MAPLES ADOLESCENT TREATMENT CENTRE (MATC): A PRACTICUM REVIEW ANALYSIS OF AN ATTACHMENT-BASED INTERVENTION FOR TREATING MENTALLY ILL AT-RISK YOUTH IN RESIDENTIAL CARE

By

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B.A. Criminology and Criminal Justice, Concentration in Psychology
Carleton University, 2007

PROJECT SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF ARTS

In the
School of Criminology

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SIMON FRASER UNIVERSITY

FALL 2009

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ABSTRACT

Attachment theory has important implications for the criminological discipline. The quality of the relationship experienced between an infant and their primary attachment figure is central for the child's development. This mutually interacting environment leads to the development of an internal working model of relationships. The internal working model forms the basis for the social behaviour of that individual throughout their life. This conceptualization of attachment theory has direct treatment implications; successful preliminary results from the Maples Adolescent Treatment Centre (MATC) have been consistently demonstrated. Based on a practicum experience, working as a child-care counsellor at the MATC, recommendations have been presented to increase the effectiveness of their programming. Attachment provides a theoretically supported intervention technique that aids in increasing healthy familial interactions, thus reducing the symptomatology of conduct disorder and the future risk of delinquency.

Keywords: attachment, at-risk youth, mental illness, intervention

ACKNOWLEDGEMENTS

Thank you to Dr. Ray Corrado and Neil Madu for their support in helping me to complete this project, my practicum, and the M.A. Program. I have appreciated your wisdom and expertise in guiding my studies. Thank you to the staff and child care counsellors at the Maples Adolescent Treatment Centre for their help and encouragement during my practicum experience. Thank you also to the at-risk youth involved with the Crossroads Program at the MATC who helped show me that attachment interventions do provide a unique opportunity to connect with this vulnerable population. I would especially like to thank Gene Semple for being an excellent source of learning and support, and for offering me a different view of the world, "a day in the life"! Finally, thank you to my parents, Siavash Mohajer, and all my close friends, for their encouragement, patience, and overwhelming support during this journey.

"The sense of having someone go in to bat for you, someone whose primary responsibility is your sense of well being, cannot be diminished for young people who have had very little experience of this in their life" (Hillan, 2005, p. 35).

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1: INTRODUCTION

Although the importance of attachment theory has long been recognized in the psychological discipline, the criminological perspective has not historically focused on attachment theory and the role childhood attachment plays as both a risk and protective factor for future delinquency and antisocial behaviour. Psychology understands attachment as a biological or psychological need to experience connection with others; if this need is not adequately met throughout the life cycle, then the psychological adjustment of the individual is not optimal. On the other hand, criminology recognizes attachment as it relates to the social relationship with family, friends, and community, and how these bonds to pro-social institutions can prevent and limit the effects of delinquent behaviour.

Attachment theory is important because the early bond experienced by an infant and their primary caregiver provides the child with their first example of interpersonal relationships, which plays a role in the healthy development of the child (Ainsworth, 1982; Bowlby, 1973). Positive interactions between the child and their primary caregiver result in the establishment of strong and effective attachment bonds, which are the foundation for pro-social and healthy future development. However, when successful bonding does not occur between the child and their primary caregiver, for a variety of reasons, the risk for future antisocial behaviour and psychiatric dysfunction are increased (Marshall, Hudson, & Hodkinson, 1993).

The interpersonal interactions experienced by the child are understood through an internal working model of relationships. Fonagy et al. (1997) conceptualized that an

> individual's social behaviour can be understood in terms of generic mental models of social relationships, constructed by the individual. These models, although constantly evolving and subject to modification, are strongly influenced by the child's experiences with the primary caregiver (p. 229).

The internal working model provides a classification system for the individual and is used to comprehend and understand interpersonal relationships over time (Ainsworth, 1982; Lyons-Ruth, 1996). When the internal working model represents unhealthy attachment relationships, maladaptive strategies for dealing with others are developed. These strategies continue to be reinforced through future interactions that are perceived negatively, which is consistent with the negative internal model of interpersonal relationships (Bartholomew & Horowitz, 1991). This concept is especially pertinent for understanding the motivation behind the behaviour exhibited by those youth who have been classified as conduct disordered (Moretti, Holland, & Moore, 2002).

The understanding of attachment theory has been expanded to include later periods of development, recognizing the importance of attachment theory throughout the lifecycle. This is especially prominent during adolescence, when the secure attachment relationship between the adolescent and their caregivers helps the adolescent to reach an adequate balance between age appropriate autonomy, independence, and support. Considering the importance of attachment for the adolescent period of development, Dr. Moretti, Dr. Moore, and

Dr. Holland presented an intervention model stemming from the attachment perspective. Through preliminary empirical testing, this intervention has shown tremendous promise as an intervention with at-risk youth (Moretti, Holland, Moore, & McKay, 2004; Moretti, Holland, & Petterson, 1994). Attachment theory provides direct intervention techniques that are theoretically supported, and can help to increase the healthy familial interactions through adolescence, and reduce the risk of delinquency (Moretti, et al., 1994).

Attachment-based intervention, as presented by Dr. Moretti and Dr. Holland, has been implemented at the Maples Adolescent Treatment Centre (MATC). Through a practicum experience at the MATC working as a child care counsellor from an attachment perspective, it has been determined that the program is in need of some minor changes, and recommendations have been presented. When comparing the program offered at the MATC to the list of best practices presented by the municipal government of Victoria, it is noted that the MATC follows the recommendations set out within this report, with a few discrepancies. The MATC intervention is strengths-based, needs based and client-centered, and treatment is provided to the entire ecological system instead of just the individual (Municipal Government of Victoria, 2007). However, there are some of recommended best practices that the MATC does not currently provide including, offering a full continuum of services (such as life skills training, interpersonal skills training, and vocational opportunities).

The MATC also does not adequately facilitate appropriate peer relationships or offer opportunities to develop relationships outside of the MATC

program, such as in the community. The MATC school system is also based off the traditional school system, which does not allow for adequate vocational opportunities, which may be more important to those adolescents who will not be returning to a traditional school system upon discharge back into the community.

A further recommendation addresses the need to provide adequate transitional services to those adolescents who have been discharged; this includes offering respite services for all programs offered at the MATC and offering transition services for those youth who are continuing their treatment within the adult service system. Considering the MATC intervention technique is based on the development of a strong attachment relationship between the youth and their staff, it is important to ensure that this relationship is utilized during transition periods.

A recommendation that affects the Crossroads program specifically involves the need to separate voluntary and involuntary adolescents. These two groups of adolescents present with very different needs, and it is essential that different programs be offered for both. The physical environment within the units also needs to be addressed, as the institutional environment provided can have a negative effect on treatment outcome. As well, because the MATC is working from a new and different intervention perspective, additional training and supervision of child-care counsellors should be considered. This would ensure that the child-care counsellors are current and confident in their understanding of attachment-based intervention.

Finally, in order to seriously consider the recommendations outlined in this report, the funding for the programs offered at the MATC needs to be re-evaluated by the provincial government. Recently, the lack of funding has resulted in cutbacks in child-care counsellor positions, the recreation program has been discontinued and any specialized services have been cut. As well, it is important to provide multiple opportunities for connection through the MATC programs, which also requires additional funding. Overall, this paper will demonstrate that attachment theory is important for the study of crime and its development as well as for providing direct prevention and intervention techniques for clinicians working with at-risk youth, especially those with co-occurring mental illness.

2: ATTACHMENT THEORY

The conceptualizations that produced attachment theory began with Bowlby (1969), whose central premise was that attachment behaviors are biologically driven, because proximity to the trusted primary attachment figure is necessary for survival. In order to ensure that this biological system occurs, “the establishment, maintenance, and renewal of that proximity beget(s) feelings of love, security, and joy. A lasting or untimely disruption brings on anxiety, grief and depression” (Karen, 1990, p. 44). Therefore, it is beneficial for survival that a secure attachment relationship develops between the primary caregiver and the infant, to ensure proximity, and the ultimate survival of the infant.

Mary Ainsworth took the concepts from Bowlby’s attachment theory and began to conduct experiments to determine the merits of the theory. Ainsworth studied the attachment relationship between infants and their primary caregivers through the Strange Situation, which was used to observe the infant’s behavior during separation from and reuniting with the primary caregiver (Ainsworth, 1982). Ainsworth’s (1982) main hypothesis was that the primary caregiver acts as a secure base for the infant to explore their environment. Through this interaction, the infant learns that the primary caregiver is dependable and trustworthy, which allows the infant to develop age-appropriate autonomy. Therefore, the Strange Situation was used to assess the interaction style of the

primary caregiver and the infant - the interaction styles were divided into three typologies.

Ainsworth (1982) concluded that securely attached infants were able to explore their environment, using the primary caregiver as a secure base, to which they returned when they were frightened or anxious. These infants demonstrated distress upon separation from their primary caregiver, but were happy and easy to console when they were reunited (Ainsworth, 1982). Insecurely attached infants were divided into two subcategories – avoidant and ambivalent. Ambivalent infants were noticeably uncomfortable exploring their environment even with the presence of the primary caregiver. These infants were also very anxious upon separation and sought contact when the primary caregiver returned, but still were not able to be soothed (Ainsworth, 1982). Finally the avoidant infants were able to explore their environment regardless of the presence of the primary caregiver. They did not use their primary attachment figure as a secure base and these infants were not anxious or aware when their primary caregiver left their environment. Avoidant infants continued to avoid the primary caregivers when they returned (Ainsworth, 1982).

Later research determined that there was a fourth pattern of insecure attachment, which is termed, disorganized attachment. This attachment pattern is most often demonstrated among abused or severely neglected infants, and is classified when an infant demonstrates confusion in their attachment behaviors including both avoidance and resistance to the attachment figure (Main & Solomon, 1990). This behavior occurs when the child does not have an

organized strategy for handling interactions with the caregiver, as a result of inconsistent parenting behavior. In these situations, the primary caregiver would represent both fear and reassurance to the infant (Main & Solomon, 1990). This inconsistency results in the child expecting to be both comforted and frightened by their primary attachment figure.

Primary hypotheses about the behavior of the primary attachment figure towards the infant were drawn from the results of Ainsworth (1982). The primary attachment figures of securely attachment infants were more responsive to signs from the infants, including feeding signals and crying behaviors. They also consistently demonstrated positive interactions, which included returning smiles and affection towards the infant (Ainsworth, 1982). On the other hand, for both types of insecurely attached infants, the primary caregivers were unresponsive or inconsistent in their behaviors, as well as rejecting of the infant (Ainsworth, 1982). Overall, Ainsworth (1982) was able to draw conclusions in regards to the early development of security and personality, and how these early interactions provide a template for future interpersonal relationships.

2.1 Internal Working Model

Bowlby (1973) hypothesized the concept of the internal working model of interpersonal relationships and Ainsworth (1982) evaluated how an individual's inner world continues to be organized from infancy, throughout their development. The interactions between an infant and their primary caregiver result in the development of the infant's sense of self, which is understood through their internal working model. Over time, the repeated interactions

between the child and the primary attachment figure result in the development of expectations regarding interpersonal relationships and interactions (Crittenden & Ainsworth, 1989). The insecurely attached individual learns that the behavior they elicit is ineffective at getting the attention of the primary attachment figure, therefore they are unworthy of this attention (Crittenden & Ainsworth, 1989). Consistent rejection, lack of availability and extreme forms of pathological parenting foster internal working models of others as unavailable and untrustworthy, as well as complementary models of the self as unworthy of sensitive treatment (Belsky & Cassidy, 1994).

The attachment behavior demonstrated by the infant acts as that infant's strategy for coping with the unavailability or inconsistency of their primary attachment figure. Ambivalently attached children cling to their primary attachment figure in an effort to influence them, because the child has learned that their figure will meet their needs occasionally, if "frequent and intense attachment behavior" (Parkes, 1982, p. 296) is displayed. The infant is committed to getting their primary attachment figure's attention and to make the figure aware of their needs. On the other hand, avoidantly attached children are angry and distant with their primary attachment figure, as this child has learned that positive attachment behaviors will be rejected and that their needs are not adequately met by the primary attachment figure. The child becomes independent and hostile to accepting help from others, and along with this comes grandiose ideas about self to offset the rejection that was felt from the primary attachment figure (Ainsworth, 1982).

During childhood, avoidantly attached children may develop a 'hostile, aggressive, and antisocial" (Greenberg, 1999, p. 481) pattern of behavior to deal with the rejection of their primary attachment figure. This may be "manifested through lying, bullying others, and blaming and being insensitive to others" (Greenberg, 1999, p. 481). A child who is ambivalently attached may display similar behaviors, but the motivation would be different, as these children are, "easily over stimulated showing impulsivity, restlessness, short attention span, and low frustration tolerance" (Greenberg, 1999, p. 481).

When insecure attachment patterns are developed between a primary caregiver and their child, the strategies used by the child to elicit a reaction from the parent may be necessary in that environment. However, the child learns that these strategies are appropriate and useful, and then continues to utilize these strategies in environments where they may be viewed as maladaptive, such as in the school system (Greenberg et al., 1997). Therefore, many of the behaviors that are seen as maladaptive within the greater social environment have, in fact, been learned and reinforced through interactions with the primary attachment figure (Greenberg, DeKlyen, Speltz & Endriga, 1997).

Once the internal working model of interpersonal relationships has been established, any new interactions are assimilated into the internal working model that has already been developed, which hinders the ability to change attachment patterns. Negative internal models tend to influence behavior, which brings conflict into current attachments and raises the risk that future attachment will be insecure (Crittenden & Ainsworth, 1989). Unfortunately, the behavior of the

insecurely attached child elicits behaviors from others that reconfirm the child's negative internal working model and distorted view of the world (Karen, 1990). These coping behaviors tend to hinder the ability of the child to securely attach to other potential figures in their lives, such as teachers, coaches, or other adult family members.

This pattern continues to affect adult interpersonal relationships, as insecurely attached adults tend to expect certain patterns in their relationships and choose partners who fulfill these patterns. This then affects the ability of this pair of parents to develop a secure attachment pattern with their own children, resulting in a cycle of negative attachments passed through generations (Crittenden & Ainsworth, 1989). Main, Kaplan, and Cassidy (1985), who worked under the supervision of Ainsworth, further determined that attachment interaction styles are transferable across generations, because how parents recall and organize their own childhood experiences is a predictor of the attachment style of their children.

