

Exploring the impact of a specific therapeutic intervention introduced in residential care was a common type of study represented in the literature. The impact of Cognitive Behavioural Therapy (CBT) and Dialectical Behavioural Therapy (DBT) interventions were two of the most common studies, followed by motivational interviewing.

In exploring the impact of CBT interventions in TRC settings, Cosgrove et al. (2022) found that a CBT treatment was effective in increasing placement stability for children who lived in out of home care, which included residential treatment. The children who received a CBT treatment were moved less frequently from one placement to another and were found to adjust

more easily to new placements. The reason for this placement stability was hypothesized to be a result of fewer externalizing and internalizing behaviours (Cosgrove et al., 2022).

In a similar study, Joiner and Buttell (2018) found that a trauma-focused CBT intervention was useful in reducing post-traumatic stress disorder symptoms amongst 132 children and youth living in one TRC setting in the United States. The authors noted that the results of their study were consistent with other studies that demonstrated the effectiveness of using trauma-focused CBT to treat post-traumatic stress disorder symptoms in the general population (Joiner & Buttell, 2018). Trauma-focused CBT appears to be an effective therapeutic intervention when adapted to TRC settings.

DBT was another commonly used CST intervention for treating children and youth living in TRC settings. A small-scale study involving 48 youths living in a residential treatment facility in the Baltimore area found that weekly individual DBT sessions over the course of one year produced an overall decrease in internalizing and externalizing behaviours (McCredie et al., 2017). Notably, there were no exclusions for involvement in the study, and the study participants presented with a range of comorbid symptoms. Just over half of the participants presented with self-harming behaviours. McCredie and colleagues (2017) used standardized measures at intake and discharge to determine changes in internalizing and externalizing behaviours. When the study authors asked participants to rank which specific DBT skills each client found the most useful, they found (in order of most important to least important) that youths' ranked distress tolerance skills as being most useful, followed by emotional regulation, mindfulness skills, interpersonal skills, and walking the middle path (McCredie et al., 2017). There was no control group for this study.

A more recent study demonstrated similar results in using DBT to treat older teenagers with severe mental health conditions living in a TRC setting. A small-scale (n= 25) mixed-methods study by Klodnick and colleagues (2021) found that DBT therapy was effective in increasing mindfulness and stress tolerance amongst participants. In the qualitative portion of the study, Klodnick and colleagues (2021) found that participants perceived the benefits of DBT as producing higher quality relationships, increasing participant abilities to deal with stress, and increasing regulation of anger and impulsivity. The authors importantly noted that DBT was a useful and important measure in producing the skills needed to help older teenagers living in care to transition out of care and into the next stage of their lives (Klodnick et al., 2021).

While the positive outcomes of DBT therapy in residential care appear to be supported in the literature (e.g., McCredie et al., 2017; McCauley et al., 2018; Klodnick et al., 2021), Espenes and colleagues (2023) wanted to determine whether DBT therapy, when implemented in TRC settings, maintained fidelity to the original therapy. The authors also sought to determine whether DBT therapy strengthened the therapeutic alliance with clients, and whether implementing DBT therapy in residential settings continued to be feasible when incorporated into the program milieu environment. The study involved adolescents in care (n= 42), caregivers willing to participate (n= 23), and TRC staff (n=79). Feasibility and alliance ratings were measured using several caregiver standardized self-reports measures, while fidelity was measured using a modified version of the DBT program fidelity scale. The authors found that while the DBT adapted program for the residential setting was feasible to implement, it was resource intensive and demanding of staff. In terms of maintaining a therapeutic alliance with clients, the authors found that the DBT intervention resulted in a strong alliance rating as

indicated by both clients and CYCWs. In terms of fidelity, the authors also found that fidelity to the DBT program was variable across the six institutions it was implemented in.

Espenes et al. (2023) importantly note that one fidelity barrier to implementing DBT into residential programs is that most residential programs have a constant influx and outflux of clients. Implementing a therapeutic intervention with a set number of sessions (e.g., weekly individual sessions for one year) can be difficult if children in residential care are being moved to new placements before treatment is complete. Therefore, fidelity to a year-long DBT program may not be maintained in a residential program.

The DBT interventions mentioned here often incorporated the milieu program environment. Child and youth care workers who helped manage the residential milieu program were trained in the DBT intervention and were used to support DBT skills training in the milieu environment in lieu of the classic DBT phone coaching (McCredie et al., 2017). Staff were often trained to support the skills children and youth learned in individual and group skills sessions (McCredie et al., 2017; Espenes et al., 2023).

Motivational Interviewing (MI) was another therapeutic intervention used in TRC settings that was present in the literature. MI interventions were often used to build positive relationships with youth, increase self-motivation for change, and decrease resistance to change (Eenshuistra et al., 2016; Harder, 2018). No studies were found that demonstrated the efficacy of motivational interviewing in TRC settings. However, Eenshuistra and colleagues conducted two studies analyzing the implementation fidelity of the MI technique in TRC settings. In the first study, 27 recorded conversations between children and care workers who had been trained in the MI technique were coded and analyzed for adherence to the MI technique (Eenshuistra et al., 2016). The researchers found that care workers often failed to follow the MI interviewing style

of affirming and reflecting the views and perspectives of the children. In addition, the researchers found a high number of neutral responses. This indicated that the children were simply adhering to the expectations of the careworkers and were not providing honest reflective responses to the problem. Unsurprisingly, the authors found that the implementation fidelity of the MI approach in TRC settings appeared to be very low (Eenshuistra et al., 2016).

A follow-up study conducted in 2023 by Eenshuistra and colleagues followed the same formula as the 2016 study, except that the same careworkers from the 2016 study underwent further MI training after the initial round of child-adult interviews was conducted. The authors found that additional MI training resulted in a high number of MI consistent change phrases and topics. Importantly however, the greater number of MI consistent change phrases was not statistically significant. The authors hypothesized that the secondary MI training was not intensive enough to evoke greater change in MI behaviours by child and youth care workers. Notably there are some severe limitations to this study and the previous 2016 study. Both studies had small sample sizes and were conducted in the same TRC facility. The second 2023 study used 13 of the same individuals from the 2016 study. It is possible that there are other hidden variables that could account for the outcome of the study.

Given the lack of studies that sought to demonstrate the efficacy of MI in residential contexts, there does not appear to be enough evidence to conclude whether MI is or is not effective in TRC settings.

Program Models in Residential Care

Therapeutic program models and the child and youth care profession have arisen out of recognition that children spend the majority of their time in TRC settings outside of the therapy hour (Anglin, 2019). The impact that one hour of therapy can have is limited if the environment

in which the child resides does not also support their well-being and growth (Anglin, 2019). Therapeutic program models attempt to create a total therapeutic environment where children, in the presence of trusting and caring adults, experience feelings of safety, security, and predictability (O'hara, 2019).

Ecologically-oriented program models take into account the totality of the child's experience including peer to peer relationships, adult-peer relationships, family relationships, client history, physical environment, and biopsychosocial functioning. The most commonly reviewed and tested program models include the Children And Residential Experiences (CARE) model (Holden & Sellers, 2019; Izzo et al., 2016), Building Communities of Care (Forrest et al., 2018), the Sanctuary Model (Galvin et al., 2022b), and the Teaching Family Model (Daly et al., 2018; Farmer et al., 2017a; Gross et al., 2015). Other experimental or one-off program models, like the Ponoma Family First Project (Chambers et al., 2016) or the Restorative Parenting Recovery Program (Parry et al., 2021) were also present in the literature and were shown to be effective, though these program models do not appear to have been replicated in other contexts. Another popular program model that reappeared in several meta-analyses on the efficacy of residential treatment models was Project Re-Ed. However, the most recent published data on the program's efficacy was from 2006 (Fields et al., 2006). This program model may not be frequently utilized or has been superannuated.

A quasi-experimental four-year study on the efficacy of the CARE program model found decreases in critical incidents (e.g., assaults, runaways, or property damage) and higher positive perceptions of adult-child relationships (from the perspective of the child). The study relied on non-standardized surveys administered to children and staff over the course of four years. The CARE program places a strong emphasis on the development of strong and positive child-adult

relationships as a pathway for changing maladaptive child behaviour. The program also places a strong emphasis on family involvement, trauma-informed principles of care, an ecologically informed program environment, the development of skills that are within a child's zone of proximal development, and the adaptation of the environment to match the child's developmental stage (Holden & Sellers, 2019). Notably, this study did not include a control group and did not used standardized measures to assess program efficacy.

Similar to the CARE program model, the Building Communities of Care program places a strong emphasis on trauma-informed care, ecological development of the program (i.e., a consideration of individual development, internal program development, and integration and interaction of the program with the broader community) (Forrest et al., 2018). The Building Communities of Care program focuses on building and healing attachments with children, strengthening emotional regulation, and fostering skills competency. Different from the CARE and Sanctuary program models is the behavioural component of the Building Communities of Care program (Forrest et al., 2018). An analysis of two TRC programs that implemented the Building Communities of Care program found that restraint usage and staff/child injuries decreased once the programs were implemented. One program demonstrated a decrease in average length of stay of residents, while the other program showed a slight increase in average stay (Forrest et al., 2018). Notably, there were no control groups in this study.

The Sanctuary program model is another trauma informed program model that focuses on the biopsychosocial impacts of trauma, social learning processes, creating a culture of non-violence, and broad systems changes (Bailey et al., 2018). A 2013 qualitative study examining child and staff perceptions of the Sanctuary model found that themes of safety, relationship, and having a voice were considered the end result of engaging in the Sanctuary program (Kramer,

2016). The only quantitative analysis on the efficacy of the Sanctuary program present in the literature found that the Sanctuary program produced decreases in run away behaviours, restraints, psychiatric hospitalizations, and depressive, anxious, and post-traumatic symptoms (Kramer, 2013). However, this analysis was not peer reviewed and was a doctoral study.

The Teaching Family Model (TFM) is a residential care model organized around a more family-like environment that is designed to build on youth strengths and prepare them for non-group home placements (Farmer et al., 2017b). In a study comparing the outcomes of TFM homes versus non-TFM homes, Farmer and colleagues (2017b) found that children showed a decrease in distressing psychological symptoms in both the TFM condition and the non-TFM condition. However, in the post-discharge follow-up, Farmer at al. (2017b) found that a reduction of distressing psychological symptoms was maintained for a longer period of time in the TFM group compared with the non-TFM group. The study suggests that children who lived in TFM program homes maintained positive outcomes for a longer period of time after discharging to other placements.

One-off programs like the Ponoma Family First program placed a heavy emphasis on decreasing the structural and environmental problems that families experience when trying to reunify after being separated by child protective services. The California-based program focused on dramatically reducing caseloads of care workers and social workers, providing extensive support during meetings between parents in children, providing all needed transportation for parents and children for visits, and providing extensive mental health and addictions support for clients and families (Chamber et al., 2016). The 48 families who participated in the Ponoma Family First program reunified at a rate of 76%. The 48 families in the control condition reunified at a rate of 44%.

The Restorative Parenting Recovery Program (RPRP) is a program focused on trauma informed principles, strengths-based competency, and attachment theory. Children participating in the program are assigned a key worker whose role is to model and embody a positive attachment with the child and to help the child build on their current strengths and to learn adaptive behaviours that will prepare them for reunification with their families (Parry et al., 2021). A study examining the outcomes of the RPRP program found general improvements across several measures for the 22 children engaged in the study. The average participation in the program during the testing period was 24 months. Paired t-tests from standardized measures administered at the beginning and end of the program indicated a statistically significant increase in the child's ability to form attachments and have positive relationships with others. Increases in children's positive self-perceptions, emotional regulation, competence, and self-awareness, were also observed in the study, though these were deemed not statistically significant (Parry et al., 2021).

Systems Management

Many of the articles reviewed above indirectly discussed the importance of, and problems associated with, the interaction between different systems that operate within therapeutic residential settings. For example, Dimitropoulos et al. (2023) found there were some disagreements within the same setting between the clinical staff (i.e., one system within the TRC setting) and the child and youth care staff (i.e., another system within the setting) over the rewards system (i.e., a third subsystem within the setting) used in the implementation of the CBT treatment. Cosgrove on the other hand argued that strong relationships between clinical staff, case worker staff, and child caregivers resulted in better care and advocacy for children under the care of child welfare services. (Cosgrove et al., 2022).

No articles were identified in the literature that directly discussed or explored the systems at work within therapeutic residential care settings. One article explored the implementation of a General Systems Theory approach to improving mental health supports in Athens, Greece. Several other articles explored how the delivery of mental health supports could be more efficient through a General Systems Analysis of care pathways or through increased agency integration and communication.

Analyzing and optimizing the relationship between systems that underlie healthcare can improve health service delivery (Johnson, 2019). Since the COVID-19 pandemic, there has been a general push to better integrate various components of the healthcare system to increase efficiency and capacity (Simpson et al., 2023). An experimental case study of applying General Systems Theory to the Hellenic Center of Mental Health and Research (HCMHR) attempted to mathematically represent the relationships between client intake, evaluation, and treatment (Katrakazis et al., 2020). The general systems model also attempted to situate the internal processes of the HCMHR within the contexts of the broader population in Athens, Greece. The authors found that by representing the HCMHR system as a general system, they could mathematically predict how a potential increase in demand for services (i.e., an increase in referrals or patients) would affect treatment times. In this way, the authors demonstrate how intake systems and the treatment systems are interrelated, can affect each other, and can affect overall outcomes.

In a retrospective qualitative study, Kaasbøll and colleagues (2022) examined staff perceptions of the affects that interagency communication and collaboration had on the identification and administration of mental health services for children living in care. After interviewing the study participants, the authors identified four main themes: 1) staff perceived

that children could access mental health supports more quickly than without the collaborative model; 2) the model produced greater communication and commitment between agencies; 3) the use of a shared screening tool amongst agencies increased awareness and perspectives of mental health issues amongst respondents; and 4) multidisciplinary meetings were deemed important in the delivery of mental health supports to youths, but that they were often underutilized.

