

# The CARE Program Model:

## Theory to Quality Practice in Residential Child Care

**Jack Holden, Bronfenbrenner Center for Translational Research (BCTR), Cornell University;**

**Charles V. Izzo, Bronfenbrenner Center for Translational Research (BCTR), Cornell University**

### **Abstract**

*This report summarizes the presentation that was delivered on April 29, 2016 at the ALIGN conference in Edmonton, Alberta. The first section describes the CARE model of practice (Children and Residential Experiences), and the model of implementation. The second section summarizes the results of a multisite study of CARE implementation in the USA.*

*CARE is a principle-based program that helps agencies use a set of evidence-informed principles to guide programming and enrich the relational dynamics throughout the agency. CARE aims to enhance the [therapeutic environment] in group care agencies by improving the quality of relationships and interactions among youth and adults.*

*Thirteen agencies in North Carolina implemented CARE for three years. Agencies provided administrative data about the monthly rate of several serious behavioral incidents. Also, each year all eligible youth were surveyed about their relationships with caregiving staff using a revised version of the Inventory of Parent and Peer Attachment, revised for the group care population.*

*Using linear mixed models, we assessed program effects by comparing the changes in attachment among the first cohort of CARE agencies with a second cohort of equivalent agencies placed on a 12 month wait list before initiating CARE.*

*Findings suggest that implementing the CARE program model can improve the capacity of staff to establish positive attachment relationships with the youth in their care.*

### **The CARE Program Model: Theory to Quality Practice in Residential Child Care**

The population of youth living in residential care has a disproportionately high rate of emotional and behavioral problems (Burns et al., 2004) and is at high risk of experiencing poor developmental outcomes throughout the life course. In addition to experiencing parental maltreatment and other forms of trauma, young people in group care often have a history of unsuccessful placement in foster care (Zinn, DeCoursey, George & Courtney, 2006), and a host of other risk factors that impair their healthy development (Ryan & Testa, 2005). Youth in group care typically receive some form of treatment by professional clinicians. Equally important, however, is their need for healthy developmental experiences throughout the day, and to be protected from experiencing additional trauma and other toxic experiences in the residential setting. In other words, they need to live within a therapeutic social milieu that supports their rehabilitation (James, 2014).

The current paper reports results from two studies examining the impact of Children and Residential Experiences (CARE), an intensive, principle-based program model designed to help organizations create more therapeutic care environments to enrich the day-to-day experiences of youth placed in out-of-home care. CARE is based on well-established scientific evidence about the developmental and relational needs of youth who experience trauma and other stressful experi-

ences associated with placement in out-of-home care (Holden, 2009).

## **CARE OVERVIEW**

Children and Residential Experiences: Creating Conditions for Change (CARE) is a multi-level program for improving services in out-of-home care (Holden, 2009). CARE was developed at the Residential Child Care Project (RCCP) in the Bronfenbrenner Center for Translational Research (BCTR), Cornell University. The underpinnings for the development of CARE can be found in the developer's realization that organizations that had strong practices did far better implementing a crisis intervention system, such as Therapeutic Crisis Intervention (TCI) (Holden et al., 2009), than those with no program model.

After more than 20 years of successfully delivering the TCI program the RCCP began studying the possibility of developing a program model that would enable child caring agencies to organize and deliver quality care of children according to research-informed principles based on the best interest of children. In collaboration with the South Carolina Association of Children and Family Services (SCACFS), the Duke Foundation, and Cornell University in 2005, research and curriculum development began. Basic and relevant best practices competencies determined by national and international standards were integrated along with qualities of strong programs determined through Jim Anglin's research (Anglin, 2002) and national and international standards. The CARE program model began piloting with seven agencies from North and South Carolina in 2007 that were subsequently studied. Additionally several other agencies that were looking for a new and research informed or based program model chose to implement the CARE practice and the "rest is history".

The CARE program model is founded on six research and standards-informed principles designed to guide residential child care staff's practice and interactions with children and families in order to create conditions for positive change in children's lives. The research-informed principles support care and treatment that is developmentally focused, family involved, relationship based, competency centered, trauma informed, and ecologically oriented. These best practices are grounded in theory, in evidenced based practices, in practice wisdom, and in quality child care standards. The principles were established after literature reviews, surveys of experienced caregivers, supervisors, and leadership and from standards review.