However, if secure attachment develops between the insecurely attached individual and a different attachment figure, this pattern of positive interaction can help to support the youth and offset earlier insecure attachment patterns (Karen, 1990). In order to change the child's attachment pattern from insecure to secure, the alternative attachment figure must display patience and consistency in the face of adversity, which will serve to help the child develop a revised internal working model of self and others (Karen, 1990).

2.2 Role of the Infant

Although attachment theorists recognize that the social experiences of the infant with their primary attachment figure are important for later development, the role of genetics as a base for the temperament and personality of the infant also needs to be addressed. It is undeniable that genetics are important for personality development, but "it is far more likely that temperament alters the style of a secure or insecure attachment pattern, not the pattern itself" (Karen, 1990, p. 67). Therefore, genetics are important for the foundation of personality but may also act as a risk factor prior to the social cues that are elicited in the attachment relationship.

Ainsworth (1982) believed that an infant is not a passive-recipient who develops attachment with the primary attachment figure simply because its needs are met. Rather, the infant plays a vital role in the attachment relationship. Although attachment figure sensitivity is a central focus, it is not the only factor contributing to attachment patterns. Most attachment figures that could support an average child may be ill equipped to support a temperamental child. The attachment figures difficulty may also be a consequence of the circumstances of that individual's life, and may be complicated by self-blame (Karen, 1990).

Early attachment research assumed that the primary attachment figure would be the mother. However, in modern times the role of primary attachment figure may fall to any number of different individuals including father, siblings, extended family, or foster / adopted family members. Although early research on attachment theory strictly utilized the mother as the primary attachment figure,

attachment theorists do not indicate that the primary attachment figure must be female or the child's mother (Marris, 1982). Instead, it is only important that the child *has* a primary attachment figure or that this role be split between one or two other adult figures. Further research has addressed the important role of the father and other parental figures such as grandparents or siblings (Marris, 1982), in forming an attachment bond with the child, as well as day-care providers (Howes, Rodning, Galuzzo, & Myers, 1988). As well, Rutter (1997) theorized, "most people have several relationships involving a strong attachment. They differ in the importance and strength of the attachment, but it is a quantitative variation and not a categorical distinction" (p. 26).

It must also be recognized that the parent-child relationship is not the only risk factor for childhood behavior problems or later antisocial behaviors. Attachment theory does not 'blame the parents' for the insecure attachment patterns that have developed. Instead, attachment theorists assume that the parent has done the best they can with the skills they have (Goldberg, 1997). As Rutter (1997) discussed, "attachment concepts are clearly useful in thinking about relationship disturbances but it is important that we should not be unduly constrained by thinking only in attachment terms" (p. 36). While it is important that other influential factors be recognized for their role in the development of early childhood problems, and adult antisocial behavior, Bowlby (1980) concluded that

> intimate attachments to other human beings are the hub around which a person's life revolves, not only when [they are] an infant or a toddler or a schoolchild, but throughout [their] adolescence and [their] years of maturity as well, and on into old age (p. 442).

3: ATTACHMENT AND CHILDHOOD

As the infant develops into a school-aged child, the biological system of attachment to the primary figure can be understood differently. The sense of security and trust that has developed between the child and their attachment figure means that the presence of the figure is no longer necessary to ensure the child feels secure. Therefore, beyond childhood and throughout life, attachment behavior only becomes activated and pertinent under periods of stress (Crittenden & Ainsworth, 1989). This is because the child has developed self-reliance and adaptive coping skills and understands that their attachment figure is trustworthy and will be available when needed.

Another development that occurs during childhood is the increased ability of the child to show insight, and to recognize and react to the motives and plans of the primary attachment figure. Once the child is able to recognize the interactive role they play in the exchanges with the primary attachment figure, the attachment relationship changes to a 'goal-corrected partnership', with each player contributing equally to the maintenance of the behaviors (Bowlby, 1969). However, the skills of self-reliance, successful coping, and age-appropriate insight have not fully developed for those individuals who have experienced insecure attachment.

Once insecure attachment patterns have developed between the child and their primary attachment figure, these patterns continue to be reinforced

throughout childhood. There are two reasons for the continuation of these negative behavioral patterns. The first is that the child has learned that their attachment strategies are useful, although these behaviors are also disruptive to the development of secure attachment with others. The second reason is that the primary attachment figure's response to the behavior of the child continues to reinforce the maladaptive internal working model (Loeber & Hay, 1994). The continuation of the negative behavioral patterns between the primary attachment figure and the child may begin to wear down the reserves of the adult figure. This may lead to the use of coercive methods, and serves to further strengthen the negative internal working model of the child. Between the continuation of the insecure attachment patterns with the primary attachment figure, and the lack of development in their skill set, the insecurely attached child is at a disadvantage upon entering the school system.

Upon entering the education system, insecurely attached children are often responded to by teachers in a similar manner to which they are accustomed. Sroufe (1983) showed that insecurely attached children tend to seek consistent contact with teachers, or respond as sullen and oppositional. This brings forth a reaction from the teacher, which serves to strengthen the child's internal working model. Sroufe (1983) also showed that teachers tended to excuse or infantilize those ambivalent children who cling to them, whereas teachers sought to control and were often angry with avoidant children.

Another way in which insecure attachment affects school-aged children is through their peer group. Unfortunately, having a negative internal model of

relationships also plays a significant role in the formation of the child's peer group. Most insecurely attached children have not developed age-appropriate relationship or social skills (Karen, 1990), which in turn hinders their ability to develop or maintain relationships with pro-social peers. Aggressive children experience higher rates of rejection, are more likely to be viewed by peers as "likely to aggress in a given situation, even when behaving neutrally, and tend to see the actions of others as similarly aggressive … [this creates] a restricted peer environment, which cannot help but limit opportunities for positive socialization" (Loeber & Hay, 1994, p. 498). Instead, the insecurely attached and aggressive child is more likely to experience peer rejection, and more likely to turn to other disruptive and like-minded peers, whom they have more in common with (Loeber & Hay, 1994), which further serves to exacerbate their behavior.

However, if the child happens to develop a secure attachment with a peer member, this attachment can also provide the "security, affection, uniqueness, ... care and protection" (Marcus & Betzer, 1996, p. 234) that was not available to the child from their primary attachment figure. Therefore, the potential influence of a positive peer or peer group is another important consideration and should be recognized. Equally important is the potential for a secure attachment relationship to develop between an insecurely attached child and an adult figure within their new school environment. Resnick, Harris and Blum (1993) found that school connectedness was the most influential protective factor across both genders for externalizing behavior, and the second most important protective factor after family connectedness for internalizing behaviors. Therefore, the

potential role of the school and of teachers as agents to minimize insecure attachment and develop secure attachment must be recognized. The educational system has the potential to, "provide a sense of belonging that may not also be provided by other sources such as family or peers" (Resnick et al., 1993, p. S7).

4: ATTACHMENT IN ADOLESCENCE

Attachment continues to play an important role through adolescence, which is recognized in the literature as the "second major 'window' of opportunity and risk in development, next only in significance to early childhood development" (Moretti & Peled, 2004, p. 551). This developmental period is commonly associated with feelings of insecurity, low-self esteem, and incompetence, which combine with the increased risk of depression and antisocial behavior. During this developmental period, adolescents are also maturing biologically, which includes changes in the hormonal and neurological structure. This, in turn, has been "implicated in increased irritability, adhedonia and risk taking behavior" (Moretti & Peled, 2004, p. 551). As a result of the challenges of adolescent development, and the increasing peer pressure, engagement in some types of delinquent activity is normative (Shedler & Block, 1990).

Along with these biological changes, the cognitive skills of the adolescent also continue to develop. These include the development of internal controls, such as "morality, empathy, caring, and commitment … and can be compromised by insecure attachment" (Fonagy et al., 1997, p. 241). For individuals who were insecurely attached during childhood, the development of these internal controls is stunted, and the inability to control their own behavior will become even more evident and detrimental during adolescence, as externally applied controls

diminish (Fonagy et al., 1997). External controls are placed on an individual by their primary attachment figure or parent; but these become less apparent as a direct consequence of the development of internal controls during adolescence (Fonagy et al., 1997). The increased reliance on internal controls to regulate behaviors may increase the risk of antisocial and disruptive behaviors if these controls have not fully developed as a consequence of insecure attachment.

The peer group also beings to play a more important role during adolescence, and time spent with parents decreases as the time spent with the peer group increases (Moretti & Peled, 2004). As well, adolescents begin to use peers as their primary attachment figures, which serves to support their need for attachment through this difficult developmental period and helps to encourage age-appropriate autonomy from parents (Allen & Land, 1999). Inherent in this new attachment relationship to peers, is the tendency for the peer group to follow its own initiatives as each member makes attempts to please the peer group, much like the relationship that used to exist between the adolescent and their primary attachment figure (Allen & Land, 1999). Unfortunately, for most adolescents who are insecurely attached, the peer group to which they are drawn is comprised of individuals much like themselves, which does not help to combat their insecure attachment.

It is difficult for insecurely attached and aggressive adolescents to secure a peer network that acts as a positive and pro-social influence, especially when considering their negative internal model of relationships. Research shows that adolescents, who demonstrate a high rate of aggression, also tend to "attribute

hostile intent to others" (Kazdin, 1993, p. 285), therefore the aggressive adolescent believes that their aggression is justified as a response to peer behavior. This is especially pertinent when interpreting ambiguous social cues, which are understood as hostile or aggressive by the adolescent. Unfortunately, the pro-social peers do not understand why the aggression was initiated, so they tend to reject the aggressive youth. This further contributes to the feelings of isolation and rejection and "provide[s] additional cues to the aggressive child that the environment is hostile" (Kazdin, 1993, p. 291), thus sustaining the aggression. Therefore, insecurely attached individuals are more likely to develop a peer group that is comprised of insecurely attached adolescents with negative internal models, and these models are continually reinforced through the peer group.

Despite the common belief that attachment to parents becomes less important through adolescence, these established relationships continue to play an important role in the development of autonomy. Rather than detaching from the primary attachment figure, the adolescent continues to rely on this support and emotional connectedness, while also exploring their expanding social context and reaching a new level of autonomy (Moretti & Peled, 2004). Parents may understand their child's new independence as a threat to their relationship, making it difficult for the parent to adequately support their child in their quest for age-appropriate autonomy (Obsuth, Moretti, Holland, Braber, & Cross, 2006).

The developmental period of adolescence can be challenging, even among adolescent-parent dyads that experienced secure attachment in

childhood. The newly developing relationship between the adolescent and the parent can be increasingly difficult for the primary attachment figures as they learn how to support the needs of their adolescent within this emerging relationship (Moretti & Peled, 2004). As well, the relationship between adolescent and primary attachment figure is evolving from a relationship of dependency to one of “mutual reciprocity” (Doyle & Moretti, 2000, p. i). During this transformation, it is very common for the rates of disagreement between adolescent and primary attachment figure to increase. Despite the difficulties inherent in this developmental period, it is important to maintain ‘relatedness’ within the dyad, despite regular disagreements (Moretti & Peled, 2004). However, “adolescents who feel understood by their parents and trust their commitment to the relationship, even in the face of conflict, confidently move forward toward early adulthood” (Moretti & Peled, 2004, p. 553).

Doyle and Moretti (2000) completed a Report to Childhood and Youth Division of Health Canada, which included recommendations for increasing the rates of effective parenting among the adolescent population. Doyle and Moretti (2000) advised that parents be aware of their continued importance to their adolescent despite conflicts that may arise, and that parents not experience this as rejection, but understand it as a function of autonomy. As well, parents need to recognize these behaviors as their adolescent's effort to increase personal autonomy, and parents need to actively support their adolescent with this development (Doyle & Moretti, 2000). Parents also need to continue to act as a secure base while their adolescent explores the existing social norms, and

should address concerns about peer approval and not disregard the emotional difficulties of adolescence (Doyle & Moretti, 2000). Finally, parents should place reasonable limits for their adolescent to guide their behavior, but also need to engage in discussion around suitable limits, in order for the adolescent to understand the importance of these limits (Doyle & Moretti, 2000).

Doyle and Moretti (2000) also presented implications for government programming. Overall, it is important that parents be supported through the difficult developmental period of adolescence to ensure that insecure attachments do not hinder the development of autonomy and cognitive skills, and to ensure that secure attachments are maintained between the parent-adolescent dyad. The recommendations made by Doyle and Moretti (2000) included funding public education to combat the myth that attachment is no longer required during adolescence, which will help to support parents in recognizing and understanding their changing relationship with their child. As well, it is important to offer parenting programs to assist parents in developing appropriate skills to support their adolescent through autonomy development (Doyle & Moretti, 2000). It is especially imperative that targeted programs be funded for parent-adolescent dyads that already manifest behaviors considered to be high-risk, and for mental health, corrections and youth workers, who are effective players in combating insecure attachment among this population (Doyle & Moretti, 2000).

4.1 Conduct Disorder and Adolescence

During adolescence, at-risk behavior that was present during childhood tends to escalate as a reaction to the changes that occur during this stage of

development, and if the problem behavior of the youth reaches a clinical level, a diagnosis of conduct disorder may be applied. Between 2% and 6% of children have received a formal diagnosis of conduct disorder, which covers a continuum of diverse behaviors (Kazdin, 1993). As well, conduct disorder has been diagnosed in approximately 5.5% of Ontario children between the ages of 4 and 16 (Waddell, Lipman, & Offord, 1999). For individuals diagnosed with conduct disorder, the risk of co-morbid disorders also increases, with 70% of diagnosed youth meeting the criteria for another disorder; attention deficit is the most common co-morbid disorder, affecting 45-70% of those diagnosed with conduct disorder (Kazdin, 1993). The high rates of co-morbidity also have to be addressed when designing and implementing treatment with these youth.