Improving collaboration and cooperation between agencies can be difficult. A scoping review of articles on inter-collaboration between various child welfare-related agencies in Norway found that collaboration between agencies was hindered by: a lack of common goals across agencies, a lack of collegiality between agencies, and a lack of information sharing agreements that protected client confidentiality (i.e., agencies were reluctant to share information about clients due to confidentiality concerns) (Pedersen, 2020). Fragmentation of mental health services was also found to be a barrier in sharing information between agencies. However, Pedersen (2020) also found that collaboration resulted in better service delivery for children and youth involved with the child welfare system. Collaboration also did not occur evenly across agencies. For example, when agencies shared similar philosophies on child welfare, there was more collaboration between those agencies (Pedersen, 2020).

In relation to the above articles, a policy paper produced by Koftinoff et al. (2023) identified similar issues with information sharing in Albertan mental health delivery contexts. In this policy paper, Koftinoff et al. (2023) conducted semi-structured interviews with twelve high level informants working across a range of government, not-for-profit agencies, and academia organizations, to explore their perspectives on collecting and measuring data collected from children and youth through patient-oriented outcome measures. Through their interviews, the authors identified that: 1) there are no standardized outcome measures universally used and

shared by mental health agencies in Alberta to assess efficacy of treatment for children in; 2) access to mental health supports in Alberta is not evenly distributed across populations; and 3) the absence of an official cross-agency coordination strategy makes it difficult for children and youth to access different mental health supports (Koftinoff et al., 2023).

One study in the literature found that attempts to increase the efficiency through systems management resulted in poorer mental health delivery. A qualitative study exploring the attitudes of care workers on a new care pathways system in a Norwegian mental health setting found that the new system increased stress and distrust amongst mental health delivery workers (Tørseth & Ådnanes, 2022). Interviews conducted with 37 frontline mental health care workers (e.g., psychiatrists, nurses, and psychologists) across four separate clinics found workers had a very limited understanding of what the purpose and goals of the new care pathway system were. Furthermore, workers perceived the rollout of the new care pathway system as being disorganized. Communication between mental health policymakers, providers, and frontline workers was lacking. This created a sense of mistrust between frontline workers and mental health providers (Tørseth & Ådnanes, 2022). Additionally, the new patient coding systems to determine the correct treatment pathway increased the burden of work on some workers. This created feelings of frustration and resentment amongst workers towards to the new system. Finally, frontline workers perceived the technology used in the new system as cumbersome and inefficient. Frontline workers therefore saw the new care pathways system as creating inefficiencies in the system, rather than making the system more efficient (Tørseth & Ådnanes, 2022).

Findings from the Literature

Thematic groupings from the academic literature exploring CSTs and program models will provide a useful analytical lens to understand the different factors which influence positive outcomes for children and youth living in TRC. Themes and subthemes are used to discuss the findings from the studies that explored the use of: 1) evidence-based therapies within TRC settings, 2) evidence-based program models used within TRC settings, and 3) integrative practices that have been used within TRC settings. After exploring the relevant themes and subthemes identified in the literature, the existing gaps in the literature and ethics of the research will be discussed.

Themes identified in the literature were: 1) client-specific evidence-based therapies are effective; 2) ecologically oriented program models are effective; 3) limitations for EBPs in TRC settings; 4) Integrative models improve efficiency of TRC programs; and 5) research quality and robustness are lacking in TRC research. A table of the identified themes and subthemes in provided below.

Table 2

Overview of Themes and Subthemes

Themes	Subthemes
Client-specific Evidence-based Therapies are Effective	a. Client Outcomes
Ecologically-oriented Program Models are Effective	a. Common Factors- Safety, Security, Predictability
Limitations for EBPs (including CSTs and Program Models) Efficacy	a. Staff Education and Training

	b. Program Compatibility and Population Matching c. EBPs Not Tested for TRC Settings d. Prohibitive Costs e. Staff Turn-over
Systems Within TRC	a. Role of Management Systems in the Integration of Other Systems
Research Quality and Robustness are Lacking	a. Problems with Existing Research b. Problematic Research is Better Than No Research c. Problematic Research as a Path Forwards

Theme 1: Client-specific Evidence-based Therapies are Effective

The dominant theme from the literature that examined the implementation of CSTs in TRC settings was that they were effective in improving positive outcomes in target sample populations. This finding is important and relevant to the topic of improving mental health supports in TRC settings because CSTs, if effective, could be used in TRC settings as a way of improving positive outcomes to children and youth. One of the criticisms of using EBPs, including CSTs, in TRC settings is that some EBPs have not been designed or tested for TRC settings (Daley et al., 2018; Lee & McMillen, 2017). The studies reviewed here suggest that CBT and DBT therapy continue to deliver evidence-based positive outcomes when adapted to TRC settings.

Client Outcomes

The CST therapies reviewed here demonstrated a range of improvement across a number of measures including: frequency of psychiatric services use (Cosgrove et al., 2022; Taussig et al., 2019), placement stability (Cosgrove et al., 2022), levels of distress tolerance (Klodnick et al., 2021; McCredie et al., 2017), adaptive functioning skills (Klodnick et al., 2021; McCredie et al., 2017), emotional regulation (Klodnick et al., 2021), interpersonal functioning (Klodnick et al., 2021), positive change talk (Eenshuistra et al., 2016), diagnoses reduction (McCredie et al., 2017), symptom reduction and severity (McCredie et al., 2017; Joiner & Buttell, 2018; Taussig et al., 2019; Masland et al. 2019) and self-reported measures of quality of life (Taussig et al., 2019). The general consensus from the studies reviewed here was that the CSTs were largely effective in producing positive outcomes for clients.

While CSTs were seen as effective in the literature, some measures showed little or no change. For example, clients receiving CBT therapy in a TRC setting accessed emergency psychiatric services less frequently than the treatment as usual group (TAU), but the results were not statistically significant (Cosgrove et al., 2022). Another study examining the use of Motivational Interviewing (MI) in a TRC setting found that MI, when used correctly, evoked positive change talk from clients (Eenshuistra et al., 2016). However, the authors found that the MI coaches often struggled to follow MI protocols and would frequently try to persuade and challenge the youths on problematic behaviours. This suggests that, while MI is an effective CST, more research is needed to explore how to strengthen its use in TRC contexts (Eenshuistra et al., 2016).

Theme 2: Ecologically Oriented Program Models are Effective

The academic literature generally showed the use of ecological program models to be effective at producing positive outcomes for children and youth across a number of measures. Several themes were present in the literature on program models that contributed to the positive outcomes for clients.

Family Involvement

One common element that all successful ecological programs appear to have in common is the involvement of family (Harder & Knorth, 2015; Herbell et al., 2022). Various interventions including general family involvement in case planning and family psychoeducation were associated with increased child functioning, a decrease in problem behaviours, shorter durations in care, and more successful returns to family (Herbell et al., 2022; Lanier et al., 2020). These studies suggest that successful program models should include family members wherever possible to improve therapeutic outcomes for children and youth.

Common Elements in TRC

In attempting to determine what factors produced positive outcomes for children and youth living in therapeutic residential care, several authors discussed the importance of the common factors in TRC. Proposed common factors in TRC include: safety, setting, staff, treatment (Farmer et al., 2017a), positive teaching, role modeling (Lee & McMillen, 2017), and the caregiver-child alliance (Lee & McMillen, 2017; Harder, 2018).

Safety. Child perceptions of safety and security within TRC contexts is an important predictor of positive outcomes in TRC (Sellers et al., 2020). In one study, adults tended to overrate their perceptions of child safety in TRC settings when compared against child self-reports of perceptions of safety (Sellers et al., 2020). Sellers and colleagues also found that

feelings of child safety were closely correlated with child perceptions of relationship quality with staff. The stronger the child-caregiver relationship, the safer the child felt (Sellers et al., 2020). Feeling safe and secure in an environment is a precondition for recovery and behavioural change (Bath & Seita, 2018), therefore fostering feelings of safety for children is an important and necessary factor in successful program models. In another study, safety was assessed by examining restraints. The permissibility and frequency of restraints was used to determine levels of safety within a TRC program (Farmer et al., 2017a). Efforts to include trauma-informed principles into TRC settings have reduced restrictive measures including restraints and confinement. This increases feelings of safety amongst children and staff in TRC settings (Matte-Landry & Collin-Vézina, 2022). TRC settings that have lower or no restrictive measures (i.e., restraints and confinements) are correlated with having higher positive outcomes for clients (Sellers, 2019).

Setting. Setting can refer to the total living environment in which children and youth reside in TRC (Farmer et al., 2017a). It is the space in which children and youth live their lives (Gharabaghi, 2024). Characteristics of TRC settings that contribute to positive outcomes include: a clean environment, amount of physical space, spaces that are nurturing and safe, and the degree to which the space matches a home-like environment (Farmer et al., 2017a). Other authors consider the totality of human-to-human interactions as being a characteristic of the setting in TRC (Gharabaghi, 2024). A qualitative study on the components that contribute to a healthy TRC setting found that opportunities to be together and grow with peers and staff, like cooking together, or watching T.V. together, positively contributed to a nurturing setting. On the other hand, this same study found that a narrow and rigid focus on organizational details, efficiency,

and the demand to meet program objectives correlated with detracting from a nurturing and positive setting (Levrouw et al., 2020).

Staff. Having adequately trained, experienced, emotionally available, and having enough staff, are critical to achieving positive outcomes in TRC settings (Farmer et al., 2017a; Nyerges et al., 2023). Effective child and youth care staff are competent in self-reflective practice, interpersonal skills, communication skills, emotional self-regulation, motivation, initiative-taking, and client-attunement and empathy skills (Holden, 2023). These skills are developed through training, supervision, and experience (Holden, 2023; Sellers et al., 2020). Conversely, Gharabaghi (2024) argues that most TRC intervention trainings do not help staff attune, empathize, or act kindly towards clients. Gharabaghi (2024) appears to argue that there are intrinsic values like kindness, healing, wisdom, and autonomy that TRC staff need to embody when entering the profession. Organizational climate, supervision, and leadership all impact how staff working in TRC settings conduct themselves with residents and are variables that impact staff efficacy and turnover rates (Nyerges et al., 2023).

Caregiver-Child Alliance. Creating a strong alliance between caregiver and child is associated with positive outcomes for children and youth living in TRC settings (Harder, 2018; Péréz-Garcia et al., 2019; Holden, 2023). A qualitative study examining the alliance between a group of psychoeducational staff in a TRC setting found that the strong therapeutic alliance between the staff group and the clients resulted in feelings of personal development and growth, acceptance, and family-like relationships (Péréz-Garcia et al., 2019). Opportunities for traumatized children to create new and healthy relationships with caregivers in TRC settings allows for new meaning-making experiences, learning healthy attachment to adults, learning new emotional and co-regulation strategies, and provides the basis for behavioural change (O'hara,

2019). Creating strong relationships between caregivers and children in TRC settings was an important component for the implementation of several EBP program models and CSTs (e.g., Dimitropoulos et al., 2023; Hoogeveen & Rigter, 2017; James et al., 2021; Farmer et al., 2017a; Holden & Sellers, 2019). In supporting the common factors idea specifically, Farmer et al.'s (2017a) study examined the positive outcome differences between Teaching Family Model (TFM) programs and non-TFM programs. They found no difference in client ratings of relationship quality between the two study groups. That is to say, no differences in relationship quality were found between the intervention group and the control group in this study– both groups rated their relationships as being helpful and of high quality (Farmer et al., 2017a).

However, James et al. (2017) argue that the evidence that demonstrates the efficacy of the therapeutic alliance between caregiver and child is not conclusive. More research is needed to more clearly understand the impact this factor has on youth outcomes.

Theme 3: Limitations for EBP (including CSTs and Program Models) Efficacy

Staff Education and Training

Maintaining adequate staff education to ensure EBPs are delivered appropriately was identified as a barrier by several authors. Staff training was reported as being the biggest barrier to implementing EBPs in a survey of 66 TRC providers in the United States (James et al., 2017). While staff training was primarily a barrier to the delivery of EBP program models, this could be a concern in the delivery of CSTs. For example, in Eenshuistra et al.'s (2018) study, the CST was delivered by MI coaches, who were specially trained child and youth care workers. The study concluded that the MI training was probably not intensive enough to adequately train the coaches in the technique (Eenshuistra et al., 2018; Eenshuistra et al., 2023). In the United States, child and youth care workers tend to be largely excluded from EBP training, which hampers the

effective implementation of an EBP into a TRC program (James et al., 2017). In an analysis of the implementation of EBPs into 66 TRC programs, James et al. (2017) found that staff training was a significant barrier to the proper implementation of an EBP.

Program Compatibility and Population Matching

Incorporating CSTs into TRC program models is a potential problem raised in the academic literature. Many of the CSTs tested in TRC settings are specifically matched to certain populations. CSTs should match the populations that will most benefit from them. Gordon Paul's famous quote asking: "what treatment, by whom, is most effective for this individual with that specific problem, and under what circumstances," (Paul, 1969, p. 49) summarizes how clinicians can approach matching a therapeutic intervention to a specific client. A number of the studies in the literature review were able to adequately match a CST to a population (e.g., matching DBT for clients struggling with a personality disorder in Masland et al.'s 2019 study). However, in non-study contexts, adequality matching populations to evidence-based CSTs is a concern where TRC programs admit a range of young clients experiencing a range of psychosocial problems (Daly et al., 2018). Despite this observation, most TRC providers that use CSTs use CBT and DBT therapies to address most client problems (Daly et al., 2018; Schutte et al., 2023). This appears to be a good enough approach where these two evidence-based therapies can address a wide-range of client symptoms without the need to specialize on a therapy designed to meet client-specific problems within a population.

