Best Practices in Children's Mental Health

A Series of Reports Summarizing the Empirical Research and other Pertinent Literature on Selected Topics

Report # 17

Home-Based Therapy: Effectiveness and Processes

A Brief Review of the National Literature
June, 2006

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Home-Based Family Therapy: Effectiveness and Processes
A Brief Review of the National Literature

Since the late 1980s, home-based family therapy has become an increasingly popular service (Zarksi, et al. 1991). The delivery of family therapy in families' homes presents various advantages and challenges. This review focuses on empirical studies, and some pertinent conceptual literature, highlighting the benefits of home-based services along with strategies for overcoming difficulties that typically arise.

Although family preservation models in the field of child welfare share features with in-home family therapy services, they are not specifically reviewed here. Evidence about the effectiveness of home-based interventions aimed to prevent out-of-home placement was previously reviewed by Tara McLendon (2003). McLendon examined and compared four specific models: Multisystemic Therapy, Homebuilders, Wraparound, and Case Management. She found that all four models shared an ecosystems approach and an emphasis on not pathologizing clients. Models differed in underlying theories, the level of specificity for program structures, rules, caseloads etc., and their level empirical support. (The full report entitled "#5 Family Centered Home-Based Models for Placement Prevention" is available at http://www.socwel.ku.edu/occ/cmh/projects.html)

Utilization and Cost Effectiveness of Family Therapy in Kansas

A retrospective cost analysis assessed healthcare costs for youth in Kansas juvenile justice or child welfare systems for a period of 2.5 years following therapy (Crane et al., 2005). Data was analyzed for 3573 (n) youth with conduct disorder who received Medicaid covered therapy either as in-office individual, in-office family, or in-home family therapy. Results indicate that family therapy was rarely provided; less than 18% of served families received any form of family

therapy as a part of their treatment program. For those who did receive family therapy, in-home family therapy was by far the most common form of treatment (13.4% versus 4.4% for in-office family therapy).

Overall, the use of any family therapy decreased subsequent costs significantly. ***In-home family therapy was the most cost effective intervention***. Associated with the lowest cost of Medicaid treatments following services, youth only averaged a total medical costs of $1,622 for the 30 months after in-home therapy. This figure is 85% less than the average cost for those who received in-office family therapy and 90% less than those who received no family therapy. In-office family therapy was superior to only individual therapy in that costs averaged 32% less medical care expenses after treatment.

Common Features of In-Home Family Therapy

In the empirical literature, in-home family therapy models typically share three main features:

1. Services most often target families ***experiencing serious difficulties that put a child at risk for out-of-home placements***.
2. Families served in researched home-based programs tend to have ***higher levels of clinical disturbance than regular outpatient populations.***
3. In-home therapy models typically use an ***ecological and/or family systems approach***.

Effectiveness of In-Home Family Therapy

While the empirical evidence for the effectiveness of in-home family therapy is not yet very broad, and often hampered by methodological difficulties, several studies point to benefits and challenges.

One benefit of in-home therapy services lies in ***higher engagement and attendance*** of therapy sessions. Higher engagement and attendance were evident in a study of in-home services for low income families of youth who had

substance abuse and runaway behaviors (Slesnick et al., 2004). Comparing families receiving in-home versus in-office therapy, the study found that families who experienced high levels of chaos, or more acting out behaviors, were able to increase their level of attendance in home-based but not in office-based therapy.

There is also some empirical evidence that families receiving home-based intervention models can make ***significant gains and/or successfully maintain youth at home despite their initially higher levels of difficulties.*** Interventions have shown to result in:

- lower symptoms in youth dropping from highly elevated disturbance levels to levels comparable to outpatient scores (Mosier et al., 2001);
- increased use of problem-solving style of coping (Zarski, et al. 1992);
- a higher impact on reducing internalizing than externalizing behaviors (Wilmshurst, 2002; Aronen et al., 1996).

At the same time, there appears to ***remain a number of youth and/or families*** (about 20%) ***who do not improve over time*** (Mosier et al. 2001).