The core challenges for agencies implementing CARE are "achieving congruency throughout the agency in serving the best interests of children", therefore the basic principles apply at all levels of the organization. This concept although seemingly embraced by most organizations presents challenges for many because of the dynamics operating at all levels of any organization. The core concepts include "best interests of the child, struggle for congruence, and evidence informed practice" (Holden, Anglin, Nunno, & Izzo, 2014). Congruency calls for reciprocity in the interactions among all persons. Consistency is when all working in an organization have the same set of values, principles, and actions demonstrated over time and at all levels. Coherence means that overall patterns of actions are cohesive and have integrity (Anglin, 2002). Evidence informed practices are based on existing research and best practices, have a set of principles that guide policy, procedures, and practices, and a well-articulated, evidence-based theory of change (Lee & Barth, 2011).

The purpose of residential care is to provide, a sense of breathing room for the child and family, a safe place for children and families to learn new skills and adults who act as teachers, coaches, and mentors to help develop and practice necessary life skills. Another important purpose is to help children realize a more normal developmental trajectory. The six CARE principles support the provision of quality residential care, and help an organization meet the core challenges and integrate core concepts.

## Relationship Based

Research indicates that the ability to form relationships is associated with healthy development and life success, developmental relationships are central to helping children develop and building competencies, and that children respond most to people they trust.

Practice implications for relationship based include taking time and developing skills to build attachments and relationships with the children, protecting the relationship between the child and worker/teacher/carer, and identifying relationship building as a primary job task for staff. Because the principles apply to all levels of the organizations the following are some of the questions to raise when considering the relationship based principle: *What kind of relationships do the adults at your agency have with the children in care and with the families of children in care? What kind of relationships do the supervisors have with their staff and administrators with staff? What policies address relationships? Do job descriptions and performance evaluations focus on relationships as a primary function of the job? What would people say about their tasks and roles in regard to relationships?*

## Developmentally Focused

Research indicates that all children have the same basic requirements for growth and development, children learn best when skills are within their zone of proximal development, and children need support to engage their innate capacity to grow and develop. *Developmentally Focused* practice implications are for staff to teach developmentally appropriate skills, provide opportunities to practice newly learned skills, adjust activities so children can succeed, and create opportunities so that children's innate capacity to develop is engaged.

Questions for organizations to ask are, what is meant by *"zone of proximal development and how do we support staff with children's skill development?"* *Do we provide staff development opportunities to increase staff's ability to deal with complex situations? Do we provide staff opportunities to grow within their zone of proximal development?*

## Family Involved

Research indicates that family contact has demonstrated positive outcomes for children, planning for adequate community support is essential for a successful return, and the child's ethnic and cultural identity is tied to the family. Family Involved practice implications are, partner with families so they have access and input into the child's life, understand and respect the family's worldview, support the child's relationship with the family, and develop culturally competent staff. Questions for organizations to ask are, *how important is the family in a child's life? How do we keep the child connected with his or her community and culture? Do we hire and/or develop staff to be culturally competent? Are family's true partners in the care and treatment of their children?*

## Competence Centered

Research indicates that problem solving skills, flexibility, critical thinking, emotional regulation, and insight are necessary life skills, focusing on strengths and positive attributes builds a positive identity, the child's personal strengths and resources are the biggest factor in making positive change. All these contribute to a child's resiliency and their ability to succeed. Competence Centered practice implications consist of matching a child's activities and expectations to the individual child's strengths and abilities to succeed, teaching life skills by ensuring that all interactions and activities are goal oriented and focused on teaching skills, and sending high expectation messages to children and help them meet expectations. Moreover the development of competence is dependent on the developmental relationship, cognitive functioning and self-regulation. Questions for organizations to ask are, *do the adults working with the children have the skills we*

*ask them to teach to the children? What skills do we presently focus on when planning children's activities and routines? What strategies do we use to teach children these skills? What opportunities do we provide for staff to develop their abilities to teach children skills?*

### **Trauma Informed**

Research indicates that trauma has a debilitating effect on children's growth and development, that maintaining a non-coercive and a safe environment is essential for children to learn new responses to stressful situations, and that challenging behavior is often pain-based behavior. In recent years, understanding the effects of trauma has become a focus for residential care providers as researchers continue to discover more about the effects of trauma on brain development. Trauma Informed practice implications include providing a consistent, predictable environment, building relationships that are based on trust and respect, providing activities that are future oriented and allow children to contribute, and avoiding events and environmental factors that might trigger a stress response. Questions for organizations to consider are, how many children in your care have experienced emotional, psychological and/or physical trauma in their lives? How has this affected their development? What is meant by pain-based behavior? How can this principle keep us focused on providing order and learning experiences versus demanding compliance and control? How do we try to prevent secondary trauma and staff burn out? How does the organization 'hold the direct caregivers and counseling staff'? Ecologically Oriented

Research indicates that children learn through interacting with their environment, the environment is influenced by the interactions with the children and adults, and environmental factors that protect children are; caring relationships, high expectation messages, opportunities for contribution & participation.