EBPs Not Tested for TRC Settings

Several authors expressed concerns that incorporating EBPs (including CSTs) into TRC settings without adequate research and testing could be risk harm to clients(Daly et al., 2018; James et al., 2017; Lee & McMillen, 2017; Chambers, 2016). There are important reasons for

questioning the efficacy of therapies that were designed outside of non-residential settings including: 1) the inability to observe some problematic behaviours in TRC settings (i.e., a lack of symptom expression); 2) TRC settings are different from community and home settings; 3) the post-discharge environmental could impact long-term outcomes; and 4) a loss of supports when leaving the TRC setting (Schutte et al., 2023).

Symptom expression within residential contexts may be suppressed due to the nature of a more restrictive setting (e.g., a food hoarding habit may not be expressed by a child because food stores are closely monitored and locked within the TRC setting) (Schutte et al., 2023).

TRC settings in which therapy is delivered are obviously different from the settings in which traditional CSTs are delivered. Conventional adaptations of EBP therapies like ACT, CBT, or DBT for children and adolescents tend to rely on caregiver support to reinforce the interventions delivered in the therapy room (Dimitropoulos et al., 2023). However, in TRC settings caregivers are typically CYCW staff members who rotate on 8 or 12-hour shifts and who are responsible for multiple children. Creating a system for rotating groups of staff to reinforce unique therapeutic interventions for multiple children may be problematic.

Factors in post-discharge environments may contraindicate any therapeutic gains that were produced in TRC settings (Schutte et al., 2023). Benefits from therapeutic interventions may not carry over into post-discharge environments (Herbell & Breitenstein, 2021). Children who are returned to environments that do not reinforce new behaviours (e.g., a chaotic homelife with unpredictable caregivers) are less likely to show a maintenance of positive outcomes initially made in a TRC setting (Schutte et al., 2023). When children and youth transition out of TRC settings, they lose access to the wrap-around supports (including access to therapy) that were useful in producing positive outcomes in the TRC setting. Some program models, like

CARE or the Ponoma Family First Project, support aftercare to help maintain gains made in the TRC setting (Holden, 2023; Chambers et al., 2016). However, many programs do not offer aftercare (Harder, 2018). A lack of aftercare has been recognized in the literature as a contributing factor to post-treatment declines in behavioural functioning of children and youth who received treatment in TRC settings (Harder, 2018; Yeheskel et al., 2020). Yet, this also remains an area of continued research to determine how much aftercare is needed to reinforce positive therapeutic changes in clients (Yeheskel et al., 2020).

Prohibitive Costs

TRC settings are expensive entities to run (Yeheskel et al., 2020; Amarbayan et al., 2021). Given the significant financial and tax burden associated with running publicly financed TRC facilities, there is pressure to reduce the costs of running these facilities (Sen et al., 2024). Some EBP interventions are designed to reduce costs (e.g., Forrest et al., 2018). The burden to reduce costs also means that some EBP's may be beyond the ability of some TRC providers' budgets (James et al., 2017). In some cases, implementation fidelity can be affected due to the need to cut costs when implementing a specific program (James et al., 2017; Breitenstein et al., 2010). In an analysis of 576 residential treatment facilities throughout the United States, DBT and family therapy were among the lowest utilized EBP interventions. Herbell and Ault (2021) speculated that financial constraints and staff turnover were the most likely explanations for this low utilization rate. CSTs are perhaps the costliest form of intervention because individual therapy hours are allotted to each client, instead of a group therapy model where individual therapy hours are allotted to the group.

Staff Turn-Over

Another limitation of successful implementation of EBPs in TRC included staff turn-over. Staff turnover in TRC settings is associated with poorer outcomes for children and youth. Children living in TRC settings may experience feelings of mistrust, loss, abandonment, and worthlessness when TRC staff leave a setting (Nyerges et al., 2023). In a survey of 66 TRC providers in the United States, staff turnover was reported as being the second biggest problem to implementing EBPs in TRC settings (James et al., 2017). Staff turnover became a significant barrier to implementing a CBT intervention in a TRC setting in the Calgary area due to the inability to retain a critical quorum of trained and knowledgeable staff in the CBT intervention (Dimitropoulos et al., 2023). Frequently losing staff results in an outflow of experience from organizations and can create financial burdens due to the need to continually re-train new staff (Nyerges et al., 2023). Staff turnover, staff education, and financial constraints are therefore all interrelated barriers to effective EBP implementation.

In one qualitative study on managerial practices in TRC settings in Sweden, program managers noted the pressure to list as many EBPs that the program could support in order to qualify for government funding allocations. The managers noted that the degree to which they could accurately deliver these EBPs to clients was significantly dependent on which staff were presently working in the TRC setting (Sallnäs & Shanks, 2021). For example, a manager might list ‘CBT’ as an EBP delivered in a particular TRC facility, but only one staff member may be trained in CBT interventions. It is possible that staffing pressures can cause managers to exaggerate the degree to which EBPs are delivered in TRC settings.

Theme 4: Systems within TRC

Organizational systems in TRC settings are designed to improve communication, gather data, assist with screening processes, improve care, prevent staff burnout, and structure treatment (Esaki et al., 2013; Kaasbøll et al., 2022). Several studies addressed the importance of inter-systems communication and collaboration with multiple groups within a TRC to improve care to clients (e.g., Dimitropoulos et al., 2023; Cosgrove et al., 2022; Holden & Sellers, 2019; Esaki et al., 2013). Collaboration between clinicians, supervisors, families, and child and youth care workers was considered especially important in the delivery of EBPs in TRC settings (Dimitropoulos et al., 2023; Cosgrove et al., 2022; Galvin et al., 2022; Holden & Sellers, 2019). In one study, increasing interagency communication and sharing resources and information resulted in more precise intake assessments of children coming into TRC. This resulted in better delivery of mental health supports (Kaasbøll et al., 2022).

Role of Management in Effective Systems Integration

The role of management in helping the integration of other systems succeed or fail was represented in the literature. A study exploring the implementation of a new mental health care pathways system in Norway appeared to demonstrate that a lack of clear direction from management resulted in confusion and frustration amongst frontline staff (Tørseth & Ådnanes, 2022). Similarly, Pedersen's (2020) scoping review indicated that a lack of collegiality, shared agency philosophies, or information sharing agreements, all impacted the ability of mental health agencies to work together. Interagency collegiality, governing philosophy, and information sharing agreements are arguably all fostered or created at the management level, and not at the level of frontline workers.

Pedersen (2020) also identified that the creation of legislation in Norway has required certain mental health agencies to work together to increase outcomes for clients or patients. The creation of legislation by the Norwegian government is arguably a higher system of management that has directed lower order systems (i.e., directors of mental health providers) to work together to improve outcomes.

In Dimitropoulos et al.'s (2023) study in the implementation of a universal protocol CBT intervention, the clinicians observed some difficulties in ensuring that frontline staff were trained in the CBT intervention due to high staff turnover. The frontline CYCW staff that were trained would leave before the trial study period was complete. This presented a problem for the clinical team and study authors. Management at Hull Services therefore decided to only train senior frontline staff in the intervention to save money and time in consistently doing the trainings. Senior staff were then tasked with fulfilling the milieu portion of the CBT intervention. This is an example of how management can help facilitate the interactions between various systems within a TRC setting.

A policy-paper examining the perspectives amongst leaders of various mental health care providers in Alberta found that a lack of consistent patient-oriented outcome measures, and a lack of integration of mental health resources resulted in inefficiencies in mental health care delivery to children and youth. The policy paper also found that this lack of information sharing resulted in lower completion rates of treatment for children and youth (Koftinoff et al., 2023). It was the opinion of the authors that the Alberta government should implement standardized outcome measures for all children and youth accessing mental health supports in Alberta. The authors suggest that higher order management (i.e., government directives or legislation) are necessary to improve the outcomes produced by lower order systems.

Theme 5: Research Quality and Robustness is Lacking

In James' 2011 review of five TRC program models, she observed that evaluating the evidence for group care as a form of treatment for children and youth was unreliable due to the heterogeneity of outcomes and measures used in each study. James also found that because the studies themselves were often poorly designed, lacked control groups, representative samples, blinds, or randomization, the basis for concluding what worked in group care was questionable (James, 2011).

A more current review of the existing literature indicates that James' 2011 observations continue to be true for more recent research on EBPs in TRC facilities. A recent systematic review by Galvin et al. (2022) concluded that of the 207 articles deemed suitable for their study (whittled down from 8522 potentially eligible articles), just four studies met the gold standard methodological requirements needed by the study. The other 203 articles were screened out of the meta-analysis due to a lack of: randomized clinical trials, clear definitions for outcome measures, adequate-sized samples, clearly described and defined interventions, study power, and ongoing client commitment to treatment (i.e., high attrition rates) (Galvin et al., 2022a).

Much of the research conducted on interventions and programs implemented in TRC settings lack control groups, randomization, or adequate sample sizes (Giraldi et al., 2022; Eriksson et al., 2024). A number of recent studies on the efficacy of program models and therapeutic interventions lack control groups or randomization including: Holden and Seller's (2019) study on the efficacy of the CARE program model; Dimitropoulos' et al.'s 2023 study on the implementation of a trans-diagnostic CBT therapy within a TRC program; Klodnick et al.'s (2020) small-scale study on the efficacy of DBT therapy within a residential care program;

McCredie et al.'s (2017) study on the efficacy of DBT-A therapy in a TRC program; and Seller's (2020) study on child feelings of safety in TRCs.

Some studies did not follow this trend. The following studies included control groups: Chambers et al.'s (2016) study exploring the efficacy of the Ponoma Family First Project; Farmer et al.'s (2017a) study on factors that influence positive outcomes in group care; Cosgrove et al.'s (2022) study on the efficacy of CBT-plus therapy in foster and TRC settings (however, Cosgrove et al. did not randomize their samples); and Taussig et al.'s (2019) study on the efficacy of the Fostering Healthy Futures Program. Taussig et al.'s study is particularly strong as it was a randomized clinical trial. RCTs are typically rare in the group care field (James 2011; Daly et al., 2018).

Some authors have concluded that the factors that produce positive outcomes in group care cannot be definitively identified (Lanier et al., 2020; Yeheskel et al., 2020; Galvin et al., 2022a). Despite the shortcomings of the existing research, there is consensus that the current research into the TRC field continues to be useful and guides current practice models (James, 2011; Whittaker, 2017; Galvin et al., 2022a). This is the baby and the bath water approach– that is, while the research has problems and shortcomings, it continues to have utility in guiding treatment approaches. While more and better-quality research is needed to better clarify the efficacy of EBPs, program models, and common factors at work in TRC, the existing research should not be discarded.

Due to the nature of conducting studies within social work contexts, fulfilling the needs of robust randomized clinical trials is rarely possible (Eriksson, 2024). Designing studies that involve a comparison of matched groups may be one possible solution to conducting research in TRC where RCTs may not be possible (Yeheskel et al., 2020). Matched groups were used in

Holstead et al.'s (2010) study comparing community treatment to residential treatment. The groups involved in both conditions were as closely matched as possible in terms of age, gender, treatment length, diagnoses, and family involvement and circumstances. In this way, the authors hoped to more accurately compare the factors that influenced the outcomes of each group without the need for random samples (Holstead et al.'s, 2010).

Gaps in the Literature

In an effort to understand how different EBPs affect children and youth in TRCs, and with the intent to improve therapeutic outcomes for children and youths living in TRC settings, James (2015) has sought to identify and explore the differences between client-specific EBPs and program-model EBPs. The utility of taking such an approach allows for a comparison and analysis of how importing different EBPs can affect not only client and youth outcomes, but also staff, organizational structures, and funding models. Few authors in the academic literature have taken this dichotic approach to understanding how different EBPs are implemented in TRC settings. Harder's (2018) exploration of the different elements in TRC "care" (i.e., the program model and common factor components) and "cure" (i.e., the clinical components like therapy) is the only other study identified which takes this approach. Despite Harder's dichotic approach, Harder only analyzes the impact of the "care" component, in this case a motivational interviewing intervention, in her study.

No research-based or scientific comparison of evidence-based CSTs versus program models was found in the academic literature. Exploring the relationship and impact of CSTs and program models could provide a better understanding of how these two EBPs can produce positive outcomes for children and youth, and how the integration of these two EBPs could

further enhance and strengthen the development of new skills and relationships that occur in TRC settings.

Two studies in the literature, Dimitropoulos et al.'s (2023) study on the use of a trans-diagnostic CBT intervention, and Taussig et al.'s (2019) use of the Fostering Healthy Futures Program, approach the comparison of two different EBPs in TRC. In implementing a trans-diagnostic CBT intervention into a TRC setting in the Calgary area, Dimitropoulos and colleagues used the ecological environment of the TRC setting to help implement their therapeutic intervention. While the therapeutic intervention was trans-diagnostic and implemented in group format, the researchers educated CYCWs about the intervention and used the CYCWs expertise and knowledge of the clients to help effectively deliver the intervention. (Dimitropoulos et al., 2023). Despite some disagreements between clinical and CYCW staff about certain aspects of the intervention (e.g., the reward system), this study suggests the kind of healthy and positive collaboration that can occur between CYCW staff (i.e., those that manage the milieu environment) and clinical staff (i.e., those that manage therapeutic interventions and client therapy).