Longer-Term Outcomes

One study shows that, if provided early, home-based interventions can have a long-term ***preventive*** effect on quantity and quality of psychiatric symptoms when children reach adolescence. In an experimental study conducted in Finland, Aronen et al. (1996) evaluated the long-term effects of an early home-based intervention on 160 families with a baby born in 1975-1976. Categorized as high or low risk, 80 of the families attended a five-year-long family counseling program that met ten times per year. The aim of counseling was to improve family interactions by influencing the parents' child-rearing attitudes and practices. Parents received information on child development, and were engaged in discussions of their own childhood experiences. Another 80 families served as a control group for the effects of counseling. When children in the study reached age 14 to 15 years, their mental state was assessed through the Child Behavior

Checklist (CBCL) and the Youth Self-Report. Adolescents in the experimental group showed significantly fewer total symptoms on both the parent and the youth reports. Results indicated that counseling reduced internalizing behaviors more effectively than externalizing ones, and that early in-home counseling predicted better mental health for adolescents in both low- and high-risk families.

Aside from the Finnish study, the maintenance of treatment effects for 12 months or longer is rarely investigated. Results of longer-term follow-up studies show ***mixed findings similar to other forms of therapy for youth with serious emotional or behavioral difficulties.***

Compared to hospitalized youth, home-based Multisystemic Therapy (MST) for youth with serious emotional difficulties initially resulted in better outcomes (Henggeler et al., 2003). However, most of the advantages dissipated at the one year follow-up. After a year, there were no longer significant differences for the rate of out-of-home placements and initially favorable results for MST on school attendance were also no longer significant. Only parenting and family relations differed in that MST youth noted slightly more family rules, whereas hospitalized youth noted fewer rules at home.

A home-based Family Empowerment Intervention (FEI) (Dembo et al., 2001) provided by paraprofessionals under guidance and supervision of professionals showed sustained positive effects of the intervention two to four years after completion of the program. However, the differences in long-term outcomes were not significant for FEI versus the comparison group, but only for youth who completed the home based intervention versus those who did not complete the program. Completers had significantly lower rates of alcohol use, crimes against persons, drug sales and total delinquency than those who did not complete home based service.

Specific Skills Required in Home-Based Therapy

Providing services in families' homes affords providers unique opportunities and challenges for which specific skills are required. Reiter (2000a) suggests ***four stages general of home-based therapy***:

(1) An entry that requires humility and sensitive by therapist to offset possible sense of intrusiveness;

(2) successfully joining family in everyday activities, utilizing naturally occurring activities, behaviors, event, available items;

(3) using all available context information about family dynamics, home and social environment in ongoing assessment, understanding, and treatment, while being flexible to utilize whatever is available; and

(4) being aware that a therapist's departure may be very emotionally charged and needs special attention and planning since in-home service may have resulted in a stronger bond and presence of the therapist in families' lives.

The most prominent difference to office-based therapy is that home-based approaches take clinicians out of the comfort and safety zone of their offices, and expose and involve them far more intensely in family and community dynamics (Reiter, 2000a). Providing home-based work thus requires skills in ***crisis intervention*** including the ability to ***assess and address safety*** of self and others in the home environment, as well as skills to build ***simultaneous relationships with child and family, their physical and social environment, and their communal networks*** (Woolston et al., 1998).

The relational intensity of being in families' homes and being exposed to their social environment can ***challenge traditional concepts of what is "professional" behavior*** in areas such as boundaries, confidentiality, timing, rules of therapeutic processes, etc. which often results in providers' heightened anxiety about what is

appropriate. In-home services thus require active rethinking and redefinition of such concepts (Stinchfield, 2004; Snyder & McCollum, 1999).

At the same time, while being an outsider to the family and community tends to raise therapists' anxieties, this ***inversion of the usual hierarchy*** in the helping relationship can be used to further empower families (Stinchfield, 2004). To this end, ***joining*** to offset the intrusiveness of the intervention and connect with the family is deemed highly important in home-based therapy (Stinchfield, 2004). Like in other therapy models, successful joining with families is characterized by a nonjudgmental, respectful attitude but it also specifically includes relating to community and neighborhood, as well as other professionals (Stinchfield, 2004).

Successfully ***utilizing the families' home environment*** also serves to strengthen the therapeutic relationship. Utilizing the physical environment can mean learning about the client and bond by touring the house (if invited), playing interactive games with children, joining in naturally occurring family activities, and accepting food and drinks (Reiter, 2000b).