*Ecologically Oriented* practice implications include, designing the program so that children can successfully meet expectations and participate fully, adjust activities so that children can succeed and progress, motivate children to participate, to get involved and interact with adults and peers through the social and physical environment. Questions for organizations to ask are, *why should we look at the environment when a child is struggling to meet basic expectations? How many people and systems make up a child's world? How do we create an environment where we learn with each other?*

For an agency to implement and integrate the CARE program principles into their organization, there are several characteristics of the CARE approach to consider. First, the agency is the locus of learning and the agency itself becomes the primary learning site, second, the agency is the unit of learning, rather than the individual (or even the team) and third, the facilitation process involves much more than skills training or knowledge transmission (Anglin, 2011). The implementation process uses CARE consultants who become engaged in a co-learning and co-creation process alongside the agency staff members; all participants are learners. CARE consultants work to realize the potential of adult learners and to align their mindsets with the needs and experiences of the children.

### **Program Implementation**

A pair of CARE Consultants works with each agency for three years to help them re-orient their practices around the six evidence-informed principles described above. For most agencies, this process calls for changes in theoretical perspective, organizational norms, and role expectations. An essential implementation activity is the development of a CARE Implementation Team (IT) that includes agency leadership, supervisors and key training and clinical staff. Its role involves providing support, modeling and mentoring to staff as they incorporate CARE principles into their work. The team also builds structures and processes that facilitate application of the CARE principles and their eventual integration into the agency culture.

The leadership and ITs are trained in the CARE principles through a five-day manualized program and a group of agency based trainers are prepared to deliver the same 5-day training to remaining staff. CARE Consultants provided quarterly on-site technical assistance (TA) visits to implementation teams and other agency staff. TA activities involve observation and feedback, training and coaching for front-line supervisors, developing routines for reflective practice, and addressing organizational barriers to creating a more therapeutic milieu.

Finally, implementing CARE involves “changing the entire operating system” i.e., the training is focused on changing a mindset, not about simply adding new information or developing new technical skills. The emphasis is on transforming the organization as a whole, and implementation is approached as a marathon, not a sprint.

Below we report a longitudinal study examining the effects of implementing CARE at multiple agencies over a three year period. Note that all results reported here have been reported in other journal articles and conference presentations.

**Central research questions:**

- To what extent does implementing CARE at residential childcare agencies lead to fewer serious behavioral incidents?
- To what extent does CARE implementation lead to improved relationship quality between youth and direct care providers?

Method

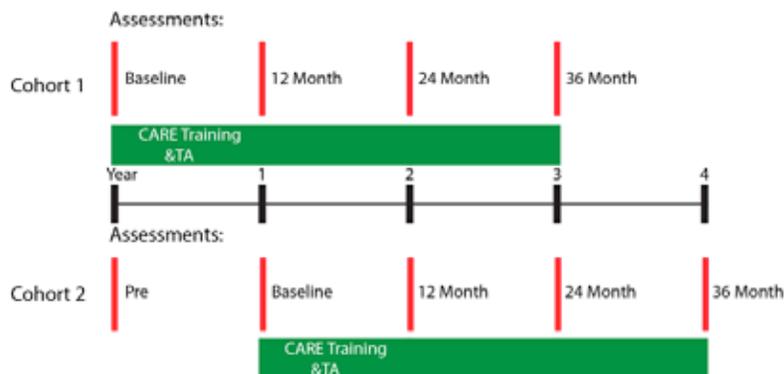
**Participating Agencies**

Sixteen agencies initially committed to participate, of which 7 were assigned to begin CARE immediately (Cohort 1), and 9 waited about 12 months before beginning CARE implementation (Cohort 2). During the study period, one agency became ineligible due to a change in target population, one closed before implementation began, and one discontinued due to change in administrative priorities.