Taussig et al.'s (2019) study explored the implementation of the Fostering Healthy Futures program model. In this program model, manualized formats of group and individual CBT therapy were implemented as part of the program model. The Fostering Healthy Futures (FHF) program model was ecologically oriented and had a strong focus on including family members in the treatment of their children in the TRC setting. The CBT group and individual treatments were focused on topics that would help clients improve their daily functioning both in the TRC environment and would prepare clients for the home or foster environment to which the clients would eventually transition to (Taussig et al., 2019). The FHF program model appears

designed to strengthen and incorporate gains made in the CBT group and individual therapy sessions into the therapeutic milieu environment. As with Dimitropoulos et al.'s (2023) study, the integration of therapeutic interventions into the milieu-environment is again present in Taussig et al.'s study.

Future research in this area could help address the concerns about whether certain evidence-based CSTs can be implemented into TRC settings. Dimitropoulos et al. (2023) and Taussig et al.'s (2019) studies suggest a path where integration between program models and clinical components of TRC can work together to produce best outcomes for children and youth living in TRC settings.

Ethics

Children in government care are one of the most vulnerable populations in our society (Forrest et al., 2018). Children in care have a greater probability of experiencing homelessness, abuse, addictions, and mental illness (Galvin et al., 2022a). A significant reason for this vulnerability is that adults who are not their parents have a significant amount of control over the decisions of these children's lives (Provincial Advocate for Children and Youth, 2016). Many provinces have an official child advocate office so that children in care have a resource they can turn to when they feel their needs are not being upheld (Bendo & Mitchell, 2017).

Participation in Research

While structures and policies exist to support the rights of children in care (Holden & Sellers, 2019), this population does not always get the opportunity to express their opinions on decisions made about their lives (Provincial Advocate for Children and Youth, 2016), and it is possible that this includes participation in primary research. The Canadian Psychological Association's (CPA) Code of Ethics for Canadian Psychologists (4th ed) states that vulnerable

groups must be afforded a greater degree of consideration and protection than the general population due to their vulnerability (CPA, 2017). Psychologists working with vulnerable populations, like children in care, must work to improve the structures that protect the moral rights of vulnerable groups (CPA, 2017). Only two of the research articles reviewed here discussed the relevance of their research in the context of protecting the rights of children in care (e.g., James et al., 2022; Matte-Landry & Collin-Vézina, 2022). It is difficult to know how to interpret this observation. On the one hand, it is possible that a discussion of protecting moral rights of children was beyond the scope of research that was published in each study. On the other, it is also possible that some researchers lose sight of the individual child and their attendant rights in a "publish or perish" academic environment.

Representation in Research

In qualitative research, children have traditionally been treated as objects of research rather than active participants that shape research and policy (Hunleth et al., 2022). As such, the voices of children involved in research have often been silent (Hunleth et al., 2022). Accurately representing children's voices and perspectives is a challenge in qualitative research. Researchers must be careful not to underrepresent or overrepresent child agency (Hunleth et al., 2022). In addition, when working with vulnerable groups, researchers must be especially careful in attending to confidentiality and creating safe and secure environments for participants (Turliuc & Candel, 2019).

Informed Consent

Many of the studies examined here included a description of gathering informed consent from participants (e.g., Dimitropoulos et al., 2023; Masland et al., 2019; McCredie et al., 2017). Furthermore, de-identification of participants was important in protecting the identities of those

participants (e.g., Masland et al., 2019; Akin & McDonald, 2018; Joiner & Buttell, 2018). McCredie's study on dialectical behavioural therapy also included a discussion about participants right to refuse participation in the study. No data was included in the analysis from participants who refused to participate (McCredie et al., 2017). Farmer et al.'s (2017a) study on TFM homes included a discussion about consent from parents and guardians and informed and signed assent from child participants prior to interviews.

Obtaining informed consent from the legal guardians of children in care can be difficult. Child intervention practitioners, case workers, and social workers, have large caseloads which can make it difficult to respond to children in care's needs (McFadden et al., 2024). It is possible that caseworkers, at the behest of researchers, may sign children in care up for research participation without properly understanding the parameters of the research and the informed consent process. Principle I.17 in the Code of Ethics for Canadian Psychologists (4th ed) states that informed consent is a process that requires the necessary time to foster and create trusting relationships with those providing consent (CPA, 2017). In the case of caseworkers providing consent to children in care, taking the time to fully explain the research and to create a trusting relationship with the consent provider, may not be fully realized.

Assent must be obtained from vulnerable individuals if their capacity to provide informed consent is diminished (CPA, 2017). Children living in TRC settings typically present with a range of behavioural and psychological symptoms and diagnoses (Galvin et al., 2022a). These presentations may dimmish the capacity of a child to provide assent to participating in research-based interventions in a TRC setting. Furthermore, withdrawing assent to participation could be compounded in a TRC setting. TRC settings can be highly structured, and at times can have a system of rewards and consequences for behaviours. It seems possible that children living in

TRC settings could be coerced into providing assent to achieve rewards or avoid consequences. In this case, the assent would not be genuine and would be a behavioural response to the structural pressures placed on the child.

Ethical Considerations for Indigenous Peoples

In Canada, indigenous children are placed in residential care at 5.2 times the rate of the non-indigenous population (Anglin et al., 2023). Therefore, in Canada, any research on children living in TRC, will likely involve indigenous children. Research involving indigenous peoples has generally not understood or reflected indigenous perspectives or paradigms. Furthermore, research carried out on indigenous peoples has not been to the benefit of those communities (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council 2022). The Tri-Council policy statement on the Ethical Conduct for Research Involving Humans (2022) acknowledges the historical harms that research on indigenous peoples in Canada has had, and furthermore argues that researchers must act in the spirit of reciprocal relations, collaboration, and to the benefit of indigenous communities. Researchers must also respect the customs, practices, rights, traditional knowledge, and governing structures of indigenous communities (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council, 2022).

Only one of the studies reviewed here, Dimitropoulos et al.'s (2023) study on a trans-diagnostic CBT intervention, was conducted in Canada. Curiously, the authors did not (at least in the journal article) include a policy, cultural, or ethical statement with regards to how researchers would interact with indigenous clients. There was no discussion of the possible impacts the CBT intervention could have on indigenous children given their cultural background, and no

discussion of how the CBT intervention could or should be adapted to match indigenous cultural values.

Schutte et al.'s (2023) systematic analysis on TRC treatment programs concluded that few instruments for measuring internalizing and externalizing behaviours had been validated for children from different cultural and racial backgrounds, including indigenous cultures and identities. It seems a reasonable conclusion that researchers working with indigenous children in care could do more to follow the Tri-Council's recommendations for working with indigenous communities.

Challenges

One of the challenges of this literature review was identifying what counted as TRC. The literature contained several articles exploring services that could be characterized as "residential" but did not really fit the topic of study. A good example of this is in-patient psychiatric treatment. Several articles discussed the implementation of clinical treatments for populations of young people experiencing behavioural or psychological challenges, but were being treated within hospital settings (e.g., Højgaard et al., 2020). While these articles could have been useful and were related to the research topic, the setting of the facility did not seem to fit the criteria of being "residential." This required some reflection and consideration of the inclusion criteria. The adoption of Whittaker et al.'s (2015) definition of TRC was useful in defining the topic of study for this project. Whittaker et al. (2015) define TRC as

> the planful use of a purposefully constructed, multi-dimensional living environment designed to enhance or provide treatment, education, socialization, support, and protection to children and youth with identified mental health or behavioral needs in partnership with

> their families and in collaboration with a full spectrum of community-based formal and informal helping resources. (p. 24)

This definition allowed for a more precise criteria by which to exclude some articles from the searches.

Additional challenges included the variety of terms used to describe TRC in different countries. Out of Home Care (OoHC) appears to be the predominant term used in Australian literature, however OoHC can also refer to foster care, kinship care, group homes, or independent living (Bailey et al., 2018). Articles that used OoHC instead of TRC (e.g., Bailey et al., 2018; Gonzalez-Garcia et al., 2022; Galvin et al., 2019) had to be more carefully explored to understand what the focus of the author's research was, and to ensure that it was indeed applicable to the topic being explored in this current literature review.

Limitations

Obvious limitations to the traditional narrative literature review are that the literature search is not thoroughly systematic or exhaustive. While a loose inclusion and exclusion criteria was imposed to assist in identifying articles pertinent to addressing the research problem, undoubtedly some useful articles were not used either due to time constraints or lack of identification.

The capstone researcher's own biases and interests likely played a role in the unfolding of the research project. For example, it is possible that the researcher unknowingly paid more attention to scholarly articles that came from journals related to TRC, than to journals related to family violence, for example.

As mentioned above, the varied use of comparable names to describe TRC settings also creates a limitation for the current literature. While psychiatric in-patient hospital studies were excluded from this literature review, it is possible that with enough time and resources, a comparison of the interventions used in this type of setting against the interventions used in TRC settings could yield some useful insights. This could also be true for therapeutic interventions used in other group or foster care settings. However, due to time and a necessity to set boundaries on the current project, the current literature review could not thoroughly explore these additional questions.

Chapter 4: Application to Clinical Practice

The objective of this study is to explore how therapeutic interventions in TRC settings can be strengthened and integrated into the broader milieu environment. The following chapter explores the implications of the findings in the previous chapter. The findings from the previous chapter will be framed in terms of clinical applications, scientific knowledge, and well-being to society.

Clinical Applications

The studies reviewed in the literature review identified several elements that contribute to positive outcomes for clients living in TRC settings. These elements that contribute to positive outcomes have utility in guiding clinical decisions in TRC settings.

Common Factors in TRC

Several studies identified common factors which contribute to positive outcomes in TRC. These proposed common factors include: role modeling, positive teaching (Lee & McMillen, 2017), setting, safety, treatment, staff (Farmer et al., 2017a), and the therapeutic alliance between child and caregiver (Lee & McMillen, 2017; Harder, 2018). Intentionally fostering these common elements by clinicians working in TRC settings could be a way to apply the findings of the literature review to everyday practice. While most program models and therapeutic interventions work to incorporate some of these common factors, it is possible that some TRC settings continue to lack either program model or therapeutic treatment. In these instances, even basic efforts to increase: child feelings of safety, child-caregiver relationships and alliance, predictability of environments, regular staffing, and opportunities for role-modelling and teaching, would likely contribute to more positive outcomes for children and youth.

Ecologically Oriented Program models

Several studies identified the efficacy of how ecological program models produce positive outcomes in TRC settings. Program models often intentionally foster the common factors identified above and incorporate some additional elements that increase positive outcomes for clients. The goal of a TRC program model is to create a total therapeutic environment where clients can experience feelings of security, safety, predictability, and have opportunities to learn new skills and patterns of interacting with themselves and others. This occurs within the presence of caring and trusting adults (O'hara, 2019). Program models may incorporate trauma-informed principles and care, family interventions (either by social workers or family therapists), or educational opportunities. While the adoption of program models occurs at the management level of TRC settings, CYCWs or clinicians working within a TRC setting can advocate for the use of an evidence-based program model to increase positive outcomes for clients. Clinicians and other practitioners should continue to reflect on how the total ecological environment of the TRC setting impacts the child.

Clinical interventions

Several therapeutic interventions were tested in TRC settings as indicated by the literature review. The most common interventions tested in the literature were CBT (e.g., Cosgrove et al., 2022; Joiner & Buttell, 2018; Taussig et al., 2019), DBT (e.g., Klodnick et al., 2021; McCredie et al., 2017; Masland et al., 2019), and MI (e.g., Eenshuistra et al., 2016; Harder, 2018). Family therapy was also explored in the literature (e.g., Herbell et al., 2022). While some authors have expressed concern that evidence-based therapies have not been tested in TRC contexts (e.g., James et al., 2017; Daly et al., 2018), the studies exploring the use of evidence-based therapies, including client-specific dyadic therapies and group therapies, suggest

they are effective in these contexts. The clinical application of this knowledge is that the adoption of evidence-based therapies within TRC settings are efficacious, and these therapies should be used by clinicians working in these spaces.

Systems Analysis

Research into the efficacy of increasing communication and collaboration within the mental health services sector has shown to qualitatively produce an increase in positive outcomes for clients (e.g., Kaasbøll et al., 2022). Failing to attend to intersystem collaboration and communication can produce feelings of mistrust amongst employees (Tørseth & Ådnanes, 2022). In some of the research into clinical interventions and program models, various systems within TRC settings collaborated and worked together to help produce positive outcomes for clients. This intersystem collaboration and communication presented its own challenges, including issues with integrating clinical interventions with program models (e.g., Dimitropoulos et al., 2023). However, increased communication and collaboration between CYCW and clinical staff could help strengthen the adoption of new strategies learned in therapy into the broader program model.

The clinical application of this knowledge is for practitioners to seek out opportunities for interdisciplinary and intersystem collaboration with the support of TRC management. Increasing communication and collaboration between TRC systems may increase the efficacy of clinical interventions in TRC.

Scientific Knowledge

The findings of the literature review contribute to a body of knowledge on the efficacy of TRC. The literature review has identified that ecologically oriented program models and evidence-based clinical interventions are effective in producing positive outcomes for clients.

The experimental quantitative studies (e.g., Chambers et al., 2016; Cosgrove et al., 2022; Farmer et al., 2017b; Holden & Sellers, 2019; Joiner & Buttell, 2018; Klodnick et al., 2021; Sellers et al., 2020; Taussig et al., 2019) all demonstrated positive outcomes from the interventions (either clinical therapeutic or program model) and produced empirical measures for the efficacy of each intervention.

The literature review also identified many studies lacking scientific rigour due to a lack of randomized samples and control groups (e.g., Holden & Sellers, 2019; Dimitropoulos et al., 2023; Klodnick et al., 2020; and McCredie et al., 2017). Part of this problem is due to the nature of TRC and how difficult it can be to implement randomized clinical trials in such settings. The body of research reviewed here indicates that more research needs to be done with better controls and randomization to increase the strength of the conclusions drawn from the study and to also better manage researcher bias and other hidden variables that may contribute to outcomes.

