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### Treatment of Choice or A Last Resort? A Review of Residential Mental Health Placements For Children and Adolescents

Karen Frensch

*Wilfrid Laurier University*, [kfrensch@wlu.ca](mailto:kfrensch@wlu.ca)

Gary Cameron

*Wilfrid Laurier University*, [camerongary@wlu.ca](mailto:camerongary@wlu.ca)

Gerald R. Adams

*University of Guelph*

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#### Recommended Citation

Frensch, K., Cameron, G. & Adams, G. (2001). Treatment of Choice or A Last Resort? A Review of Residential Mental Health Placements For Children and Adolescents (Rep., pp.1-66). Waterloo, ON: Wilfrid Laurier University, Partnerships for Children and Families Project.

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# Partnerships for Children and Families Project

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of Residential Mental Health Placements  
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K. Fensch  
G. Cameron  
G. Adams

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Karen M. Frensch, M.Sc., Project Manager, Partnerships for Children and Families Project,  
Wilfrid Laurier University, Waterloo, Ontario, N2L 3C5

Gary Cameron, Ph.D., Professor, Faculty of Social Work,  
Wilfrid Laurier University, Waterloo, Ontario, N2L 3C5

Gerald R. Adams, Ph.D., Professor, Dept. of Family Relations and Applied Nutrition,  
University of Guelph, Guelph, Ontario, N1G 2W1

## **Treatment of Choice or A Last Resort? A Review of Residential Mental Health Placements For Children and Adolescents**

### **What is Residential Treatment?**

A unique challenge to reviewing the literature on residential treatment is the lack of consensus around common characteristics that define residential treatment (Lyman & Wilson, 1992). The term residential treatment has had such diverse definitions that include a broad range of placement settings from group homes for 8-10 children or adolescents located within neighbourhood communities to institutional programs for 100 children or adolescents in facilities isolated from the community. However, the common denominator is that treatment requires children and adolescents to reside away from their natural homes. Residential treatment has been defined in the following ways:

“A 24 hour facility not licensed as a hospital that offers mental health treatment programs for mentally disturbed children” (Tuma, 1989, p.193)

Residential treatment emphasizes “group living while also providing special education and recreation programs, psychological and psychiatric services, and work with parents and families of children in care” (Mishne, 1986, p.301)

“While providing the basic care needs of children and adolescents, residential treatment also concentrates on delivering therapeutic services to residents” (Bates, English, & Kouidou-Giles, 1997, p.9)

“Residential treatment centres are psychiatric organizations that provide children with individually planned mental health treatment in conjunction with residential care” (Sholevar, 1995, p.319)

Residential treatment has its roots in child welfare, the juvenile justice system, and the

mental health system (Sholevar, 1995; Yelton, 1993). Many residential treatment programs began as orphanages in the non-profit, non-government sector often with a religious affiliation. They were built on the premise of providing surrogate care and the assumption was to “provide these disturbed children with enough, good enough, care they will be able to overcome the damage done in their families and lead more successful lives” (Durrant, 1993, p. 6).

Residential treatment programs that originated in the juvenile justice system were either institutions operated by the state, often called youth training centres, or programs devised by other organizations as alternatives to correctional facilities. The emphasis in the juvenile system was on providing control as many residents had a history of out of control behaviour. The assumption was to impose consistent external control on youth so as to internalize that control in the form of acceptable behaviour (Durrant, 1993).

The mental health sector fostered residential treatment programs that focused on the treatment and cure of an allegedly identifiable pathology. These programs were usually more structured and professional in appearance and entailed a variety of individual, group, family and milieu therapy programs. According to Durrant (1993), contexts in which residential treatment programs developed seems largely a result of historical or funding determinants and the children and adolescents in each of these systems are more than likely very similar.

### **A Continuum of Residential Treatment**

In order to understand the types of treatment available to children and adolescents, and the level of restrictiveness that accompanies these treatments, mental health services are often placed on a continuum of restrictiveness to children and families. Residential treatment, in particular,

generally falls into an area on the continuum that is characterized as more restrictive with the assumption that the more restrictive, the more intense the treatment (Bates et al., 1997). For example, treatment provided in foster care should be less intense than treatment provided by either residential treatment homes or inpatient hospitalization. However, there are variations in both restrictiveness and intensity at various points on the continuum. In reality, some residential programs may be less restrictive than some foster care programs. This poses further difficulty in clearly defining what characterizes residential treatment. What follows is the general order of residential care from least to most restrictive.