At the start of CARE, the average number of residential staff at these agencies was 13, and the average number of youth was 24, resulting in an average youth to staff ratio of 1.81. Most agencies typically served youth from 7 to 18 years of age; Most served both males and females, and one agency served only males. All agencies previously relied on homegrown programs (e.g., point and level systems, enrichment activities) but had no coherent model that guided daily childcare practices and organizational management.

**Data Collection**

Collection of survey data from staff and youth occurred annually. As shown in Figure 1, Cohort 1 received one baseline (2009) and Cohort 2 received two baseline assessments (2009 and 2010).



## Measures

Behavioral Incidents. Agencies provided monthly behavioral incident data from their administrative records during the baseline and implementation periods. Each year, agency quality assurance staff were asked to count the number of incident reports filed in the previous year, indicating the monthly frequencies for each of five incident types: verbal threats or physical aggression toward staff, verbal threats or physical aggression toward peers, an act or threat of self-harm, property destruction, and attempted or completed runaways. Incidents involving multiple residents were counted separately for each resident, unless the resident was only a victim in the incident.

Organizational Social Context (OSC). The baseline staff assessment included the OSC survey, which assesses dimensions of culture (proficiency, resistance, rigidity) and climate (stress, engagement, functionality) at the agency level (Glisson & Hemmelgarn, 1998). Following Glisson, Hemmelgarn, Green, and Williams (2013), agencies were classified into one of three profiles (1=negative, 2=average, 3=positive) based on the pattern of scores across the six subscales. Negative profiles reflect lower scores on engagement, functionality, and proficiency and higher scores on stress, resistance, and rigidity. Positive profiles reflect an opposite pattern of subscale scores.

Youth Adult Relationship Quality. All residents age 8 and older were asked to complete a survey about their relationships with staff called the **Inventory of Parent and Peer Attachment (IPPA)**, Armsden & Greenberg, 1987). This self-report instrument measure the cognitive and affective dimensions of the relationships between adolescents and either parents or peers. We adapted the original parent version by rewording items to more accurately reflect residents' circumstances (e.g., referencing direct-care residential staff rather than "parents"). Because a respondent's relationship was likely to differ across caregivers, we changed the response choices from a 5 point agree/disagree scale to the following scale asking how often the respondent felt this way about residential staff members at their cottage over the past month: 1=never, 2=rarely, 3=sometimes, 4=often, 5=always. Respondents were asked to answer thinking about all direct care staff at their cottage, which usually included two pairs of caregivers that worked alternating one or two-week shifts.

A member of the research team met annually with all residents whose parents or legal guardians had provided written consent, explained the study details, and administered the survey by reading the items aloud to small groups of youth. For various reasons, this format was not possible for 16% of respondents, and a clinical case manager at the agency was asked to provide youth with a private space to complete the paper or on-line version of the survey.

For Cohort 1 agencies, annual youth surveys began about 4 weeks prior to CARE initiation. For Cohort 2 agencies, surveys began about 12 months prior to CARE initiation.

Assessment of staff characteristics. Staff surveys were administered anonymously to all agency personnel 2-4 weeks prior to the first training session. Most 92% surveys were administered on paper by research staff at agency-wide meetings with 8% being self-administered online or mailed in for those not present on survey day. Respondents were informed that their survey data would not be linked to their identity and that no agency personnel would ever see them. Survey questions asked about demographics and their perceptions about organizational climate and culture.

### Study 1: Effect of CARE on Behavioral Incidents

To test the effect of CARE implementation on behavioral incidents, we used an interrupted time series design (ITS) (Shadish, Cook, & Campbell, 2002). Specifically, by obtaining multiple base-

line assessments ITS was used to examine how CARE implementation was related to changes in the frequency of behavioral incidents in two successive cohorts of agencies. Specifically, we compared incident rates in the 12 months before implementation (baseline period) to rates in the 36 months during implementation (implementation period). Comparing the trends between the baseline and implementation periods, helps us be able to rule out the possibility that any changes we see during implementation were simply the continuation of existing trends. Data for this study came from the 11 agencies that remained in the study and for whom the collection of incident data was consistent and detailed enough to be aggregated together for analysis.

Data Analysis. The details of the analytic strategy are described in Izzo et al (2016). For each of the five types of behavioral incidents, we constructed a mixed effects negative binomial regression model to estimate the number of behavioral incidents per resident per month. Each model estimated [an intercept and] two slopes, or time trends: one for the baseline period prior to CARE (Months -12 to 0) and one for the program implementation period (Months 1 to 36). We tested for a program effect by comparing the difference between the trends during the baseline and implementation periods. Covariates were added to the model to adjust for variations related to cohort and OSC profile score.

