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East Tennessee State University

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Youth and Family Based In-Home Services Program in Tennessee: Factors for Success

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A dissertation

presented to

the faculty of the Department of Educational Leadership and Policy Analysis

East Tennessee State University

In partial fulfillment

of the requirements for the degree

Doctor of Education in Educational Leadership

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by

Craig S. Hall

December 2013

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Dr. Don Good, Chair

Dr. Steve Cockerham

Dr. William Flora

Dr. James Lampley

ABSTRACT

Youth and Family Based In-Home Services Program in Tennessee: Factors for Success

by

Craig S. Hall

Intensive in-home services is a family-centered, strength-based intervention program offering comprehensive treatment that includes family therapy, mental health treatment and parenting skills for caregivers, development of positive social systems, and assistance with accessing community resources for long-term support (Youth Villages, 2013b). Framed on family system theory, Intensive-In Home Services (IIHS) was developed from Cognitive Behavioral Therapy, Functional Family Therapy, Social Development, and Crisis Intervention models as a means to modify behaviors that place youth at risk for out-of-home placement. The socio-historical development of these models is examined in the literature review.

The purpose of this study was to evaluate predictors that may influence outcome measures of a youth's inclination to remain in the home after having received IIHS treatment. The significant predictors were determined to be age, race, and total length of service received. The study sampled 3,131 youth ages birth through 17 who received IIHS services in Tennessee over a 10-year period and were discharged from July 2001 to July 2010. The study was limited to youth designated under Comprehensive Child and Family Treatment (CCFT), which is classified as part of TennCare coverage. The primary goal of CCFT is to empower families to monitor and manage mental health needs and high-risk youth behaviors in order to provide permanency and longterm stability in the natural home environment (UnitedHealthcare, 2012).

Archival data were derived from the research department of a youth and family organization located in Tennessee. The data were collected through an 8-component survey by research department staff members from youth and their families at the conclusion of the fiscal year. Results from the study indicate that age is the only predictor variable measured that influenced the youth's inclination to remain in the home after having completed an IIHS program. The age distribution showed that youth over the age of 12 are more likely to be referred for IIHS treatment and that there was a significantly higher distribution (2,203) of males (64.6%) than females (35.4%).

DEDICATION

This work is dedicated to my late father Danny Hall who believed that hard work and perseverance is the way to accomplish anything in life. His work ethic and just being available for me anytime I needed him made me into the person that I am today. I miss you, Dad.

ACKNOWLEDGEMENTS

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CHAPTER 1

INTRODUCTION

The Child Welfare League of America (CWLA) released a report in 2012 on child welfare, juvenile justice, and educational factors that identified children with emotional disturbances and complex family problems who are at risk of entering hospitals, residential treatment centers, juvenile detention, and state child welfare custody (Casey Family Programs, 2010; Child Welfare League of America, 2012). Data from Tennessee in 2011 indicate that of 90,347 referrals made to child protective services, 57,153 were referred for investigation and 9,066 were determined to be victims of abuse or neglect; 59% of those were neglected, 15% were physically abused, and 31% were sexually abused. Some of the children referred fell into more than one category. Of the 6,723 children in Tennessee living out of the home apart from their biological families in 2009 there were 1,979 age 5 or younger, 2,097 were 16 and older, and the remaining 2,647 were between the ages of 5 and 15. An estimated 34,000 children between the ages of 12 and 17 were alcohol or drug dependent, 18,000 youth between the ages of 16 and 19 were not enrolled in school, and 33,399 children had been arrested.

The Tennessee Commission on Children and Youth indicated that 91% of children entering into the juvenile justice system suffered from mental health or substance abuse problems (Lawley, 2009), and the Tennessee Bureau of Investigation (2011) reported that juveniles comprised 8.9% of total arrests nationwide in 2011. The problem is compounded when considering that the juvenile justice system is becoming the default system for youth who do not have access to mental health care (Bonham, 2006). Gonzalez (2003) points to family conflict and domestic violence as factors influencing juvenile delinquency.

There is compelling evidence that maltreated children and children who are exposed to violence are at an increased risk of psychopathology compared to children who have not experienced maltreatment or domestic violence (Maikovich, Jaffee, Odgers, & Gallop, 2008). Children exposed to traumatic events may experience altered psychobiological development that can influence inclinations toward high-risk behaviors (Briggs et al., 2013). Those high-risk behaviors can result in a variety of serious repercussions that include coming into contact with the criminal justice system (Black, Woodworth, Tremblay, & Carpenter, 2012).

Gonzalez (2003) outlined other factors that affect psychopathology and social behaviors. In addition to maltreatment and domestic violence the factors include strict or lenient parenting styles, communication barriers between parents and children, lack of pro-social values, and socioeconomic marginalization. Children of all ages are social beings and their initial experience occurs in the family system and gradually broadens to include peer relationships (Webb, 2011). By the time children reach school age they define themselves in terms of group membership and not merely as individuals (Webb, 2011). Regarding social functioning, past studies revealed that behavior is shaped by antecedents or consequences (Haugaard, 2008). Parents have the ability to create environments that can positively or negatively affect child behavior (Haugaard, 2008). The extrinsic shaping originates in the home. Maikovich et al. (2008) note:

> Intervention efforts to reduce rates of mental health problems in child victims of maltreatment must focus not only on protecting children from revictimization but must also work to decrease even nonabusive forms of physical discipline and the amount of domestic violence children witness in their homes. Intervention efforts might help parents manage relationship conflict, or, at the very least, educate parents about the importance of buffering children from exposure to conflict. (p. 1509)

Statement of Purpose

The purpose of this study was to evaluate the level of effectiveness of IIHS (Intensive In-Home Service) programs as an alternative to out-of-home placement for youth and determine if

those predictors were associated with the outcomes. An IIHS program targets youth who would otherwise be placed in foster care, residential treatment, detention centers, hospitals, or juvenile facilities (Youth Villages, 2012). This study was an investigation of the predictors for youth success after having completed an IIHS program to prevent youth from entering state custody and remaining in the home. The predictors were categorized as age, gender, race, and total length of service received. The study objective was to evaluate variables that may affect service delivery of an IIHS program service provider.

The data reflect that educational, mental health, juvenile justice, and child welfare systems must consider a large number of referral behaviors that may result in out-of-home placements. Researchers have linked traumatic experiences to removal from the home (Thompson et al., 2012). Youth who are removed from the home may be placed in hospitals, residential treatment centers, juvenile detention, or state welfare custody for a short- or long-term period depending on the youth's behavior and the family dynamics (Child Welfare League of America, 2012). Previous studies affirm that a wide range of pathologic problems such as depression, anxiety, and conduct problems may occur in traumatized children (Haugaard, 2008). Brofenbrenner's (1979) ecological model of child and adolescent development emphasized the importance of contextual factors including families, communities, and social institutions.

A longitudinal study conducted in North Carolina found that more than 67% of children up to age 16 have encountered at least one traumatic event (Copeland, Keeler, Angold, MRCPsych, & Costello, 2007). Dysfunctional parenting in the form of neglect, maltreatment, and the inability to provide appropriate structure and supervision contribute to emotional and behavioral disorders in children (Jenson & Fraser, 2011). Evidence-based, family-centered, home-based services emerged as a viable alternative to out-of-home placement in the early 1990s

(Woodford, 1999). Intensive in-home services have since been put into place to decrease the number of out-of-home placements that may result from referral behaviors. Conceptual and empirical evidence provide a unified framework for a two-tiered prevention and treatment model (Weisz, Sandler, Durlak, & Anton, 2005).

A 2012 study by the Prevention and Research Center at Penn State sampled 67 Pennsylvania counties, each with at least one evidence-based intervention. The findings showed a 49% decrease in restrictive placement – defined as group care or an institutional setting – from 5,001 in 2001 to 2,557 in 2006 (Campbell & Bumbarger, 2012). The *Journal of Clinical and Adolescent Psychology* (Silverman & Hinshaw, 2008) featured 10 reviews of evidence-based treatments for child and adolescent problems and disorders. The findings of this study supported the previous evidence that structured, empirically-tested treatment programs can have beneficial effects on youth and their families (Kazak et al., 2008). Though there is voluminous material showing the immediate effects of evidence-based practice with youth and families, only a small amount of literature explores predictors of future expectations (Thompson et al., 2012).

<u>Research Questions</u>

Four research questions guided the study.

RQ1:   Is there a significant difference in the proportion of youth who remain in the home after having received Intensive In-Home Services (IIHS) treatment among the four age groups (0-8, 9-11, 12-14, and 15-17)?

RQ2:   Is there a significant difference in the proportion of youth who remain in the home after having received Intensive In-Home Services (IIHS) treatment among the two genders (male and female)?

RQ3:   Is there a significant difference in the proportion of youth who remain in the home after having received Intensive In-Home Services (IIHS) treatment among the four race groups (African American, Caucasian, Hispanic, and Bi-Racial & Other)?

RQ4:   Is there a significant difference in the proportion of youth who remain in the home after having received Intensive In-Home Services (IIHS) treatment among the three length of service groups (30-90 days, 90-120 days, 120+ days)?

<div align="center">Significance of the Study</div>

The findings from this study added to the knowledge base about IIHS as an alternative to out-of-home placement. The results can serve as an evaluation tool to IIHS providers in seeking ways to improve the quality of service delivery, to improve outcome measures for program funding, and for reducing the number of youth at risk of out-of-home placements that result in hospital, residential treatment, juvenile detention, or state custody. This research also indicated predictors of at-risk behaviors among youth and their families that result in out-of-home placement for youth. Service agencies may use the results of this study as a tool for making appropriate referrals to treatment preventative services geared toward family preservation and reunification.

<div align="center">Definition of Terms</div>

This study included terms that may not be familiar to the reader, which are included in language specific to the culture at the selected family service provider agency. These terms are presented to help the reader become familiar with the component of Intensive In-Home Services (IIHS) offered by service providers targeting youth and families.

Intercept – A comprehensive system of care for troubled youth most commonly referred to as Intensive In-Home Services (IIHS).

Referral Issues – Behavior problems and mental health diagnoses that qualify youth for in-home services.

Youth – Children and adolescents ages 0-17.

Cover Kids – Free comprehensive health insurance coverage for children under the age of 18 and pregnant women, who are residents of Tennessee, who earn 250% of the poverty level, and who are ineligible for TennCare (Cover Tennessee, 2013).

Limitations and Delimitations

Limitations and delimitations include the psychosocial and medical histories of the children and their families, referral issues, and geographic locations. The sample size was limited to data representing youth who received treatment through the Evidentiary Family Restoration (EFR) treatment model.

Youth and family service providers may or may not implement treatment strategies in addition to or outside of EFR components, which may or may not affect outcome measures. The sample was limited to youth who received services covered under Comprehensive Child and Family Treatment (CCFT) otherwise identified as youth at imminent risk of out-of-home placement and are covered by TennCare.

Youth funded through DCS, as they are in state custody but are receiving IIHS treatment for family reunification, were excluded from the study. This study also did not include youth under Cover Kids or who are in an out-of-home placement because they are deemed ineligible for an IIHS program. Staff turnover rates may or may not be another predictor variable for outcome measures.

Organization of the Study

Chapter 1 includes the introduction and statement of the problem, theoretical foundations that shaped the study, the design that was implemented, the sources from which data were derived, the four research questions, definitions of terms for clarification, and the overall organization of this dissertation. Chapter 2 includes a review of the literature relevant to this study. In particular, the background and developments of IIHS are presented along with fundamental EBT treatment methodologies including Cognitive Behavioral Treatment (CBT), functional family therapy (FFT), and social learning theories. Chapter 2 concludes with a discussion regarding the accountability and funding of IIHS programs. Chapter 3 explains the methodology used in this study including a description of the intervention implemented in treatment, the means of collecting data and its analysis, the assumptions and limitations of the study, and ethical considerations. Chapter 3 concludes with a summary of the methodology. The data collection and analysis as specifically related to each of the four null hypotheses are contained in Chapter 4. The outcomes of this study along with suggestions for further research are offered in Chapter 5.