Zarski et al. (1992) suggested that ***teaching different coping styles***, and the ***use of triadic (circular) questions*** are particularly helpful in home-based therapy. Because families typically experience a multitude of needs, the authors also recommended ***adding case managers*** to in-home therapy.

Lawson and Foster (2005) conducted a survey study of 120 home based counselors to assess their ego development, ability to conceptualize complex situations and their satisfaction with supervision. The authors' premise was that home based services require higher ego development of the therapist to be able to successfully join family, and ally with parents and youth without being drawn into difficult family dynamics. Authors found it disturbing to find that only 14% of the counselors scored at high levels on the ego assessment and a full 44% scored below a category of "self-awareness."

Counselors' ability to conceptualize complexities was also mixed.. Fifty-five percent scored in the high range but 45% scored in moderate or low range of conceptual abilities. High scores were associated with counselor's ability to ***ask open ended exploratory questions, to be more flexible and able to articulate own beliefs and hypotheses***—all assumed to be vital in the complexity of home-based work.

Training

Most clinicians are not trained in the specifics of home-based therapy and feel ill prepared and anxious about providing such services. A small qualitative study (Adams & Maynard, 2000) identified the following areas of training needs (in order of ranked importance):

1. Crisis intervention/safety
2. Working with multi-problem families
3. Addressing sexual abuse
4. Working with single parents
5. Addressing drug/alcohol abuse
6. Understanding severe mental illness
7. Understanding adolescent development
8. Addressing therapist demoralization.

Supervision

Given the complexities and differences of home-based versus tradition office-based therapy, ongoing and effective supervision is considered a vital element to ensure therapists' effectiveness. In their survey study of home-based counselors Lawson and Foster (2005) found that a majority felt unsupported or undersupervised even though 56% of counselors indicated receiving weekly supervision. Quality and availability of supervision were either "feast or famine" (Lawson & Foster, 2005, p.157).

Zarski et al. (1991) suggest an ***in-home supervision*** in which supervisors join in-home therapists at families' homes. Being exposed to the same factors in families' homes, in-home supervisors can more aptly assess and assist therapists in negotiating boundaries, modifying their level of involvement with family members, or can directly intervene to change therapist-family interactions if necessary. The authors outline a process of preparing therapist and supervisor for in-home supervision. Preceding in-home supervision sessions, therapist and supervisor should discuss "rules" of engagement, location of session, etc.; consider how to facilitate the entry and exit of the in-home supervisor with the family; and plan a time for the therapist to reflect upon the in-home supervision experience.

Conclusion

There is comparatively little empirical and conceptual literature about the specific effectiveness and processes of home-based family therapies. Still, evidence indicated that in-home therapy, although not a panacea, can result in higher engagement and attendance, may be effective to maintain troubled youth in their homes, and may have a preventive effect if provided early. At the same time, in-home therapy posed particular challenges to providers who must be adequately prepared and supervised in order to adjust to, and utilize, the unique setting.