Study 1 Results. During the baseline period, there was an increasing trend for Aggression toward Peers, Aggression toward Staff, and Property Destruction for Cohort 1, which occurred in 2009. In Cohort 2, for whom the baseline period was in 2010, an increasing trend was evident for Property Destruction, and other incident types showed no change. During CARE implementation, the incident rate declined significantly for all outcomes.

The program effects for each incident type are represented as the difference between the trend estimates during the baseline and implementation periods. For three outcomes (Aggression toward Staff, Property Destruction, and Runaway), there was a declining trend during implementation, and it was significantly different from the baseline trend, as predicted. These results were the same for both cohorts. This same pattern was observed for Aggression toward Peers and Self-Harm, but only in Cohort 1 agencies.

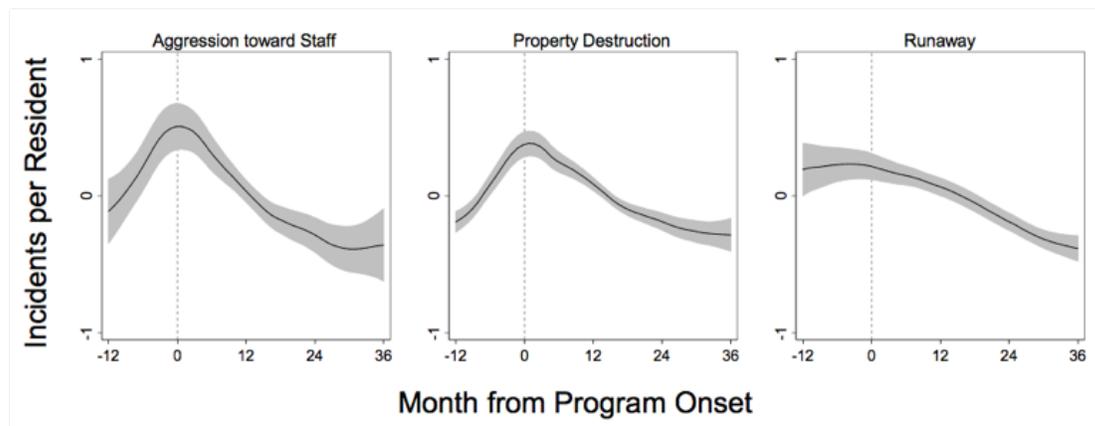


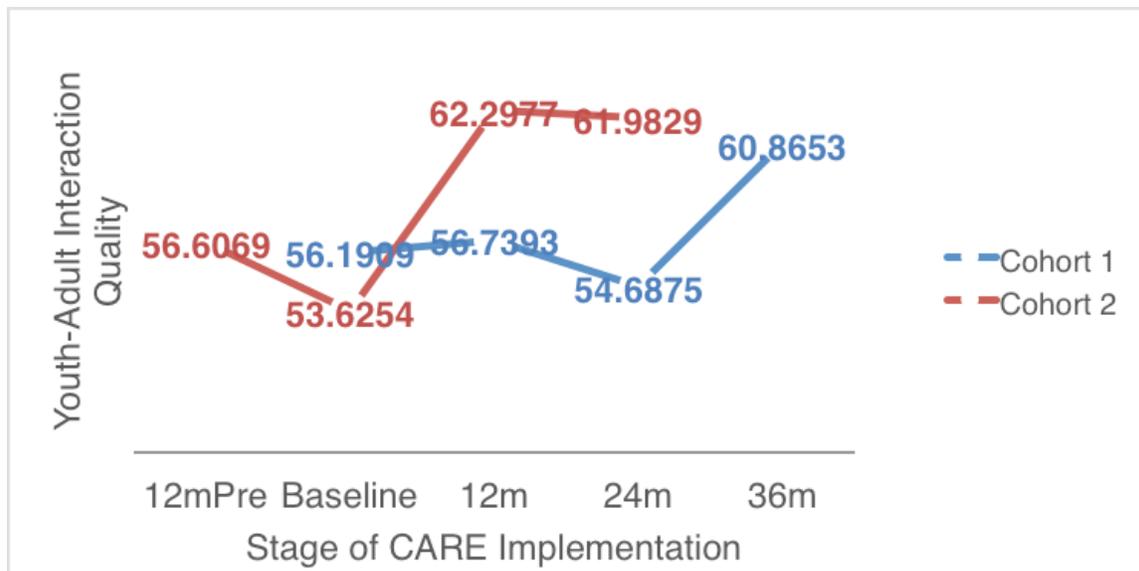
Figure 2 illustrates adjusted estimates for the frequency of incidents per resident over the entire four-year study period. The figure shows the three outcomes for which results were consistent across Cohorts 1 and 2. To adjust for overall agency differences in the frequency of incidents, estimates were centered at each agency mean. More information about incident rates and trends across different time periods and cohorts is provided in the full report (see Izzo et al., 2016).