CHAPTER 2

LITERATURE REVIEW

Theoretical Foundations

The common theoretical framework of Intensive In-Home Services (IIHS) is built around cognitive-behavioral, functional, and social learning theories all of which are threaded by the ecological systems paradigm. The family-centered approach is rooted in systems theory (Iglesias & Tomas, 2010). The entire family system is targeted at the client rather than the individual; the rationale for this approach is that children and their families are understood as interdependent. Treatment focuses beyond the youth and onto all family members in order to understand the problem source and to determine the best course of intervention (Webb, 2011).

Brofenbrenner (1979) proposed a model outlining three extrinsic components that influence child behavior and development. The components include the microsystem, the mesosystem, and the exosystem – each of which is inter-linked (Haugaard, 2008). The Brofenbrenner (1979) model is the ecological perspective that emphasizes interdependence between the youth and the individual's environment. Youth can be understood in terms of the biological, cognitive, emotional, and social relationships with physical and social components that comprise the individual's environment (Heller & Gitterman, 2011).

Cognitive-behavioral therapy (CBT) evolved from Ellis's (1993a) Rational-Emotive-Therapy (RET) model (Cohen, 2007) to Beck's (1972) CBT model. CBT is a pragmatic, action-oriented approach initially developed to treat anxiety and depression; this approach has been modified to address other psychological disorders and is used as an aid to medication management (Wright, 2006).

Functional family therapy (FFT) is a three-phase, shortterm, outcome-driven, direct prevention program developed by Sexton and Alexander (2000) in 1969 and was designed to treat dysfunctional youth ages 11-18. Treatment ranges from 8 to12 1-hour sessions for mild cases and up to 30 sessions for more difficult cases. Therapists implementing FFT target antisocial behavior, violence, substance use, and substance abuse. FFT is a strength-based and confidence-building family intervention that is divided into three phases intended to engage and motivate, change behavior, and generalize treatment for relapse prevention. FFT has been implemented in a diverse group of cultural contexts and populations (Sexton & Alexander, 2000). The primary foci of FFT are to foster communication, resolve conflict, and build community support.

Drawing from Vygotsky's (1934a) Social Development Theory, Bandura (1977) bridged the gap between behavioral and cognitive learning theories through his social learning theory model. Social learning occurs in a shared context where the individual is influenced by social norms and role models (Bandura, 1977; Eyal & Rubin, 2003). Family-centered therapy incorporates social learning because the family is viewed as the primary source of all learning (Hogben & Byrne, 1998). Outcome behaviors are determined by the level of family functioning and types of reinforcement given within the family system (Hart & Kritsonis, 2006).

Intensive In-Home Services

Intensive In-Home Services (IIHS), which implements the Evidentiary Family Restoration (EFR) model, is part of an extensive inventory of family preservation services (Hurley, 2008). IIHS is a team approach grounded in a systemic-ecological perspective that focuses on the whole family as the client (Bogenschneider et al., 2012; Jenson & Fraser, 2011). Ecological systems theory is rooted in Brofenbrenner's 1990 ecological paradigm and in

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Munchin's 1974 transactional family patterns (Bogenschneider et al., 2012). Brofenbrenner (1990) placed child behavior and development in the context of the bio-ecological system that included four systemic layers: the microsystem (family, neighborhood, or school), mesosystem (connections between teacher and parents or school and neighborhood), exosystem (community-based resources), and macrosystem (norms, customs, and laws) (Brofenbrenner, 1990).

The IIHS clinician applies family systems theory to guide the process of understanding a wide range of forces that may influence child development and pathology (Haugaard, 2008). Though the family system is regarded as a unit youth are targeted for treatment (Webb, 2011). The qualifying criteria for entry into an IIHS program, as designated under Comprehensive Child and Family Treatment (CCFT), include a diagnosis based on the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) published by the American Psychiatric Association (2000), evidence that the youth's clinical status presents a jeopardy to the community, the youth and family consent for treatment, and a determination that the needs of the youth cannot be met by traditional outpatient treatment (Volunteer State Plan, 2012).

Targeted youth are those with significant emotional and behavioral problems in their home and community who are at risk for out-of-home placement including juvenile detention, residential treatment centers, and foster care (Daleiden, Pang, Roberts, Slavin, & Pestle, 2010). Davies (2010) declared that risk applies to the child, the parental or family system, and the social environment. IIHS also targets youth who are already in state custody but are in the process of transitioning back into the home (Barth et al., 2007; Thompson, Bender, Windsor, & Flynn, 2009). Webb (2011) estimated that 14%-23% of all children experience a wide range of disturbances including developmental, emotional, and behavioral disorders. Hinshaw (2008) wrote that children and adolescents who experience emotional and behavior issues often find

themselves with "serious impairments in such crucial life domains as academic achievement, interpersonal competencies, and independent living skills" (p. 4). Webb (2011) further noted that children who have experienced at least one out-of-home placement are at a higher risk of posttraumatic stress syndrome (PTSD) issues resulting from parental separation, abandonment, or death. Helton (2011) concurred that emotional and behavioral problems increase the likelihood for out-of-home placement, but placement stability is a means to alleviate symptoms. Fisher, Stoolmiller, Mannering, Takahashi, and Chamberlain (2011) identified child behavior as a predictor of placement disruption and further discovered that those disruptions have a bearing on brain development. Studies conducted by the Department of Social Work at the University of Tennessee revealed that the environment may shape brain development and human behavior (Egan, Neely-Barnes, & Combs-Orme, 2011); other studies identified the brain as the main receptor of environmental stimuli (Pennington, 2009; Young, 2009). These studies shed light on brain function and maladaptive responses to stress and trauma (Egan et al., 2011). Table 1 illustrates concerns regarding child psychopathology (Fraser, 2011).

Table 1

Diagnostic Prevalence Rates for Children 9 to 11 Years Old

Diagnosis	US Population	SED Population
Anxiety: *Phobias, separation anxiety disorder, generalized anxiety disorder, obsessive-compulsive disorder, PTSD*	8%-10%	41%
Depression: *Major depressive disorder, dysthymia*	6%	19%
Disruptive Disorders: *Conduct disorder, oppositional defiant disorder*	4%-10%	67%
Attention Deficit Hyperactivity Disorder	5%	12%
Childhood Schizophrenia	0.30%	-
Eating Disorders: *Bulimia nervosa, anorexia nervosa*	1%-3%	-

Doyle (as cited in Koch, 2007) conducted a comparative study in 2007 sampling 15,000 children between 1990 and 2002 in Illinois to test the effect on children in foster care versus children who remained with their family. The findings revealed that children who remained with their family were less likely to become juvenile delinquents and more likely to become productive citizens in adult life.

IIHS is rooted in the evidence-based Homebuilders program that began in Tacoma, Washington, in 1974 for family preservation. The primary aim of the program was to prevent children's out-of-home placement. The Homebuilders concept is to ensure that a family therapist is on call 24 hours a day, 7 days a week. The services are shortterm and limited to an average of 4-6 weeks; clinicians' caseloads are small, intake is within 24 hours of referral, and therapy occurs in the natural home environment. The guiding mission of Homebuilders is to ensure that children and family are safe and that out-of-home placements are prevented at all measures. The Homebuilder ideal is for children to be raised by their own family whenever possible (Al et al., 2012; Berry, 1997; Leavitt, 2010; Puyenbroeck et al., 2009; Southam-Gerow, Rodriguez, Chorpita, & Daleiden, 2012). A report from the Institute for Family Development (2010) contains data establishing that 86% of children served by Homebuilders have avoided out-of-home placement and remained safely in their homes with a substantial reduction in risk. The findings in a recent study conducted by Daleiden et al. (2010) likewise inferred that IIHS is reasonably successful in deterring highly restrictive placements.

<div align="center">Family Preservation Services</div>

The Homebuilders model was designed for reunifying and preserving families with children (newborn to age 17) who are at risk for out-of-home placement into foster care, group or residential treatment, psychiatric hospitals, or juvenile justice facilities (Office of Justice

Programs, 2012). Since the introduction of the Homebuilders programs in 1974, there has been a trend of moving away from residential care to home- and community-based alternatives (Barth et al., 2007; Cicchetti & Toth, 2009). Family preservation is a blanket of services that was developed through the recognition that out-of-home placement may result in traumatic longterm effects on children being removed from the home (Mullins, Cheung, & Lietz, 2012). Providers who implement family preservation services (FPS) do so with the conviction that children and families fare better in the long term when children are kept in their homes (Child Welfare Information Gateway, 2012). The central focus of family preservation is to build more effective family functioning, to disengage youth from deviant peer networks, and to enhance school performance. The services are built on providing parents and children with support, education, and empowerment to change (Child Welfare Information Gateway, 2012; Henggeler & Schoenwald, 2011). The core of family preservation service is delivered through home visits by professional counselors who educate, support, and serve as accountability partners to their respective assigned families (Gockel, Russell, & Harris, 2008).

Studies sponsored by the American Psychological Association (APA) and Division of Clinical Psychology revealed that a positive client-counselor relationship is a central component needed to ensure the effectiveness of therapeutic outcomes (Norcross & Lambert, 2010; Webb, 2011). Research shows that effective IIHS service delivery depends greatly on positive counselor-client relationships (Haine-Schlagel, Brookman-Frazee, Fettes, Baker-Ericzen, & Garland, 2012; Seligman & Ollendick, 2011; Thompson et al., 2009) and that parents play a critical role in the effectiveness of treatment outcomes (Dowell & Ogles, 2010; McKay et al., 2010; Podell & Kendall, 2011; Webb, 2011).The parent partners with a clinician to learn skills and ways to apply those skills in parenting, which leads to improved treatment efficacy

(Brookman-Frazee, Haine, Baker-Ericzen, Zoffness, & Garland, 2010; Deković, Asscher, Manders, Prins, & van der Laan, 2012; Haine-Schlagel et al., 2012). In this regard, the parent acts as a consultant providing information for the clinician, the collaborator who arranges treatment schedules, and the central support person who assists with the child's acquisition of coping skills during in vivo exposures (Podell & Kendall, 2011). Webb (2011) assumed that effectiveness is measured by the degree that therapy focuses on the client. Family-focused therapy allows for self-determination that may be realized when the practitioner understands that his or her values may differ from those of the family served (National Association of Social Workers, 2008; Webb, 2011).

IIHS Family Preservation Services (FPS) consists of three treatment phases that occur within 24 hours of the initial referral; they are engagement and alignment, treatment, and generalizations (Youth Villages, 2012). Engagement is a critical component of effective treatment to increase retention, which is the single greatest predictor of positive outcomes (Thompson et al., 2009). The primary goals of FPS are to protect children from harm, preserve existing family units, promote children's development, and to require a diversity of permanency planning alternatives including family reunification, placement with relatives, and different forms of guardianship should the child be in danger at home (Pecora et al., 2009).

<div align="center">Home-Based Services</div>

Youth and family service providers partner with DCS in Tennessee to deliver family preservation and reunification services. IIHS providers partner with educational, mental health, juvenile justice systems, and DCS to strive for decreasing the level of severity factors faced by children who are at risk of out-of-home placement (Casey Family Programs, 2010). The selected agency now serves more than 3,100 youths in 11 states and the District of Columbia. This goal is

sought through family preservation and reunification. The Evidentiary Family Restoration

(EFR)™ approach emphasizes five core tenets outlined as family, measurement, community,

intensity, and accountability (Youth Villages, 2012). EFR™ incorporates a trauma-focused

Cognitive Behavioral Therapy (CBT) treatment (Youth Villages, 2011). Intensive in-home

service averages 90-120 days depending on the needs of the children and their families. The

organization offers IIHS programs and other family and community-based services including

nine residential facilities in Tennessee, Georgia, and Oregon, where the majority of employees

are IIHS counselors (Mills, 2011). Pilot and Comprehensive Child and Family Treatment

(CCFT) are two categories under the IIHS program that differ in terms of funding and referral

sources.