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#	Author(s) & Date	Type of Article	Key Variables/Components	Main Conclusions
1	Adams, J.F., & Maynard, P.E. (2000). Evaluating Training Needs for Home-Based Family Therapy: A Focus Group Approach, *American Journal of Family Therapy, 28* (1), 41- 52	Small qualitative study of home-based therapists and their supervisors focused on identifying training needs.	Two rounds of focus group interviews first explored concerns, training needs, and ranked identified areas as to importance to be addressed in training.	Identified areas were (in order of ranked importance): 1. Crisis intervention/Safety 2. Multi-problem families 3. Sexual abuse 4. Single Parents 5. Drug/Alcohol 6. Severe Mental Illness 7. Adolescent development 8. Therapist demoralization.
2	Aronen, E.T. & Kurkela, S.A. (1996). Long-term effects of an early home-based intervention, *Journal-of-the-American-Academy-of-Child-and-Adolescent-Psychiatry, 35* (12), 1665-1672.	Experimental study to evaluate the long-term effects of an early home-based intervention on the quantity and quality of psychiatric symptoms in adolescents (Finnish study)	*Sample*: 160 families with a baby born in 1975-1976, categorized as high or low risk families. Eighty families attended a 5-year-long family counseling program (10 times/year). The other half of the families served as a control group for the effects of counseling. *Measures:* The mental state of the adolescents was assessed at age 14 to 15 years by the Child Behavior Checklist and the Youth Self-Report. *Intervention*: The aim of counseling was to improve family interactions by influencing the parent's child-rearing attitudes and practice. Child developmental information was shared, parents' own childhood experiences were discussed.	*Results*: Adolescents in experimental group scored significantly fewer total symptoms on both the parent and the youth reports. The counseling reduced more effectively internalizing than externalizing symptoms. The counseling predicted better mental health in adolescence in both low- and high-risk families.
3	Crane, D.R., Hillin, H.H., & Jakubowski, S.F. (2005) Costs of Treating Conduct Disordered Medicaid Youth with and without Family Therapy, *American Journal of Family Therapy, 33,* 403-413.	Retrospective cost analysis of 3573 (n) **Kansas** youth with conduct disorder who received Medicaid covered therapy either in-office individual, in-office family, or in-home family.	*Sample:* 3086 youth received care that included individual therapy (and no family therapy), 503 received in-home family therapy and 164 others received in-office family therapy. Majority of youths in all groups were male Caucasians. *Measures:* Healthcare costs for a period of two and one half years after therapy were available for analysis. *Interventions:* In-home family therapy was most often "Behavior Management in Home Family Therapy" (BMHFT). It is most often time limited requiring prior authorization. The services are provided by contractors to the Kansas Juvenile Justice Authority or Children and Family Services	*Results*: Family therapy is a rarity in this rural state. Of the over 3,000 adolescents and their families, less than 18% had any form of family therapy as a part of their treatment program. For those that did, in-home family therapy was by far the most common form of treatment (13.4% versus 4.4% for in-office therapy). Those who did receive family therapy (in-office or in-home) used less health care after treatment than those who did not. Those who received in-office family therapy averaged 32% less medical care overall than those who received only individual therapy. In-home family therapy was associated with the lowest cost of Medicaid treatments overall, with total medical costs

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			division of Kansas Social and Rehabilitation Services (SRS). In-office family therapy was generally "fee for service" treatment provided by doctoral level practitioners in their offices or by doctoral or masters level clinicians (e.g., MFT's, social workers, etc.) working in or for Community Mental Health Centers	of an average of only $1,622 for the 30 months after receiving treatment. This figure is 85% less than for those who receive in-office family therapy and 90% less than those who receive no family therapy. Authors suggest that providing in-home family therapy is an excellent way to provide this form of intervention (for youth who are not placed out-of-home) and wonder about the high number of youth not receiving any form of FT. It does not seem likely that 82% of youth are in family situations that would preclude family therapy. Since the family structures of some poor families are dissimilar to those of the often middle-class care providers, do providers assume that family involvement is simply not an option for poor families? Authors suggest to try and intervene at a family level early and to promote in-home family therapy.
4	Dembo, R., Schmeidler, J., Seeberger, W., Shemwell, M., Rollie,-M., Pacheco, K., Livingstone, S., & Wothke, W. (2001). Long-term impact of a Family Empowerment Intervention on juvenile offender psychosocial functioning, *Journal of Offender Rehabilitation, 33*(1), 59-109	Experimental longer-term outcome study of the impact of home-based family empowerment intervention on juvenile offenders' psychosocial functioning	*Sample*: 278 (n); 56% male, mean age 14, 56% Caucasian, 41% African-American. Randomly assigned to one of two interventions. *Interventions:* Home-based Family Empowerment Intervention (FEI): Improve family functioning through empowering parents; 10-week systems-oriented, structural family therapy approach, 3 1-hour meetings per week provided by paraprofessionals under guidance and supervision of professionals; or Extended Services Comparison group: (n=146) consisting of phone calls, referral services, but no in-home service. *Measures*: 2-4 years post completion of program Psychological/emotional functioning; delinquency; drug use	*Results*: Overall youth who completed FEI (n=75) had better outcomes than comparison group (n=146) or those youth who did not complete FEI (n=57). Differences in outcomes were statistically significant for youth who completed home based intervention versus those who did not complete the program (but not significant for FEI versus comparison group). Completers had significantly lower rates of alcohol use, crimes against persons, drug sales and total delinquency than those who did not complete home based service. Results indicate sustained positive effects of the intervention.
5	Henggeler, S.W., Rowland, M. D., Halliday Boykins, C., Sheidow, A. J., Ward, D. M, Randall, J., Pickrel, S. G, Cunningham, P. B, & Edwards,	One year follow up of experimental study comparing MST to usual services (hospitalization)	*Sample*: SED youth ages 10-17 in psychiatric crisis Follow-up N=156 families, a majority economically disadvantaged households (retention rate 97.5%) *Interventions:*	*Results:* Although reported results show positive developments for participating youth in terms of symptoms, this longer term follow up showed that gains youth in the MST condition had made on earlier measuring points dissipated over the course