### Foster Care

Foster care provides on a daily basis a home-like environment with minimal overall restrictiveness for the re-education of children and adolescents (Fahlberg, 1990). There is seldom an intensive treatment focus. Instead, the underlying philosophy to foster care is the exposure to an acceptable home environment that has the potential to correct problems. Placement in foster care can involve extended periods of time from one month to upwards of fifteen years. There are generally no more than four or five children living in a foster home and this can include the natural children of the foster parents. Children or adolescents in foster care usually continue to attend public school.

Therapeutic foster care is a specialized type of care in which foster parents are regarded as the primary agents of therapeutic change. Care is usually provided to only one or two children concurrently by foster parents with training in youth service with emotionally disturbed children. Parents receive training in treatment skills that include establishing a therapeutic environment, designing and implementing a treatment plan, and monitoring therapeutic progress (Bates et al.,

1997). Parents also receive intensive ongoing supervision or support from professional staff and fellow foster parents.

### Group Homes

A group home has the superficial appearance of a family house, however, it is differentiated from foster care by the number of children in one home (from 8 to 12 children). In addition, a formal treatment program or philosophy is usually evident. The length of stay in a group home can range from one month to a number of years.

According to Fahlberg (1990), there are generally two types of group homes: (1) homes managed by house parents who live on site and are available 24 hours to no more than eight children or adolescents; and, (2) homes staffed by caregivers who work shifts. In both cases, children and adolescents in the group home are either of the same age range or have the same underlying condition.

### Residential Treatment Centres

Residential treatment centres utilize fully the concept of milieu therapy in which daily living is used for therapeutic benefit (Fahlberg, 1990). In most facilities, there is a well defined treatment philosophy or program coupled with 24 hour care provided by a variety of professionals such as child care workers, teachers, social workers, psychologists, and nurses.

Residential programs are usually more isolated from the community and are less like a child's natural environment than a group home or foster home. School and leisure activities are generally provided within the facility and children still engage in normalizing activities.

The size of a residential program can vary up to 100 children; however, children or adolescents usually belong to functional units of up to 15 persons that are housed separately. The

length of residential treatment can range from three months to a number of years.

### Inpatient Hospitalization

Inpatient or psychiatric hospitalization is often used for emergency placements such as a suicide crisis or psychotic episode (Fahlberg, 1990). Treatment takes place within either an identified hospital or a medical setting such as a psychiatric facility. Under the direction of a physician, treatment is commonly administered by a nursing staff. Inpatient hospitalization is extremely dissimilar to children's natural environments as there is little to no opportunity to engage in normalizing activities such as playing outside or bedroom tidying. Hospitalization is shorter in duration from one week to a year.

Also under the guise of hospitalization is long term institutional treatment in which length of stay is measured in years. Institutional treatment is extremely regimented and offers little personal freedom to patients. Treatment facilities are isolated from the community by attitude and physical location (Lyman, Prentice-Dunn, Wilson, & Taylor, 1989). There is marked de-emphasis of patients' re-entry back into the natural environment.

### **Focus of the Paper**

According to a review of residential treatment and its alternatives (Bates et al., 1997), there are several defining characteristics common to U.S. residential treatment programs: a de-emphasis of a medical model of pathology; a moderate length of treatment (up to 2 years); the therapeutic use of the daily living milieu; the staffing of fewer medical professionals than in psychiatric facilities; the use of a multi-disciplinary, team-based approach; and, the exclusion of psychotic or highly suicidal children and adolescents. Most residential treatment programs



provide several modalities of therapy, including a combination of individual, group, and family therapy. Commonly, the placement of children or adolescents in residential treatment is in response to a crisis situation or a series of acting-out episodes (Mishne, 1986).