Well-Being of Society

The findings of the literature review contribute to the well-being of society by seeking to improve the lives of a vulnerable group of people living in our society. It is an obligation of psychologists to work towards the betterment of society and to protect the rights of vulnerable groups (Canadian Psychological Association, 2017). By exploring what interventions produce positive outcomes for clients living in TRC, it is hoped that the outcomes for this population can be improved. Improving the outcomes of this group has several benefits to society.

First, improving the efficacy of TRC treatment can result in decreased wait times for children in need of TRC services. Increasing the efficacy of treatment could reduce the length of time children need to be in TRC care. This would mean an increase in TRC efficiency.

Increasing TRC efficiency would mean an increase in availability of TRC care for children who do not currently have an adequate placement that can meet their complex needs.

Secondly, increasing the efficacy of treatment could reduce the number of days a child spends in TRC care. This is desirable by society because TRC care is a restrictive living environment and returning them to less restrictive environments where they can achieve success reflects an intent to protect their moral values and autonomy. Psychologists should strive to protect the moral rights of all people (CPA, 2017).

Thirdly, an increase in efficiency could result in a reduction in per child costs of delivering TRC services. By reducing the number of days a child spends in a TRC facility, the lower the cost of delivering TRC services per child is. TRC facilities are expensive to run (Yeheskel et al., 2020) and place a considerable tax burden on society (Sen et al., 2024). TRC facilities are frequently impacted by budgetary constraints (Sen et al., 2024). Demonstrating the efficacy and efficiency of TRC facilities could protect such facilities from further public funding cutbacks.

Finally, improving the long-term outcomes for children living in TRC care by delivering evidence-based therapeutic supports can improve the mental health and functionality of this population. This could result in a healthier population with a lower mental health burden. Not only is this beneficial to children and youth who have experienced significant life challenges and mental health struggles but is also beneficial to society by ensuring that the most vulnerable people in society are cared for.

Cultural and Diversity Implications

Indigenous children in government care are overrepresented in Canada (Government of Canada, 2024). The overrepresentation of indigenous children in care is a result of the Canadian

residential school system and other forms of structural discrimination that sought to assimilate indigenous peoples irrespective of their communities, culture, and relationship to the land (Ball & Benoit-Jansson, 2023; Government of Canada, 2020.

It is possible that bill C-92 and the recognition that indigenous peoples have the right to manage child and family services within their own jurisdictions (Ball & Benoit-Jansson, 2023) will change the way that TRC settings are structured in Canada. Connection to land and culture are integral to indigenous systems of wellness (Ball & Benoit-Jansson, 2023). With the potential for changes that bill C-92 may bring, it is possible, and indeed hopeful, that cultural programming will no longer be a TRC subsystem, but will rather permeate and structure the entire environment of the milieu.

A deeper incorporation of indigenous culture into TRC settings has been shown to increase feelings of resilience and belonging amongst indigenous children and youth experiencing a range of mental health issues (Ball & Benoit-Jansson, 2023; Njeze et al., 2020). A prototypical example of how indigenous culture has structured the milieu program environment in Alberta is the Nightwind Treatment Centre. This facility incorporates indigenous cultural practices into the milieu environment to foster resilience and promote healing (Nightwind Treatment Centre, 2024). Bill C-92 may change the relationship of indigenous-lead TRC settings with other systems outside of the TRC setting.

Indigenous children who have experiences with Child and Family Services perceive these interventions as continuations of a forced colonial imposition on their lives similar to that of the residential school system in Canada (Navia et al., 2018). In this context, the term “residential” in “therapeutic residential care” should be challenged and questioned. Recent name changes to several TRC facilities in Alberta suggest a transition away from the term “residential care” to

"Provincial Campus-Based Care" (PCBCs) (e.g., Canadian Accreditation Council, 2024a; Canadian Accreditation Council, 2024b; rdnews Now, 2022). These changes are presumably a response to associations between TRC and the harm done by Canada's residential school system.

Chapter 5: Conclusions and Recommendations

The purpose of this capstone project is to explore the question of how mental health therapeutic supports can be strengthened in Therapeutic Residential Care (TRC) settings to produce better outcomes for clients. The following section will provide some conclusions, recommendations, and areas of future research, based on the results of this literature review.

Conclusions from the Literature Review

Children in government care are a vulnerable population who have poorer long-term outcomes than children living outside government care (Galvin et al., 2022). Children living in Therapeutic Residential Care (TRC) settings are more likely to experience severe psychological and behavioural challenges than their counterparts living in less restrictive settings like foster or kinship care (Galvin et al., 2022; Harder & Knorth, 2015). Children coming into TRC care settings are likely to have experienced trauma and abuse (Cosgrove et al., 2022). These adverse experiences can produce internalizing and externalizing behaviours. These are some of the most common challenges amongst this population and these behaviours impact their ability to function in less restrictive placements (Cosgrove et al., 2022). Given the vulnerability and severe difficulties these children experience in their daily lives, it is an ethical responsibility of psychologists to work towards improving the quality of their lives (CPA, 2017) in both short and long-term timeframes by improving therapeutic supports in TRC settings.

The literature review in this project analyzed EBPs in TRC including program models and therapeutic interventions, and systems-level analyses of mental health organizations. Conclusions from the findings of this literature review are as follows.

Program Models

Ecologically-oriented program models that emphasized family involvement, trauma informed principles, a nurturing predictable environment, caring and emotionally available caregivers, and opportunities to learn and try out new behaviours and strategies, were successful in producing positive outcomes for children living in TRC settings. Some examples of program models explored in the literature review include the Children And Residential Experiences program (CARE) (Holden & Sellers, 2019), the Sanctuary model (Galvin et al., 2022b), Building Communities of Care (Forrest et al., 2018), the Ponoma Family First Project (Chambers et al., 2016), and the Teaching Family Model (Farmer et al., 2017a, 2017b).

Client-Specific Therapies (CSTs)

Client specific and group therapy interventions that have been implemented in TRC settings have demonstrated positive outcomes in the measures used by each study. Therapeutic interventions that demonstrated positive outcomes for clients when adapted to TRC contexts included Dialectical Behavioural Therapy (DBT), Cognitive Behavioural Therapy (CBT), and Motivational Interviewing (MI). Family therapy and family psychoeducation were two important interventions that contributed to positive outcomes for children living in TRC settings (Herbell et al., 2022; Lanier et al., 2020). Adapting these therapeutic interventions to TRC settings resulted in increased distress tolerance (Klodnick et al., 2021), adaptive functioning (Klodnick et al., 2021; McCredie et al., 2017), placement stability (Cosgrove et al., 2022), reductions in symptom severity (McCredie et al., 2017), and increased measures of quality of life (Taussig et al., 2019).

Challenges to TRC Efficacy

A number of factors negatively impact the efficacy and implementation of Evidence-Based Practices (EPBs) in TRC including the costs and administrative burdens of staff education

and training, compatibility of programs with certain EBPs, adequately matching populations to appropriate interventions, using therapeutic interventions not tested for use in TRC settings, high costs of implementing EBPs, staff attrition and the associated loss of expertise, training, and child-caregiver relationship through loss of staff.

General Systems and Integration

Regarding the use of a general systems approach and integration within TRC, adopting a systems-level analysis to understand how systems interact and influence each other in mental health settings can result in increased collaboration and communication between different systems within mental health settings. A systems analysis can help mental health settings understand how changes in treatment or assessment protocol can impact other parts of the mental health setting (Katrakazis et al., 2020). When different systems within mental health settings increase their collaboration and communication, mental health support delivery can improve (Kaasbøll et al., 2022). A study by Tørseth and Ådnanes (2022) demonstrated how a lack of communication and collaboration can negatively impact the delivery of supports.

Methodological Conclusions

The following conclusions are derived from the methodological critiquing conducted in chapter 2. The research designs of the reviewed studies included quantitative, qualitative, mixed methods, and systematic analyses approaches. Each design had relative strengths and weaknesses in contributing to the knowledge of interventions in TRC.

Quantitative approaches were useful in producing numerical quantitative data and analyses that provided readers with an understanding of the efficacy of the therapeutic interventions tested in studies (e.g., the use of Cohen's *d* and *h* to indicate effect sizes of interventions).

Many of the quantitative approaches lacked random sampling (e.g., Dimitropoulos et al., 2023; McCredie et al., 2017; Klodnick et al., 2021; Joiner & Buttell, 2018). This was noted by several authors to be a problem in TRC research because it decreased generalizability of results and increased risk of bias in the studies (Galvin et al., 2022; Eriksson et al., 2024). Other challenges in the quantitative research included high degrees of bias in research (Galvin et al., 2022; Bailey et al., 2019), lack of control groups (e.g., Holden & Sellers, 2019; Dimitropoulos et al., 2023; Klodnick et al., 2020; and McCredie et al., 2017), the relative rarity of randomized clinical trials in TRC research (James et al., 2017; Yeheskel et al., 2019), and the wide variety of measures used to measure positive outcomes for children and youth in TRC (Bailey et al., 2019; Galvin et al., 2022).

The qualitative research focused on the meanings of participant experiences in relation to a certain phenomenon. Data was most often collected via interviews and focus groups, and was then analyzed for themes (e.g., Kaasbøll et al., 2020; Tørseth and Ådnanes, 2022). The qualitative data is especially useful in this field as it can represent the voices and experiences of a population whose voices are often silenced or left out of research and decision-making (Hunleth et al., 2022; Gharabaghi, 2019; Office of the Provincial Advocate for Children and Youth, 2016). Children's perspectives are rarely utilized in medical health research (Hunleth et al., 2022). Including children's perspectives in research functions as advocacy (Gharabaghi, 2019). This could encourage TRC administrators and government agencies to reassess their policies and procedures to improve the health, well-being, and protection of moral rights of children in care.

Recommendations

Clinical Therapeutic Level

The information gathered from the literature review has helped guide some recommendations for how organizations and practitioners can optimize therapeutic supports in TRC. The recommendations can be summarized as follows: 1) transdiagnostic group therapies be implemented alongside regular interventions; 2) TRC caregiver staff be included in the implementation of therapeutic interventions where possible and appropriate; 3) implement standardized intake and outcome measures; and 4) integrate positive gains made in therapeutic interventions into the broader milieu environment through a systems analysis of the TRC setting.

Transdiagnostic Group Therapy

Implementing transdiagnostic group therapies to work alongside regular therapeutic interventions has several potential benefits. First, TRC facilities typically do not admit clients based on diagnoses or symptoms (Dimitropoulos et al., 2023) and therefore the populations living in these facilities tend to have a wide array of mental health challenges. Utilizing a transdiagnostic group approach could benefit children by treating a broad range of challenges and disorders amongst a varied population. Since children live in groups or cohorts in TRC settings, group therapy could allow the groups to simultaneously learn and try out new skills and techniques together.

Caregiver Inclusion for Therapeutic Supports

Including program milieu caregiver staff in supporting gains made in therapeutic interventions could help maximize the benefits of dyadic or group therapy. For example, in CBT therapy, homework outside of the therapy hour is typically supported by parents or guardians in the home. Since this is not possible in TRC settings, program milieu caregivers can help support

children and youths with practicing and implementing new techniques and skills in the broader program milieu environment (Dimitropoulos et al., 2023; Taussig et al., 2019).

Standardized Measures

Implementing standardized intake measures, like the Achenbach System of Empirically Based Assessments (ASEBA) within a TRC setting, and ideally across a region, would allow for better understanding of emerging mental health and behavioural concerns prior to entering TRC (Kaasbøll et al., 2022; Yeheskel et al., 2020). This would assist in guiding treatment decisions during their care in TRC and would allow for a tailoring of supports to the child. It would also create a baseline measure by which TRC staff could measure child progress. Outcome measures to be completed at the end of treatment would allow TRC programs to assess efficacy. From a broader systems perspective, outcome measures could also allow TRC management to have an understanding of program success rates and could help provide an understanding of which parts of the TRC program are most helpful or challenging to the child (Yeheskel et al., 2020). This could allow for further tailoring and refining to optimize the TRC program for future clients.

Integration

Integration of the different systems within a TRC setting could maximize the therapeutic benefits clients derive from each setting. Clinical and program milieu staff tend to focus on different and diverging areas of client functioning and this occasionally occurs to the detriment of the client (Harder, 2018). Increased communication and collaboration between clinical, program milieu, and other systems (e.g., family program, cultural programming, school/educational programming) within a treatment setting could increase understandings of how clients function in different environments and could help harmonize supports across systems in which clients interact (Kaasbøll et al., 2022). This kind of integration could occur through a

collaborative team meeting or a new framework for incorporating different staff members from one system into another. For example, children who learn new skills and strategies in therapy (i.e., the clinical system) could be supported in using these new skills in the program milieu by having clinical staff communicate and collaborate with program milieu staff on how to incorporate these new skills in the regular environment (e.g., Dimitropoulos et al., 2023). Ideally, TRC facilities should conduct a systems analysis to understand the variety of systems at work within and outside the TRC setting, and to understand how those systems interact with each other. Such a systems analysis would be a prerequisite to introducing new systems of collaboration and communication between systems. Furthermore, an understanding of the systems at work in each client's life through the use of a strategic questionnaire using Bronfenbrenner's Ecological Systems Theory (e.g., Alispahic, 2024) could help TRC staff understand how the internal systems of the child may interact with TRC systems.

Future Research Recommendations

This capstone project has identified several ways that mental health supports in the form of EBPs could be improved in TRC. However, as many authors identified in the literature review, much more research is needed in this area. The following section discusses areas of future research that could help strengthen therapeutic supports in TRC settings.