Conduct disorder is responsible for a third to a half of all psychiatric referrals in North America and is the most costly disorder of adolescence (Kazdin, 1995). There are numerous costs associated with the diagnosis of conduct disorder, because this diagnosis carries across generations and social systems. Conduct disorder is often transferred inter-generationally, as a result of the transmission of parental antisocial values and inadequate parenting (Kazdin, 1995). As well, 60% of youth who are diagnosed with conduct disorder remain at high-risk of becoming increasingly involved with antisocial behavior, antisocial personality, substance abuse, education and occupational difficulties, and resulting relationship and social issues (Kazdin, 1995). “For many, if not most diagnosable cases, conduct disorder represents a pervasive developmental

disorder in the sense that broad areas of functioning are deleteriously affected" (Kazdin, 1993, p. 301).

Considering the negative probable outcomes for such a high proportion of youth diagnosed with conduct disorder, interventions need to target both the symptoms of conduct disorder and the environment in which they are maintained (Moretti et al., 1997). "There is a child-parent-family context gestalt that includes multiple and reciprocal influences that affect each participant (child and parent) and the systems in which they operate (family, school)" (Kazdin, 1993, p. 282). However, it is also imperative that blame is not placed on the parents specifically, just that the pattern of interactions is acknowledged and assessed during treatment. Overall, in reaction to the identified causes and ongoing effects of a conduct disorder diagnosis, an attachment framework has potential for combating the destructive behavior of adolescents diagnosed with conduct disorder, and these intervention techniques have been applied at the Maples Adolescent Treatment Centre (MATC).

4.2 The Role of Protective Factors

One issue that needs to be considered when discussing adolescents who are 'at-risk' for later delinquent activity is those individuals who were 'at-risk' but who did not exhibit adolescent or adult delinquent behavior. Although development can be negatively affected by the presence of risk factors, it may also be positively affected by new opportunities for adaptive growth and development (Moretti, et al., 2002). It is proposed that the role of protective factors needs to be considered when explaining why some at-risk adolescents do

not exhibit antisocial behavior (Kazdin, 1993). Werner and Smith (1992) conducted a longitudinal study, and results showed that youth who were identified as 'high-risk' and who did not exhibit delinquent activity had numerous protective factors. These included: being perceived as affectionate by their mothers, high self-esteem and locus of control, access to numerous attachment figures, and having an appropriate adult-model who provided structure (Werner & Smith, 1992). These factors directly relate to the ability of the youth to establish secure attachment and the benefits that proceed from that. If an appropriate attachment figure is available to the child, then this can act as a protective factor for that 'at-risk' adolescent and can be used to explain their lack of delinquent activity (Kazdin, 1993). The role of protective factors in reducing the risk of adolescent and adult delinquency needs to be considered when designing interventions for those adolescents.

5: USING ATTACHMENT TO FRAME INTERVENTIONS

Traditional treatment interventions attempt to modify adolescent behavior through adult control and authority (Moore, Moretti, & Holland, 1998). However, techniques of control will do little to change the negative internal model of relationships that has developed for an adolescent who exhibits conduct disorder. Control techniques will actually serve to maintain and confirm the negative internal model of relationships that has developed for that youth, as controlling techniques “enhance the sense of being rejected, victimized, and vulnerable” (Vander Ven, 1994, p. 29). Instead of attempting to control adolescent behavior, intervention techniques for adolescents with conduct disorder need to focus on connection (Moore, et al., 1998).

Interventions that focus on connection will help the youth to accept personal responsibility for their behaviors, through experiencing positive relationships, learning to trust other people and developing secure attachment (Moore, et al., 1998). The move from control to connection techniques involves intervention from an attachment-perspective, which seeks to understand the meanings behind the behavior exhibited by the adolescent (Moore, et al., 1998). Attachment interventions recognize the importance of the early experiences of the child, which contributed to their insecure attachment patterns, and the resulting consequences of these relationships. It postulates that insecurely attached adolescents are unable to express their attachment needs in a pro-

social manner, therefore they resort to aggression, and coercion to get their needs met. Attachment-based interventions acknowledge that, "strategies that emphasize control and containment of problem behaviors demand that young people abandon maladaptive coping strategies. It is unrealistic to expect that young people will completely abandon particular ways of acting that have been crucial to their survival" (Price, 2001, p. 51). Insecurely attached individuals engage with others in ways that are compatible with their internal working models of interpersonal relationships and are rational when considering their history of attachment patterns (Moore, et al., 1998). Therefore, the treatment team needs to begin with an understanding that the conduct-disordered behaviors have proven beneficial for the youth and will not be easily abandoned. However, by building a secure relationship with the youth, and through modeling, patience, and understanding, the treatment team can begin to influence the internal working model in a more pro-social manner.

The attachment perspective recognizes that it is important to take into account the attachment style and the particular internal model that has developed for the conduct disordered youth, and this becomes an intervention target. Moretti, et al. (1994) go so far as to state that, "insecure attachment and behavioral problems are conceptualized as two related but distinct co-occurring conditions … aggressive behavior actually constitutes a particular type of attachment style" (Moretti, et al., 1994, p. 361). In order to fully address the negative behavior being exhibited, it is imperative that the treatment team has an

understanding of the underlying motivation, and then patiently demonstrates a different way of interacting.

Another target of attachment-based intervention is the emotional capabilities of the youth. Kobak (1988) postulates that the central premise in the issues of insecurely attached individuals is that they are unable to confidently display their emotions. Whereas securely attached youth have been supported in communicating both their negative and positive feelings, the insecurely attached youth is unable to express these negative emotions. As well, two important skills that are commonly underdeveloped with insecurely attached adolescents are empathy and emotional regulation (Osborn, 2006). Therefore the youth needs to learn to regulate their own emotions and change their emotional displays depending on their environment (Osborn, 2006), and these skills need to be a focus for attachment-based therapy and can be taught through modeling within a secure relationship.

Attachment interventions seek to improve these underdeveloped skills through role modeling and the development of secure attachment with others. This also involves the difficult task of rebuilding the ability of the youth to trust others, thus adapting their internal model of relationships (Hughes, 2004). Using the relationship that is established between the adolescent and their primary staff, the youth should be encouraged to undergo self-reflection, in order to gain a new understanding of their behaviors and how they influences others. Overall, the emphasis of the attachment perspective "is on *how* children approach situations … the primary focus is on the thought *processes* rather than the

outcome or specific behavioral acts that result" (Kazdin, 1993, p. 285). Each time the individual demonstrates conduct disordered behavior, they need to be redirected to the motivation behind their actions, instead of concentrating on the specific behavior that was exhibited. Therefore, the punishment for their behavior is not necessarily punitive, because the focus remains on providing new positive experiences to change the negative internal working model. Relying on a purely punitive approach means that the youth will continue to experience themselves as unworthy of getting their needs met, and others as untrustworthy. By providing a new positive experience, instead of the anticipated negative response, the treatment team begins the important process of self-reflection, which is aided by the secure relationship that has developed with their primary staff member.

Attachment interventions also stress the importance of external factors for the development of the conduct-disordered behaviors. Although the negative behaviors of the youth must be addressed during intervention, research demonstrates the significant role of family adversity and hostile parenting practices in the development of conduct disorder and antisocial behavior (Patterson, 1982). As well, there are similarities between the environmental risk factors leading to both conduct disorder and insecure childhood attachment (Moretti, et al., 1994). Therefore, treatment should focus on the combination of risk factors, not just the destructive behavior exhibited by the youth, and respond by targeting the environment, as well as the individual's behavior.

It is important to consider both the environment in which the adolescent experiences the interventions, as well as the community environment the adolescent will return to upon completion of their treatment program. In this way, the environment in which the attachment intervention takes place must optimize positive interpersonal experiences (Moretti, et al., 1994). The community environment of the youth must also be adjusted, which involves increasing parental ability to positively interact with their adolescent through a parenting program, and the creation of a care plan to guide further interventions with the youth once they return to the community.

Attachment therapy does not offer a specific intervention that best addresses the difficulties of the insecurely attached adolescent, just that the importance of the child-parent relationship should be acknowledged and targeted during interventions (Moretti et al., 1997). Therefore, the difference between each adolescent's attachment experiences needs to be considered when designing an intervention to target the needs of that specific individual. This means that the environment in which the intervention takes place needs to be tailored to reduce the adolescent's anxiety and to ensure the adolescent feels protected and acknowledged (Moretti et al., 1997). Adolescents, who are insecurely attached, respond better in environments that are “safe, consistent, and predictable ... with clear boundaries, expectations, and routines” (Osborn, 2006, p. 155). Furthermore, interventions with the adolescent who is diagnosed with conduct disorder need to be “presented in a non-authoritarian manner” (Osborn, 2006, p. 155) and need to ensure the adolescent is not feeling

threatened when presented with opportunities to behave differently and break the cycle of negative behavior. It is important for the adolescent to experience the natural consequences of their negative behavior, and that the attachment intervention helps aid the adolescent in recognizing the link between their negative behavior and the related consequences (Osborn, 2006).

The attachment perspective is also a 'strengths-based approach', which means that the strengths of the adolescent are identified and then become a focus of the intervention in an effort to increase the individual's self-worth. At-risk adolescents are often considered “problem saturated” (Price, 2001, p. 51), meaning that the focus is on the adolescent and their shortcomings. From a strengths-based approach, staff, youth and their families focus instead on finding solutions and identifying strengths for the individuals involved. This helps the youth and their families to move past the problems that have been identified, to focus on possible solutions, and to recognize the capabilities that are inherent in the youth (Price, 2001). Recognizing and helping to develop these strengths ensures that “[interventions are] delivered to a person, not a package of behaviors” (Morton, Clark, & Pead, 1999, p. xv). The personal qualities of the individual, both negative and positive need to be recognized by the treatment team, the at-risk youth, and their family. However, it is imperative that the strengths existing within the youth, their family, and their environment also be recognized and utilized through a strengths-based intervention. The link between the attachment framework and its role as a strengths-based approach increases the integrity of the intervention as a whole (Price, 2001).

5.1 Child-care Counsellors as Attachment Figures

Working from an attachment perspective involves having a full understanding of the theoretical change from control to connection; this has direct implications for those individuals who are working as child-care counsellors. It means understanding the role of relationships, and how they shape all interactions for that adolescent, and building a secure relationship between the adolescent and the child care counsellor based on “respect, trust, and mutuality” (Leaf, 1995, p. 15). Working from an attachment perspective means respecting the adolescent's history and coping strategies, in an effort to connect with the youth instead of control their behaviors and decisions (Leaf, 1995). The child-care counsellor must be able to support the youth, but allow them to make their own decisions and mistakes, and live with the natural consequences.

It is very important that child-care counsellors and caregivers remain aware of how limits and freedoms are set for the insecurely attached youth. Limits are an important aspect of the learning process for at-risk adolescents and treatment staff must ensure that limits are “clear, consistent, powerful, and personally meaningful” (Morton, et al., 1999, p. xvi) for the youth. It is important for at-risk adolescents, especially those who have lived independently and taken care of themselves, to feel part of the process for negotiating their limits (Price, 2001). This will help the youth to understand why limits are important within a relationship-based context. This process also helps to demonstrate that limits are not necessarily punitive, but do help to ensure the relationship remains strong

and everyone's needs are met. Including the adolescent in the decision-making process benefits the youth in many ways, by increasing their sense of inclusion and value and decreasing powerlessness, increasing the likelihood their needs will be adequately met, developing decision making skills and providing them the skills to transition to independence (Price, 2001). Including the youth in the discussion around limit setting, helps to develop their internal controls, and begins the "gradual transition to self-regulation" (Morton et al., 1999, p. 91).

From an attachment perspective, limits should remain "relationship-based" (Morton et al., 1999). Therefore, instead of punishing the individual through punitive means, the child care counsellor will use their relationship to demonstrate they are unhappy with the youth's behavior, not because the youth is unworthy, but because their behavior is inappropriate. The traditional intervention strategies relied on punitive limit setting, but this undermines the effects of modeling a positive relationship, therefore "natural occurring and relationship-based limit setting, related to consensual norms, works best" (Morton et al., 1999, p. 57). A common technique for communicating this to the adolescent would be to state they the child-care counsellor is angry with the youth because they were hurt as a result of the negative behavior. Once the situation has dissipated, the child care counsellor and the youth will reconcile, where it is clearly communicated to the adolescent that their behavior is inappropriate, and deserves a negative response, but that the relationship between the child care counsellor and the youth remains strong and supportive, even though they have experienced difficulty. Through this relationship, the

youth learns that their needs can be met through different means, and that other people are trustworthy and that they deserve to have their needs met.

Attachment theory postulates, “every human exchange has the potential to be an intervention” (Leaf, 1995, p. 19). This is because the intervention for the conduct-disordered youth occurs within the relationship context, so as long as the youth is experiencing a positive and secure relationship with their primary staff, they are taking part in their treatment intervention. Working from an attachment perspective as a child-care counsellor means spending time with the youth on and off the residential unit, it means sharing activities they enjoy, and building a secure relationship with the youth through every-day interactions. The child-care counsellor also acts as a role model for the adolescent. As discussed by Leaf (1995):

> I see my job as being a role model, a safe person who isn't always right, who is not unemotional, but who is safe, consistent within herself, and available. I don't want to model aloofness and the ability to take heaps of abuse. I want to assert my rights as a person, to model boundaries and the right to expect respect and fair treatment (p. 17).

It is the child-care counsellor’s role to model appropriate interpersonal relationships, and to aid the youth in further developing their own interpersonal skills. The adolescent will also learn how to maintain a positive and secure relationship despite experiencing conflict (Leaf, 1995). Finally, it is important to offer the adolescent the opportunity to practice their own interpersonal skills with individuals outside of the secure attachment relationship, including peers.

The attachment framework theorizes that therapeutic relationships can initiate and support change for an at-risk adolescent. The therapeutic

relationship between a primary worker and the youth can increase the novel experiences of that youth and teach them a new way of interacting in interpersonal relationships (Radmilovic, 2005). Novel experiences offer new strategies for understanding the social world, and it is through these experiences that change can occur to the internal working model. As the youth comes to terms with the novel information and a new understanding is developed, the individuals' internal working model assimilates this new information, and the negative model is slowly replaced with a more positive model of interpersonal relationships (Radmilovic, 2005).