Youth in the Pilot Program are referred by the Department of Children's Services (DCS)

because they are at imminent risk of placement into state custody. Cases designated as Pilot are

funded by a grant through DCS, and the IIHS program works to prevent state custody placement

in those cases. CCFT is broader in comparison to the Pilot program because CCFT is funded

directly by TennCare. CCFT targets youth who have received previous therapy, those who have

a DSM-IV diagnosis, and youth at risk for out-of-home placement to detention or residential

placement facilities. The focus of this study was limited to youth and their families classified

under CCFT in Tennessee. The youth and service provider agency were selected for this study

because the agency is one the largest not-for-profit behavioral health organizations in the

southeastern United States (Hurley, 2008).

Evidence-Based Therapy

Evidenced-based therapy (EBT) is a systematic approach to clinical decision making

(Hidecker, Jones, Imig, & Villarruel, 2009). As early as the clinical concepts of Witmer (1909)

and the developments of Sackett (1979), EBT linked science with clinical care (Kratochwill, Morris, & Robinson, 2008). The purpose is to assist the client with decision making (Hoffman, Bennett, & Del Mar, 2013). The American Psychological Association (APA) initiated Presidential Task Forces in 1998 and 2005 with the goal of reducing the research-to-practice gap and promoting evidence-based interventions in school psychological services with a special focus on the determinants influencing behaviors of children and adolescents (Jenson & Fraser, 2011; Kratochwill et al., 2012). Blueprints for Violence Prevention, through the Center for the Study and Prevention of Violence, outlined an evaluative model for EBT that included these four measures: EBT confirms a deterrent effect on the behavior, a valid research design, a sustained treatment effect, and potential for replication at multiple sites (Kratochwill et al., 2012). Interventions within the EBT model target family systems as a whole and focus on a wide array of disorders in youth (Kaslow, Broth, Smith, & Collins, 2012; Woolf, 2008).The guiding principles for Evidence-Based Practice are:

1.   Children and adolescents should receive the best available care based on scientific knowledge and integrated with clinical expertise in the context of patient characteristics, culture, and preferences. Quality care should be provided as consistently as possible with children, their caregivers, and their families across clinicians and settings.

2.   Care systems should demonstrate responsiveness to youth and their families through prevention, early intervention, treatment, and continuity of care.

3.   Equal access to effective care should cut across age, gender, sexual orientation, and disability inclusive of all racial, ethnic, and cultural groups.

4.   Effectively implemented EBT requires a contextual base, collaborative foundation, and creative partnership among families, practitioners, and researchers.

A full body of evidence on youth psychotherapy sponsored by the APA and the Society for Prevention Research contains over 1,500 clinical trials that met inclusion criteria for four meta-analyses. The findings reflected that 75% of children who received evidence-based treatment showed an improvement in functioning levels (Weisz et al., 2005). The Pennsylvania Commission on Crime and Delinquency at Penn State published a report covering the effect of EBT that reflected an overall 17% decrease in juvenile justice placements between 2005 and 2010 in counties that adopted the EBT model; juvenile justice placement in Pennsylvania counties without EBT services reflected no change over the 6-year period (Campbell & Bumbarger, 2012).

Studies also confirmed the cost effectiveness of EBT, which consumes a smaller part of state budgets designated for youth mental health as compared to residential care or psychiatric hospitalization (Barth et al., 2007; Daleiden et al., 2010). Illinois spent nearly 75% of its total mental health services budget for the 50,000 children in longterm residential treatment centers and psychiatric hospitals in 2006 (Barth et al., 2007). Of California's total budget designated for home care, 60% was spent on children in residential care (Barth et al., 2007). The Annie E. Casey Foundation (2012) stated that the average cost for operating detention centers is in excess of $70 thousand annually and a single bed over 20 years will cost approximately $1.5 million. According to the report, EBT program costs are significantly lower than out-of-home placements and save taxpayers an average of $30 thousand per year.

In 2004 the Florida Department of Juvenile Justice sponsored the *Redirection* project designed to move troubled youth from residential placements to family-focused evidence-based treatment. The project implemented programs – Multisystemic Therapy (MST) and Functional Family Therapy (FFT) – outlined in the Blueprint for Violence Prevention due to evidence-based

outcomes. Figure 1 illustrates Florida's cost savings from 2004 to 2012 (Evidence Based

Associates, 2012).
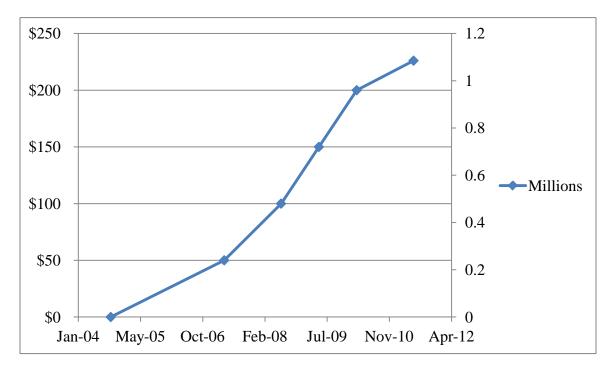
Figure 1. EBT Cost Savings (Evidence Based Associates, 2012)

Though confirmation is available that supports Evidence Based Therapy (EBT), there are

nevertheless two schools of thought regarding the model. Proponents of EBT assert that

intervention with positive outcome measures should be used in preference to interventions that

have not been tested. Opponents say that structured, manual-guided EBT interventions are too

rigid and limited in scope (Weisz, Jensen-Doss, & Hawley, 2006). Weisz et al. (2005) surmised

that EBT tends to be a one-size-fits-all therapeutic intervention, whereas usual care offers

broader contexts for intervention. Converse to inflexible ends-based EBT formats, usual care is a

process-oriented approach tailored to the needs of the individual (Weisz et al., 2005). Mullen and

Streiner (2004) concurred with Wesiz's criticism of EBT with four limitations: 1) treatment

practices adhere to standardized manuals or guidelines, 2) treatment practices were evaluated

with controlled researched designs, 3) outcomes are measured on the basis of objective measures, and 4) different research teams conducted evaluations. Some significant pros and cons of EBT are (Education Queensland, 2012):

> Pros include:
> - Encourages therapists to monitor and review practice;
> - Promotes best practice and quality student management;
> - Facilitates clinical reasoning and allows opportunities for informed decision making;
> - Assists with informing overall service delivery through pathways to clinical standards;
> - Assists with informing departmental and service decisions, policies, or legislation; and
> - Facilitates accountability and increased credibility that in turn may lead to additional resources.
>
> Cons include:
> - Time consuming to do a literature search and find no answers to questions,
> - Some argue that it encourages recipe book intervention,
> - Some argue that it limits clinical judgment,
> - It may limit creativity, and
> - There are increased expectations from consumers or colleagues that interventions are justified.

Henggeler and Schoenwald (2011) published a report outlining successes and failures within the juvenile justice system. Of 2.11 million juvenile arrests, 30% were female and approximately 25% were considered violent (Puzzanchera, 2009). The findings show an increase in criminal behavior and activities following juvenile processing, juvenile transfer, shock incarceration interventions, and residential placement in facilities such as boot camps, group homes, detention centers, and wilderness camps (Henggeler & Schoenwald, 2011; Petrosino, Turpin-Petrosino, & Guckenburg, 2010; Redding, 2010; Sedlak & McPherson, 2010).

<u>Integrated Treatment Models</u>

Evidentiary Family Restoration (EFR) is an integration of cognitive-behavioral therapy (CBT), functional family therapy (FFT), and social development theories; it is a unique

proprietary approach implemented by IIHS service providers (Youth Villages, 2012). The five

core tenets of EFR are identified as:

1. Evidentiary Family Restoration treats children and families simultaneously.
2. Evidentiary Family Restoration requires measurable long-term outcomes.
3. Evidentiary Family Restoration is sustained in the community.
4. Evidentiary Family Restoration uses highly intensive protocols that are delivered 24/7.
5. Evidentiary Family Restoration delivers unprecedented accountability to families and funders. (Youth Villages, 2012, para. 1-5)

<div align="center">Cognitive-Behavioral Therapy</div>

Cognitive-Behavioral Therapy (CBT) is one of three treatment models that comprise

EFR. CBT is rooted in Ellis's (1993a) Rational-Emotive Therapy (RET) (Cohen, 2007) that was

developed into Rational-Emotive-Behavioral Therapy (REBT) in the 1990s as a response to

critics like Mahoney (1995) and Guidano (1991) pointing out that there is no absolute criterion

for rationality (Ellis, 1999; Farley, 2009). Ellis began his career as a disciple of Freud but soon

became disgruntled with the psychoanalytic method because of its inefficient and indirect overall

nature (Ellis, 1993b). Ellis developed the RET model by drawing from the Stoic philosophers

Epictetus and Marcus Aurelius,. Epictetus wrote in *The Enchiridion*, "Men are disturbed not by

things, but by the view which they take of them" (Epictetus, 2009); this view guides the

philosophy behind Ellis's method. Ellis wrote that thoughts, emotions, and behaviors are clearly

linked (Haugaard, 2008). The RETB ABC theory of Emotional Disturbance (Ellis, 1993a) held

that people: a) encounter undesirable events, b) have irrational beliefs about the stimuli

encountered, and c) experience negative emotional consequences from the beliefs. Ellis asserted

that the locus of emotional disturbance is found in unrealistic and irrational self-talk rather than

in the events themselves (Ellis, 1962). People tend to *catastrophize* actual or anticipated events

and the consequences that may follow the event (Haugaard, 2008). The goal of RETB is to guide

clients to change their thoughts and feelings that would in turn influence their responses to the

events (Ellis, 1993b). REBT is clarified in this statement by Ellis (2001):

> People can choose to change their ways, though difficult, even when they are born and reared to be self-defeating. The reason is that they are able to see how demanding they frequently are and *choose* to do the hard work and practice that is usually required for change. Being innate constructivists, they can even change their habitual destructive tendencies including some of their biological tendencies, even in the face of neurological deficiencies such as attention deficit disorder and learning disabilities. But they can learn to improve them and become less deficient. They may have endogenous depression, which makes them prone to catastrophic and awfulizing thinking. But they can use REBT and other forms of cognitive-behavior therapy to improve their depressive thinking. (p. 63)

The developments of CBT can also be attributed to Beck (1972) who developed

Cognitive Therapy as a means to treat depression. Beck began his career as a psychoanalyst and

soon moved in a different direction after developing his view that Freudian ideas were

experimentally unconfirmed (Rosner, 2012). Rosner (2012) wrote that cognitive therapy was

born with the development of "Thinking and Depression: I. Idiosyncratic Content and Thinking

Distortions (TDI)" (Beck, 1963) and "Thinking and Depression: II. Theory and Therapy (TDII)"

(Beck, 1964). The goal of cognitive therapy is to guide the patient to identify and overcome

distorted thinking, behavior, and emotional responses by replacing them with positive beliefs that

underlie distorted thinking and lead to positive behavioral changes (Rosner, 2012). As part of

TDII, Beck (1964) developed the schema that is used to describe the phenomenon of depression.