Increasing Design Quality

TRC research quality could be improved in experimental studies by randomizing samples, including control groups, selecting representative samples, and increasing study participant numbers (Yeheskel et al., 2020). More randomized clinical trials in TRC research would help to definitively demonstrate the efficacy of certain interventions introduced in TRC settings and could help to significantly reduce researcher bias (Galvin et al., 2022a).

Incorporating Standardized Measures

Encouraging research designers to use at least one standardized measure in their studies would allow for cross-study comparisons and meta-analyses. For example, if research authors collectively agreed to use the CBCL, the YSL, or the Youth Outcome Questionnaire (Y-OQ), then researchers could more easily compare the efficacy of certain interventions (Yeheskel et al., 2020).

Representing Client Voices

Qualitative TRC research could be improved by including more voices of child participants. Sharing the voices of children living in TRC (while also protecting their identities) is a form of advocacy that ensures that perspectives of this vulnerable population are privileged and shared (Gharabaghi, 2019; Hunleth et al., 2022).

Topic Related Research

More research on the implementation of EBPs in TRC settings is needed to establish their efficacy. Many EBPs have not been tested or adequately adapted for TRC contexts. To optimize benefits and minimize harm to clients, more testing of EBPs with TRC populations is needed. A potential research question on this topic could be: “What is the effect of adapting community-tested EBP mental health interventions into TRC settings?”

Research is needed to evaluate how systems analysis and GST can be applied to TRC settings. Existing research has focused on the application of GST in broader mental health settings but has not been applied to TRC. A useful research question needed to better explore the efficacy of systems analysis in TRC could be: “What is the effect of systems analysis in TRC settings on: 1) client outcomes, and 2) staff perceptions of collaboration and communication?”

A greater understanding of how indigenous culture, knowledge, teachings, and medicine can be incorporated into clinical and program milieu systems in TRC could help decolonize TRC and improve outcomes for indigenous clients (Ball & Benoit-Jansson, 2023). More research needs to be done in Canadian contexts on how cultural and indigenous programming can be incorporated into TRC to maximize benefits to indigenous children and youth.

This capstone project explores how therapeutic supports could be strengthened in TRC settings to improve client outcomes. The purpose of this research is to improve the outcomes of children living in residential care settings. Compared to other populations of children in government care, and compared to the general child population, this group has significantly poorer outcomes (Galvin et al., 2022). In Canadian contexts, indigenous children living in TRC are overrepresented and this is a product of historical structural discrimination against indigenous peoples of this land (Ball & Benoit-Jansson, 2023; Government of Canada, 2024). Decolonizing TRC practices and working to include indigenous culture and peoples into TRC settings could be an important step in improving the efficacy of TRC for indigenous children. However, recommendations for how to decolonize TRC settings and improve the lives of indigenous children living in care has regrettably been beyond the scope of this project. The research and recommendations in this capstone project aspire to work in solidarity with the research and recommendations of indigenous researchers working to decolonize TRC settings and improve the lives of indigenous children.

More needs to be done to help and improve the outcomes of children and youth living in TRC settings. The literature review in this capstone should provide an understanding of the current strengths and weaknesses of evidence-based clinical interventions and program models that are designed to produce better outcomes for children and youth living in TRC. The

recommendations suggested here are somewhat aspirational and will require more research to understand how they could be introduced in TRC contexts. They have been suggested with the intention to protect, advocate, empower, and maximize the benefits to children living in care.

References

Akin, B. A., & McDonald, T. P. (2018). Parenting intervention effects on reunification: A randomized trial of PMTO in foster care. *Child Abuse & Neglect*, *83*, 94–105. https://doi.org/10.1016/j.chiabu.2018.07.011

Alessandri, G., Zuffianò, A., & Perinelli, E. (2017). Evaluating intervention programs with a pretest-posttest design: A structural equation modeling approach. *Frontiers in Psychology*, *8*, 223. https://doi.org/10.3389/fpsyg.2017.00223

Alispahic, S., (2024, March 9). *Ecological systems theory worksheet*. Happier therapy. https://happiertherapy.com/ecological-systems-theory-worksheet/

Amarbayan, M. M., Carpenter, T., Hébert, M. L., Santana, M., & Zwicker, J. (2021). Value-based mental health services for youth and families: The role of patient-reported outcome measures in youth mental health services. *School of Public Policy Publications*, *14*(1), 1-12. https://doi.org/10.11575/sppp.v14i1.71573

American Psychological Association. (2021). *Policy statement on evidence-based practice in psychology*. American Psychological Association. https://www.apa.org/practice/guidelines/evidence-based-statement

Anglin, J. (2019). The legacy of *the other 23 hours* and the future of child and youth care. *Residential Treatment For Children & Youth*, *36*(1), 27–34. https://doi.org/10.1080/0886571X.2018.1515602

Anglin, J. P., Saint-Girons, M., & Trocmé, N. (2023). Residential care for children and youth in Canada. In J. K. Whittaker, L. Holmes, J. F. Del Valle, & S. James (Eds.), *Revitalizing residential care for children and youth: Cross-national trends and challenges* (1st, pp. 75–90). Oxford University Press.

Association of Children's Residential Care. (2023). *ACRC 2023 Annual Report*. https://togetherthevoice.org/who-we-are/2023-annual-report/

Association of Children's Residential and Community Services (ACRC). (2024, June 12). Senate finance committee hearing & report released today. *ACRC Action Alert*. https://members.togetherthevoice.org/EmailTracker/LinkTracker.ashx?linkAndRecipientCode=Lr90IGxDxvkDZJwrc4V7MJUHoTUqqXAsqgQ5CHzkolbA%2bDcGgoNZ4V4wO6QyZXYhQL%2ba2d3pIOU6MlnVXn8qAbhNOtF0WPQsaJ5In3%2buKHM%3d

Bailey, C., Klas, A., Cox, R., Bergmeier, H., Avery, J., & Skouteris, H. (2019). Systematic review of organisation-wide, trauma-informed care models in out-of-home care (OoHC) settings. *Health & Social Care in the Community, 27*(3), e10–e22. https://doi.org/10.1111/hsc.12621

Ball, J., & Benoit-Jansson, A. (2023). Promoting cultural connectedness through indigenous-led child and family services: A critical review with a focus on Canada. *First Peoples Child & Family Review, 18*(1), 34–59. https://fpcfr.com/index.php/FPCFR/article/view/567

Bath, H., & Seita, J. (2018). *The three pillars of transforming care: Trauma and resilience in the other 23 hours*. University of Winnipeg Faculty of Education Publishing.

Becvar, R.J., Becvar, D.S., & Reif, L.V. (2024). *Systems theory and family therapy: A primer* (4th ed.). Rowman & Littlefield Publishers.

Bendo, D. & Mitchell, R. (2017). The role of Canada's child and youth advocates: A social constructivist approach. *International Journal of Children's Rights, 25*(1), 1-24. https://doi.org/10.1163/15718182-02502002

Bertalanffy, L. V. (1967). General theory of systems: Application to psychology. *Studies in semiotics*, *6*(6), 125-136. https://doi.org/10.1177/053901846700600610

Breitenstein, S. M., Gross, D., Garvey, C., Hill, C., Fogg, L., & Resnick, B. (2010). Implementation fidelity in community-based interventions. *Research in Nursing & Health*, *33*(2), 164–173. https://doi.org/10.1002/nur.20373

Brown, R. J., Burton, A. L., & Abbott, M. J. (2022). The relationship between distress tolerance and symptoms of depression: Validation of the Distress Tolerance Scale (DTS) and short-form (DTS-SF). *Journal of clinical psychology*, *78*(12), 2609–2630. https://doi.org/10.1002/jclp.23370

Cameron, C., Hollingworth, K., Schoon, I., van Santen, E., Schrodoer, W., Ristikari, T., Heino, T. & Pekkarinen, E. (2018). Care leavers in early adulthood: How do they fare in Britain, Finland, and Germany. *Children and Youth Services Review, 87*, 163–72.

Canadian Accreditation Council. (October, 2024a). *Provincial campus based care (PCBCs)-SAAMIS*. https://www.canadianaccreditation.ca/accredited-org/alberta-government-provincial-campus-based-treatment-centres-saamis/

Canadian Accreditation Council. (October, 2024b). *Provincial campus based care (PCBCs)-Topaz House*. https://www.canadianaccreditation.ca/accredited-org/1126yellowhead-youth-centre/

Canadian Psychological Association. (2017). *Canadian code of ethics for psychologists* (4th ed). Canadian Psychological Association. https://cpa.ca/docs/File/Ethics/CPA_Code_2017_4thEd.pdf

Carlucci, L., Saggino, A., & Balsamo, M. (2021). On the efficacy of the unified protocol for transdiagnostic treatment of emotional disorders: A systematic review and meta-analysis. *Clinical Psychology Review*, *87*, 101999. https://doi.org/10.1016/j.cpr.2021.101999

Chambers, R. M., Brocato, J., Fatemi, M., & Rodriguez, A. Y. (2016). An innovative child welfare pilot initiative: Results and outcomes. *Children and Youth Services Review*, *70*(1), 143–151. https://doi.org/10.1016/j.childyouth.2016.09.004

Cosgrove, J. A., Lee, B. R., Greeno, E. J., & Horen, M. J. (2022). Cognitive behavioral therapy–plus for youth in out-of-home care: A quasi-experimental evaluation. *Social Work Research*, *46*(3), 229–241. https://doi.org/10.1093/swr/svac016

Creswell, J. & Poth, N. (2018). *Qualitative inquiry and design: Choosing among five approaches*. Sage Publications.

Cummins, I. (2017). *Critical psychiatry: A biography*. Critical Publishing.

Daly, D. L., Huefner, J. C., Bender, K. R., Davis, J. L., Whittaker, J. K., & Thompson, R. W. (2018). Quality care in therapeutic residential programs: Definition, evidence for effectiveness, and quality standards. *Residential Treatment for Children & Youth*, *35*(3), 242–262. https://doi.org/10.1080/0886571X.2018.1478240

Dimitropoulos, G., Lindenbach, D., Anderson, A., Rowbotham, M., Wang, E., Heintz, M., Ehrenreich-May, J., & Arnold, P. D. (2023). A qualitative study on the implementation of a transdiagnostic cognitive behavioral therapy for children in a child welfare residential treatment program. *Child Abuse & Neglect*, *146*(1), 106487. https://doi.org/10.1016/j.chiabu.2023.106487

Eenshuistra, A., Harder, A. T., van Zonneveld, N. L., & Knorth, E. J. (2016). A motivational interviewing based observation study of one-on-one conversations between residential

care workers and adolescents. *International Journal of Child and Family Welfare*, *17*(1/2), 64-84.

Efron, S. E., & Ravid, R. (2019). *Writing the literature review: A practical guide* (1st ed.). The Guilford Press. https://pure.rug.nl/ws/portalfiles/portal/34832675/Eenshuistra_et_al._2016_IJCFW_17_1__2_.pdf

Eriksson, P., Aaltio, E., & Laajasalo, T. (2024). Short-term effectiveness of residential out-of-home care for children and youth—A scoping review. *The British Journal of Social Work*, *54*(7), 3135-3157. https://doi.org/10.1093/bjsw/bcae084

Esaki, N., Benamati, J., Yanosy, S., Middleton, J. S., Hopson, L. M., Hummer, V. L., & Bloom, S. L. (2013). The sanctuary model: Theoretical framework. *Families in Society: The Journal of Contemporary Social Services*, *94*(2), 87–95. https://doi.org/10.1606/1044-3894.4287

Farmer, E. M. Z., Murray, M. L., Ballentine, K., Rauktis, M. E., & Burns, B. J. (2017). Would we know it if we saw it? Assessing quality of care in group homes for youth. *Journal of Emotional and Behavioral Disorders*, *25*(1), 28–36. https://doi.org/10.1177/1063426616687363

Farmer, E. M. Z., Seifert, H., Wagner, H. R., Burns, B. J., & Murray, M. (2017b). Does model matter? Examining change across time for youth in group homes. *Journal of Emotional and Behavioral Disorders*, *25*(2), 119–128. https://doi.org/10.1177/1063426616630520

Fidanboy, M. (2022). *Organizations and complex adaptive systems*. Routledge. https://doi.org/10.4324/9781003182764

Fields, E., Farmer, E. M. Z., Apperson, J., Mustillo, S., & Simmers, D. (2006). Treatment and posttreatment effects of residential treatment using a re-education model. *Behavioral Disorders, 31*(3), 312-322. https://doi.org/10.1177/019874290603100302

Forrest, S., Gervais, R., Lord, K. A., Sposato, A., Martin, L., Beserra, K., & Spinazzola, J. (2018). Building communities of care: A comprehensive model for trauma-informed youth capacity building and behavior management in residential services. *Residential Treatment for Children & Youth*, *35*(4), 265–285. https://doi.org/10.1080/0886571X.2018.1497930

Galvin, E., O'Donnell, R., Breman, R., Avery, J., Mousa, A., Halfpenny, N., & Skouteris, H. (2022a). Interventions and practice models for improving health and psychosocial outcomes for children in residential out-of-home care: Systematic review. *Australian Social Work, 75*(1), 33–47. https://doi.org/10.1080/0312407X.2020.1856394

Galvin, E., O'Donnell, R., Avery, J., Morris, H., Mousa, A., Halfpenny, N., Miller, R., & Skouteris, H. (2022b). Residential out-of-home care staff perceptions of implementing a trauma-informed approach: The sanctuary model. *Journal of Child & Adolescent Trauma*, *15*(3), 653–667. https://doi.org/10.1007/s40653-021-00427-0

Geertz, C. (1973). *The Interpretation of cultures: Selected essays*. New York: Basic Books. https://philpapers.org/archive/GEETTD.pdf

Gharabaghi, K. (2024). Quality care in residential care and treatment settings in North America: From complex research to four everyday principles for practice. *Youth*, *4*(1), Article 1. https://doi.org/10.3390/youth4010017

Gharabaghi, K. (2019). *A hard place to call home: A Canadian perspective on residential care and treatment for children and youth.* Canadian Scholars.