The changes that occur to the internal working model are not dramatic, but very slow, as the internal model has been developed based on years of experience and it serves a protective function (Radmilovic, 2005). When the child-care counsellor becomes a secure base, the youth can seek out these novel experiences and opportunities can be provided for the adolescent to practice new ways of interacting (Radmilovic, 2005). It is through everyday interactions that the adolescent learns through novel experiences, which aids in changing the internal working model (Radmilovic, 2005). These changes to the model are especially important for attachment theory because, “enduring change in an individual's behaviour occurs only when there is change in the internal working model supported by change in the system(s) that one lives in and there is sufficient time, opportunity, and support to integrate the new experience” (Moore, et al., 1998, p. 18). Therefore, the child-care counsellor has a very direct and important role in attachment-based interventions.

6: MAPLES ADOLESCENT TREATMENT CENTRE (MATC)

6.1 Overview of Agency

The Maples Adolescent Treatment Centre (MATC) falls under the jurisdiction of the Ministry of Children and Family Development (MCFD). The MCFD supports both provincial and regional services, which ensures the protection and care of vulnerable children, their families, and their communities (Holden, 2008). The MCFD is responsible for supporting at-risk youth, youth forensic psychiatric services, youth justice services and youth mental health services, as well as a wide variety of community resources to support children, adolescents, and families (Holden, 2008). Although interventions from an attachment-perspective could be applied to any of the services that fall under the jurisdiction of the MCFD, this paper will exclusively focus on the Maples Adolescent Treatment Centre (MATC).

The MATC is one of the supports offered by British Columbia's Child and Youth Mental Health (CYMH). The MATC is part of British Columbia’s tertiary prevention and risk reduction model of services, and has been designated as a tertiary support by the provincial Mental Health Act. Tertiary prevention services are developed to care and maintain for established mental health or behavior problems, with a focus on restoring the adolescent to the highest possible level of functioning and to minimize the effects of their problem behavior (Horizons Community Development Associates [HCDA], 2008). If an at-risk adolescent

requires tertiary prevention and risk reduction services, then primary prevention was unsuccessful at meeting the needs of this individual and reducing their negative behaviors and risk. However, secondary services may have been useful at minimizing the negative potential impact of the adolescent's at-risk behavior (HCDA, 2008).

The MATC mandate includes residential, non-residential, and outreach services, which target the mental health needs of adolescents (aged 12 to 17). Adolescents who are commonly served by the MATC experience significant psychiatric and behavioral difficulties, as well as adolescents who are under the care of the criminal justice system and have been found Not Criminally Responsible by Reason of a Mental Disorder (NCRMD) or unfit to stand trial. The continuum of services offered through the MATC includes stabilization and intensive intervention for the youth, as well as support and education for the caregivers and community (HCDA, 2008).

All of the programming offered through the MATC is attachment-based, which provides a strong framework to guide programming throughout the organization. Despite the unique circumstances, experiences, and diagnoses of the individuals treated at the MATC, “a common theme among this vulnerable population is an attachment disorder, which has the ability to affect all aspects of the individual’s life experience” (Morton, et al., 1999). As a result of this outlook, the MATC avoids strategies that focus on control of behavior, instead the MATC supports attachment-based interventions that serve to strengthen the attachments between adolescent and their family, as well as the development of

personal responsibility, empathy, and conflict resolution (HCDA, 2008). This overarching framework helps to unite staff and offers a common language and view of adolescent behavior (Hillan, 2005), which helps staff, clients, and their families in understanding the attachment-perspective.

The MATC takes a multi-systems intervention approach, which means that intervention occurs across many different areas of adolescent development and addresses a continuum of needs. The MATC uses a “broad-based intervention model [in] an effort to expand the comprehensiveness or scope of interventions to address a large set of domains relevant to the individual youth's dysfunction” (Kazdin, 1993, p. 301). As the MATC complex is multi-systemic, offering intervention across different aspects of the individual's life, the staff employed by the MATC is also multi-disciplinary. The staff includes psychologists, psychiatrists, medical doctors, social workers, psychometrists, nurses, child-care counsellors, teachers, recreation supports, vocational workers, outreach workers, and administrative staff. Besides the specific programs offered at the MATC, additional programming includes the recreational program, which offers supervised recreational outings in the community (HCDA, 2008). The Maples Secondary School is also offered as part of the MATC program, and provides educational services to those youth involved either residentially or non-residentially with MATC. The Maples Secondary School is located on the MATC campus and ensures that the educational experiences of the adolescents will not be disrupted during their treatment at the MATC. The school is funded and

staffed by the Burnaby School District (HCDA, 2008). Classes include math, science, English, social studies, and woodwork.

6.2 History of the MATC

Within the past 20 years, the provincial government of British Columbia has put forth three mental health plans to increase the ability of provincial services to support the needs of adults and adolescents living with serious mental illness. The most recent of these plans was the 1998 Mental Health Plan, which spanned the 10 years from 1998 to 2008. The Mental Health Plan called for a stronger focus on promotion, prevention and early intervention for the most vulnerable populations, which includes at-risk adolescents. Reducing the stigma and discrimination associated with mental illness was another goal of this ten-year plan (British Columbia's Coroners Service, 2008).

As well as the 1998 Mental Health Plan, the provincial government of British Columbia approved the five-year Child and Youth Mental Health Plan in February 2003, with an investment of $44 million, which doubled the annual budget for these services (Ministry of Children and Family Development [MCFD], 2008). The four strategies of this plan included risk reduction for onset of mental illness, capacity building to strengthen positive community influences, treatment and support to ensure access to effective services, and performance evaluation to strengthen the existing infrastructure of the mental health system (MCFD, 2008). One of the key principles driving the Child and Youth Mental Health Plan was improving effectiveness of treatment through a focus on evidence-based practice.

As a result of the legislative changes implemented by the provincial government between 1998 and 2008, the MATC also underwent changes that resulted in a shift from the traditional punitive approach towards a new focus on attachment theory, which has demonstrated success as an evidence-based practice (Moretti, et al., 1994). Despite the potential usefulness of interventions utilizing attachment theory, the implementation of these interventions has progressed slowly and unevenly across Canada, as a result of different provincial political initiatives and social environments (Moretti et al., 1997).

In British Columbia, the political environment has been more welcoming of these new therapeutic interventions. Reasons for this include the high cost of ineffective behavioral and pharmacological interventions, along with the changes made to the Mental Health Act of 1989, which further protects youth against detainment without personal consent (Moretti et al., 1997). This has led to the development of attachment-based therapies that service the province of BC, including those offered through the MATC. One of the benefits of the programs offered through the MATC is that they can be used in a community setting, which has direct financial benefits, but does require the coordination and integration of services. However, this has been successfully accomplished within BC, with the creation of a single Ministry for Children (Moretti et al., 1997). Quebec and New Brunswick have also adapted interventions with roots in attachment therapy, although to a lesser extent than British Columbia.

6.2.1 Orinoco C.A.R.E. Program

When the theoretical framework of the MATC changed from control to connection, a program was implemented to test the new attachment focus, called the Orinoco C.A.R.E. Program. This program previously provided traditional long-term secure care but changed their approach as a result of the changing theoretical framework, by providing medium-term treatment and assessment from an attachment perspective. The changes implemented resulted in the move to an open unit and a stronger connection to the community and supports offered there.

The Orinoco C.A.R.E. Program provided a three-month residential program for assessment and treatment, run during the week with adolescents returning to their communities on the weekends (Osborn, 2006). The focus of this intervention was on creating a positive interpersonal relationship between the primary worker and the individual, both on and off the unit, and through individual and group therapy (Osborn, 2006). As well as the new attachment focus, the Orinoco C.A.R.E. Program also utilized family therapy, therapeutic home based care, parent training social, cognitive, and school interventions, and vocational training (Osborn, 2006). In order to address the ecological risks for conduct disorder, the caregivers of these youth also attended the Connect Parenting Group. Under the current programs offered at the MATC, the Orinoco C.A.R.E. Program has developed into the Bifrost program, which continues to address at-risk adolescents within their communities.

6.3 Current Organization of the MATC

The organization of the staff at the MATC is consistent across all of the residential programs, which will be the focus of this paper. The front-line staff for each program includes three teams of three child-care counsellors and a nurse. Each of the adolescents is assigned a “primary” from each team, which means that each adolescent has a consistent contact even though the teams rotate through the shifts. This arrangement serves to strengthen the attachment relationship between the adolescent and their specific primaries, as well as enabling consistency of care and privileges across teams (Moretti, et al., 1994). In theory, this is one of the best systems to aid in the development of connection and a secure relationship between the staff and the adolescents. Attachment relationships do develop between the adolescent and their primary staff member and often times it is the relationship itself that stops the escalation of a youth’s behavior. As well, the arrangements of youths and their primary often occur based on the strengths of the staff member as well as the specific needs of the adolescent upon entry to the MATC.

From an attachment perspective, this arrangement benefits the youth because they have to interact with the same staff member regardless of the situation, which means staff splitting rarely happens. Staff splitting is a common occurrence in situations where the youth seeks privileges from different staff members – they continue their quest until they find a staff member that is willing to grant their request. At the MATC, this practice rarely occurs because the youth is always referred back to their primary contact. This helps to teach the youth to

deal with their issues and feelings through problem solving and communication, instead of running away from the situation and / or persons involved.

As well, the consistency of staff members teaches the youth that regardless of whether or not they have had a difficult day together, their primary caregiver will try to support them. Most of these youth come from homes where inconsistent parenting practices were the norm, so to provide an example of consistency of consequences and expectations; the youth learns to self-regulate their own behavior (Moretti, et al., 1994). Furthermore, the youth learns that it is permissible and reasonable to be angry at their primary caregiver and vice versa, but that these feelings do not permanently harm the relationship, and regardless of the behavior exhibited, the primary caregiver will continue to support the youth (Moretti, et al., 1994). The motto for the primary teams is that each day is a new day, and regardless of what happened the previous day, the youth and this caregiver are a team and they work through issues together.

The primary staff teams attend weekly “clinical meetings” during which the treatment team discusses each adolescent’s progression through their personalized program. This is an opportunity for each individual from the treatment team to discuss his or her personal experiences and provides the rest of the treatment team with a full perspective on each adolescent. The psychiatrist and treatment manager from the MATC also attends these clinical meetings, so the treatment team gains insight from outside sources – this also provides an opportunity for brainstorming ideas for managing particularly challenging adolescents. As well, on a daily basis at the beginning of their shift,

the team of childcare counsellors is involved with a team meeting where the treatment team reviews the individual privileges of each adolescent and makes decision in regards to any changes. This high level of communication between the staff members of the MATC, and each treatment team ensures a high quality of care and attention for each adolescent. Overall, the staff organization at the MATC facilitates the development of secure attachment relationships between the primary child-care counsellor and their youth, which aids in the development of a more pro-social interpersonal model of relationships for that youth.

7: CURRENT PROGRAMS OFFERED AT THE MATC

7.1 Connect Parenting Program

Given the ongoing importance of the family as a secure base during adolescence, as well as the potential impact of the environment on the development and maintenance of the youth's conduct disorder behavior (Moretti & Peled, 2004), it is not surprising that treatment from an attachment-perspective includes the parents as active participants. As well, given that residential placements remove the adolescent from their community, it is important that the fragile relationships between the youth and their family and /or community are maintained. Literature has shown that attachment to both caregivers and community can act as a protective factor and will help to deter antisocial behavior (Fonagy, et al., 1997). Therefore, it is very important to maintain ties between the youth, their family, and their community during their residential placement.

This can be achieved by including the adolescent’s family in their treatment, which also helps to address the ecological system that serves to maintain the pattern of behavior (Moretti, et al., 2004). The Connect Parenting Program offered at MATC is an example of a program that targets the ecological system of the at-risk adolescent, and allows the bond between adolescent and family to be maintained through residential intervention. The Connect Parenting Program draws its focuses from attachment theory and the factors that influence security of attachment, and the program is based around nine attachment

principles that must be understood to effectively change attachment patterns (see Appendix).

The Connect Parenting Program aids the caregivers of severely conduct disordered adolescents to understand the aggressive behavior of their youth through an attachment perspective, as well as develop more appropriate communication and limit setting skills given their new knowledge of attachment theory (Moretti, et al., 2004). The Connect Parenting Program focuses on improving parenting skills in the following areas, “parental attunement, empathy and effective dyadic affect regulation” (Osbuth, Moretti, Holland, Braber, & Cross, 2006, p. 6). Further development of these parenting skills allows the parent to “reframe” their child's conduct disordered behaviour as an expression of their attachment needs.

This recognition allows the parent the opportunity to adjust their own emotional response, and use different parenting strategies to deal with the behavior that still support secure-attachment with their adolescent (Osbuth et al., 2006). As Moretti and Peled (2004) explain, “helping parents to reframe the meaning of conflict [provides] an opportunity to build their relationship with their adolescent child” (p. 553). Overall, the Connect Parenting Program aids in the development of the necessary parenting skills, “to alter their child's behavior in the home” (Kazdin, 1993, p. 286) upon completion of their program at the MATC, which increases the ability of the youth and their parents to function as a dyad within the community.

Moretti et al. (2004) addressed the perceived usefulness of the Connect Parenting Program from the perspective of the caregivers and youth. The majority of respondents rated the education focus as helpful (46%) or very helpful (38%) (Moretti et al., 2004). Similar levels of effectiveness were demonstrated across ratings of increased understanding of their child (50% and 38%), and understanding themselves as parents (33% and 46%). Furthermore, 87% of parents agreed that the ideas covered by the Connect Parenting Program were useful in parenting their child; 48% indicated some change in their relationships with their adolescents, whereas 22% reported major changes (Moretti et al., 2004). Overall, Moretti et al. (2004) demonstrated that the Connect Parenting Program improved attachment-relationships between the parent and adolescent, and that these changes should continue to provide positive effects during follow-up. Therefore, participants perceive attachment-focused interventions for caregivers as useful. As well, attachment theory offers a framework for understanding externalizing disorders and can be used to guide intervention techniques.

Osbuth et al. (2006) also completed an assessment of the Connect Parenting Program and results indicate that there were significant pre- to post-treatment decreases in negative parenting practices ($p = .01$). Results also indicate increases in family adaptability ($p < .05$) and closeness ($p=.07$), as well as reductions in adolescent externalizing ($p < .001$), internalizing ($p = .001$) and overall conduct disordered behaviors ($p< .001$). Overall, Osbuth et al. (2006) concluded that the Connect Parenting Program improved the functioning of the

child-parent dyad and significantly reduced adolescent conduct disordered behavior. Therefore, this parenting skills workshop shows great potential as an up-and-coming intervention for conduct disordered youth and their family.