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	J. (2003). One-year follow-up of multisystemic therapy as an alternative to the hospitalization of youths in psychiatric crisis, *Journal of the American Academy of Child and Adolescent Psychiatry*, *42* (5), 543-551.		Experimental Treatment: MST adapted to begin with crisis assessment and stabilization, followed by usual MST protocol Control condition: Hospitalization *Measures*: Symptom reports (self reports and parent reports using standardized instruments (GSI and CBCL), self esteem, days in out of home placement, school attendance, family adaptability and cohesion (FACES - III).	of a year resulting in a convergence of both treatment conditions. Both treatments led to overall reduction of psychiatric symptoms although the patterns of change were different. In terms of out of home placements no significant difference could be detected after a year. Initially favorable results for MST on school attendance at regular school settings dissipated after a year. Parenting and family relations differed in that MST youth noted slightly more family rules, whereas hospitalized noted fewer rules. Youth adaptability improved for both conditions with no significant differences after a year, caregivers in both conditions reported increases in control and supervision. Hospitalized youth scored higher on improved self-esteem. Home based MST may not be a sufficient treatment for these youth. More as well as less intensive services are required to meet the ongoing needs of these youngsters and their families.
6	Lawson, G. & Foster, V. A. (2005) Developmental Characteristics of Home-Based Counselors: A Key to Serving At-Risk Families, *Family Journal: Counseling and Therapy for Couples and Families, 13*(2), 153-161.	Survey study of 120 (n) home based counselors focused on ego development framework, conceptual complexity and satisfaction with supervision	*Sample*: 73% female, 60% white, 30% African-American, majority master's degree, mean home based therapy experience of 3 years. *Measures*: Washington University sentence completion test (ego level assessment) Paragraph completion method (Conceptual complexity assessment) Counselor Supervision inventory	*Results*: Authors suggest that home based services require higher ego development of therapist to be able to successfully join family, ally with parents and youth, while navigating the intense relationships without being drawn into difficult dynamics. Only 14% of surveyed counselors scored at the associated high levels on the ego assessment and 44% scored below the "self-aware" category which authors found disturbing. Therapists' ability to conceptualize was also mixed. 55% scored in the high range but 45% scored in moderate or low range. High range scores are associated with counselor's ability to ask open ended questions, being more flexible and able to articulate own beliefs and hypotheses—all assumed to be vital in the complexity of home-based work. Supervision: A majority of home-based therapists felt unsupported or undersupervised even though 56% indicated receiving weekly supervision. Quality and