According to Beck, the schema is developed through experiences in early childhood and is

carried through adolescence and into adulthood (Davison & Neale, 2001). Beck (1964) described

the schema as:

> The schemas are conceived as relatively stable cognitive structures which channel thought processes, irrespective of whether or not these are stimulated by the immediate environmental situation. When a particular set of stimuli impinge on the individual, a schema relevant to these stimuli is activated. The schema abstracts and molds the raw data into thoughts or cognitions ... In the formation of cognition, the schema provides the

conceptual framework while the particular details are "filled-in" by the external stimuli. (pp. 562-563)

CBT in IIHS is implemented in a phase-based fashion. Safety is the highest priority when implementing treatment (Courtois & Ford, 2009; Deblinger, Runyon, Mannarino, Cohen, & Steer, 2011; Heggeness & Davis, 2010). For CBT to progress, the youth must be clear from ongoing dangers that include suicidal ideations or behaviors, self-injury, ongoing violence or abuse toward the youth, and risk-taking behaviors such as substance abuse (Cohen, Mannarino, & Murray, 2011). Delinquent and antisocial behaviors have been associated with traumatic-related effects brought on by traumatic events (Duke, Pettingell, McMorris, & Borowsky, 2010). Results of a study by Duke et al. (2010) showed that high school youth who engaged in violent activities had experienced a multiple set of traumas in their lifetime. Traumatic events are defined as those perceived as terrifying, shocking, sudden, or that potentially pose a threat to personal safety or integrity (Buffington, Dierkhising, & Marsh, 2010; Deblinger et al., 2011).

CBT is a time-limited method that focuses on the here and now (Seligman & Ollendick, 2011); Cohen et al. (2011) investigated ways CBT can reduce symptoms resulting from *past* trauma. They discovered that the key is found in safety planning. By realizing that the youth is no longer in a dangerous situation he or she can feel safe when confronted by a possible reminder that may have once been a trigger for anxious behavior. After ensuring safety, a therapist collaborates with the family to identify treatment goals so that identified themes are followed during psycho-education. The therapist may use assessment tools or Socratic questioning as a means of identifying where psycho-education is most needed. These areas may include parenting training, self-awareness skill building, or cognitive coping strategies. Treatment consolidation and closure is the final phase of IIHS CBT. The therapist reviews ways

to continue to establish positive peer networks, redirect cognitions, and to maintain safety in

daily living. According to Gatchel and Rollings (2008), there are six phases in CBT:

1. Assessment
2. Reconceptualization
3. Skills acquisition
4. Skills consolidation and application training
5. Generalization and maintenance
6. Post-treatment assessment follow-up

<u>Functional Family Therapy</u>

Developed in 1972 by Alexander, Functional Family Therapy (FFT) is an evidence-

based, empirically-grounded, family-based multisystemic, and multilevel program targeting

troubled youth ages 11-17 from diverse cultural and ethnic groups. The average number of

sessions ranges from 8 to10 for mild cases and up to 30 for more severe cases (Sexton &

Alexander, 2000). The aim of FFT is to replace dysfunctional family behaviors with new patterns

through assertiveness training, anger management, communication training, and other protocols

targeting relational strategies (Henggeler & Schoenwald, 2011). The Center for the Study and

Prevention of Violence has designated FFT as a successful treatment blueprint for delinquency,

violence, and other co-occurring high-risk behaviors and in mental health systems; FFT is a

primary treatment program for a wide range of problem youth (from early first offenders, to

serious offenders, to high-end youth) (Sexton, 2011). FFT is used instead of juvenile probation

with the goal of improving client care in community settings through meetings with the client at

home and in the clinician's office (Sexton & Turner, 2010). Comparable to CBT, FFT is likewise

a stepped clinical method focusing heavily on disruption within the family system. The three

phases are: 1) to engage and motivate youth and their family by decreasing negativity

surrounding the family, 2) to change behavior by reducing and eradicating problem behaviors

that affect family relations (realized through conflict management and goal setting), and 3) to

generalize changes across family problems by increasing the ability to access multisystemic community resources that can improve the family system and prevent relapse (Sexton, Alexander, Bonomo, Ostrom, & Kopp, 2002).

To test the validity of FFT, Sexton and Turner (2010) sampled 900 juvenile offenders on a statewide trial and found a significant (34.9%) reduction in felony and violent crime but an insignificant (21%) reduction in misdemeanor crime. The researchers concluded from these data that FFT is most effective with the highest level of at-risk youth (Sexton & Turner, 2010). Studies by Mercer Health & Benefits, LLC (2008) also rendered results affirming the success of FFT in decreasing violence, drug abuse or use, conduct disorder, family conflict, and residential and juvenile correction placement. The Washington State Institute for Public Policy (WSSIP) applied a cost-benefit analysis based on a meta-analysis of FFT among a wide range of prevention and intervention programs and determined that FFT qualifies as a cost-effective treatment program (Drake, Aos, & Miller, 2009).

The key components of the Functional Family Clinical model are:

1. *Engage and motivate* youth and their families by decreasing the intense negativity (blaming, hopelessness) so often characteristic of these families. Rather than ignoring or being paralyzed by the intense negative experiences these families often bring (e.g., cultural isolation and racism, loss and deprivation, abandonment, abuse, depression), FFT acknowledges and incorporates these powerful emotional forces into successful engagement and motivation through respect, sensitivity, and positive reattribution techniques.

2. *Change Behavior*: Reduce and eliminate problem behaviors and accompanying family relational patterns through individualized behavior change interventions. During this

phase FFT integrates a strong cognitive or attributional component into systematic skill-training in family communication, parenting, problem solving, and conflict management skills.

3.   *Generalize changes* across problem situations by increasing the family's capacity to implement multisystemic community resources adequately and to engage in relapse prevention.

Social Development

Vygotsky (as cited in van der Veer, 1985) established a pedagogic theory that child development is a dialectical process of crises and revolutions. The child experiences periods of stable growth followed by sudden transformations and even regression. The constructivist principle lies outside the individual in psychological tools and interpersonal relations. As the child develops, his or her extrinsic social environment shapes to those cognitive intrinsic changes (van der Veer, 1985). This view is contrary to the behaviorist method that promotes child behavior as being conditioned by the environment (Vygotsky, 1997). The Vygotskian method is also assumed to be a correction of Gestalt and association psychologies in that meaning is found externally rather than internally. The child creates meaning by interacting with and internalizing his or her social environment through social activities like thought and speech (Mahn, 1999). The child becomes aware of initial passive mental functions and converts those functions to control his or her social environment by using signs and language (Vygotsky, 1978). Vygotsky (1998) proposed five dialectic cognitive stages of development:

Period	Age
Infancy	0.2-1
Early Childhood	1-3
Preschool Age	3-7
School Age	7-13
Adolescence	13-17

Each period is punctuated by periods of crisis, each of which is resolved through "new formations" (*novoobrazovanie*) developed through adult interaction (van der Veer, 1985). The three periods of crisis that occur during early childhood happen during infancy, at age 3, and at age 7. Behavioral changes result from cognitive reconstruction and regeneration at the conclusion of each crisis (Vygotsky, 1998). As applied to IIHS, youth and children must work through the naturally occurring changes that result through conflicts at the conclusion of each developmental stage. These cognitive transitions move more smoothly through the guidance of an adult teacher, counselor, or parent (Keefer, 2005).

Central to Vygoskyian theory is the Zone of Proximal Development (ZPD) (Vygotsky, 1933) used to differentiate between two levels of development achieved by problem solving and adult guidance (Vygotsky, 1978). Vygotsky (1934b) made a distinction between "lower" natural memory functions like primitive perception, memory, attention, will, and "higher" or cultural functions that are specifically human and appear gradually in a course of radical transformation of lower functions. Vygotskian theory states that developmental status is determined more by what children can do with others than what they can do alone (Kleinspehn-Ammerlahn et al., 2011). Therefore, the lower functions are transformed through human interactions. Vygotsky (1998) affirmed:

> It is equally important to determine the upper threshold of instruction. Productive instruction can occur only within the limits of these two thresholds of instruction... The teacher must orient his work not on yesterday's development in the child but on tomorrow's. (p. 121)

Kleinspehn-Ammerlahn et al. (2011) conducted a study on dyadic drumming to measure the concept of Interpersonal Action Synchronization (IAP) implied in ZPD. A sample of 72 individuals (*n* =18 per age group) ages 5, 12, 20-30, and 70-80 were grouped into three pairs of same-age peers, two different age children, and children and adults. The findings revealed that both younger and older children showed higher synchronization accuracy in the drumming tempo. The clinician implementing the IIHS guided the youth through the ZPD process by introducing evidence-based interventions such as problem-solving skills and other strategies that lead to a higher functioning level. The youth moved through the process using IAP (Kleinspehn-Ammerlahn et al., 2011).

Bandura (1971) popularized a cognitive-based social learning theory through a series of investigations on family antecedents of child behavior disorders that come through observational learning. Bandura and Barab (1973) inferred that modeling combined with guided participation could be used as a means to eliminate negative phobias and motivate positive behavior. Negative phobias are reduced by graded exposure to the feared stimuli, cognitive therapy (examining and challenging irrational thoughts associated with the fears), and relaxation exercises to calm anxieties.

Social learning theory is a cognitive-based treatment model that builds on observing other people's actions, whether positive or negative (Maschi, Bradley, & Morgen, 2008). Duffy and Atwater (2008) defined social learning as "a process in which we learn by observing events and other people (or models) without any direct rewards or consequences" (p. 37). Bandura's (1986) model depends on four components: attention, retention, reproduction, and motivation. The child's behaviors are shaped on the basis of real-life experiences and direct or indirect exposures (O'Connor, Matias, Futh, Tantam, & Scott, 2013). There is a reciprocal relationship between the

child and the environment (Jenson & Fraser, 2011). The youth's meaning and identity are therefore constructed through dynamic interaction within his or her social context (Muro & Jeffrey, 2008; Prell, Reed, Racin, & Hubacek, 2010).

The likelihood of engaging in positive behavior increases with a greater number of positive interactions and those behaviors become internalized over time (Maschi et al., 2008). One of the ways social learning interventions are applied in IIHS is through developing parenting skills targeted for positive and negative reinforcements to increase the child's desired behaviors and decrease undesired behaviors (O'Connor et al., 2013). Webb (2011) observes that some parents are "so disabled by their own upbringing that they do not know how to parent effectively" (p. 65). Barth (2009) identified parenting issues such as parental substance abuse, parental mental illness, and domestic violence as predictors of child maltreatment. Parents and the clinician become partners in the therapy process to move toward increasing the youth's willingness to adapt to positive changes brought to the family system (Reed et al., 2010).

Bandura (1989) expanded the social development method with social cognitive theory. Social cognitive theory explains psychosocial functioning in terms of triadic reciprocal determinism (Wood & Bandura, 1989). The causal triad is comprised of behavior, personal factors, and the environment as adapted from Bandura's (1989) Social Learning Theory and illustrated in Figure 2.
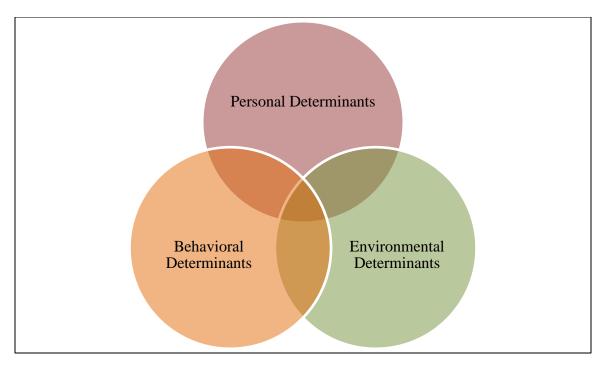
Figure 2. Social Learning Theory (Bandura, 1989)

The learner is thoroughly integrated with his or her environment. Cognitive responses, behaviors, and environment are all interconnected in a triadic reciprocal relationship. Contrary to the Vygoskyian or behaviorist views, social cognitive theory purports that people are neither driven by inner forces nor are they controlled by external stimuli (Bandura & Barab, 1973). Bandura (1997) indicated that the skills learned through observation are translated into action.

Bandura (1973) conducted several correlational studies on social learning and aggression and discovered that violence influences the way the youth processes conflicting interactions. Bradshaw, Rodgers, Ghandour, and Garbarino (2009) researched aggression among school children and found that exposure to violence is a strong predictor of maladjustment and aggressive behaviors. Card (2011) affirmed the findings in a similar study on aggression in school-aged children. Both studies indicate that aggressors are more likely to experience longer-

term delinquency or substance abuse and they may become victims of abuse, neglect, or other factors that place them at risk for out-of-home placement (Bradshaw et al., 2009; Card, 2011).