Our primary focus is a review of residential treatment options that emphasize the treatment of children and adolescents in a group milieu and support the re-entry of children and adolescents back into their natural environment. Residential treatment programs reviewed herein can be generally identified by the following characteristics: the possession of a formal treatment program or philosophy; employment of agency personnel as treatment staff; and, the provision of on-site schooling for at least some of the residents. As a result, our review captures the portion of the residential continuum that is marked by (1) residential treatment centres, and (2) group homes of four or more children. Our focus does not include residential treatment options that involve individual treatment only, such as individual foster care. Nor does it encompass inpatient hospitalization or institutionalized treatment in which little to no emphasis is placed on returning children or adolescents to their natural environment.

Our survey of residential treatment begins with an overview of some of the elements that comprise residential treatment. These are milieu therapy, a description of physical facilities, the role of treatment staff, on-site schooling, and frequently used models of treatment. In an effort to understand the context in which residential treatment operates, a discussion of recent issues and controversies in the domain of residential care is also undertaken. We then review characteristics common to children and adolescents in residential treatment, as well as their families, to obtain a clearer sense of the populations served by these programs.

The second half of our review is an effort to summarize what is currently known about the

effects of residential treatment for children and adolescents. The information is organized into two sections: studies of the effectiveness of group home residential treatment and studies of the effectiveness of residential treatment delivered in residential treatment centres. In both areas, we have attempted to identify trends within treatment as well as patterns found in the literature that characterize post residential treatment adaptation. We have also included a discussion of several additional factors that appear to share a relationship with residential treatment outcomes crossing both short-term and long-term trends. We conclude our review with suggestions for future directions in residential treatment for children and adolescents.

## **Characteristics of Residential Treatment**

### Milieu Therapy

Early theorists such as Redl and Wineman (1952 as cited in Lyman & Campbell, 1996) identified the goal of residential treatment as providing a therapeutic milieu in which everyday events could be turned into corrective experiences. These corrective experiences are intended to offset some of the damaging experiences that these children and adolescents presumably have endured (Lyman & Campbell, 1996). Corrective experiences in residential treatment enable children and adolescents to recognize problems and conflict, to develop communication skills and self control, and to learn problem solving skills. The primary instrument and vehicle for milieu therapy is the human interactions that occur within the residential program (Sholevar, 1995).

Many early residential programs relied on a psychoanalytic perspective which emphasized the separation of a child from the so-called pathogenic family environment (Lyman & Campbell, 1996). Children's and adolescents' maladaptive behaviours often stem from inconsistent, unstable,

and chaotic relationships and family environments, and as a result, the uniqueness of residential treatment rests on the premise that the stability and consistency of the therapeutic environment offered by residential treatment is critical to child and adolescent adjustment (Lyman & Campbell, 1996). Residential treatment exposes children and adolescents to adaptive experiences that they have presumably missed in growing up. Children and adolescents are dealt with in a therapeutic and corrective—rather than a reactive—manner. Behaviour is handled with insight, tolerance, and support for its correction (Sholevar, 1995).

### Residential Facilities

The therapeutic milieu requires the presence of a comprehensive care climate in which the basic needs of children and adolescents are met on a continuous basis, as well as a physical setting that provides safety. Residential treatment proposes to offer safety and health to residents by guaranteeing their physical and psychological safety. Physical safety is ensured through the design of the environment and delivery of necessary provisions. Residential facilities may be a traditional house with minor modifications, as in the case of smaller group homes, or larger structures built specifically for housing residents and equipped with child proof windows and secure time out rooms (Lyman & Wilson, 1992).

Psychological safety encompasses building trust with residents and treating children and adolescents in fair and humane ways (Lyman & Campbell, 1996). Residential treatment programs also adhere to the protection of children and adolescents' rights. In residential settings which impose some impediments on an individuals' ordinary freedoms, the protection of children's rights includes the right of access to family and friends, freedom from undue invasion of privacy, and preserving confidentiality of the child and family (Lyman & Campbell, 1996).

## Residential Treatment Staff

Residential treatment programs generally employ child care and professional staff such as psychiatrists, psychologists, social and child and youth workers. Residents spend a large portion of their stay engaging in group living for which the staff provide a structured environment constituting the therapeutic milieu. Patterns of staffing can differ from rotating 8 hour work shifts to “living in” for an extended period of time (Powers, 1980). Child care staff usually provide 24 hour care for residents and are often the final agent of observation and intervention in residential treatment facilities (Sholevar, 1995).