Giraldi, M., Mitchell, F., Porter, R. B., Reed, D., Jans, V., McIver, L., Manole, M., & McTier, A. (2022). Residential care as an alternative care option: A review of literature within a global context. *Child & Family Social Work*, *27*(4), 825–837. https://doi.org/10.1111/cfs.12929

González-García, C., Vassiliadis, E., Moreno-Manso, J. M., Alcántara, M., del Valle, J. F., & Bravo, A. (2023). Changes in mental health of children and young people in residential care: Outcomes and associated factors. *Psychosocial Intervention*, *32*(1), 11–19. https://doi.org/10.5093/pi2022a16

Gopal, D. P., Chetty, U., O'Donnell, P., Gajria, C., & Blackadder-Weinstein, J. (2021). Implicit bias in healthcare: Clinical practice, research and decision making. *Future Healthcare Journal*, *8*(1), 40. https://doi.org/10.7861/fhj.2020-0233

Government of Canada. (2024, May 24). *Reducing the number of indigenous children in care.* https://www.sac-isc.gc.ca/eng/1541187352297/1541187392851.

Graaf, G., Accomazzo, S., Matthews, K., Mendenhall, A., & Grube, W. (2021). Evidence-based practice in systems of care for children with complex mental health needs. *Journal of Evidence-Based Social Work*, *18*(4), 394–412. https://doi.org/10.1080/26408066.2021.1891172

Gross, T. J., Hurley, K. D., Sullivan, J. J., Lambert, M. C., Van Ryzin, M. J., & Thompson, R. W. (2015). Program records as a source for program implementation assessment and youth outcomes predictors during residential care. *Children and Youth Services Review*, *58*, 153–162. https://doi.org/10.1016/j.childyouth.2015.09.016

Gutterswijk, R. V., Kuiper, C. H. Z., Lautan, N., Kunst, E. G., van der Horst, F. C. P., Stams, G. J. J. M. & Prinzie, P. J. (2020). The outcome of non-residential youth care compared to

residential youth care: A multilevel meta-analysis. *Children and Youth Services Review*, *113*, 104950. https://doi.org/10.1016/j.childyouth.2020.104950

Hansen, A. S., Telléus, G. K., Mohr-Jensen, C., & Lauritsen, M. B. (2021). Parent-perceived barriers to accessing services for their child's mental health problems. *Child and Adolescent Psychiatry and Mental Health*, *15*(1), 4. https://doi.org/10.1186/s13034-021-00357-7

Harder, A. T. (2018). Residential care and cure: Achieving enduring behavior change with youth by using a self-determination, common factors and motivational interviewing approach. *Residential Treatment for Children & Youth*, *35*(4), 317–335. https://doi.org/10.1080/0886571X.2018.1460006

Harder, A. & Knorth, E. (2015). Uncovering what is inside the "black box" of effective therapeutic residential youth care. In Whittaker, J. K., Fernandez del Valle, J., & Holmes, L. (Eds.), *Therapeutic residential care for children and youth: Developing evidence-based international practice* (pp. 217-230). Jessica Kingsley Publishers.

Herbell, K., & Ault, S. (2021). Differences in treatment approaches by residential treatment facilities. *Residential Treatment for Children & Youth*, *38*(3), 224–247. https://doi.org/10.1080/0886571X.2021.1910613

Herbell, K. S., & Breitenstein, S. M. (2020). Parenting a child in residential treatment: Mother's perceptions of programming needs. *Issues in Mental Health Nursing*, *42*(7), 639–648. https://doi.org/10.1080/01612840.2020.1836536

Herbell, K., Breitenstein, S. M., Ault, S., & Price, M. (2022). Variation in evidence-based practices among youth-serving residential treatment facilities. *Journal of the American*

Psychiatric Nurses Association, 10783903221120828. https://doi.org/10.1177/10783903221120828

Holden, M. (2023). *CARE: Creating conditions for change* (3rd ed.). Child Welfare League of America.

Holden, M. J., & Sellers, D. (2019). An evidence-based program model for facilitating therapeutic responses to pain-based behavior in residential care. *International Journal of Child, Youth & Family Studies*, *10*(2–3), 63–80. https://doi.org/10.18357/ijcyfs102-3201918853

Huefner, D.L., Bender, K.R., Huefner, J.C., Davis, J.L., Whittaker, J.K., & Thompson, R. W. (2018). Quality care in therapeutic residential programs: Definition, evidence for effectiveness, and quality standards. *Residential Treatment for Children & Youth*, *35*(3), 242–262.

Hunleth, J. M., Spray, J. S., Meehan, C., Lang, C. W., & Njelesani, J. (2022). What is the state of children's participation in qualitative research on health interventions?: A scoping study. *BMC Pediatrics*, *22*, 328. https://doi.org/10.1186/s12887-022-03391-2

Izzo, C. V., Smith, E. G., Holden, M. J., Norton, C. I., Nunno, M. A., & Sellers, D. E. (2016). Intervening at the setting level to prevent behavioral incidents in residential child care: Efficacy of the CARE program model. *Prevention Science*, *17*(5), 554–564. https://doi.org/10.1007/s11121-016-0649-0

Jacobs, P., & Lesage, A. (2019). The public cost of mental health– and addiction-related services for youth (ages 12-17) in Alberta. *Canadian Journal of Psychiatry, 64*(5), 323-328. https://doi.org/10.1177/0706743718795676

James, S. (2015). Evidence-based practice in therapeutic residential care. In Whittaker, J. K., Fernandez del Valle, J., & Holmes, L. (Eds.), *Therapeutic residential care for children and youth: Developing evidence-based international practice* (pp. 142-155). Jessica Kingsley Publishers.

James, S. (2011). What works in group care? — A structured review of treatment models for group homes and residential care. *Children and Youth Services Review*, *33*(2), 308–321. https://doi.org/10.1016/j.childyouth.2010.09.014

James, S., Thompson, R. W., & Ringle, J. L. (2017). The implementation of evidence-based practices in residential care: Outcomes, processes, and barriers. *Journal of Emotional and Behavioral Disorders*, *25*(1), 4–18. https://doi.org/10.1177/1063426616687083

Jason, L. A., & Bobak, T. (2022). Using systems theory to improve intervention outcomes. *Professional psychology, research and practice*, *53*(4), 415–422. https://doi.org/10.1037/pro0000467

Johnson O. (2019). General system theory and the use of process mining to improve care pathways. *Studies in health technology and informatics*, *263*, 11–22. https://doi.org/10.3233/SHTI190107

Joiner, V.C., & Buttell, F. 2018. Investigating the usefulness of trauma-focused cognitive behavioral therapy in adolescent residential care. *Journal of Evidence-Informed Social Work, 15*(4):457–72. https://doi:10.1080/23761407.2018.1474155

Kaasbøll, J., Ådnanes, M., Paulsen, V., & Melby, L. (2022). Interagency collaboration for early identification and follow-up of mental health problems in residential youth care: Evaluation of a collaboration model. *Nordic Social Work Research*, *12*(4), 592–607. https://doi.org/10.1080/2156857X.2020.1833964

Karjalainen, P., Kiviruusu, O., Aronen, E. T., & Santalahti, P. (2019). Group-based parenting program to improve parenting and children's behavioral problems in families using special services: A randomized controlled trial in a real-life setting. *Children and Youth Services Review, 96*, 420–429. https://doi.org/10.1016/j.childyouth.2018.12.004

Kast, F. E., & Rosenzweig, J. E. (1972). General systems theory: Applications for organization and management. *Academy of Management Journal (Pre-1986), 15*(4), 447. https://www.proquest.com/scholarly-journals/general-systems-theory-applications-organization/docview/229545927/se-2

Katrakazas, P., Grigoriadou, A., & Koutsouris, D. (2020). Applying a general systems theory framework in mental health treatment pathways: The case of the Hellenic center of mental health and research. *International Journal of Mental Health Systems*, *14*(67), 1-8. https://doi.org/10.1186/s13033-020-00398-z

Kim, H., Sefcik, J. S., & Bradway, C. (2017). Characteristics of qualitative descriptive studies: A systematic review. *Research in Nursing & Health*, *40*(1), 23–42. https://doi.org/10.1002/nur.21768

Klodnick, V. V., Kissane, B., Johnson, R. P., Malina, C., Ewing, A., & Fagan, M. A. (2021). Adapting dialectical behavior therapy for young adults diagnosed with serious mental health conditions in residential care: A feasibility study. *Residential Treatment for Children & Youth*, *38*(3), 269–288. https://doi.org/10.1080/0886571X.2020.1751017

Koftinoff, J., Amarbayan, M. M., Wittevrongel, K., Santana, M., & Zwicker, J. (2023). Measuring patient-oriented outcomes in children and youth with mental health concerns:

Albertan key informant perspectives. *The School of Public Policy Publications*, *16*(1), 1-15. https://doi.org/10.11575/SPPP.V16I1.75412

Kramer, M. G. (2016). Sanctuary in a residential treatment center: Creating a therapeutic community of hope countering violence. *Therapeutic Communities: The International Journal of Therapeutic Communities*, *37*(2), 69–83. https://doi.org/10.1108/TC-01-2015-0005

Kramer, M. G. (2013). *From a culture of violence to a culture of hope: Creating sanctuary in a residential treatment facility* (Publication No. 3558183) [Doctoral dissertation, Fordham University]. https://www.proquest.com/dissertations-theses/culture-violence-hope-creating-sanctuary/docview/1348690326/se-2

Lanier, P., Jensen, T., Bryant, K., Chung, G., Rose, R., Smith, Q., & Lackmann, L. (2020). A systematic review of the effectiveness of children's behavioral health interventions in psychiatric residential treatment facilities. *Children and Youth Services Review*, *113*, 104951. https://doi.org/10.1016/j.childyouth.2020.104951

Lee, B. R., & McMillen, J. C. (2017). Pathways forward for embracing evidence-based practice in group care settings. *Journal of Emotional and Behavioral Disorders*, *25*(1), 19–27. https://doi.org/10.1177/1063426616688210

Levrouw, D., Devlieghere, J., Vandevelde, S., & Roose, R. (2020). Developing a positive living climate in residential youth care: A qualitative study. *Children and Youth Services Review*, *116*, 105221. https://doi.org/10.1016/j.childyouth.2020.105221

Li, N., Tan, M., Thuma, P. E., & Grigorenko, E. L. (2023). Pediatric symptom checklist-17: Factor structure and uniform differential item functioning across gender and age in HIV orphans and vulnerable children in Zambia. *European journal of psychological*

assessment: official organ of the European Association of Psychological Assessment, *39*(3), 165–175. https://doi.org/10.1027/1015-5759/a000707

Liu, X., Guo, C., Liu, L., Wang, A., Hu, L., Tang, M., Chai, F., Zhao, G., Yang, J., & Sun, L. (1997). Reliability and validity of the Youth Self-Report (YSR) of Achenbach's Child Behavior Checklist (CBCL). *Chinese Mental Health Journal*, *11*(4), 200–203.

Mahtani, K., Spencer, E. A., Brassey, J., & Heneghan, C. (2018). Catalogue of bias: Observer bias. *BMJ Evidence - Based Medicine*, *23*(1), 23. https://doi.org/10.1136/ebmed-2017-110884

Matte-Landry, A., & Collin-Vézina, D. (2022). Patterns of change in restraints, seclusions and time-outs over the implementation of trauma-informed staff training programs in residential care for children and youth. *Residential Treatment for Children & Youth*, *39*(2), 154–178. https://doi.org/10.1080/0886571X.2021.1929660

McCredie, M. N., Quinn, C. A., & Covington, M. (2017). Dialectical behavior therapy in adolescent residential treatment: Outcomes and effectiveness. *Residential Treatment for Children & Youth*, *34*(2), 84-106. https://doi.org/10.1080/0886571X.2016.1271291

McFadden, P., Davies, H., Manthorpe, J., MacLochlainn, J., McGrory, S., Naylor, R., Mallett, J., Kirby, K., Currie, D., Schroder, H., Nicholl, P., Mullineux, J., & McColgan, M. (2024). Safe staffing and workload management in social work: A scoping review of legislation, policy and practice. *The British Journal of Social Work*, *54*(5), 2006–2026. https://doi.org/10.1093/bjsw/bcae017

Njeze, C., Bird-Naytowhow, K., Pearl, T., & Hatala, A. R. (2020). Intersectionality of resilience: A strengths-based case study approach with indigenous youth in an urban Canadian

context. *Qualitative Health Research*, *30*(13), 2001–2018. https://doi.org/10.1177/1049732320940702

Nightwind Treatment Facility. (2024). *About us*. Nightwind treatment centre: Miyokiw (grow well). http://nightwind.ca/about-us/

Nyerges, E., Antle, B. F., Logsdon, A. R., Kendrick, J., Barbee, A. P., & Purdy, L. M. (2023). Strengthening the residential care workforce: Exploring the role of organizational climate and culture and staff intention to stay or leave. *Residential Treatment for Children & Youth*, 1–20. https://doi.org/10.1080/0886571X.2023.2202891

O'Hara, C. A. (2019). From therapy to therapeutic: The continuum of trauma-informed care. *Children Australia*, *44*(2), 73–80. https://doi.org/10.1017/cha.2019.4

Olmos-Vega, F. M., Stalmeijer, R. E., Varpio, L., & Kahlke, R. (2023). A practical guide to reflexivity in qualitative research: AMEE guide no. 149. *Medical Teacher*, *45*(3), 241-251. https://doi.org/10.1080/0142159X.2022.2057287

Owens, J. K. (2021). Systematic reviews: Brief overview of methods, limitations, and resources. *Nurse Author & Editor*, *31*(3–4), 69–72. https://doi.org/10.1111/nae2.28

Parry, S. L., Williams, T., & Burbidge, C. (2021). Restorative parenting: Delivering trauma-informed residential care for children in care. *Child & Youth Care Forum*, *50*(6), 991-1012. https://doi.org/10.1007/s10566-021-09610-8

Paul, G. L. (1969). Behavior modification research: Design and tactics. In C. M. Franks (Ed.), *Behavior therapy: Appraisal and status* (pp. 29–62). McGraw-Hill.