#	Author(s) & Date	Type of Article	Key Variables/Components	Main Conclusions
				availability of supervision were either "feast or famine."
7	Mosier, J., Burlingame, G.M., Wells, M., G., Ferre, R., Latkowski, M., Johansen, J., Peterson, G.; Walton, E. (2001). In-home, family-centered psychiatric treatment for high-risk children and youth, *Children's Services: Social Policy, Research, and Practice, 4*(2), 51-68	Study of 104 (n) youth in 6-8 weeks of home-based therapy.	*Sample*: 104 (n) mostly male (62%) Youth ages 3-17 (most in the 9-14 years group); most prevalent diagnoses: ADHD, depressive disorder, conduct disorder *Outcome Measures:* Youth Outcome Questionnaire *Intervention*: Intensive individualized in-home case management	*Results:* Youth in sample had significantly higher clinical disturbances than normative outpatient youth, and even higher scores than inpatient youth. Results of the study show that for a majority of youth difficulties dropped significantly by the end of week eight reaching levels comparable to usual outpatient scores. About 20% of youth did not improve over time. *Limitation*: Considerable attrition (at 4th data collection point only 29 of 104 participants remained); No comparison group
8	Reiter, M.D. (2000a). Structuring home-based therapy: four phases to effective treatment, *Journal of Family Social Work, 4* (2), 21-35	Conceptual article delineating four phases of home based therapy	stages of general family therapy stages of specific modalities (Haley, Bowen, Milan team, Berg/de Shazer Stages of home-based therapy	*Stages of home-based therapy* Entry: requires humility and sensitive by therapist to offset possible sense of intrusiveness Transition: Successfully joining family in everyday activities, utilizing naturally occurring activities, behaviors, event, available items to join (See also Reiter, 2000b) Working (middle) phase: include available context information about family dynamics, home and social environment in ongoing assessment, understanding, and treatment, be flexible to utilize whatever is available Departure: Be aware that because of heightened reality context there may have been a stronger bond and presence of therapist in families' lives. Thus therapists' departure may be very emotionally charged and needs special attention and planning.
9	Reiter, M.D. (2000b). Utilizing the home environment in home-based therapy, *Journal of Family Psychotherapy, 11* (3), 27-39	Conceptual article addressing ways to join families in home-based therapy by utilizing their environment.	Definition of Utilization. Case scenarios highlight utilization of The physical environment Interactive games Accepting food and drink	Utilization rests on Milton Erickson's concept meaning "readiness of the therapist to respond to any and all aspects of the patient of environment" including language, interests, frames of reference, verbal and non-verbal behaviors, and items available in the home or larger environment, all in the interest of strengthening the therapeutic relationship.

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				Physical environment: Learn about the client and bond by touring the house (if invited) Interactive games: play games with children, Join naturally occurring activities; accept food and drinks.
10	Slesnick, N. & Prestopnik, J.L. (2004). Office versus Home-Based Family Therapy for Runaway, Alcohol Abusing Adolescents: Examination of Factors Associated with Treatment Attendance, Alcoholism Treatment Quarterly, 22(2), 3-19.	Experimental study comparing outcomes for 77 (n) youth with alcohol and runaway problems randomly assigned to one of two forms of family therapy	*Sample*: mean age 15, 46 female, 31 male, majority Hispanic, Native American. *Interventions*: 16 sessions of either A traditional, office-based systemic family therapy (Functional Family Therapy, FFT) (N=30), or A non-traditional, home-based, multisystemic approach (Ecologically-based family therapy , EBFT) (N=37) *Measures*: Youth self report externalizing behaviors, substance use	*Results*: Home based therapy was associated with higher engagement and attendance of families. Low income families and those experiencing more chaos participated more in home based than office based therapy. Higher youth acting out behaviors was associated for more attendance of families in home-based but not office based therapy
11	Snyder, W.& McCollum, E.E. (1999). Their home is their castle: Learning to do in-home family therapy, *Family Process, 38*(2), 229-242.	Model of learning in-home therapy based on qualitative study of three student interns learning to do in-home therapy	Contrasts students' training in clinical settings with their experiences of in-home therapy. Presents model of necessary adjustments, training issues	Increased familiarity with clients in their home environment challenged and changed students' views of therapy. Definition of "professional" behavior (like boundaries, hierarchy, confidentiality, timing etc.) was changed by social environment, leading therapists to feel heightened anxiety about what is appropriate. They redefined concepts, developed strategies to deal with anxiety and address specific challenges, and had to accept unpleasant experiences as part of the work.
12	Stinchfield, T.A. (2004). Clinical competencies specific to family-based therapy, *Counselor-Education and Supervision, 43*(4), 286-300.	Qualitative study of home based therapists' perception about what specific competencies are needed	10 Individual interviews and focus groups with 7 other participants identified two main themes: Joining Ability to apply therapy skills in family homes	Joining is more important in home-based therapy because of invasiveness of intervention. Successful joining with family is characterized by nonjudgmental, respectful attitude. Joining in home based setting also includes relating to community and neighborhood. Being the outsider to family and community, therapists may encounter a reverse hierarchy that can be used to further empower families. Therapists also need to be aware of surroundings to assess potentially dangerous situations. In relation to schools and other professionals home based therapists need to be