7.2 Response Program

The Response Program is offered through the MATC, and can accommodate up to twelve adolescents in the residential facility. Adolescents who are not adequately supported within their communities are referred from community mental health agencies for behavioral issues. The Response Program offers both a residential and non-residential service. Adolescents stay in the residential facility for twenty-eight days for assessment and case planning, including the development of a Care Plan. Non-residential adolescents attend the programming at the MATC, but do not live in the residential services and remain living in the community during their assessment. The Response Program also offers respite for those youth who are transitioning back to the community; this helps to ensure that the fragile attachment relationships between the youth, their family and their community are maintained and that the youth and their family feel supported. Respite can be offered for up to two weeks, and is usually pre-planned into the follow-up of that youth, therefore acting in a preventative manner, instead of being initiated during times of crisis (Maples Adolescent Treatment Centre [MATC], 2008).

The central focus of the Response program is the creation of a Care Plan. The Care Plan is a tool that seeks to explain the underlying problems of the particular youth, and how they relate to their social environment. The Care Plan

attempts to outline the youth's past and present functioning and offers strategies to effectively respond to their behavior (MATC, 2008). The Care Plan addresses all the important relationships for the youth (including family, friends, and professionals), and spans five assessment areas: childcare/nursing, social work, psychology, education, and psychiatry. Through these assessments, information is collected on the youth's functioning in their lifestyle and vocation, as well as development of their social skills, health and sexuality. A social history is taken from the family, and the youth's social-emotional, behavioral, and cognitive abilities are assessed, along with their educational strengths, learning needs, and mental health needs (MATC, 2008).

The staff members that take part in the assessment of the youth and the creation of the Care Plan meet with community resources and family members of the youth. The Care Plan meeting is large, and can include the youth, caregivers, parents, case manager, child care counsellor, nurse, social worker, psychologist, teacher, psychiatrist and care plan consultant (MATC, 2008). This meeting explains the concepts in the Care Plan, and offers strategies that can be utilized to better support the youth within the community and to create an environment which best supports the needs of the adolescent (Hillan, 2005). A Care Plan consultant is assigned to each client to ensure that proper follow-up is initiated once the youth leaves the residential services, and to help with implementation of the Care Plan within the community. The Care Plan consultant continues to aid and support the adolescent, family, and community until the client turns nineteen and transfers into the jurisdiction of adult services.

Moretti, et al. (1994) addressed the usefulness of the Response Program at six, 12, and 18-month follow-ups after treatment completion. This study extended and replicated early findings by Holland, Moretti, Verlann, and Peterson (1993). Results indicated that 70% of caregivers reported the individualized care plan as useful at six-, 12-, and 18-month follow-up. As well, reports from the youth at six, 12, and 18-months demonstrate their support for the program, and belief that they had benefited from the program (77%, 64%, and 82%). The Response Program was also successful in reducing the symptoms of conduct disorder, oppositional defiant disorder and attention deficit hyperactivity disorder, as recognized by the caregivers at six-month, 12-month, and 18-months (Moretti, et al., 1994).

In general, the Response Program demonstrated therapeutic success when conceptualizing conduct-disordered behavior as an attachment strategy, and when intervention focused on this interpretation of the behavior. This conceptualization aided the family unit in understanding and responding to the behavior in a positive way. Parents were found to respond more supportively and less critically, and these positive reactions helped the youth to become less coercive in their exchanges and communications with parents, as well as reducing their externalizing behaviors (Moretti, et al., 1994). Therefore, when the youth was taught and reinforced more positive and effective attachment strategies, and were responded to in a more positive and understanding manner, the pro-social attachment behaviors were consistently exhibited, and the maladaptive attachment strategies experienced a reduction.

7.3 Crossroads Program

The Crossroads program includes an eight-bed residential facility to treat adolescents who are experiencing significant issues within their communities and are diagnosed with severe conduct disorder, co-morbid disorders (most commonly with attention deficit hyperactivity disorder or attention deficit disorder), and psychiatric disorders. This program's mandate extends across two types of adolescents, including those that have been designated to undergo treatment by the courts, and who have been found unfit to stand trial or NCRMD. The Crossroads program also admits individuals on a voluntary basis, and these adolescents remain in residential care until the youth is stabilized and treatment can be completed in a less intrusive setting, or could be discontinued. The average voluntary stay is three months; those youth who are legally held at the Crossroads program are under the care of the Review Board and /or the legal system.

One difference for the Crossroads program compared to the other programs offered at the MATC, is that this facility is locked to provide "containment and intensive supervision" (HCDA, 2008, p. 94) of the adolescents. Most youth may leave the locked facility under staff supervision or on unsupervised outings, depending on their security level and personal circumstances. Family members of the adolescents enrolled in the Crossroads program are encouraged to take part in the Connect Parenting group and home visits are arranged for the youth whenever possible to ensure that fragile connections are maintained throughout their stay at the residential program. The

Crossroads program also involves the development of a Care Plan, similar to the Response program, and offers limited respite when possible; both these services are only available to voluntary residents. No assessments have been completed on the Crossroads program specifically because of the small number of adolescents treated through this program.

7.4 Dala Program

The Dala program focuses on voluntary interventions for youth who are diagnosed with anxiety, thought, or mood disorders; these services are offered non-residentially, or in the six-bed residential facility. The typical residential experience lasts three months, but this is also dependent on the particular needs of each adolescent. The central focuses for the Dala program include a reduction in psychiatric symptoms for the youth, and involvement of the youth's family to ensure attachments are maintained and fully developed. The Dala program also develops a Care Plan to support the youth with the transition back to the community; the Care Plan is modeled to that used in the Response Program. Respite is also offered through the Dala program, and parents are encouraged to attend the Connect Parenting Group to gain a deeper understanding of the attachment-perspective. No assessments have been completed on the Dala program.

7.5 Bifrost Program

Considering that residential services are viewed as a last resort for at-risk adolescents, it is very difficult to offer a positive residential experience for

learning and development. This attitude demonstrates to the at-risk adolescents that it is their fault, and their fault alone, that they are in residential care. Therefore, the MATC also offers a program for those adolescents who can be adequately treated within their community, the Bifrost program. The Bifrost program is modeled after the Orinoco C.A.R.E. program, except that it is run entirely on an outreach basis, within the community of the adolescent.

The Bifrost program is different from the other programs offered through the MATC because it is a non-residential program that offers, “intensive, home-based, short-term intervention” (HCDA, 2008). This program is important because its specific focus is aimed at developing the community's capacity to effectively care for the at-risk adolescent without relying on the option of institutionalization, which can greatly affect a fragile attachment relationship (Radmilovic, 2005). The Bifrost program targets the interaction patterns within the family environment, and strives to develop alternative ways to interacting, and problem solving skills (HCDA, 2008). The length of the Biforst program is three and a half months, and treatment takes place solely in the community environment of the youth, although the caregivers do attend the Connect Parenting group.

8: ANALYSIS OF THE PROGRAMMING AT THE MATC

8.1 Overview of Recommendations

The municipal government of Victoria presented a list of best practices to guide interventions that target the at-risk adolescent population (Municipal Government of Victoria, 2007). When comparing this list of best practices to the programs offered at the MATC, it can be noted that the MATC includes many of these best practices in their model of service delivery. Commonalities between the best practice guidelines presented by the municipal government and the MATC programs involve offering a "client-centered, individualized, and strengths-based approach" (Municipal Government of Victoria, 2007, p. 26). The MATC also demonstrates the following best practices: ensuring case management is needs-based, ensuring parent/family involvement during the residential care experience, and providing treatment for the adolescent within the context of their ecological system of family, peers, and community (Municipal Government of Victoria, 2007).

However, some of the best practices presented by the municipal government of Victoria need more consideration by those designing the MATC programming. These include offering an integrated system of accessible services, such as substance abuse counseling, vocational development, and life skill development, all of which are important to the continued support of the at-risk adolescent. Although the MATC program does provide both residential and

non-residential adolescents access to the Maples Secondary School to ensure that their educational experience continues as smoothly as possible, there is a lack of emphasis on life-skills, and vocational skills, and no substance abuse counseling offered. These are areas that should be adequately addressed by the MATC programs. A life-skills program and vocational program could be included in the school program offered at the MATC, and substance abuse counseling could be offered at the MATC or through collaboration with an outside agency.

Employment opportunities are also limited within the MATC environment. Although there is a vocational coordinator employed by the MATC, opportunities available to the youth in treatment are limited. As well, the role of arranging these vocational experiences tends to fall to the child care counsellors, and as a result of lack of time, these opportunities are often not follow-up adequately, resulting in that youth missing out on an important vocational opportunity. This is especially pertinent for those youth attending the Dala and Crossroads program, as they are usually residential patients who remain living at the MATC for many months, who would benefit from a positive vocational experience within the community sector.

Another best practice that is not included in the MATC program is providing adequate peer support and opportunities to develop relationships with more conventional peers. The MATC program is a residential facility that is separated from the community at-large, making relationships with community peers difficult. The MATC also provides a unique and specialized school system, which is geared towards the children in treatment at the MATC but also limits the

ability of the clients to develop pro-social relationships with community peers. The MATC could provide outings planned in conjunction with an appropriate community agency to ensure the opportunity to develop peer relationships within more conventional environments. Finally, it is important to offer strong educational and vocational programs to re-establish the link between education and employment opportunities. Although the MATC program does offer a school-based program, it is not mandatory for youth to attend on a daily basis. As well, there are not alternative educational programs provided for these youth, some of which who will not be returning to the traditional school system.

It is also extremely important to the success of the at-risk adolescent to receive supports through discharge into the community; this is an area that is lacking at the MATC. Considering the MATC works from an attachment perspective and the child-care counsellor takes on the role of attachment figure, this continued connection between adolescent and child-care counsellor is especially pertinent. Although the Care Plan has been implemented in most of the programs at the MATC, there continues to be a lack of follow-up for youth who leave the Crossroads program where respite services are not offered, and a Care Plan is only created for those youth who are voluntary clients. There are also no transitional services offered for those youth who are shifting into the adult mental health system from the MATC program.

Although most of the recommendations presented in this paper are appropriate for all the MATC programming, there is one issue that specifically limits the effectiveness of the Crossroads program that needs to be addressed.

The Crossroads program has a more complicated service delivery platform, as this program caters to both voluntary individuals and involuntary individuals who are being treated through the youth criminal justice system. Although the inclusion of both these types of at-risk adolescents may be useful from a monetary perspective, treatment of these two very different populations within one program deserves further consideration by the MATC. The Crossroads program should be designed into two separate programs catering to the specific needs of both groups of at-risk adolescents.

Another area of interest is the physical environment within the different units at the MATC. The MATC physical building is very institutional, especially on the Crossroads unit where the bathroom, kitchen, room doors, and doors to the outside remain locked. The literature addressing the role of the environment in adequately treating mental illness should be considered, as well as the negative impact on those voluntary adolescents attending the Crossroads program.

As well, considering the MATC is working from an attachment perspective, which is relatively new and very different from traditional means of treatment for mentally ill and conduct disordered youth, additional training and supervision of child-care counsellors should be implemented. This would ensure that the staff members who are the most involved with the treatment at the MATC remain current and comfortable with the attachment perspective, both theoretically and practically. As it is the child-care counsellors who implement this intervention on a daily basis, it is with this group of staff that the increase in training and supervision should be concentrated.

Finally, in order to implement any changes at the MATC program, the funding for this program needs to be considered. Although the provincial government of British Columbia does continue to support the programs at the MATC, the funding for these programs has not been adequate. Recently, there have been staff cutbacks among child-care counsellors, the recreation program has been discontinued and any specialized services have been cut as a result of recent budget arrangements with the government. In order for the adolescents treated at the MATC to get the most out of their experience, the funding needs to be adequate to support the services offered through the MATC. Literature continues to demonstrate the importance of multiple opportunities for connection (Price, 2001), and these opportunities are being discontinued as a result of the lack of funding.

8.2 Increased Focus on the Development of Practical Skills

In 2007, a Task Force was developed in Victoria, B.C. to offer recommendations on how to break the cycle of mental illness, addictions, and homelessness. The mandate of the Task Force was to research the best practices for services in this area and develop an evidence-based model of services for Victoria, B.C. Specific recommendations were made for supporting homeless youth, who often have left home as a result of a negative family environment, a cycle, which includes family conflict, violence, abuse, or neglect (Municipal Government of Victoria, 2007). Recommendations made by the Task Force included increasing the protective factors for these youth, building life skills

while in residential care, and using peer-based strategies such as modeling and involvement in conventional activities.

8.2.1 Life-Skills

The recommendations made by the Task Force include important considerations for the MATC program, which often deals with this population of marginalized adolescents. Although the MATC program does concentrate on development of protective factors through attachment based interventions and utilizing peer-based strategies, there is less of a focus on life skills. This is an important area to develop while in residential care, considering the experience should ensure the youth is set up to best support them when they leave the MATC. Hillan (2005) further recommended that an independent life skills program be implemented in all residential services to ensure that adolescents are adequately prepared for their discharge and return to the community. Therefore, life-skills need to be adequately targeted by residential treatment centers and the MATC.

A five-year retrospective review of child and youth suicide in British Columbia was completed to assess the ability of the Ministry of Children and Family Developmental Services to support those adolescents who are at-risk of committing suicide (British Columbia's Coroners Service, 2008). This review offered the recommendation that there should be an increased focus on skill-building programs throughout the province. The importance of these skill-building programs for at-risk adolescents is the ability to strengthen the existing protective factors for youth, as well as teach this at-risk population resiliency and

coping skills (British Columbia's Coroners Service, 2008). This recommendation should also be considered for the at-risk adolescents who are currently residing at the Maples Adolescent Treatment Centre or who attend the Maples public school, under the jurisdiction of the British Columbia Ministry of Education.

An important consideration when working with at-risk adolescents in the role of education in creating life chances, despite behavior difficulties. Related to the importance of education is skill-based training with a focus on interpersonal relationships and relating styles. Difficulties relating and communicating with other individuals will greatly hinder the ability of the at-risk adolescent to achieve meaningful relationships and occupational opportunities through adolescence and into adulthood (Morton, et al., 1999). More specific areas for skill building include: assertiveness, negotiation, coping skills and the ability to self-sooth, mindfulness and empathy (Morton, et al., 1999).