For treatment to approach success, a coordinated effort is required on the part of the entire child care staff. Observations of residents by child care staff are systematically recorded and shared with professional staff to inform the treatment plan and monitor treatment progress. Frequent communication among staff members assists in arriving at an understanding of a child in order to enhance therapeutic staff-child interactions. In addition, effective inter-staff communication is necessary to help the total staff work as a cohesive group in providing integrated interventions. According to Powers (1980), “there must be a strong, prevailing therapeutic attitude throughout the staff, one based on self-understanding as well as on an understanding of the dynamics and needs of any particular child. There must also be an understanding of the group needs of staff as well as children” (p. 5).

The amount of education, selection, and training of child care staff varies from one type of residential treatment program to the next. Child care work is often described as a marginal, low status occupation in terms of salary, education, and power (Mishne, 1986). Frequently child care workers have high expectations placed on them; however, they tend to receive the least

recognition and are the first to be blamed when something goes awry (Powers, 1980).

### Educational Component

Many residential treatment programs provide on-site schooling to their residents. According to Sholevar (1995), on-site schooling is usually required to enhance both the supervision of children and adolescents and the communication between educational and therapeutic staff. An academic component to residential treatment can facilitate children and adolescents' progress toward adequate emotional adjustment, self-sufficiency, and future employment. Furthermore, the learning and interpersonal opportunities provided by an academic component can be used to improve children and adolescents' self-esteem, to increase their motivation to learn, and to acquire adaptive skills.

Residential school teachers are generally skilled in special educational assessment and special training techniques. Ideally there is a low student to teacher ratio in residential treatment classrooms. Residents are commonly uneven in their academic performance and, as a result, the need for flexible curriculum and individual academic treatment plans is paramount (Mishne, 1986). Teachers need to be involved in individual case planning to determine, for example, whether a resident should be placed in a one-to-one educational setting or a group class.

The relationship between teachers and residents frequently assumes a therapeutic quality similar to that of the child care worker; however, the therapeutic implications of learning are often underestimated and the teacher's role in nurturing, therapeutic, and limit-setting can be overlooked (Mishne, 1986). Ideally teachers should be equipped with sufficient knowledge about a resident's behaviour and background to make informed observations in the classroom that will facilitate an understanding of a child or adolescent's current dysfunction (Sholevar, 1995). As

such, teachers require access to residents' records and communication with other treatment team members via routine discussions and attendance at case conferences.

## **Models of Treatment**

Residential treatment programs can also be characterized by the adherence to a particular theoretical orientation. A program's theoretical orientation shapes the primary intervention techniques used to treat children and adolescents (Lyman et al. 1989). In the literature, there are several theoretical models of residential treatment that receive the most discussion. What follows is a brief description of four theoretical models and their defining elements.

### The Psychoanalytic Model

The residential treatment of children and adolescents using a *psychoanalytic model* addresses both the internal workings of the resident and the internal workings of the family (Stamm, 1989). "Psychoanalysis as a therapeutic process is predicated on the idea that becoming consciously aware of the memories, thoughts, feelings, and fantasies stored in the unconscious will lead to a working through of unconscious mental conflict, thus producing symptomatic relief and release from emotional suffering" (Stamm, 1989 p.27). As a result, this model often includes individual psychotherapy for residents as well as offering family therapy (Lyman & Wilson, 1992). Modes of psychotherapy used in residential treatment include intensive individual psychotherapy with a child, group therapy with selected children, and group or individual therapy or both for parents (Lewis & Summerville, 1991). The psychiatric team is considered the pivotal treatment agent and generally consists of a psychiatrist, a psychologist, and one or more social workers.

The basic elements of the psychoanalytic model, as articulated by Bettelheim (1950, 1974

as cited in Lyman & Wilson, 1992), include isolation of children and adolescents from their families, the primary role of psychoanalysis in treatment, and the resolution of internal dynamic conflicts. “The goal of treatment is to foster the development of basic ego skills and capacities such as reality testing, anxiety tolerance, and trust in others” (Stamm, 1989 p.28).