<div align="center">Crisis Intervention</div>

IIHS-FPS is largely grounded in crisis theory, which stems from a systems approach perspective (Al et al., 2012). Crisis theory, as applied to behavioral health, can be traced to Willy (1899) who argued in favor of an "epistemological basis" for psychology. Driesch (1925) published a booklet originally in English titled "The Crisis in Psychology" through which he established five points of crisis. Buehler (1927) followed with *Die Krise der Psychologie* wherein languages are conceived as three interrelated dimensions (expression, appeal, and representation). Lindemann (1944) expanded on Driesch's (1925) and Buehler's (1927) work by developing crisis theory within the context of specific human dilemmas. Lindemann (1944) declared that internal stability is threatened by changes or crises in an individual's social environment that creates disturbance (Poal, 1990). Caplan (1964) echoes Lindemann as crisis theory is framed around the concept of homeostasis. As applied to the family, crisis may create an imbalance in the family system, which according to Caplan creates reactive emotions among family members (as cited in Poal, 1990). Caplan's 1965 theory is outlined in Poal (1990) as:

1. In the initial phase the individual is confronted by a problem that poses a threat to his homeostatic state: the person responds to feelings of increased tension by calling forth the habitual problem-solving measures in an effort to restore his emotional equilibrium.
2. There is a rise in tension due to the failure of habitual problem-solving measures and the persistence of the threat and problem. The person's functioning becomes disorganized and the individual senses feelings of upset and ineffectuality.
3. With the continued failure of the individual's efforts, a further rise in tension acts as a stimuli for the mobilization of emergency and novel problem-solving measures. At this stage, the problem may be redefined, the individual may resign himself to the problem or he may find a solution to it.
4. If the problem continues, the tension mounts beyond a further threshold or its burden increases over time to a breaking point. The result may be a major breakdown in the individual's mental and social functioning. (pp. 126-127)

<div align="center">41</div>

Reactive emotions may manifest through aggressive or defiant behavior creating more

stress within the system (Mandler, 2011). Webb (2011) noted that clinicians working with

families should be equipped to understand crisis theory so they will be able to intervene in a

timely manner when families experience crisis. The major characteristic of a crisis is that it tends

to be shortterm and lasts between 6 and 8 weeks (Poal, 1990). Lindemann (1944) stated that

behavioral responses during crisis are not based on predispositions but on the crisis itself.

Crisis intervention is built on the assumption that families are in immediate need of

assistance (Al, Stams, van der Laan, & Asscher, 2011). Based on crisis theory, clinicians may

assume that the duration of crisis is approximately 6 to 8 weeks but there are multi-problem

families who stay in a chronic state of crisis (Al et al., 2011). Drake et al. (2009) suggested that

long-term duration of crisis may not be consistent with crisis theory. In this regard, IIHS

programs are designed to serve youth and families on a shortterm basis for an average of

approximately 90 days (North Carolina Department of Health and Human Services, 2012). This

concludes that IIHS-EBT is designed to enter the family home, implement safety planning,

establish rapport, impart skills to the family members, and collaborate with parents and youth to

resolve the crisis in order to lead to a healthy and stable family system (Norcross & Lambert,

2010; Webb, 2011). Ultimately the goal of EFR is to prevent out-of-home placement and

preserve the family (Youth Villages, 2012).

<div align="center">Summary</div>

Evidentiary Family Restoration (EFR) synchronizes cognitive-behavioral therapy (CBT),

functional family therapy (FFT), and social development models into Intensive In-Home

Services (IIHS) (Webb, 2011; Youth Villages, 2012). The three models implement step-based

and shortterm treatment interventions. FFT and social development began as child-based models

whereas CBT was programmed for all age groups (Eyal & Rubin, 2003; Hogben & Byrne, 1998; Sexton & Alexander, 2000). IIHS providers modified CBT methods to target children from birth through age 17 (Whitefield & Williams, 2003). Service providers that offer EFR-based IIHS treatment seek to prevent out-of-home placement and promote family preservation (Shute, 2010). IIHS treatment interventions target emotional or behavioral challenges that place children at-risk of home disruption (Youth Villages, 2013a; Youth Villages, 2013b).

The 1974 Homebuilder's Model is the foundation for IIHS. The objective was to ensure that services were available to families 24 hours a day and 7 days a week. The intent of the Homebuilders service was to replace in-patient with out-patient treatment (Barth et al., 2007; Cicchetti & Toth, 2009). Characteristics of Homebuilder's programs included crisis intervention, treatment in a natural setting, accessibility and responsiveness, intensity, low caseloads, research-based interventions, and flexibility (Institute for Family Development, 2013).

IIHS service providers were able to expand their programs by building partnerships with the Department of Children's Services (DCS), mental health providers, juvenile justice systems, local schools, and state insurance programs (Tennessee Department of Children's Services, 2003; The District of Columbia Department of Behavioral Health, 2013). IIHS counselors are trained to implement the three pragmatic action oriented approaches into shortterm family-centered sociopsychological therapy using a treatment manual that contains the integrated models. The central components of IIHS are the step models based on integrated interventions (CBT, FFT, and Social Development) (Amos-Young & McGuire, 2013). Those steps are engagement and alignment (phase one), treatment (phase two), and generalizations (phase three). Safety is the common denominator throughout all phases of treatment (Gambrill, 2007).

CHAPTER 3

RESEARCH METHOD

The purpose of this study was to evaluate the outcome characteristics of youth and their families who received Intensive In-Home Services (IIHS). Outcomes were described as benefits in youths' knowledge, attitudes, values, skills, behaviors, condition, or status (Plantz, Greenway, & Hendricks, 2006). The benchmark for data measurement was set at 1-year postdischarge from the IIHS program. Four research (RQ)/hypotheses (HO/HA) guided this investigation. The four predictor variables were age, gender, race, and total length of service received and the outcome variable contained two subcategories: desirable and undesirable.

The sample for this study was derived from an archived database of information collected through nonrandom surveys conducted by the sample agency's research department at 1-year postdischarge from July 2001 to June 2011 using the dataset collected from an Electronic Medical Records (EMR) database. This study used a cross-sectional nonexperimental design. The study limited the number of independent variables to four in order to decrease the potential risk of Type I and Type II errors. The data were organized into four multivariate frequency tables each of which represented the respective independent variable. Each table consisted of polytomous categorical data that represented each independent categorical variable and the one dependent variable with two subcategories.

The dependent variable was the outcome at 1-year postdischarge with two subcategories: desirable (with family, independently living, no trouble with the law, no out-of-home placement, in school or graduated) and undesirable (not living at home, living at home but involved in one of three negative categories that include legal problems, school problems, or various interrupted out-of-home placements).

Independent variables consisted of (age: 0-8 years, 9-11 years, 12-14 years, or 15-17 years), gender (male or female), race (African American, Caucasian, Hispanic, or Bi-Racial & Other), and total length of service received (30-90 days, 90-120 days, and 120+ days). The sample size of 3,131 youth who receive IIHS services was taken as a representative sample of the total population of youth receiving IIHS services. The sample data covered a 10-year period ranging from June 2001 to July 2011.

The cross-sectional research method used in this study implemented a Pearson's Chi Square analysis to determine if there was a statistical relationship between each independent and dependent variable. Each test was divided in terms of the respective category and measured by effect size (ϕ): age (4x2 table), gender (2x2 table), race (4x2 table), and total length of service received (3x2 table).

<div align="center">Research Questions and Corresponding Null Hypotheses</div>

Four research questions were used to guide the study; the corresponding null hypotheses were tested.

RQ1: Is there a significant difference in the proportion of youth who remain in the home after having received Intensive In-Home Services (IIHS) treatment among the four age groups (0-8, 9-11, 12-14, and 15-17)?

Ho1: There is no significant difference in the proportion of youth who remain in the home after having received Intensive In-Home Services (IIHS) treatment among the four age groups (0-8, 9-11, 11-14, and 15-17).

RQ2: Is there a significant difference in the proportion of youth who remain in the home after having received Intensive In-Home Services (IIHS) treatment among the two genders (male and female)?

Ho2:   There is no significant difference in the proportion of youth who remain in the home after having received Intensive In-Home Services (IIHS) treatment among the two genders (male and female).

RQ3:   Is there a significant difference in the proportion of youth who remain in the home after having received Intensive In-Home Services (IIHS) treatment among the four race groups (African American, Caucasian, Hispanic, and Bi-Racial & Other)?

Ho3:   There is no significant difference in the proportion of youth who remain in the home after having received Intensive In-Home Services (IIHS) treatment among the four race groups (African American, Caucasian, Hispanic, and Bi-Racial & Other).

RQ4:   Is there a significant difference in the proportion of youth who remain in the home after having received Intensive In-Home Services (IIHS) treatment among the three length of service groups (30-90 days, 90-120 days, 120+ days)?

Ho4:   There is no significant difference in the proportion of youth who remain in the home after having received Intensive In-Home Services (IIHS) treatment among the three length of service groups (30-90 days, 90-120 days, 120+ days).

<u>Sample</u>

The representative sample consisted of 3,130 cases gathered from 13 agencies that offer IIHS in Tennessee. The study was limited to Comprehensive Child and Family Treatment (CCFT) designated youth who received previous therapy and had at least one diagnosis listed in the DSM-IV manual. The nonrandom sampling method consisted of youth from birth to 17 who received IIHS at least 30 days over a 1-year period from June 2001 to July 2011. The sample was identified as a representative sample of the total population of youth receiving IIHS services. The

youth sampled in this study were homogenous as determined by their receiving the same funding and referral source and because they met the same admission criteria as defined by CCFT. Youth enrolled in CCFT less than 30 days were excluded from the study in order to increase the accuracy of outcome measures.

<div align="center">Instrumentation</div>

The instrument used in this study was a redacted archival dataset supplied by the research director of a youth and family service provider in Tennessee. The outcome evaluation process was developed internally to provide the administration with information for program monitoring and improvement. Surveys were administered to youth and families through phone, text messaging, email, and mail to youth and families who have been 12 months out of the IIHS program. The standardized survey instrument, the *Strengths and Difficulties Questionnaire*, included emotional symptoms, behavior issues, attention-hyperactivity struggles, peer problems, social characteristics, and the impact of the youth's difficulties. The response rate was between 40%-60%. The research department conducted extensive analysis to ensure that the respondent pool was demographically heterogeneous in order to reduce bias within the survey results (Youth Villages, 2013b).

The dataset covered the 10-year period from June 2001 to July 2011 with benchmarks set at 1-year postdischarge. Demographics and total length of service received were labeled as predictors of outcome data and were subcategorized by desirable (with family, independently living, no trouble with the law, no out-of-home placement, in school, or graduated), and undesirable (not living at home living at home but involved in one of three negative categories that include legal problems, school problems, or various interrupted out-of-home placements).

The data were analyzed and results were used to assist youth and family service providers in improving or modifying service delivery to increase or maintain the levels of successful youth and family discharges from Intensive In-Home Services (IIHS). Successful discharges are identified as youth who remain in the home at the end of service delivery that ranges between 90-120 days.

<div align="center">Data Collection</div>

Each youth who qualified for the IIHS program under the CCFT guidelines received 4 hours of intensive in-home therapy each week; sessions ranged from approximately 30 to 120 or more days depending on progress and on meeting treatment goals. A response team provided on-call services 24 hours a day, 7 days a week. IIHS services included skills training, behavioral therapy, interventions, intensive case-management, and linkage to community resources. The on-call team provided services for weekly crises and in-home stabilization (McCall, 2011). IIHS is a program designed to keep youth in their respective homes by preventing placement into detention and residential facilities. The data collected served as an evaluation to identify predictors of success.