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				advocates for families and be able to successfully collaborate with school staff. Because relationships with families can be more intense in home based treatments, ethical issues, boundaries, and other related skills and training must be appropriately addressed.
13	Wilmshurst, L. A. (2002). Treatment programs for youth with emotional and behavioral disorders: An outcome study of two alternate approaches, Mental-Health-Services-Research, 4 (2), 85-96.	Experimental study comparing outcomes for family preservation vs. residential program for youth with EBD three months and 1 year post treatment	*Sample* : 82 (n) youth with EBD, majority male Caucasian *Interventions:* Residential program (n=27, after attrition): (5 days/week, weekends at home) used solution-focused approach, for 3 months, plus three months reintegration, included family sessions. Family preservation program (n=38, after attrition): 12 week, up to 12 hrs/week, intensive, multisystemic, cognitive-behavioral approach *Measures:* Standardized client information system (used in Ontario) includes items from CBCL; Social Skills Rating System	*Results* show differential outcomes for youth internalizing scores: youth in the FP group showed a gradual decrease of internalizing symptoms (anxiety and depression), whereas RT group had opposite trend. Both groups showed decreases in externalizing symptoms. Because the two programs differed in method of service delivery (in home vs. residential) and treatment methods (cognitive–behavioral vs. brief solution focused therapy), it is possible that treatment method alone may have been instrumental in producing the differential outcome effects. Still, the significant percentage of youth from the RT Program who had increased symptoms for internalizing (anxiety and depression) 1 year posttreatment suggests the need to pay particular attention to the effects of out of the home placement on these children. As the authors point out, implications of these results become even more concerning when one considers that the residential alternative investigated in the current study was a relatively short-term (3 months) and modified version (5 day vs. full-time) of more traditional residential placements.
14	Woolston, J.,L., Berkowitz, S.J., Schaefer, M.C., & Adnopoz, J.A., (1998). Intensive, integrated, in-home psychiatric services: The catalyst to enhancing outpatient intervention, *Child and*	Description of Yale intensive children and adolescent psychiatric services (YICAPS), an in-home psychiatric service program, includes case studies.	Overview and background of psychiatric in-home services.	YICAPS combines psychopathology model with systems approach, uses “transactional risk model” evaluating phenomena and interventions on individual/family, community/ neighborhood and social context level with multidisciplinary team Three R’s of home-based work: Relationship with child and family

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	Adolescent Psychiatric Clinics of North America, 7(3), 615-633.			Relationship with physical environment Relationship with communal network
15	Zarski , J.J, Sand-Pringl, C., Greenbank, M., & Cibik, P. (1991). The invisible mirror: in-home family therapy and the supervision, *Journal of Marriage and Family Therapy, 17* (2), 133-143.	Description of alternative supervision format for in-home therapists: In-home supervision	Utilizes a structural therapy approach (Minuchin)	In-home supervisor can more aptly assess and assist in-home therapist in negotiating boundaries, level of involvement with family members, directly intervene to change therapist-family interactions. Outlines process of preparing for in home SV session, discussing "rules", location of session, etc.; facilitating entry and exit of in-home supervisor, reflection of in home SV experience.
16	Zarski, J.J., & Fluharty, L.B. (1992). Treating emotionally disturbed youth: a comparison of home-based and outpatient interventions, *Contemporary Family Therapy: An International Journal, 14* (4), 335-350.	Quasi experimental study of 70 (n) families receiving either home-based family systems therapy or outpatient family therapy	*Sample*: 34 families with children considered at risk for placement, majority Caucasian. Home based group had more relatives and nonrelatives living in the household, had lower income and higher difficulties. *Measures*: Family environment scale Family assessment Device Ways of Coping inventory Perceived Stress Scale Structured pediatric Psychosocial interview.	*Results :*Despite higher level of difficulties the home-based group's gains were comparable to the gains made by the outpatient comparison group. Both groups reported a relationship between ability to set rules and children's ability to respectfully follow these rules. Home-based families began to use more effective problem-solving style of coping moving away from a style that used to draw in third parties. Authors conclude that use of different styles of coping, and triadic (circular) questions (See Karl Tomm) are helpful in home-based therapy. In addition, case managers would be useful to assist families with their multitude of needs. *Limitation*: comparison group not matched to experimental group.