Pedersen, L.-M. L. (2020). Interprofessional collaboration in the Norwegian welfare context: A scoping review. *Journal of Interprofessional Care*, *34*(6), 737–746. https://doi.org/10.1080/13561820.2019.1693353

Pérez García, S., Águila Otero, A., González García, C., Santos, I., & Del Valle, J. (2019). No one ever asked us: Young people's evaluation of their residential child care facilities in three different programs. *Psicothema*, *31*(1), 319-326. https://doi.org/10.7334/psicothema2019.129.

Pitsch, H. (1992). Children in residential care and their families: A systems perspective. *Residential Treatment for Children & Youth*, *10*(1). https://doi.org/10.1300/J007v10n01_08

Prince, M. (2012). Epidemiology. In P. wright, J. Stern, & M. Phelan (Eds.), *Core Psychiatry* (3rd ed.) (pp. 115-129). Saunders. https://www.sciencedirect.com/sdfe/pdf/download/eid/3-s2.0-B9780702033971000094/first-page-pdf

Provincial Advocate for Children and Youth. (2016). *Searching for home: Reimagining residential care*. Office of the Provincial Advocate for Children and Youth. https://cwrp.ca/sites/default/files/publications/en/residentialcarereport_en.pdf

Rajabalinejad, M., van Dongen, L., & Ramtahalsing, M. (2020). Systems integration theory and fundamentals. *Safety and Reliability*, *39*(1), 83–113. https://doi.org/10.1080/09617353.2020.1712918

Rand, J. (2011). Residential schools: Creating and continuing institutionalization among aboriginal peoples in Canada. *First Peoples Child & Family Review*, *6*(1), 56-65. https://fpcfr.com/index.php/FPCFR/article/view/105/169

Rau, T., Ohlert, J., Ramsthaler, H., Fegert, J. M., & Keller, F. (2020) Profitieren Kinder und Jugendliche mit underschiedlichen Aufnahmegründen gleichermassen von einer Heimunterbringung? [Do children and adolescents with different reasons for admission

equally benefit from institutional care?], *Praxis Der Kinderpsychologie Und Kinderpsychiatrie*, *69*(3), pp. 218–35.

rdnewsNOW (2022, April 18). Alberta children's services announces new implementations for support. rdnewsNOW. https://rdnewsnow.com/2022/04/18/alberta-childrens-services-announces-new-implementations-for-support/

Ringle, J. L., James, S., Ross, J. R., & Thompson, R. W. (2019). Measuring youth residential care provider attitudes: A confirmatory factor analysis of the Evidence-Based Practice Attitude Scale. *European Journal of Psychological Assessment*, *35*(2), 241–247. https://doi.org/10.1027/1015-5759/a000397

Sallnäs, M., & Shanks, E. (2021). Therapeutic content in Swedish residential care for children and youth – managers choices and the reasoning behind. *European Journal of Social Work*, *26*(2), 376–388. https://doi.org/10.1080/13691457.2021.2016642

Schutte, V., Danseco, E., Lucente, G., & Sundar, P. (2023). Mental health treatment programs for children and young people in secure settings: A systematic review. *International Journal of Mental Health Systems*, *17*(30), 1-13. https://doi.org/10.1186/s13033-023-00599-2

Scott, M. J. (2022). Reasons things happen for a reason: An integrative theory of teleology. *Perspectives on Psychological Science: A Journal of the Association for Psychological Science*, *17*(2), 452–464. https://doi.org/10.1177/1745691621995753

Sellers, D. E., Smith, E. G., Izzo, C. V., McCabe, L. A., & Nunno, M. A. (2020). Child feelings of safety in residential care: The supporting role of adult-child relationships. *Residential Treatment for Children & Youth*, *37*(2), 136–155. https://doi.org/10.1080/0886571X.2020.1712576

Sen, R., Ulybina, O. A., & Holmes, L. (2024). Charting the 21st century rise of for-profit residential child care. *Youth*, *4*(1), 272-287. https://doi.org/10.3390/youth4010019

Simpson, G., Entwistle, C., Short, A. D., Morciano, M., & Stokes, J. (2023). A typology of integrated care policies in the care home sector: A policy document analysis. *Frontiers in public health*, *11*, 943351. https://doi.org/10.3389/fpubh.2023.943351

Spring, B., Hoffman, S., & Steglitz, J. (2019). History and process of evidence-based practice in mental health. In S. Dimidjian (Ed.), *Evidence-based practice in action* (pp. 9-27). Guildford Press.

Stockholm Conference. (2003). *Stockholm declaration on children and residential care*. Retrieved from https://resourcecentre.savethechildren.net/library/stockholm-declarationchildren-and-residential-care-12-15-may-2003

Suzuki, M., & Yamamoto, Y. (2021). Characterizing the influence of confirmation bias on web search behavior. *Frontiers in Psychology*, *12*, 771948. https://doi.org/10.3389/fpsyg.2021.771948

Taherdoost, H. (2022). What are different research approaches? Comprehensive review of qualitative, quantitative, and mixed method research, their applications, types, and limitations. *Journal of Management Science & Engineering Research*, *5*(1), 53–63. https://doi.org/10.30564/jmser.v5i1.4538

Taussig, H. N., Weiler, L. M., Garrido, E. F., Rhodes, T., Boat, A., & Fadell, M. (2019). A positive youth development approach to improving mental health outcomes for maltreated children in foster care: Replication and extension of an RCT of the fostering healthy futures program. *American Journal of Community Psychology*, *64*(3–4), 405–417. https://doi.org/10.1002/ajcp.12385

Theall, L., Arbeau, K., Willoughby, K., St. Pierre, J., Ng, G., & Stewart, S. L. (2021). Assessing needs and outcomes of children and youth receiving intensive services. *Residential Treatment For Children & Youth*, *39*(1), 16–33. https://doi.org/10.1080/0886571X.2021.1964415

Tørseth, T. N., & Ådnanes, M. (2022). Trust in pathways? Professionals' sensemaking of care pathways in the Norwegian mental health services system. *BMC Health Services Research*, 22(1), 33. https://doi.org/10.1186/s12913-021-07424-x

Trowler, P. (2011). Researching your own institution: Higher education. *British Educational Research Association*, 1-8. http://www.bera.ac.uk/resources/researching-your-own-institution-higher-education

Turliuc, M.N., & Candel, O.S. (2019). Ethical issues in couple and family research and therapy. In Sandu, A., Frunza, A., & Unguru, E. (Eds.), *Ethics in Research Practice and Innovation* (pp. 226-244). IGI Global. https://doi.org/10.4018/978-1-5225-6310-5

Weisz, J. R., Kuppens, S., Ng, M. Y., Eckshtain, D., Ugueto, A. M., Vaughn-Coaxum, R.,Jensen-Doss, A., Hawley, K. M., Krumholz-Marchette, L. S., Chu, B. C., Weersing, V. R., & Fordwood, S. R. (2017). What five decades of research tells us about the effects of youth psychological therapy: A multilevel meta-analysis and implications for science and practice. *American Psychologist*, *72*(2), 79–117. https://doi.org/10.1037/a0040360

Wherry, J. N., & Herrington, S. C. (2018). Reliability and validity of the trauma symptom checklist for children and trauma symptom checklist for young children screeners in a clinical sample. *Journal of child sexual abuse*, *27*(8), 998–1010. https://doi.org/10.1080/10538712.2018.1517109

Whittaker, J. K. (2017). Pathways to evidence-based practice in therapeutic residential care: A commentary. *Journal of Emotional and Behavioral Disorders*, *25*(1), 57-61. https://doi.org/10.1177/1063426616686345

Whittaker, J. K., Fernandez del Valle, J., & Holmes, L. (Eds.). (2015). *Therapeutic residential care for children and youth: Developing evidence-based international practice*. Jessica Kingsley Publishers.

Whittaker, J., Valle, J., & Holmes, L. (2015). Introduction: The current landscape of therapeutic residential care. In Hans Grietens, Amaia Bravo, Erik Knorth, Richard Barth, Megan Cummings, Mike Stein, Mark Courtney, Christopher Bellonci, Ronald Thompson, and Charles Izzo (Eds), *Therapeutic Residential Care for Children and Youth: Developing Evidence-Based International Practice*, (23-34). Jessica Kingsley Publishers.

Whittaker, J. K., Holmes, L., del Valle, J. F., Ainsworth, F., Andreassen, T., Anglin, J., Bellonci, C., Berridge, D., Bravo, A., Canali, C., Courtney, M., Currey, L., Daly, D., Gilligan, R., Grietens, H., Harder, A., Holden, M., James, S., Kendrick, A., … Zeira, A. (2016). Therapeutic residential care for children and youth: A consensus statement of the international work group on therapeutic residential care. *Residential Treatment for Children & Youth*, *33*(2), 89–106. https://doi.org/10.1080/0886571X.2016.1215755

Yeheskel, A., Jekielek, A., & Sandor, P. (2020). Taking up residence: A review of outcome studies examining residential treatment for youth with serious emotional and behavioural disorders. *Children and Youth Services Review*, *111*, 104842. https://doi.org/10.1016/j.childyouth.2020.104842

Appendix

List of Articles Used for Methodological Analysis

Author	Year	Title	Journal	Type
Chambers et al.	2016	An innovative child welfare pilot initiative: Results and outcomes	*Children and Youth Services Review*	Quantitative
Cosgrove et al.	2022	Cognitive behavioral therapy–plus for youth in out-of-home care: A quasi-experimental evaluation	*Social Work Research*	Quantitative
Daly et al.	2018	Quality care in therapeutic residential programs: Definition, evidence for effectiveness, and quality standards	*Residential Treatment for Children & Youth*	Qualitative
Dimitropoulos et al.	2023	A qualitative study on the implementation of a transdiagnostic cognitive behavioral therapy for children in a child welfare residential treatment program	*Child Abuse & Neglect*	Qualitative
Eenshuistra et al.	2016	A motivational interviewing-based observation study of one-on-one conversations between residential care workers and adolescents	*International Journal of Child and Family Welfare*	Qualitative
Farmer et al.	2017(a)	Would we know it if we saw it? Assessing quality of care in group homes for youth	*Journal of Emotional and Behavioral Disorders*	Mixed-methods
Farmer et al.	2017(b)	Does model matter? Examining change across time for youth in group homes	*Journal of Emotional and Behavioral Disorders*	Quantitative
Galvin et al.	2022(a)	Interventions and practice models for improving health and psychosocial outcomes for children in residential out-of-home care: Systematic review	*Australian Social Work*	Qualitative

Harder	2018	Residential care and cure: Achieving enduring behavior change with youth by using a self-determination, common factors and motivational interviewing approach	*Residential Treatment for Children & Youth*	Qualitative
Herbell & Ault	2021	Differences in treatment approaches by residential treatment facilities	*Residential Treatment for Children & Youth*	Quantitative
Holden & Sellers	2019	An evidence-based program model for facilitating therapeutic responses to pain-based behavior in residential care	*International Journal of Child, Youth & Family Studies*	Quantitative
James et al.	2017	The implementation of evidence-based practices in residential care: Outcomes, processes, and barriers	*Journal of Emotional and Behavioral Disorders*	Mixed-methods
Joiner & Buttell	2018	Investigating the usefulness of trauma-focused cognitive behavioral therapy in adolescent residential care	*Journal of Evidence-Informed Social Work*	Quantitative
Kaasbøll et al.	2022	Interagency collaboration for early identification and follow-up of mental health problems in residential youth care: Evaluation of a collaboration model	*Nordic Social Work Research*	Qualitative
Klodnick et al.	2021	Adapting dialectical behavior therapy for young adults diagnosed with serious mental health conditions in residential care: A feasibility study	*Residential Treatment for Children & Youth*	Mixed-methods
Katrakazis et al.	2020	Applying a general systems theory framework in mental health treatment pathways: The case of the Hellenic center of mental health and research	*International Journal of Mental Health Systems*	Quantitative (Experimental)
McCredie et al.	2017	Dialectical behavior therapy in adolescent	*Residential Treatment for*	Quantitative

		residential treatment: Outcomes and effectiveness	*Children & Youth*	
Lanier et al.	2020	A systematic review of the effectiveness of children's behavioral health interventions in psychiatric residential treatment facilities	*Children and Youth Services Review*	Qualitative
Schutte et el.	2023	Mental health treatment programs for children and young people in secure settings: A systematic review	*International Journal of Mental Health Systems*	Qualitative
Sellers et al.	2020	Child feelings of safety in residential care: The supporting role of adult-child relationships	*Residential Treatment for Children & Youth*	Quantitative
Taussig et al.	2019	A positive youth development approach to improving mental health outcomes for maltreated children in foster care: Replication and extension of an RCT of the fostering healthy futures program	*American Journal of Community Psychology*	Quantitative
Tørseth & Ådnanes	2022	Trust in pathways? Professionals' sensemaking of care pathways in the Norwegian mental health services system	*BMC Health Services Research*	Qualitative
Yeheskel et al.	2020	Taking up residence: A review of outcome studies examining residential treatment for youth with serious emotional and behavioural disorders	*Children and Youth Services Review*	Qualitative