8.2.2 Interpersonal Relationship Skills

Another report that is significant for assessment of the MATC program is the Adolescent Placement Research Project, which analyzed the literature and related programs in an effort to design a system of services for at-risk adolescents who present with specific needs making them difficult to place (Price, 2001). One of the targets identified by the research project was the importance of assisting youth in the development of interpersonal skills to increase their ability to connect positively with peers and others (Price, 2001). This can include practicing appropriate relationship and friendship skills with caregivers and debriefing after social experiences with peers (Price, 2001).

Inclusion of training opportunities which allow for the further development of both life skills and interpersonal skills are important for at-risk adolescents, as they can act as protective factors and can facilitate positive vocational experiences for this population.

Morton, et al. (1999) recommended that a therapeutic educational day program could be implemented to provide a balance between educational and vocational programs, specifically tailored to at-risk adolescents. This program could easily include a life-skills component, along with other programs such as skills training, interpersonal relationship skills with both peers and staff, and individual or group therapy. A further recommendation by Morton et al. (1999) was offering an additional advanced education day program, which would be marked by a graduation ritual and a clear change of status within the unit, including both more responsibility and more independence. Providing at-risk adolescents with a graduated program for any skill-building training is beneficial because their continued progress throughout the program is clearly outlined and celebrated (Morton et al., 1999). As long as the benchmarks for each graduation are shaped around the developing skills sets of the youth, this graduated program could help to increase their self-esteem, as well as teach them interpersonal skills and supports for their peers also graduating through the day program.

Overall, the MATC and all residential services tailored to at-risk adolescents need to consider the importance of building life-skills and interpersonal relationship skills among this population. The MATC specifically

does not have a focus on these areas of skill building, although they do provide a more traditional educational day program. However, it would be important to consider including a life-skills and interpersonal relationship skills program within the existing education system provided at the MATC.

8.2.3 Vocational Opportunities

Morton, et al. (1999) presents an evaluation of the residential services for high-risk adolescents with serious mental illness and / or behavioral issues in Australia. The report set out to determine the specific needs of the youth who were not being adequately treated by the existing social services, to determine international best practices, and to make recommendations to strengthen the existing system in Australia (Morton, et al., 1999). Considering the high prevalence of disordered attachment styles among this at-risk adolescent population, it is important that interventions with these youth ensure their personal safety, maintain and develop secure attachment relationships, and ensure an appropriate balance between empowerment and limit setting (Morton, et al., 1999). The most important areas for intervention with this group of at-risk adolescents includes building and supporting healthy relationships with family, peers and staff, as well as providing educational opportunities, vocational training and pro-social recreational outlets (Morton, et al., 1999).

The development of specific skills through trade and vocational opportunities is an important component to any residential service. This is especially critical for services that support at-risk adolescents who are unable to complete adequate education within the mainstream system (Centre for

Excellence in Child and Family Welfare [CECFW], 2008). Examples of such programs presented by youth currently involved in the system include: retailing, fast food, fashion and beauty therapy, financial skills, and trade programs (CECFW, 2008). The MATC Response Program does not offer a vocational program because of the short time frame (30 days) in which the assessment and the Care Plan are completed. These adolescents are also more likely to maintain their community ties, considering their short stay at the MATC, and their vocational strengths are addressed in the Care Plan, which is then followed-up within the community upon discharge.

However, the youth who are residing at the MATC in the Dala or Crossroads programs stay for a minimum of three-months; therefore, it is important to offer appropriate vocational experiences for these youth. Although there is a vocational program available to the residents of the Dala and Crossroads programs, the lack of coordination and organization in regards to vocational opportunities, often inhibits these experiences for the youth. There is a vocational coordinator available to help with organizing vocational opportunities, however she is responsible for setting up these experiences with all the youth at the MATC. Considering the time it takes to meet with the youth, find an appropriate placement, organize the initial meetings and prepare an appropriate schedule between the youth and the vocational opportunity, one coordinator is not enough to effectively work with all the youth at the MATC.

Therefore, the role of vocational coordinator often falls to the child-care counsellors, including finding and organizing vocational opportunities; however,

vocational placements are not a priority for the child-care counsellors and often becomes overlooked. Therefore, it is recommended that the vocational program offered at the MATC be reformulated to ensure that it is meeting the needs for all the at-risk adolescents who are available for such a placement. A vocational placement has the opportunity to increase self-esteem, to practice pro-social interpersonal relationships, to provide the youth with the opportunity to display autonomy and to build on the strengths of that youth (CECFW, 2008). Even for those youth who are not stable enough to partake in a vocational opportunity within the community, they could be offered such a placement on the MATC campus. Although these on-campus placements are utilized once in a while, the same time frame issues and coordination difficulties inhibit these opportunities as well as those within the community.

Finally, one simple way to ensure that the youth is prepared for employment is to aid the youth in obtaining all the necessary documentation to proceed in this environment (i.e. social insurance number and identification) (CECFW, 2008). Usually the adolescents, who do not have access to this documentation, also do not have the skill capacity to complete this process independently or the community supports to ensure that the paperwork is filled out correctly and submitted. Ensuring that the proper documentation has been submitted will help to increase the attachment between the child-care counsellor and the youth, as well as show the youth that they have the support they need to reach their goals.

8.3 Peer Support and Opportunities

One of the primary focuses of the attachment perspective is the development of a positive and healthy attachment between the primary child-care counsellor and the at-risk adolescent. However, it is also important to consider supporting and helping in the development of a positive attachment relationship with unit peers as well. Morton, et al. (1999) discussed the importance of peer relationships: “the need for peer relationships amongst young people with extreme levels of disturbance must be considered in service provision. The young person cannot be restricted to adults … peer relationship difficulties must be addressed” (p. 97). This goes hand-in-hand with the focus in the previous section, on the development of interpersonal skills through targeted intervention. Furthermore, it has been acknowledged in the literature that at-risk adolescents often describe feeling isolated from their peers as a result of their mental illness, excessive behaviors, and negative life experiences (Price, 2001). Individuals, who have difficulty attaching to others as a result of their internal working model and insecure attachment history, would still experience loneliness and isolation, and the biological need to feel connected to others remains strong.

Although facilitating and supporting developing relationships between unit peers is an important part of creating a secure attachment foundation for the at-risk adolescent, a challenge in promoting these relationships is the potential negative effect of antisocial peers. Each youth at the MATC has specific attachment needs and abilities, which means that peer relationships may have a negative effect depending on how they are monitored and experienced.

Promotion of a pro-social culture among residential peers is important to offset any negative effects of providing care for numerous at-risk adolescents who have independent issues and needs (Morton, et al., 1999). Specifically, the effects of antisocial peers can be detrimental to the residential treatment experience; “unless peer culture is directly and continuously monitored and addressed it is likely that the negative peer culture will overwhelm the positive influence of staff or carers” (Morton, et al., 1999, p. 97).

Overall, the positive effects of a significant peer relationship outweigh the potential negative effects of such a relationship. Therefore, it is important that the MATC provide appropriate environments to increase the secure attachment between unit peers, and peers within the community. Although these relationships will have to be monitored, the child-care counsellor can aid in achieving positive experiences with a peer group, through modeling and debriefing attachment experiences with the youth after the fact. As well, peer opportunities provide the youth with the possibility of practicing their developing interpersonal skills. Consequently, the MATC should have a stronger focus on the development of appropriate peer relationships, both on and off the unit. This could be achieved by collaborating with a community agency that addresses the at-risk adolescent population to provide outings, thus ensuring the opportunity to develop peer relationships within more conventional environments.

8.4 Collaboration with Outside Agency for Addictions Services

The provincial government of British Columbia approved the five-year Child and Youth Mental Health Plan in February 2003. In 2008, five years after

implementation of the Child and Youth Mental Health Plan, the Ministry of Children and Family Development (MCFD) commissioned a review of the mental health system to assess the effectiveness of this plan, the gaps existing in the services, and to recommend further improvement (MCFD, 2008). One of the recommendations of the Child and Youth Mental Health Plan of 2003 was the development of a Ten Year Mental Health and Substance Use Plan. Since 2003, there has also been an increasing need to address adolescent substance abuse. Therefore, the Child and Youth Mental Health Services review of 2008 recommended that the MCFD be included in the Ten Year Mental Health and Substance Use Plan to ensure those youth who present with concurrent disorders and require services from both Ministries are adequately supported (MCFD, 2008).

In response to community pressure in regards to inadequate treatment options for at-risk, treatment-resident adolescents, the Secure Care Working Group (SCWG) was appointed to discuss the issue of secure care in the province of British Columbia in February of 1998. The group was mandated to offer their opinion to the provincial government in regards to whether secure treatment options should be developed for high-risk adolescents (Wijnsma-Bil, 2005). Dr. Roy Holland, the clinical director of the MATC was included as part of the 10-member SCWG. The final report from the SCWG offered that the primary threat to the overall well being of these high-risk adolescents is the abuse of alcohol and drugs. This risk is increased because of the lack of appropriate services and

resources provided to this at-risk group of adolescents, as well as their resistant attitude towards the help that is offered (Wijnsma-Bil, 2005).

The recommendations by the Child and Youth Mental Health Plan and the SCWG have important implications for the MATC. The MATC does not currently offer any substance abuse services to the youth who are treated residentially, despite acknowledgement from the government that there is a growing need to address this issue. As well, the issue of substance abuse affects most of the at-risk adolescents at the MATC. Although the MATC could offer prevention or addictions services specifically on site, it is recommended that the MATC consider consulting with an outside agency for delivery of these services. For some of the programs offered at the MATC, such as the Response Program, the targeted population is young adolescents who are still being adequately treated within the community. For these youth, it is recommended that their high-risk of becoming involved with substances be considered during the Care Plan meeting, and that follow-up services within the community be presented as an option to combat their growing risk of substance abuse.

However, for those youth who are enrolled in the Dala or Crossroads programs, which includes a lengthier stay at the MATC, it is recommended that substance abuse services be provided on an outpatient basis in the community. The MATC staff would coordinate with the community service to ensure that the youth attends their meetings as scheduled. Drug treatment services would be an important component to this residential treatment unit, and harm minimization

approaches may be appropriate for some older adolescents (Morton, et al., 1999).

8.5 The Importance of Transiting for At-Risk Adolescents

Another recommendation presented by the Task Force in Victoria, B.C. involved the issue of youth from the age of 19 to 25, who are not adequately supported in their transition into the adult care services. Services need to be developed in this area to support emerging adults, as, “this safety net gap can have lifelong consequences for youth who are already marginalized” (Municipal Government of Victoria, 2007, p. 25). It is especially important to support at-risk adolescents through transition periods where high levels of disturbance and stress may extend beyond the individual’s coping ability (Morton, et al., 1999).

It was also recommended that adolescents be provided with follow-up and transition services upon discharge to ensure that they are supported through their return to the community. This will guarantee their sense of connectedness with the staff at the residential facility is maintained (Hillan, 2005), which will help to support the youth through their transition to the community. Although the MATC does offer the Care Plan to assist in the transition from the MATC program back into the community, this is only prevalent within the Response Program. Those individuals who are residing at the Crossroads program do not have the same level of support during their transition, especially those who are not being held voluntarily, and there are very limited respite services to assist in the transition.

8.5.1 Transiting into the Community

The literature on residential treatment programs continues to demonstrate that antisocial behavior is not reduced through traditional treatment approaches, and that community-based treatments are a necessary component of successful treatment (Carter, Blood, & Campbell, 2001). Community-based treatments can be provided as an alternative to residential treatment or as a follow-up for longer intervention at the completion of residential treatment (Carter, et al., 2001). Therefore, an important aspect of the MATC approach is that it offers the Care Plan to further support the adolescent upon completion of their assessment at the MATC. The Care Plan has great potential to ensure the youth is adequately supported within their community upon discharge from the MATC. However, often in northern and rural communities, the community resources available to the adolescent may be lacking and may be unable to offer the supports delineated by the MATC Care Plan.

One of the ways a similar program has adjusted to the lack of community supports upon discharge is to develop Regional Teams that offer follow-up support for at-risk youth within the communities. The Provincial Youth Treatment Program (PYTP) operating in New Brunswick is modeled on the Response Program at the MATC, with one modification. The PYTP has Regional Teams, which represent the health regions within the province and are composed of mental health, social services and educational supports (Carter, et al., 2001). The mandate of the PYTP Regional Teams is to provide expertise to the local communities in regards to conduct disorder as a mental illness. The Regional Teams are also the primary resource for local communities and are gatekeepers

for admission to the PYTP (Carter, et al., 2001). Throughout the youth's stay at PYTP, the Regional Teams continue to support the youth's case within the community and develop community resources for the youth upon discharge.

8.5.2 Respite Services

Although offering adequate community supports is ultimately an issue that needs to be combated by the community and provincial government, one way that MATC supports their discharged youth is through offering respite services. Morton et al. (1999) recommends the use of short-term detainment if there is immediate and substantial risk that the relationship between the at-risk youth and their family is deteriorating. Respite services also helps to ensure that residential intervention can be utilized to support the adolescent if the environment in their community begins to negatively impact their behavior. Although the Response program offered at MATC offers both a Care Plan and respite services, the Crossroads program has yet to implement these options. It is recommended that the Crossroads program delineate resources to ensure the implementation of respite services for those individuals who are released from the MATC as voluntary patients.

Another form of respite is to allow the youth to continue attending the day program upon discharge, and in the case of MATC, this would include continued attendance to the Maples Secondary School. This allows the youth to maintain a connection to the residential unit and their staff, as well as continue with their educational program until the youth is settled within their community. Therefore, it is recommended that when the youth leaves the residential treatment centre,

they will continue to attend the day program when possible and remain in contact with staff to continue these relationships (Morton et al., 1999).