### Study 2: Effect of CARE on Youth-Adult Relationship Quality

To test whether agency participation in CARE was associated with improvements in youth-adult

relationship quality, we used a Cohort Sequential design in which 7 agencies were assigned to begin CARE immediately (Cohort 1), and 9 agencies waited about 12 months before beginning CARE implementation (Cohort 2). We examined whether youth outcome variables in Cohort 1 showed greater improvement during the first year of CARE compared to the change observed in Cohort 2 during the same year (i.e., before CARE). Beyond the first year, we assessed program impact by testing whether the duration of CARE implementation predicted improvements in youth outcomes, pooled across all 13 agencies. Both sets of analyses incorporated linear mixed model analysis of variance to account for clustering within agency and within residential unit (e.g., cottage).

**Study 2 Results.** As shown in Figure 3, for the first cohort, relationship quality scores showed a slight, non-significant improvement during the initial year of CARE implementation, and a significant increase during the second year, which was sustained into the third year. For Cohort 2 (wait-list) agencies, attachment scores did not change during the year before CARE implementation, but increased significantly during the first year of implementation. Scores for the second cohort remained high in the second and third years of implementation.



## Discussion

Despite the stressful conditions that lead to out-of-home placement, group care can represent a tremendous opportunity to provide youth with corrective or therapeutic experiences that promote social and emotional development (Manashko, 2009). The current paper summarizes recent results (previously reported elsewhere) on the effects of CARE, a setting-level intervention to improve residential care quality.

The first study indicated that agencies' participation in CARE led to significant declines for three important types of behavioral incidents (aggression toward staff, property destruction and run-aways).

The second study indicated significant effects of CARE implementation on youth-adult relationship quality. Youth reports from the first cohort of agencies indicated gradual, significant improvement in relationship quality during the three year implementation period. Significant improvement was also observed in the second cohort of agencies during the implementation period, but not in the year preceding implementation (the baseline period).

There have been few rigorous studies of organizational or setting-level interventions in the field of residential youth care (James, 2014). Our use of rigorous quasi-experimental designs involving implementation across multiple sites provides strong evidence to conclude that the observed improvements in agencies were related to their participation in CARE.

Our research demonstrates that by focusing only at the staff and organization-levels CARE significantly reduced the prevalence of behavioral incidents that create a distressing, non-therapeutic environment in the daily lives of residents. Given that incidents such as these can escalate into physical restraint or, in extreme cases result in injury or death (Day, 2002; Nunno, Holden, & Tollar, 2006), the potential benefits of reducing behavioral incidents can be profound. The program's impact can also be considered in terms of the reduction in "ambient stress" created by such incidents, which adds to the cumulative developmental risk they already face (Evans, 2003; Gorman-Smith & Tolan, 1998).

Given the commensurate improvements in youth-adult relationships quality observed in Study 2, it is plausible to attribute the reductions in behavioral incident rates partly to improved youth-adult relationships and greater flexibility, such that staff were more likely to respond to transgressions in ways that avoided power struggles, hostility, or alienation. This explanation is also consistent with results from Anglin's qualitative study (Holden, Anglin, Nunno, & Izzo, 2014) based on interviews and observations across seven experienced CARE agencies that were actively working to sustain CARE after four years of implementation. Staff reported greater understanding of trauma's effect on youth behavior, leading to fewer confrontations and power struggles, less fear, and a more peaceful environment in the homes.

The current study illustrates a contextual approach that reduces dangerous incidents and improves youth-adult relationships by providing a common set of principles that change how agency leaders and staff think, how they interact with residents, and with each other. Results suggest that by adopting the CARE framework agencies can build key capacities within their workforce that improve their ability to serve the best interests of children.