The psychoanalytic model appears to be most suited for highly verbal children from middle class backgrounds with emotional difficulties rather than conduct disorders. The model has not proven to be effective with children of non-middle class backgrounds, limited verbal ability, and behaviour disorders that appear to be rooted in maladaptive social learning (Lyman & Wilson, 1992).

### The Behavioural Model

The limited applicability of the psychoanalytic model to certain populations led to the search for alternative approaches, in particular, to the application of laboratory based learning principles to address human psychological problems. The emphasis of a *behavioural treatment model* is on children’s and adolescents’ overt behaviour. “Remediation of these behaviours consists of systematic management of positive and negative consequences or control of stimulus-response pairings in accordance with established learning principles” (Lyman & Wilson, 1992, p. 835). Maladaptive behaviours are viewed as resulting largely from past learning experiences (Lyman & Campbell, 1996). As a result, residential treatment programs that employ a behavioural model tend to use various types of external motivational systems, also known as token systems or token economies, that encourage each child to learn new, appropriate behaviours in exchange for privileges.

Within the behavioural model, child care workers are viewed as the primary treatment

agent in contrast to the importance of the therapeutic team in the psychoanalytic model. The inherent restrictiveness of residential settings allows behaviourists greater environmental control and greater opportunities for direct observation of reinforcement patterns than community-based alternatives (Lyman & Campbell, 1996). However, in criticism of the behavioural model “the ultimate purpose of residential and inpatient treatment is to improve functioning in the home environment, not merely to control behaviours in the residential setting” (Lyman & Wilson, 1992, p. 839).

### The Psychoeducational Model

A variation of the behaviour model, the *psychoeducational model* teaches more appropriate behaviours and coping skills to children and adolescents (Lyman & Wilson, 1992). “The teaching of competent and appropriate behaviour is in itself a constructive response to a child’s problems and may well lead to generalized improvement in behaviour” (Lewis & Lewis, 1989, p. 97). In particular this model emphasizes the learning of specific skills, rather than stimulus-response patterns, that appear to be needed for children to cope with their own families, schools, and neighbourhoods.

Community involvement and continued contact between the child and the family is emphasized, where possible. Instead of asking ‘what causes deviant behaviour in a child?’, the psychoeducational model considers ways to increase the competence among all members of a child’s ecological unit or natural behaviour settings. Ideally, changes in a child’s ecology would facilitate the support of a child’s growing competencies and provide greater opportunity for full development (Lewis & Lewis, 1989). As a result, the psychoeducational model appears to be successful in promoting the generalization of treatment effects to the home environment and to



have applicability to a broad range of client types and clinical conditions (Lyman & Wilson, 1992).

### The Peer Cultural Model

A *peer cultural model* to residential treatment recognizes the importance of interpersonal factors in therapeutic programming. The therapeutic potential of a residential program's peer subculture was first recognized by early theorists such as Polsky (1962 as cited in Lyman & Wilson, 1992) who posited that peer influences are often of far greater significance to children in residential treatment than the efforts of staff. The peer cultural model to treatment is intended to enlist peer support for positive behaviours. The model relies heavily on formal and informal group discussions as well as group control of rewards and privileges. The effectiveness of this model comes from confrontation and feedback from other residents in group discussions.

The composition of the group of children at any one time is also of importance (Redl, 1966 as cited in Lyman & Wilson, 1992). The peer group provides information about a resident's strengths and weaknesses and children continually compare themselves with their fellow residents on various characteristics such as honesty, intelligence, and aggressiveness. The peer group acts as a therapeutic agent through the use of group problem-solving methods, use of group contingencies and reinforcement, and reliance on formal group meetings and therapy. In the peer cultural model, children usually play a pivotal role in determining their own goals and in the evaluation of their progress.

### **Issues and Controversies in Residential Treatment**

Residential treatment has been generally characterized as an extremely invasive

intervention given that residing outside of the natural home environment affects not only the child but disrupts the entire family. As a result of both public policy and professional preference, residential care has been regarded as a treatment of last resort since the advent of the least restrictive environment treatment principle in the mid 1970s. The goal of deinstitutionalization and a strong normalization philosophy in public health has further lead residential treatment to become a last resort (Elson, 1996). Given that residential treatment is offered as a last resort, Elson (1996) contends that “children and adolescents who need residential treatment are the losers when they are forced to fail a variety of outpatient services prior to being referred” (p. 34). Furthermore, “much residential work has reflected ideas of children being damaged or disturbed, children possessing some problem or pathology, or parents being incompetent or deficient” (Durrant, 1993, p. 12).