One of the challenges of providing respite services is that it needs to be formulated so that the youth does not experience the break as a rejection from their family or community. Respite is important when relationships are vulnerable and /or still being established. However, respite must be provided in such a way as to benefit both the primary caregiver and the youth. If respite is designed with only the primary caregiver's needs in mind, the adolescent may experience rejection by the caregivers (Price, 2001). However, respite if designed for both parties, the breathing space provided may benefit both the adolescent and the caregiver. One of the ways in which the Response program at the MATC has combated this challenge is to pre-arrange respite weeks prior to the transition to the community. This way, the respite break is offered, which may be necessary to ensure that the developing relationships are maintained, but no one experiences rejection, as the respite services are offered prior to a breakdown of the relationship (Price, 2001). Framing the respite services in this way allows this service to help prevent the environment within the community from deteriorating, instead of being utilized as a crisis service.

Morton et al. (1999) discuss the difficulty in transitioning from the residential experience back into the community, especially once positive attachment relationships have developed for the youth during their treatment experience. Although the use of respite services is very common at the MATC in the Response Program, it is less common in the Dala program and not offered in

the Crossroads program. Considering the potential of respite services to help ensure the development of a positive attachment between the youth and their community, the recommendation of extending this service should be considered by the MATC.

8.5.3 From the Youth System to Adult Social Services

The Child and Youth Mental Health Plan of 2003 also addressed the issue of transitioning services between the adolescent to adult mental health services. Despite this, 80% of professionals surveyed in the Child and Youth Mental Health Services review of 2008 discussed how this problem had not change or had worsen since implementation of the Plan in 2003. One of the at-risk adolescent populations that is specifically affected by the transition from adolescent to adult mental health services are those that are diagnosed with ADHD and/or conduct disorder. The adult mental health system maintains a focus on axis I psychotic and mood disorders, including schizophrenia, depression, and bipolar disorder (MCFD, 2008). However, many of the at-risk youth who are transitioning into the adult system have issues with ADHD or conduct disorder, which is not as recognized within the adult system, leaving these individuals without sufficient support. This is specifically important to the Crossroads program at the MATC, which focuses on adolescents with diagnoses of conduct disorder and severe ADHD (MCFD, 2008).

Another issue that was raised in the 2008 review of the Child and Youth Mental Health Services discussed the arbitrary legal age between adolescence and adulthood. It is an important consideration for transitional planning to

support mentally ill individuals who are in late adolescence and may not mature as quickly as their peers. They may not be well-suited to adult mental health facilities, despite their adult age (MCFD, 2008). As well, it is very important that at-risk adolescents receive support into their early twenties, as this is an important transition period in development (Hillan, 2005). These considerations are important for the MATC programs, as their mandate only covers adolescents between the ages of 12 and 17. Therefore, upon reaching late adolescence, the MATC is no longer a service offered to at-risk adolescents, despite their potential inability to deal successfully in an adult facility. This results in a gap in the service delivery for this vulnerable group of at-risk adolescents, which needs to be addressed by the MATC and the Ministry of Children and Family Development.

8.6 Separation of Voluntary and Legally Held Clients

8.6.1 The Secure Care Act in British Columbia

The Secure Care Working Group (SCWG) was appointed to discuss secure care in British Columbia in February 1998, and they recommended that a continuum of appropriate services is available to those who are considered high-risk, as they are vulnerable to returning to their old environment even after intensive treatment is completed (Wijnsma-Bil, 2005). The final report offered by the SCWG recommended that a safe care option be implemented in British Columbia. The focus of the SCWG was strategically placed on safe care instead of secure care, as the emphasis was about ensuring the safety of this group of high-risk adolescents, compared to security measures (Wijnsma-Bil, 2005). As

well, the SCWG stressed that safe care should be considered as part of the continuum of service, along with appropriate long-term support services offered to voluntary clients at the community level, not as a last resort for these at-risk youth (Wijnsma-Bil, 2005). The SCWG offered safeguards to ensure that safe care is used only when the adolescent requires immediate assessment of their situation to ensure their safety. These safeguards include: a need to demonstrate that safe care will not further harm the youth, that safe care will not be utilized out of convenience by community supports or parents, and that safe care will promote autonomy and growth for the at-risk adolescent (Wijnsma-Bil, 2005).

The recommendations from the SCWG were used to implement the Secure Care Act in the summer of 2000, and the Premier committed to spending $10 million on implementing the safe care option (Wijnsma-Bil, 2005). One of the major questions surrounding the Secure Care Act included a debate about the effectiveness of long-term detention, and the SCWG determined that, “intrusive, restricted and institutionally-based interventions” (Wijnsma-Bil, 2005, p. 101) are ineffective in the reduction of high-risk and antisocial behavior. The SCWG recommended that interventions be “coordinated, individualized, [and] community-based” (Wijnsma-Bil, 2005, p. 101). Furthermore, one of the major criticisms of the Secure Care legislation included skepticism around the ability of involuntary detention in a secure care facility to positively impact deeply ingrained anti-social behavior of the at-risk adolescents (Wijnsma-Bil, 2005). However, a high proportion of the adolescents who are institutionalized in secure care

facilities could not be successfully treated in less restrictive, community-based programs (Carter et al., 2001). Therefore, the use of secure treatment is necessary for a small group of at-risk adolescents, although it is imperative that this intervention be evidence-based and non-punitive. Despite the fact that the idea of safe care was initiated to offer increased residential support for those adolescents who were at-risk in the community and resistant to treatment, the recommendations made by the SCWG are important for the population of adolescents who fall under the mandate of the MATC. The MATC has taken these findings into account and provides intervention through an attachment-perspective, which has demonstrated success as an evidence-based practice.

8.6.2 Mentally Ill Adolescents Involved in the Criminal Justice System

There is extensive overlap between the mentally ill population and the population of individuals involved with the Criminal Justice System. Hence, evolution in law and policy affects the health and justice systems, which are used to support these two populations. The overlap between these two systems becomes even more prominent when mental illness becomes an important factor in criminal justice proceedings (Canadian Centre for Justice Statistics [CCJS], 2003). Offenders who are deemed unfit to stand trial and/or not criminally responsible on account of mental disorder (NCRMD) often have an extensive history of psychiatric treatment. As such, there is concern that some individuals who are mentally ill are criminalized as a way to provide them with inpatient treatment to reduce their overall risk (CCJS, 2003). This also has negative consequences for both the justice and health systems, as it increases resource

demands of psychiatric facilities that may negatively impact the quality of health care for both voluntary and forensic patients. Within the MATC, an issue that has arisen on the Crossroads unit specifically involves the overlap between resources for both voluntary and involuntary clients.

Those offenders who are found NCRMD and do not receive an absolute discharge from the justice system, are sent for detention in a psychiatric facility, where appropriate psychiatric care is made available to the accused. Detention within a psychiatric facility does not mean that the accused must succumb to psychiatric treatment (CCJS, 2003). However, if the mental health of the accused deteriorates to the point where a psychiatrist can prove the accused is not able to make their own medical decisions, the mental health policy can be utilized to ensure the accused receives psychiatric care despite their initial refusal. In this circumstance, the accused will be treated under the mental health policy as an involuntary patient (CCJS, 2003).

This policy affects adolescents who held under court order for treatment at the MATC, which has been designated by the Minister of Health as an appropriate facility for the treatment and assessment of adolescents. Adolescent offenders held at the MATC are not required to succumb to psychiatric treatment when held under a court order, but when their mental health deteriorates, they can be treated as an involuntary patient under the Mental Health Act. The MATC therefore has developed into a secure care facility for at-risk adolescents who could not be adequately supported by their community mental health services and have become involved with the criminal justice system.

8.6.3 Voluntary Adolescents Treated in the Crossroads Program

Individuals who are under the age of 16 may be admitted to a designated mental health facility on the request of a guardian as long as there is one recommendation from a physician that the adolescent is mentally ill (Solomon, 1988). Although the adolescent has not given their personal approval for treatment, this is considered a voluntary admission to the mental health facility. This poses a problem specifically for programs that consider an expanded definition of mental illness, an example of which is the MATC (Solomon, 1988). The Maples Adolescent Treatment Centre is a designated provincial mental health facility that is mandated to provide treatment for adolescents who are diagnosed with a major mental illness, including conduct disorder (Ministry of Health, 1987). The criteria for a diagnosis of conduct disorder is broad and all encompassing, incorporating normalized adolescent activities such as lying, cheating, running away from home, substance abuse including tobacco, and early sexualized behavior (American Psychological Association [APA], 1987).

A consequence of relying on this broad definition of mental illness is that individuals who are not diagnosed with a traditional psychiatric illness, but demonstrate delinquent behavior are being mixed with individuals who have a major axis I psychotic or mood disorder (Solomon, 1988). This is a specific concern at the MATC, as some individuals within the Crossroads program have a diagnosis of severe conduct disorder and / or ADHD, while others have an axis I psychotic or mood diagnosis. This calls into question the ability of one facility to support these two very different at-risk adolescent populations, as well as any

negative impacts that may result from having these different populations mixed in a residential facility.

Attempting to support these two different populations within one facility presents some challenges. Hillan (2005) set out recommendations to improve the residential care experience. One of the recommendations was that at-risk adolescents should be matched for services that target their specific needs, and to ensure that they are not placed in services that are “over-restrictive or under capacity” (Hillan, 2005, p. 6) to meet their needs. This is a recommendation that should be considered by the MATC, as they currently have matched voluntary and involuntary patients in the Crossroads unit. The Crossroads program services adolescents who have been found unfit to stand trial and / or not criminally responsible on account of mental disorder (NCRMD). This unit also houses at-risk youth who are receiving voluntarily residential treatment to deal with their specific behaviors. The mixture of these two groups does not necessarily create an appropriate environment for those individuals who are at the MATC under voluntary circumstances (locked doors, high security, higher risk of victimization).

One of the main issues of mixing these populations in the Crossroads program at the MATC was that adolescents who are being held under the Criminal Justice System need to be residing on a locked unit, where as those adolescents who are voluntary are not allowed to be locked. This obviously leads to some difficulties for the voluntary adolescents. In order to combat this difficulty, the child-care counsellors remain very clear on the privileges of each of

the adolescents, and this is reviewed on a regular basis. As well, the adolescent is normally referred to their primary staff member if they want to be let off the unit, which limits mistakes being made and gives each youth the freedom to which they are entitled. Despite the good intentions of the child-care counsellors at the Crossroads unit, there are still many disadvantages and harmful consequences of attempting to treat these two different populations within one residential facility.

However, providing care to both voluntary and involuntary adolescents within the same residential facility can negative impact the behavior of the voluntary individual, who is less likely to be entrenched in their mental illness and behavior. The inclusion of both these adolescent populations within one residential facility can also cause unease and concerns for the personal safety of voluntary individuals, who are less likely to be successfully treated within such an environment (CECFW, 2008). Residential care of both voluntary and involuntary adolescents within the same facility needs to address "cross-contamination issues" that may arise (CECFW, 2008, p. 30). Especially hazardous for at-risk youth is introducing peers with substance abuse issues, as this is a common way for adolescent peers to engage one another (CECFW, 2008). The long-term consequences of providing services to these two separate populations within one residential facility include an increase in the antisocial behavior that has been modeled by antisocial peers, as well as lessening educational and social opportunities with pro-social peers (CECFW, 2008). Therefore, it is imperative that the residential services and the specific needs of voluntary at-risk adolescents are considered prior to the introduction of such services. It is

necessary that the MATC consider the negative consequences of treating both voluntary and involuntary at-risk adolescents within the same program, and that separate programs be developed to adequately support the unique needs of these two different populations.

8.7 Attention to the Unit Environment

The literature review conducted through the Youth Justice Feasibility Study assessed the usefulness of residential treatment programs that occur within an institutional or psychiatric environment. This study determined that residential programs that take place in a psychiatric or correctional institution are less able to reduce antisocial behavior among individuals at-risk. The lack of positive response from these treatment programs stems from the fact that the environment presented within the institutional setting is so different from that of the community environment to which the youth is returning (Carter, et al., 2001). This is an important consideration for MATC, as this program is housed in an institutional setting. Although two of the residential programs, the Response and Dala programs, are unlocked and offer a less institutional feel for the adolescents residing there, the Crossroads program specifically is very institutional in both its design and environment.

Hillan (2005) also recommended that further research should be completed to determine how the physical environment at the residential facility impacts the quality of intervention for at-risk adolescents. It is clear from the literature that the environment in which treatment takes place has a significant impact on the adolescent. “If the environment is shabby, unkept, and uncared for

then it is likely that young people feel this way about how they are treated by staff and the system as a whole" (Hillan 2005, p. 56). Furthermore, providing care and intervention within an institutional setting gives the physical sense of being institutionalized despite the quality and type of care provided by the service (Hillan, 2005). These are important considerations that affect the programming offered through the MATC, especially the Crossroads program, which remains a locked unit despite the fact that there are voluntary adolescents who reside there.

8.8 Initial Training of the Child-Care Counsellors

From an attachment perspective, the entire treatment experience relies on the development of a positive attachment relationship between the primary child-care counsellor and the youth. As the youth learns through the modeling and relationship experiences with their child-care counsellor, they will begin to assimilate their new experiences with their internal working model. Considering the important role of the child-care counsellor at the MATC, providing appropriate supervision, consultation, guidance, and training to front-line staff is of the utmost importance (Morton, et al., 1999). One of the most important characteristics of the MATC program is that it based on the attachment perspective. Therefore, it is very important that the front-line staff and child-care counsellors be given the skills and understanding to successfully build positive relationships and demonstrate investment with their clients, as well as how to manage these relationships within a "highly charged emotional environment" (Anglin, 2002, as cited in Hillan, 2005, p.36).

One conclusion that was drawn from the MATC program was that the child-care counsellors apply the attachment perspective in their own way and that not all child-care counsellors adequately understand the theoretical underpinnings of attachment-based intervention. One consistent example of this is the mistaken belief that attachment-based interventions equate to the adolescent not having any consequences for their behavior, as the consequences are not punitive in nature. The consequences through this perspective involve debriefing with the primary caregiver - discussing why this behavior was exhibited, and teaching the adolescent how to self-regulate their behavior or how to express their needs through communication instead of through conduct-disordered behavior.

For many of the youth, this debriefing session is much more demanding and influential than locking the adolescent in their room or removing positive experiences as a consequence. This debriefing session serves to further the understanding of that adolescent, and to teach them how to interact pro-socially to gain what they need. This is often an experience that they have not had before, as most of the parenting practices that these youth have exhibited at home are very much punitive and authoritarian or non-existent. Knowing there are consequences to their behaviors, but also that they will be supported and are expected to partake in a discussion around their behavior, is a much more beneficial experience for this youth than a purely punitive approach (Moretti et al., 2002). Of course, there are situations where safety concerns arise, and in these situations it is necessary to remove the youth from the other adolescents and the

staff to give them a chance to calm down before the debriefing process can begin.