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#### References

- Anglin, J. P. (2002). *Pain, normality, and the struggle for congruence: Reinterpreting residential care for children and youth*. Binghamton, NY: Haworth Press.
- Burns, B.J., Phillips, S.D., Wagner, H.R., Barth, R.P., Kolko, D.J., Campbell, Y. & Landsverk, J. (2004). Mental Health Need and Access to Mental Health Services by Youths Involved With Child Welfare: A National Survey. *Journal of the American Academy of Child & Adolescent Psychiatry* 43(8), 960-970.
- Day, D. M. (2002). Examining the therapeutic utility of restraints and seclusion with children and youth. *American Journal of Orthopsychiatry*, 72, 266-278.
- Evans, G.W. (2003). A multimethodological analysis of cumulative risk and allostatic load among rural children. *Developmental Psychology*, 39, 924-933.
- Glisson, C. & Hemmelgarn, A. (1998). The effects of organizational climate and interorganizational coordination on the quality and outcomes of children's service systems. *Child Abuse and Neglect*, 22, 401-421.

- Glisson, C., Hemmelgarn, A., Green, P., & Williams, N.J. (2013). Randomized trial of the availability, Responsiveness and Continuity (ARC) organizational intervention for improving youth outcomes in community mental health programs. *Journal of the American Academy of Child and Adolescent Psychiatry*, 52(5), 493-501.
- Gorman-Smith, D. & Tolan, P. (1998). The role of exposure to community violence and developmental problems among inner-city youth. *Development and Psychopathology*, 10, 101-116.
- Holden, M.J. (2009). *Children and residential experiences: Creating conditions for change*. Arlington, Va: Child Welfare League of America.
- Holden, M. J., Anglin, J. P., Nunno, M. A., & Izzo, C. V. (2014). Engaging the total therapeutic residential care program in a process of quality improvement: Learning from the CARE model In J. K. Whittaker, J. Fernandez Del Valle, & L. Holmes (Eds.), *Therapeutic residential care with children and youth: Identifying promising pathways to evidence-based international practice*. Philadelphia, PA: Jessica Kingsley.
- Holden, M.J., & the TCI Instructors of the Residential Child Care Project. (2009). *Therapeutic crisis intervention, reference guide (6<sup>th</sup> ed.)*. Ithaca, NY: Cornell University.
- James, S. (2014). Evidence-based practices in therapeutic residential care. In J. K. Whittaker, J. Fernandez Del Valle, & L. Holmes (Eds.), *Therapeutic residential care with children and youth: Identifying promising pathways to evidence-based international practice (142-155)*. Philadelphia, PA: Jessica Kingsley.
- Izzo, C.V., Smith, E.G., Holden, M.J., Norton-Barker, C.I. & Nunno, M.A. (2016). *Preventing Behavioral Incidents in Residential Child Care: Efficacy of a Setting-Based Program Model*. *Prevention Science*.
- Lee, B.R., & Barth, R.P. (2011). Defining group care programs: An index of reporting standards. *Child Youth Care Forum*, 40, 253–266.
- Manashko, S., Besser, A. & Priel, B. (2009). Maltreated children’s representations of mother and an additional caregiver: A longitudinal study. *Journal of Personality*, 77(2), 561-599.
- Nunno, M., Holden, M., & Leidy, B. (2003). Evaluating and monitoring the impact of a crisis intervention system on a residential child care facility. *Children and Youth Services Review*, 25, 295-315.
- Nunno, M., Holden, M., & Tollar, A. (2006). Learning from tragedy: A survey of child and adolescent restraint fatalities. *Child Abuse & Neglect*, 30, 1333-1342.
- Ryan, J. P., & Testa, M. F. (2005). Child maltreatment and juvenile delinquency: Investigating the role of placement and placement instability. *Children and Youth Services Review*, 27, 227–249.
- Shadish, W.R., Cook, T.D., & Campbell, D.T. (2002). *Experimental and quasi-experimental designs for generalized causal inference*. Boston, MA: Houghton-Mifflin.
- Sunseri, P. A. (2004). Preliminary Outcomes on the Use of Dialectical Behavior Therapy to Reduce Hospitalization Among Adolescents in Residential Care. *Residential Treatment for Children & Youth*, 21(4).

Zinn, A., DeCoursey, J., Goerge, R., & Courtney, M. (2006). A study of placement stability in Illinois. Chicago: Chapin Hall Center for Children. Retrieved from <http://www.chapinhall.org/research/report/study-placement-stability-illinois>