Data were supplied by the research director at a youth and family service provider agency. The data were derived using Evolv from the Clinician's Desktop (CDT) program from a redacted dataset accessed from an electronic medical records (EMR) database. Using Citrix XenApp software operated through a Microsoft Windows Server, CDT allows therapists, administrative leadership, and researchers to access data and maintain daily, weekly, and monthly records about clients (Hurley, 2008).

Using data from a redacted dataset eliminated traceable information and ensured that all ethical considerations were followed including maintaining client confidentiality. The administration and research department removed all identifiers prior to granting this researcher access. This method removed the possibility for harm to the youth and families included in the study. Data collection and preservation methods adhered to HIPPA standards and Institutional Review Board (IRB) guidelines for exemption (see Appendix A).

Informed consent was not an issue as the data were derived from archival records. The researcher had no direct contact with youth or families included in the dataset; therefore, no consent was required. Collected data were coded to ensure that all identifying markers remained anonymous. Data will be stored on a flash drive and secured in the researcher's confidential files for 5 years after the completion of this study.

The postdischarge archived data were collected through a medical electronic records (EMR) database housed at the agency's corporate headquarters in Tennessee. The selected service provider for this study has maintained the EMR database since September 2000 (Hurley, 2008). The system is fully compliant with HIPAA guidelines. Data were checked and corrected on a weekly basis to ensure accuracy (Hurley, 2008). The researcher was careful to adhere to the research policy outlined by the selected service provider (see Appendix B). As per policy guidelines, no contract was necessary for this study.

The research department Director provided a letter of support and granted permission for this study (see Appendix C). The researcher worked at the agency in Morristown, Tennessee, as an IIHS counselor and had no contact with any youth participants or families served during the time of this study from July 2001 to June 2011. All identifying information was redacted by the agency prior to release for this study.

Data Analysis

The nonparametric study was a two-tailed hypothesis with a standard normal distribution implementing a series of Pearson's Chi Square analyses. The variables were categorical and nominal with reliance on frequency tables input into the Statistical Package for the Social Sciences (SPSS) software. These procedures allowed the researcher to determine the actual divergence of the observed and expected frequencies of data from the Pearson's Chi Square transcript. All data were analyzed at the .05 level of significance.

CHAPTER 4

RESULTS

The 2012 national average of children living in out-of-home care was estimated at 6.8%

for every 1,000 children in the general population (Casey Family Programs, 2013). The purpose

of this study was to examine the level that Intensive In-Home Services (IIHS) have contributed

to reducing these numbers, as indicated by the predictor variables for success determined by the

numbers of youth living in the home at 1-year postdischarge from an IIHS program. Data housed

in the research department of a youth and family service organization located in Tennessee were

selected as a representative sample of all IIHS providers. The agency's director provided

quantitative data, collected through a postdischarge assessment instrument the *Strengths and*

Difficulties Questionnaire, from agency archives that had been entered into their Electronic

Medical Records (EMR) database. Data provided represented youth referred to an Intensive In-

Home Services (IIHS) program through mental health, juvenile court, probation agencies, or

educational providers who had been discharged from the program between June 2001 and July

2011. The data were limited to independent variables (age, race, gender, and total length of

service received) and two subcategorical dependent variables (outcome measures). Each

category was coded respectively.

Demographics

The archived records for this study sampled 3,130 cases that received treatment through

IIHS services ranging from 30 to 120+ days and that provided follow-up responses for the

research team at a youth services organization at 1-year postdischarge. The data were limited to

youth in Tennessee receiving treatment designated under Comprehensive Child and Family

Treatment (CCFT) funded through TennCare. These cases are also defined as youth who are at imminent risk of out-of-home placement.

The demographic data reflect that ages 15-17 (36.1%) and 12-14 (33.2%) comprise the two largest age groups among the population sampled. The males outnumbered females by 29.2%. Among the race groups sampled 91% of the total population was either African-American (20.5%) or Caucasian (70.5%). There was a 50% increase between the youth who received service 120 or more days (58.2%) and those who were in the IIHS program 90-120 days (28.9%) with the least number of youth in the 30-90 range (12.9%). Figures 3, 4, 5, and 6 show the demographic distributions.
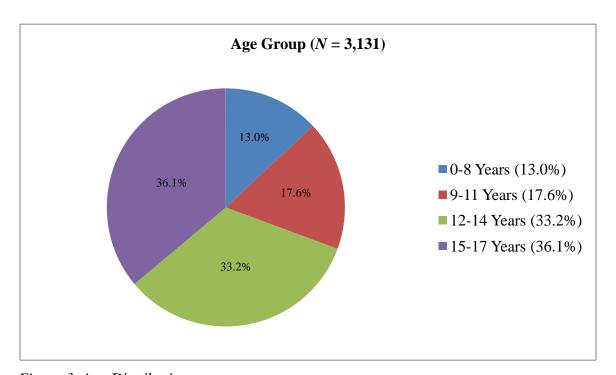
Figure 3. Age Distribution
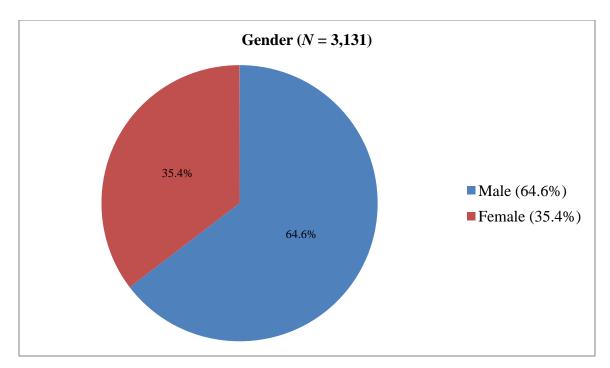
Figure 4. Gender Distribution
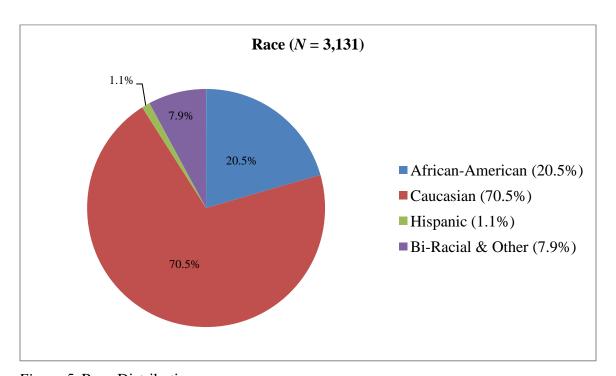
Figure 5. Race Distribution

Length of Service (N = 3,131)

- 30-90 Days (12.9%)
- 90-120 Days (28.9%)
- 120+ Days (58.2%)

12.9%

28.9%

58.2%
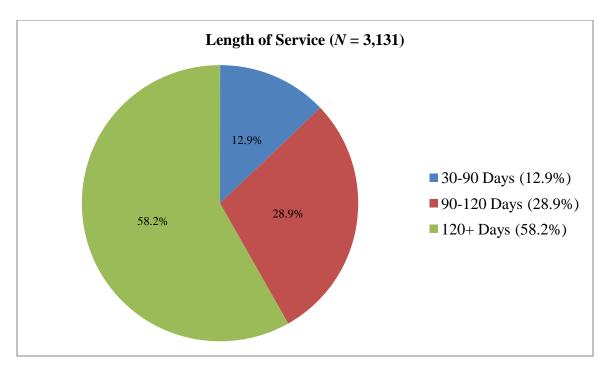
Figure 6. Total Length of Service Received

<u>Research Question 1</u>

Is there a significant difference in the proportion of youth who remain in the home after having received Intensive In-Home Services (IIHS) treatment among the four age groups (0-8, 9-11, 12-14, and 15-17)?

A two-way contingency table analysis was conducted to evaluate whether youth in the study group were more likely to remain in the home posttreatment among the three age groups. The two variables were the four age groups (0-8, 9-11, 12-14, and 15-17) and whether or not the study subjects remained in the home after treatment (yes or no). Age and remaining in the home were found to be significantly related, Pearson χ^2(3, N=3,058) = 142.94, p <.001, Cramer's V = .216. The proportion of youth in the four age groups who remained in the home were (observed and expected) ages 0-8 316/2,266 = .14, ages 9-11 463/2,266 = .20, ages 12-14 742/2,266 = .33, and ages 15-17 745/2,266 = .33.

Follow-up pairwise comparisons were conducted to evaluate the differences among these proportions; Table 2 shows the results of these analyses. The Holm's sequential Bonferroni method was used to control for Type I error at the .05 level across all six comparisons. All six pairs were found to be statistically significant. The youth in the two older groups (12-14 and 15-17) were 1.65 times (.33/.20) more likely to remain in the home than the 9-11 age group and 2.36 times more likely to remain in the home than the 0-8 age group.

Table 2

Pairwise Comparisons by Age

Age Comparison	Pearson Chi Square	*p* value (Alpha)	Cramer's V
0-8 vs. 9-11	21.296	<.001 (.008)	.155
0-8 vs. 12-14	75.443	<.001 (.010)	.234
0-8 vs. 15-17	104.680	<.001 (.012)	.267
9-11 vs. 12-14	30.773	<.001 (.016)	.139
9-11 vs. 15-17	59.368	<.001 (.025)	.188
12-14 vs. 15-17	7.527	.006 (.050)	.059

Research Question 2

Is there a significant difference in the proportion of youth who remain in the home after having received Intensive In-Home Services (IIHS) treatment among the two genders (male and female)?

A two-way contingency table analysis was conducted to evaluate whether youth in the study group were more likely to remain in the home posttreatment among the two gender groups. The two variables were the two gender groups (male and female) and whether or not the study subjects remained in the home (yes or no). Gender and remaining in the home were not found to be significantly related, Pearson $\chi^2(1, N=3,131) = 2.757$, p =.097, Cramer's V = .030. The

proportion of subjects in the gender group who remained in the home were (observed and expected) male 1,509/513.7 = .097 and female 826.7/281.3 = .097. The findings illustrated in Table 3 indicate that there is no significant relationship between gender and the success of IIHS treatment.

Table 3

Frequency Distribution by Gender

Gender	Remained in Home	
	Yes	No
Male	1,490	533
Female	846	262

Research Question 3

Is there a significant difference in the proportion of youth who remain in the home after having received Intensive In-Home Services (IIHS) treatment among the four race groups (African American, Caucasian, Hispanic, and Bi-Racial & Other)?

A two-way contingency table analysis was conducted to evaluate whether youth in the study group were more likely to remain in the homes posttreatment among the four race groups. The two variables were the four race groups (African American, Caucasian, Hispanic, and Bi-Racial & Other) and whether or not the study subjects remained in the home after treatment (yes or no). Race and remaining in the home were found to be significantly related, Pearson $\chi^2(3, N=3,010) = 15.652$, p =.001, Cramer's V = .072. The proportion of youth in the four race groups who remained in the home were (observed and expected) African American 477.4/163.6 = 2.92, Caucasian 1,643.9/563.1 =2.91, H 26/10= 2.6, and Bi-Racial & Other 90/36 = 2.5.

Follow-up pairwise comparisons were conducted to evaluate the differences among these proportions; Table 4 shows the results of these analyses. The Holm's sequential Bonferroni method was used to control for Type I error at the .05 level across all six comparisons. Only the African American and Caucasian comparison was found to be statistically significant. The youth in the African American and Caucasian groups were 2,24 times (5.83/2.6) more likely to remain in the home than the Hispanic group and 2.33 times (5.83/2.5) more likely to remain in the home than the Bi-Racial & Other group.

Table 4

Pairwise Comparisons by Race

Race Comparison	Pearson Chi Square	*p* value (Alpha)	Cramer's V
African American vs. Caucasian	14.959	<.001 (.008)	.072
African American vs. Hispanic	.187	.666 (.010)	.017
African American vs. Bi-Racial & Other	.342	.559 (.012)	.021
Caucasian vs. Hispanic	.333	.564 (.016)	.012
Caucasian vs. Bi-Racial & Other	1.585	.208 (.025)	.026
Hispanic vs. Bi-Racial & Other	.926	.926 (.050)	.007

Research Question 4

Is there a significant difference in the proportion of youth who remain in the home after having received Intensive In-Home Services (IIHS) treatment among the three length of service groups (30-90 days, 90-120 days, 120+ days)?