One recommendation for the Maples Adolescent Treatment Centre would be to provide more education both for new child-care counsellors, as well as follow-up educational seminars for existing child-care counsellors in an effort to enhance the theoretical understanding of attachment-based interventions. New staff that are hired on as child-care counsellors at the MATC take part in a one day attachment-based interventions training session, which is run by Dr. Marlene Moretti. Dr. Moretti is a psychology professor at Simon Fraser University who completes all of the research at the Response Program at the MATC. However, a recommendation in regards to this initial training is that it could be expanded to a two-day seminar, perhaps having the second day run by Dr. Roy Holland, who is the father of attachment-based interventions, and who is currently employed at MATC.

8.9 Supervision of Child-Care Counsellors

As well as recommending changes for the initial training for the child-care counsellors, there is a need for more supervision and guidance for those child-care counsellors who are already employed at the MATC. Hillan (2005) recommended that staff should submit to ongoing review assessments to ensure that levels of ongoing care are consistent with evidence-based practice. Currently, if there are specific situations in which staff is having difficulty dealing with a particular behavior exhibited by a youth, Dr. Holland holds a meeting with the child-care counsellors to guide them through the experience from an

attachment perspective. These meetings provide a very clear understanding for all involved and often the child-care counsellors feel they have been supported and are better able to deal with the youth after this meeting with Dr. Holland. However, the supervision offered at the MATC needs to be expanded, as the current system does not ensure that the attachment perspective is meeting the criteria for evidence-based practice.

One of the issues addressed by the Child and Youth Mental Health Plan of 2003 was the need for appropriate clinical supervision. During the Child and Youth Mental Health Services review of 2008, it was determined that 70% of front-line staff reported relevant clinical supervision, which is a significant improvement compared to before the Plan was implemented (MCFD, 2008). However, it was still recommended in the 2008 review that clinical supervision remain a priority within the field, considering the stress and risk of front-line work, and the hiring increases as a consequence of the 2003 Plan. This is especially important given the new focus on evidence-based practice to ensure effectiveness of mental health services and programs for supporting at-risk adolescents (MCFD, 2008).

Post-hire training specifically is important and needs to be addressed by the provincial government. The Child and Youth Mental Health Services review of 2008 determined that many entry-level new employees have limited mental health experience. Therefore, they may share inaccurate public perceptions in relation to mental illness and may not have a full understanding of the evidence-based practice being implemented. Even new hires that have experience

working with at-risk mentally ill adolescents may not have experience with the newly implemented evidence-based interventions. Many of the new interventions require a shift from control to connection, and a shift in the way behavior is understood and treated by the front-line staff. Therefore, it is very important to embed the new practical changes and evidence based practices beyond just initial training events (MCFD, 2008). This is a directly applicable and important concern for the MATC, which is an evidence-based practice based on interventions from an attachment perspective. As this is still a relatively new and developing area of intervention, it is extremely important that the child-care counsellors and other front-line staff have adequate initial and post-hiring training, as well as the frequent opportunity to ask questions from professionals trained in attachment based interventions.

Therefore, the program offered at Maples Adolescent Treatment Centre as well as the child-care counsellors themselves would benefit from extended training sessions on attachment-based interventions, both when they are hired as well as throughout their employment at the Maples. Unfortunately, a challenge of increasing the training and supervision of the child care counsellors employed at the MATC is financial, as cutbacks are currently being implemented to government run programs, including at the MATC.

8.10 The Need for Increased Funding

In 2006, the British Columbia Children and Youth Review: An Independent Review of British Columbia's Child Protection System was completed, known as the Hughes Review. The recommendations from the Hughes Review included

recognizing the importance of improving services to support vulnerable children and adolescents within the province of British Columbia (Turpel-Lafond, 2007). As a result of the Hughes Review, the provincial budget of 2006 allocated $100 million to improve the continuum of services available for at-risk children and youth (Turpel-Lafond, 2007). In response to the recommendations set out in the 2006 British Columbia Children and Youth Review (the Hughes Review), the Ministry of Children and Family Development developed a provincial Framework for Children and Youth, to outline the expectations of the ministry. This Framework presents with a common vision, "B.C. Children and Youth are strong, safe, and supported to reach their full potential" (MCFD, 2007, p. 4). Attempts to reach this goal will be made through five avenues, called the five pillars: prevention, early intervention, intervention and support, the Aboriginal approach, and quality assurance.

Following the principles set out in the Framework will ensure that adolescents are supported in their development into resilient, strong and healthy adults (MCFD, 2007). The Strong, Safe, and Supported program introduced indicators of success to ensure that the five pillars were being met. The most relevant pillar for MATC was geared towards intervention and support of vulnerable adolescents. The indicators of success for this pillar included an increase in the number of adolescents in care or custody who demonstrated positive gains in their education and / or had a "secure, safe, lifelong, positive relationship" (MCFD, 2007, p. 24) with a caring adult. As these are the indicators of successful intervention and support, as listed in the Framework, it is important

that the MATC also use these factors as indicators of their own success. Thus far, the literature has been very consistent in regards to the ability of the MATC attachment-based framework to support healthy and positive relationships.

Despite the recent acknowledgement by the government that funding needs to be accessible to support at-risk youth, and the development of the Framework for Children and Youth, there remains a gap in the service delivery for these youth. The Child and Youth Mental Health Services review of 2008 acknowledged the existing gap between available resources and at-risk adolescents in need of services. According to the conservative estimates from the 2003 Plan, 10% of children experience mental health concerns, which is an estimated 97, 343 adolescents in need of services (MCFD, 2008). However, it has been estimated that only 20,000 adolescents are receiving service through the Ministry of Children and Family Development, which means that only 20.5% of adolescents are receiving the care they require from the government (MCFD, 2008). These estimates impact the MATC, as this is a secure residential treatment facility that addresses those individuals who are no longer manageable within their communities. However, if prevention and early intervention are not sufficiently applied and successful, more at-risk individuals will come into contact with the MATC, which should ideally just be utilized as a last resort.

Therefore, the government needs to ensure that the prevention and early intervention community services are strong and applicable throughout the province to reduce the impact of at-risk adolescents. This is especially important because residential services specifically were not addressed as part of the Child

and Youth Mental Health Plan of 2003. This is an important consideration because 92% of professionals approached by the Child and Youth Mental Health Services review of 2008 felt the mental health system did not have an adequate continuum of residential services and had not improved since implementation of the Plan in 2003 (MCFD, 2008). The 2008 review recommended several options for dealing with this oversight, including residential services that could be offered throughout the province as a bridge between day programs and residential programs at the institutional level (MCFD, 2008). This would also help to reduce the number of referrals to the MATC, and to ensure at-risk adolescents who are experiencing moderate difficulties dealing with their mental illness and high-risk behavior do not fall through the cracks.

Despite the relatively recent acknowledgements from the government that service delivery for at-risk adolescents and their families' needs to be more important when considering funding, the MATC continues to experience a lack of funding. Hillan (2005) reported that the residential care services offered in British Columbia have become more focused on budgets and political pressure, rather than research and the specific needs of those most at-risk within the population. There has been a great decrease in the amount of residential services utilized within the province, but this decision was made as a result of budget cuts and political philosophy, instead of academic research and opinion (Hillan, 2005).

The lack of funding has significant impacts on the programs offered at the MATC and has resulted in the loss of the recreational program offered to the residents of the MATC, as well as the discontinuation of any specialized services

(such as art therapy). Another area that is affected by the financial strain includes the respite services, which are only offered consistently in the Response program, neglecting the Dala and Crossroads programs. Respite services are extremely important in the successful maintenance of benefits achieved in residential intervention (CECFW, 2008). However, funding cutbacks and restrictions obstruct the successful delivery of respite services, which often have the ability of preventing a serious setback for an at-risk adolescent, their family and their community. Offering adequate respite services when they are needed is also important for reducing the reliance on tertiary prevention and risk reduction services (CECFW, 2008), which ultimately require additional funding.

8.10.1 Multiple Opportunities for Attachment

The Adolescent Placement Research Project analyzed the literature and related programs in an effort to design an adolescent system of services for at-risk adolescents who present with specific needs making them difficult to place (Price, 2001). A key principle that was recognized in this design was the importance of connection as a protective factor against high-risk behaviors. More specific factors to consider in relation to connection included: strengthening relationships between youth and family, youth and staff, and youth and peers, as well as balancing the need for adolescent autonomy with support and guidance (Price, 2001). This can be successfully completed by providing multiple opportunities to connect; a buffer is developed, which acts as a protective factor, so when one of the relationships weakens, the youth can drawn on other sources for support (Price, 2001). As well, “young people with extreme levels of

disturbance often have limited experience with satisfying recreational activities and tend to gravitate towards entertainment that will compound their problems" (Morton, et al., 1999, p. 97).

Therefore, it is especially important that residential facilities offer the opportunity to build multiple connections and connections outside of the direct placement setting, through education, employment and recreational activities (Price, 2001). One way of offering new environments in which to build these multiple connections is through the development of a weekend recreational and adventure program (Morton, et al., 1999). However, considering the lack of funding received by the MATC, opportunities such as these will not be available in the foreseeable future.

9: CONCLUSION

Although attachment theory is psychological in nature, and has been primary attributed to negative life outcomes from a psychological perspective, attachment also has important implications for the criminological discipline. The first interpersonal relationships experienced by an infant are with their primary attachment figure, and the quality of these relationships is very important for the healthy development of the child (Ainsworth, 1982). This mutually interacting environment leads to the development of an internal working model of interpersonal relationships (Ainsworth, 1982; Bowlby, 1973). The internal working model of the self and others forms the basis for the social behaviour of that individual in the context of interpersonal relationships (Bartholomew & Horowitz, 1991). These interactions set the foundation for pro-social and healthy future development when secure attachment is exhibited; however, unsuccessful bonding increases the risk for future antisocial behavior and psychiatric dysfunction (Marcus & Betzer, 1996).

The internal working model of interpersonal relationships is developed through infancy and childhood, but extends to relationships outside of the family during adolescence, when the importance of the peer group increases. When the internal working model represents interpersonal relationships in a negative manner, maladaptive attachment strategies are developed and are generalized to all interpersonal relationships experienced by the youth. As well, the youth may

develop a hostile view of others, which is also influential in guiding the behaviors exhibited by that youth (Bartholomew & Horowitz, 1991). The internal working model concept is especially important for understanding conduct-disordered behaviour as an extension of the attachment strategies utilized by this youth. This conceptualization has direct treatment implications, as can be demonstrated through the MATC, which has shown promise during preliminary research (Moretti, et al., 1994). By addressing the early relationships exhibited between the child and their parents, attachment theory can be used to help explain both positive and negative development and how this impacts future development and interactions through childhood (Ainsworth, 1982; Lyons-Ruth, 1996) and into adolescence and adulthood (Bartholomew & Horowitz, 1991).

The MATC has implemented interventions based on an attachment perspective. Although the MATC programming has continued to demonstrate treatment success, recommendations have been presented that are drawn from the first-hand practicum experience of working as a child-care counsellor in the Crossroads program. Recommendations presented to the MATC include: an increased focus on the development of a practical skills set, offering appropriate peer support and opportunities, and collaborating with an outside agency to provide addictions services. As well, it is important to strengthen the transition services to better serve the adolescents upon discharge, create separate units for voluntary and involuntary clients in the Crossroads program, increase the attention being paid to the unit environment, and strengthen the training and supervision of child-care counsellors. Finally, in order to consider implementation

of the recommendations outlined, there is a need for increased funding for the MATC programs. Overall, attachment theory provides theoretically supported intervention techniques and can aid in increasing healthy and pro-social familial interactions, thus reducing the symptomatology of conduct disorder and the future risk of delinquency (Moretti, et al., 1994). Attachment theory is important for the study of crime and its development as well as for providing direct prevention and intervention techniques for clinicians working with at-risk youth, especially those with co-occurring mental illness.

LIST OF RECOMMENDATIONS

1. Provide a full continuum of services for the development of practical skills, including life-skills training, interpersonal skills training, and appropriate vocational opportunities.
2. Facilitate appropriate peer relationships at the MATC complex and in the community to ensure that life-skills and interpersonal skills are practiced with peers, and to facilitate the development of secure attachment relationships with peers.
3. Provide substance abuse counseling through collaboration with an outside agency, if necessary.
4. Increase the services to aid in transitioning youth into their communities, and for those entering the adult system; offer appropriate respite services for all MATC programs.
5. Ensure the separation of voluntary and legally held residents in the Crossroads program.
6. Increase the specific attention paid to the physical environment within the units.
7. Adjust the initial training of the child-care counsellors to ensure that a solid understanding of attachment-based interventions is achieved.

8. Increase the supervision of the child-care counsellors to ensure appropriate follow-up of initial training and to aid in the development of the practical skills necessary to work from an attachment perspective.
9. Adjust the funding for the MATC to ensure that all services are appropriately staffed, and to increase the ability to provide multiple opportunities for attachment.

APPENDIX

Attachment Concepts from the Connect Parenting Program

1. All behavior has meaning
   - Behavior as a form of communication about attachment needs
2. Attachment is for life
   - Recognition that attachment needs continue throughout development
3. Conflict is part of attachment
   - Parent-child relationships experience conflict, especially during adolescence
4. Secure Attachment: A balance between connection and independence
   - Development of adolescent autonomy requires parental availability / support
5. Growth involves moving forward while understanding the past
   - Understand current internal working models and strive to adjust them
6. Understanding growth, and change begins with empathy
   - Understand the role of empathy for secure attachment in the parent-child dyad
7. Relationships include being connected & independent: maintaining balance is key
   - Adolescence means developing a new sense of self and relationships, while maintaining and drawing support from prior relationships
8. Attachment brings job and pain
   - Joy through connection and pain through conflict and change
9. Attachment means trusting the relationship; adversity is a learning opportunity
   - Change is not easy or straightforward – *expect* setbacks, adjust motivation

As cited in Osbuth et al. (2006, p. 10)

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