A two-way contingency table analysis was conducted to evaluate whether youth in the study group were more likely to remain in the home posttreatment among the three length of service groups. The two variables were the three length of service groups (30-90 days, 90-120 days, and 120+ days) and whether or not the study subjects remained in the home (yes or no).

Length of service and remaining in the home were found to be significantly related, Pearson

χ^2(3, N=3,058) = 142.94, p <.001, Cramer's V = .216. The proportion of subjects in the three

length of service groups who remained in the home were (observed and expected) 30-90 days

273.6/130.4 = 2.10, 90-120 days 703/203 = 3.46, and 120+ days 2,336/1,113 =2.10.

Follow-up pairwise comparisons were conducted to evaluate the differences among these

proportions; Table 5 shows the results of these analyses. The Holm's sequential Bonferroni

method was used to control for Type I error at the .05 level across all three comparisons. The 30-

90 days group vs. 90-120 days group comparison was found to be statistically significant. The

youth in the 30-90 days group vs. the 120+ days group comparison was equally (2.1/2.1) likely

to remain in the home. The 90-120 days group was 1.64 times (3.46/2.1) more likely to remain in

the home than both the 90-120 days and 120+ days groups.

Table 5

Pairwise Comparisons by Total Length of Service Received

Length of Service Comparison	Pearson Chi Square	*p* value (Alpha)	Cramer's V
30-90 days vs. 120+ days	11.197	<.001 (.016)	.066
30-90 days vs. 90-120 days	5.580	.018 (.025)	.018
90-120 days vs. 120+ days	62.935	.001 (.050)	.144

<u>Summary</u>

The purpose of this study was to determine the extent to which age, gender, race, and

total length of IIHS service received predicted youths' success in remaining in the home after 1-

year postdischarge of services. Statistical tests indicated that age, race, and length of service

received were factors strongly associated with youths' likelihood to remain in the home after

receiving IIHS treatment (p < .001). The frequency distribution within the age category likewise

showed that the highest percentage of youth who were referred for IIHS services were ages 12-17 (a total of 69.3%). However, the Pearson Chi Square analysis indicated that youth ages 6-11 are more likely to remain in the home after having received IIHS treatment.

There was a disproportionate male and female distribution in the sample (45% more male than female youth are referred) although findings indicate that gender has no association with the youth's likelihood to remain in the home after having received IIHS treatment. The frequency distribution revealed that 91% of youth sampled were either African American or Caucasian indicating that youth representing these two categories are more likely to be referred for IIHS treatment. The Pearson's Chi Square analysis likewise indicated that African American and Caucasian youth are more likely to remain in the home postdischarge. The highest number of referrals (1,891) was found in the 120+ days group. The Pearson's Chi Square analysis indicated that youth receiving 90-120 days of treatment are more likely to remain in the home than those receiving less than 90 days and more than 120 days of IIHS treatment.

CHAPTER 5

SUMMARY OF FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

This study was used to investigate the level of significance between predictor variables – age, race, gender, and total length of IIHS service received – and youths' likelihood to remain in the home after having received Intensive In-Home Services (IIHS) treatment. Specifically, this study focused on an organization located in Tennessee that provides IIHS services for youth from birth to age 17. This study was intended to be an evaluation tool for IIHS providers to use as a means for locating areas where improving service delivery leads to the goal of further decreasing youth out-of-home placements. Although previous studies have been conducted on measuring the level of overall effectiveness of IIHS services, this researcher has found no previous studies that have assessed predictor variables in this type of treatment.

Research Question 1

Is there a significant difference in the proportion of youth who remain in the home after having received Intensive In-Home Services (IIHS) treatment among the four age groups (0-8, 9-11, 12-14, and 15-17)?

Age was significantly related to youths' likelihood to remain in the home at 1-year postdischarge from IIHS. State custody is defined as DCS custody, juvenile detention, residential treatment, or foster care. Youth are referred to IIHS services through schools, courts, mental health providers, and DCS as a means to prevent out-of-home placement. The age frequency distribution reflected that adolescent youth ages 12-17 are at least 45% more likely to be referred for IIHS treatment as compared to youth younger than 12 years; youth age 6-11 are more likely to remain in the home at 1-year postdischarge.

These findings may be explained by other service interventions in place that target behaviors and emotional disturbances in youth from birth to age 5 and for youth age 12-17. These interventions may be provided through mental health, juvenile justice, or school-based providers. Tennessee has numerous early childhood interventions in place for school-age children that offer preventative services to youth and families. The *Individuals with Disabilities Education Act* (IDEA) paved the way for three-tiered prevention models focusing on emotional and behavioral issues that studies found are more widespread at the elementary and middle school levels as compared to the high school level (Kalberg, Lane, & Lambert, 2012). The Tennessee Department of Education (2012) presented the goal of early childhood intervention programs in terms of supporting families to promote the optimal development in their children. President Obama recently proposed a 2014 budget to expand federally funded pre-K programs (Nothdurft & Pullman, 2013). The increase in federal funding toward early childhood intervention programs may also enable IIHS treatment providers to find ways of concentrating on older age youth who may not have received the benefits from those services at a younger age.

Research has shown that teenage youth have more complex needs than younger youth in such areas as self-esteem, obesity, substance abuse, and pregnancy (DoSomething.org, 2013). Providers funded through the US Department of Health and Human Services and SAMSA implemented a diversity of interventions that target youth age 12-17 (Office of Adolescent Health, 2013). IIHS providers could integrate evidence-based interventions outside of IIHS programs into existing IIHS treatment interventions to increase positive outcomes among older youth.

This study excluded Pilot IIHS cases described as family reunification treatment targeting youth already in state custody and returning home for a trial period. Pilot cases receive their funding directly through DCS because the youth are in state custody and in the process of transitioning back to the custody of their respective families. The study also did not include youth who are currently living out of the home. Studies reflect that 8,323 youths in Tennessee under the age of 18 were in DCS custody at the close of the 2012 fiscal year (Tennessee Department of Children's Services, 2013). A large percentage of children under the age of 10 were referred to the Tennessee juvenile court system in 2009 according to a report produced by the Tennessee Council of Juvenile and Family Court Judges (2010); this may indicate that material reported in this study would change significantly if these data were included. Figure 7 illustrates outcomes based on age.
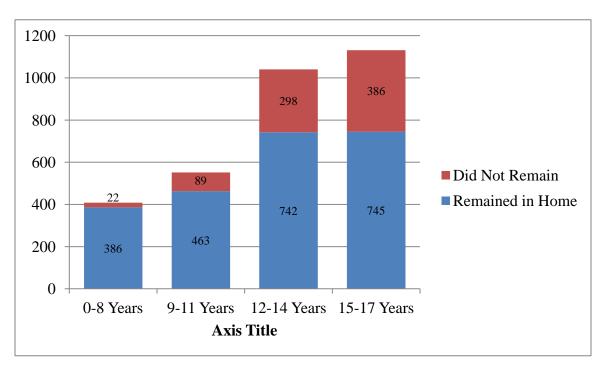

Figure 7. Outcomes Related to Age Group (*N* = 3,131)

Research Question 2

Is there a significant difference in the proportion of youth who remain in the home after having received Intensive In-Home Services (IIHS) treatment among the two genders (male and female)?

The null hypothesis regarding gender (There is no significant difference in the proportion of youth who remain in the home after having received Intensive In-Home Services (IIHS) treatment among the two genders (male and female)) was not rejected, which suggests that male and female youth are equally likely to remain in the home after receiving IIHS treatment. This finding may be explained by the uniform treatment method used by all IIHS counselors that integrates principles from Cognitive Behavior Therapy (CBT), Functional Family Treatment (FFT), Social Development, and Crisis Intervention models. The gender distribution illustrated in Figure 8 further evidences that males referred to IIHS treatment outnumber females by 45%. Data in a report published by the Tennessee Juvenile Justice System reflect 60.5% more male than female children are referred to juvenile court in 2009 (Tennessee Council of Juvenile and Family Court Judges, 2010). The overrepresentation of males in this study could be attributed to a number of possible causes such as girls' tendency to keep their problems private resulting in their being overlooked by teachers whereas boys may externalize behaviors that are more difficult to manage (McIntyre & Tong, 1998). Another report stated that boys (13.2%) were more likely than girls (5.6%) to be diagnosed with ADHD (Centers for Disease Control and Prevention (CDC), 2010).
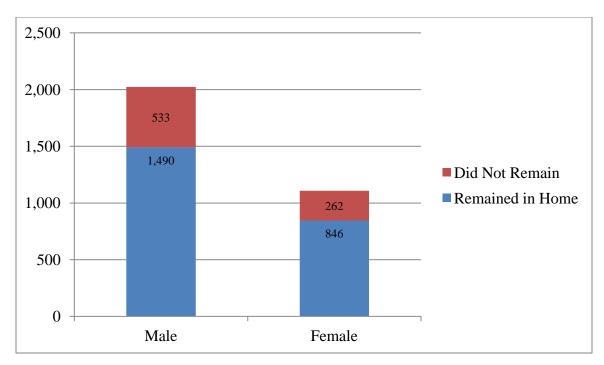
Figure 8. Outcomes Related to Gender (*N = 3,131*)

The results indicate that female youth and their families could benefit if IIHS providers could find ways to increase awareness among educators, mental health providers, and legal personnel about female youth who tend to be underrepresented but could equally benefit from IIHS services. Increased awareness could translate into finding ways to address female youths' emotional issues that may remain otherwise undiscovered.

Research Question 3

Is there a significant difference in the proportion of youth who remain in the home after having received Intensive In-Home Services (IIHS) treatment among the four race groups (African American, Caucasian, Hispanic, and Bi-Racial & Other)?

The findings in this study indicate that there is a significant association between race and youths' likelihood to remain in the home after receiving IIHS treatment. The distribution of Caucasian (70.5%) and African American (20.5%) youth could be attributed to the normal

population distribution in Tennessee. According to the 2011 Tennessee census, 79.5% were Caucasian and 16.9% were African American (Tennessee Department of Economic and Commerce Development, 2011).

The most striking number in the frequency distribution was 1.1% representing the Hispanic youth population in the sample. A recent study conducted by the University of Tennessee Center for Business and Economic Research revealed that Tennessee experienced the third highest Hispanic growth rate in the nation by the end of 2012 (Nagle, Gustafson, & Burd, 2012). One of the factors attributing to the disparity could be that the study was limited to Comprehensive Child and Family Treatment (CCFT) designated youth. Lack of awareness of services, language barriers, and the stigma associated with mental illness could be other contributing factors for this low number among Hispanic youth (American Psychiatric Association, 2010; Tennessee Department of Mental Health and Developmental Disabilities, 2004). National statistics show that 33% of Hispanic families were uninsured as compared to 16% of all Americans (American Psychiatric Association, 2010), and 2.29% of all youth in Tennessee in 2009 were of Hispanic origin (Tennessee Council of Juvenile and Family Court Judges, 2010). This data suggests that Hispanic youth may be underrepresented due to lack of insurance coverage but could otherwise benefit from IIHS services as the findings in this study indicate.

A 2012 federal law, Deferred Action for Childhood Arrivals (DACA), creates a path to citizenship for childhood immigrants; Tennessee youth covered by this legislation could be entitled to TennCare benefits and become eligible for IIHS referrals. A University of Tennessee report indicated that the median age among Hispanics in Tennessee is nine and over half of those individuals were born in the United States (Nagle et al., 2012). This means that within 5 years,

Hispanic children will be in the higher age category (12-17) featured in this study if

comprehensive preventative services targeting Hispanic elementary age children are not

increased. IIHS providers could increase service benefits should they begin preparing for the

change of demographics among IIHS clientele within that predicted time frame. Figure 9

illustrates the racial composition of the youth considered in this study.
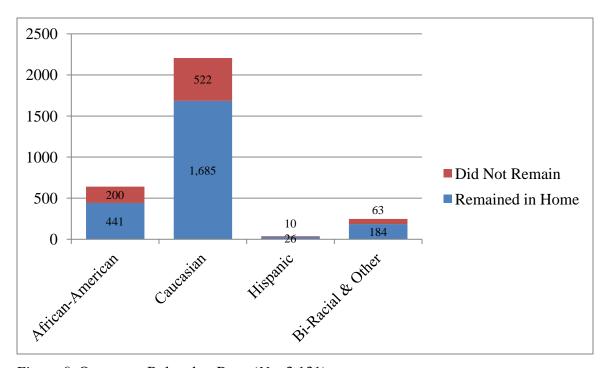
Figure 9. Outcomes Related to Race (*N* = 3,131)

Research Question 4

Is there a significant difference in the proportion of youth who remain in the home after

having received Intensive In-Home Services (IIHS) treatment among the three length of service

groups (30-90 days, 90-120 days, 120+ days)?

The fourth null hypothesis (There is no significant difference in the proportion of youth

who remain in the home after having received Intensive In-Home Services (IIHS) treatment

among the three length of service groups (30-90 days, 90-120 days, 120+ days)) is rejected,

which indicates that there is a significant association between length of IIHS treatment received and youths' likelihood to remain in the home after completing the program.

Frequency distributions increased with respect to each treatment subcategory. Of the 3,130 total cases sampled, 12.9% received IIHS treatment from 30 to 90 days, 28.9% fell into the 90- to 120-day range, and 58.2% received services more than 120 days during a 1-year period. These statistics indicate that there is a 44% increase past the 90-day mark and a 51% increase of youth receiving IIHS services from the 90-120 day range into a longer length of service. This indicates that over 81% of youth receive services longer than 60-90 days, which is the median state requirement (UnitedHealthcare, 2012).

The standard period of IIHS treatment ranges between 90-120 days depending on the insurance provider and youth's rate of success in the program. Under the TennCare program, families covered by BlueCare are approved for 90 days and United Health Care recipients are approved for 120 days of treatment. The pairwise follow-up analysis supported time limits determined by insurance providers. Youth receiving the standard 90-120 days of IIHS treatment are more likely to remain in the home at postdischarge than those who leave the program too early. Figure 10 illustrates outcomes based on the total length of service received.
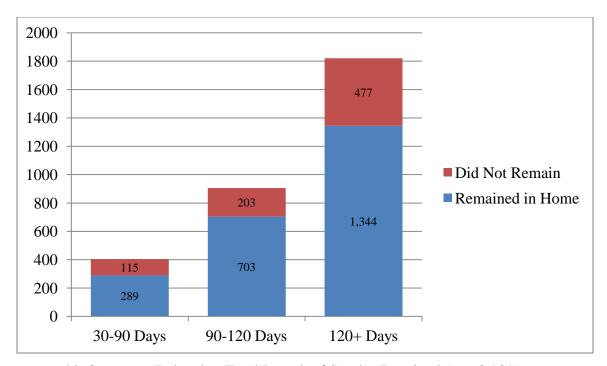
Figure 10. Outcomes Related to Total Length of Service Received (*N* = 3,131)

Conclusions

Of the four predictors tested (age, gender, race, and total length of service received) age, race, and length of service were determined to have significant associations with the likelihood of youth to remain in the home after 1 year of having received IIHS treatment. Findings in this study show that Caucasian males between 12 and 17 years old are more likely to receive more than 120 days of IIHS treatment in Tennessee and are more likely to be referred by outside providers in the first place, whereas youth in the 6-9 age range are more likely to remain in the home after treatment. Factors that contribute to the results of this study include: race distribution in Tennessee, lack of insurance among minority populations, DCS custody, inclination of males to externalize behaviors more than females, and the tendency for service providers to target older age youth.

Recommendations for Practice

Youth ages 6-11 are more likely to remain in the home after having received IIHS treatment. Therefore the following recommendations for practice should be considered.

1. IIHS should expand the age frequency through marketing the program to early childhood learning centers, day care centers, and elementary schools in order to raise awareness that the program can also meet the needs of early childhood intervention.

2. IIHS providers should use a standard treatment manual that includes CBT interventions geared for youth from birth to age 5. Increasing available treatment interventions designed for younger age youth would allow IIHS providers to increase the effectiveness of treatment delivery for younger youth.

3. IIHS providers should implement training to in-home counselors that more intently targets the complex and diverse needs of youth between the ages of 12 and 17.

These three recommendations would prevent issues from arising at a later age that could warrant the need for IIHS services as a means of prevention of out-of-home placements. Because there was a significantly higher frequency in the African American and Caucasian pair, the following recommendations for practice should be considered.

1. The underrepresentation of Hispanic and Bi-Racial & Other youth may be attributed to a lack of knowledge that IIHS treatment is available among their respective communities. Increasing awareness within minority communities would increase numbers within those populations.

2.	Hiring bi-lingual or bi-cultural in-home service workers would increase trust and comfort levels among minorities, which will encourage more families to participate in IIHS programs. Service providers could post employment vacancies on boards that are accessible to those communities.

Length of service was also determined as a predictor of a youth's likelihood to remain out of state custody after having received IIHS treatment. The following are recommendations with respect to this variable.

1.	Finding ways to maintain youth in the program within the projected time (90-120 days) and discharging those youth on time would increase the effectiveness of service delivery.

2.	Changing to a different counselor midway in the treatment models inconsistency and reduces trust between families and IIHS providers. This change results in families voluntarily leaving the program too early or having to stay too long because of having to adjust to new counselors. Therefore, increasing staff retention rates would improve the effectiveness of service delivery.

<u>Recommendations for Further Study</u>

This study was limited to CCFT designated cases that provide TennCare-funded IIHS treatment to youth who are at imminent risk of removal from the home. The targeted goal of these services is to preserve the family through intensive services designed to equip youth and families with the skills necessary to prevent custodial disruption. Further studies that include IIHS family reunification services would broaden the sample and render different results of predictors that were found in this study. Therefore, the following recommendations for further study are made.

1. Regarding the recently proposed federal budget that seeks to expand pre-K programs, results from a longitudinal study beginning at early intervention and moving through the stages of development would provide a clearer picture that early childhood intervention programs contribute to the large age disparity found in the results of this study.

2. Researching programs other than IIHS that target youth ages 12-17 including residential treatment and juvenile justice centers may provide more information as to which interventions may or may not be effective for targeting older youth.

3. Replicating this study in other states where populations are dispersed differently would provide a clearer picture that race predictor renders different results from state to state. For example persons of Hispanic origin in Texas comprise 38.1% of the population while 44.8% are Caucasian. New York records show Asians comprising 7.8% of the population as compared to 1.5% in Tennessee (US Census Bureau, 2012). Combining data from several studies in different states nationwide would increase the reliability of the race predictor on youths' inclination to remain in the home after receiving Intensive In-Home Services.

4. Including DCS funded Pilot cases (defined as immediate risk of out of home placement or youth in transition between DCS and family reunification, labeled as a trial in home stay) would expand the data and render different results than were found in this study.

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APPENDICES

Appendix A

Letter of Approval from ETSU Institutional Review Board

East Tennessee State University
Office for the Protection of Human Research Subjects • Box 70565 • Johnson City, Tennessee 37614-1707
Phone: (423) 439-6053 Fax: (423) 439-6060

May 20, 2013

Craig Hall
4418 Brockland Dr.
Morristown, TN 37813

Dear Mr. Hall,

Thank you for recently submitting information regarding your proposed project "Youth and Family Based In-Home Services Program in Tennessee."

I have reviewed the information, which includes a completed Form 129.

The determination is that this proposed activity as described meets neither the FDA nor the DHHS definition of research involving human subjects. Therefore, it does not fall under the purview of the ETSU IRB.

IRB review and approval by East Tennessee State University is not required. This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about whether these activities are human subject research in which the organization is engaged, please submit a new request to the IRB for a determination.

Thank you for your commitment to excellence.

Sincerely,
Chris Ayres
Chair, ETSU IRB

Accredited Since December 2005

Research Policy from Service Provider

SECTION: Organization Wide
SUBJECT: Research Activities with External Individuals/Entities
POLICY #:   U-119
DATE REVISED: January 12, 2010
LAST REVIEW: January 2, 2008

I) Purpose:
   a) This policy is intended to govern the sharing of data with individuals/entities outside of Youth Villages for the purpose of research. Also addressed within in this policy are issues of authorship and presentation/manuscript preparation and approval.

   b) The purpose of engaging in research activities with external individuals and/or entities is to promote the creation/extension of knowledge in the field of child welfare, mental health, juvenile justice, and related areas. Research in other areas including, but not limited to human resource issues, information technology, marketing, and community relations will also be encouraged, and will be covered by this policy.

II) Procedure:
   a) Data will be shared with external individuals/entities in compliance with all applicable HIPAA regulations regarding access to and distribution of personal health information. Identifying information will not be provided to external individuals/entities. Data files containing personal health information will not contain identifying information which would allow the external individual/entity to link the PHI with individual youths/families served by this agency.

   b) External individuals/entities wishing to engage in research activities must contact the Director of Research with a proposal which includes the following information:
      i) Purpose of the research
      ii) Names and vitae of research team
      iii) Description of the population of interest
      iv) Listing of data fields requested
      v) Plan of analysis for data
      vi) Description of time period of interest
      vii) Expected timeline of research project
      viii)   Presentations and/or manuscripts that are expected to be produced from the project.

   c) Proposals will be reviewed by the Director of Research, in consultation with Youth Villages leadership staff, to determine if the project is compatible with the agency's mission and values, and whether the topic is of interest to agency at the time.

   d) After review by Youth Villages, external entities are required to submit their proposal to a federally-approved IRB. For studies involving data-sharing only, approval gained through an expedited review ill be acceptable. For studies involving collection of primary data from youths, approval following a full board review is necessary. Documentation of IRB approval must be submitted to the YV Director of Research prior to the collection of data from youths.

Date Created: September 28, 2005
Dates Revised: August 1, 2007; January 2, 2008; May 20, 2009; January 12, 2010

Appendix C

Letter of Support from Service Provider

YouthVILLAGES®
The force for families

May 14, 2013

Craig Hall
4418 Brockland Drive
Morristown, TN 37813

Dear Mr Hall,

This letter is written in support of your project entitled, "*Youth and Family Based In-Home Services Program in Tennessee.*" Youth Villages will provide you with a deidentified data set that contains the variables you need to complete this project including youth demographics and outcomes at one year post-discharge.

Please feel free to contact me at 901-251-4950 if you have questions or need further information. You may also email me at sarah.hurley@youthvillages.org.

Sincerely,

Sarah Hurley, Ph.D.
Director of Research

VITA

CRAIG S. HALL

Education:	East Tennessee State University, Johnson City, TN, Ed.D., Educational Leadership, December 2013.
	Asbury Theological Seminary, Wilmore, KY, M.Div., Master of Divinity, 2008.
	East Tennessee State University, Johnson City, TN, B.S.W., Bachelor of Social Work, 2004.
Professional Experience	Family Intervention Specialist, Youth Villages, Morristown, TN, 2011-Present.
	Case Manager, Appalachian Regional Coalition on Homelessness (ARCH), Johnson City, TN, 2009-2010.
	Minister, The United Methodist Church, Holston Conference, Alcoa, TN, 2004-2009.
Professional Affiliations:	National Association of Social Workers (NASW)
	North American Christians in Social Work (NACSW)
	Tennessee Professional Interpreters Association (TAPIT)
Honor Societies:	Pi Gamma Mu, International Honor Society in Social Sciences
	Sigma Delta Pi, Sociedad Nacional Honoraria Hispánica
	Phi Alpha, Honor Society for Social Work