The reality of having a child in residential treatment often amplifies a family’s sense of failure. According to Goldberg (1991), families experience varying levels of guilt associated with having “failed the child in the eyes of the community”(p.1) and guilt associated with a sense of relief from having to minister to a child’s excessive needs. “Sadly, children are often taken to residential programs in much the same way that cars are taken to workshops. The family understandably wants them to be repaired; however, the successful repair may confirm their lack of expertise” (Durrant, 1993, p. 13). In addition when a child is placed in residential treatment, the perceived threat by a program and its staff on a family’s autonomy, coupled with the exposure of family idiosyncracies during treatment, can leave a family feeling vulnerable and fearful (Goldberg, 1991).

Residential treatment has also been plagued by negative perceptions of the quality of life

during placement. The general sentiment toward residential treatment has become increasingly suspicious and hostile (Chamberlain & Friman, 1997). A commonly held belief is that the relationship between residents and staff is by nature adversarial. Children and adolescents frequently not exposed to the degree of adequacy, sensitivity, and consistency of care provided by staff often rebel against it by testing the limits of the staff and program (Sholevar, 1995). Furthermore, the negative perceptions of authority often held by children and youth entering residential treatment can lead to resistance rather than cooperation in treatment. Admittedly, adversarial postures between staff and residents can and do occur (Mishne, 1986). However, it is often the relationship between residents and staff that facilitates positive outcomes for children and adolescents. In particular, the influence of supportive staff in the areas of teaching new skills and providing supervision has been shown to contribute to successful child adjustment. Low supervision has been associated with poor school achievement and negative peer relationships (Dishion, 1990 as cited in Chamberlain & Friman, 1997).

According to Bates et al (1997), a challenge to determining when residential treatment is an appropriate treatment is the lack of guidelines and diagnostic tools to make this determination. Evidence suggests that clinicians use widely differing standards when assessing whether or not residential treatment is warranted. As a result, children in the most restrictive setting are not that dissimilar to those in the least restrictive residential setting. Often because of a scarcity of resources, the decision to place a child or adolescent depends on where there is an opening available rather than matching the treatment program's characteristics to the family's needs (Bates et al., 1997).

Undoubtedly, residential treatment has been influenced by the broader social, economic,

and political contexts in which it operates. Public policy makers have used the high number of children and youth in costly out-of-home placement as argument for the funding of community and home-based alternatives. At the same time, child advocates argue that more intensive services be made available to the growing number of children and youth with special needs who require care outside of the home. Residential treatment programs have the challenge of contending with this double message.

### **Characteristics of Children and Adolescents in Residential Treatment**

The paradigm shift in social policy from institution-based service to a family-centred, community-based system of care has impacted on the characteristics of children found in residential care as well as the expectations of treatment providers. Increasingly, residential treatment programs are being asked to address the needs of very troubled children and adolescents (Yelton, 1993). “Although we cannot determine if youths are more disturbed than in the past, study data document that at least this sample of youths do indeed have severe, diverse, and diffuse problems, have significant deficits in their social competencies, and have failed in other treatment programs” (Wells & Whittington, 1993, p. 214). The problems these children and adolescents experience have far reaching implications affecting future personal, social, and financial well-being of individuals themselves as well as their families and communities (Quinn & Epstein, 1998).

Table 1 provides an overview of the population characteristics described in each of the studies reviewed for this paper. In the sections to follow, we provide a summary of the salient characteristics identified by this research and highlight selected findings.

**Table 1: Characteristics of Children/Adolescents and Families Using Residential Treatment Programs**

Source	Facility/Program	Method	Population Characteristics
Lehman & Irvin (1996)	<ul style="list-style-type: none"> <li>•100 parents of children with emotional and behavioural problems were recruited through the Oregon Family Support Network data base.</li> </ul>	<ul style="list-style-type: none"> <li>•Self administered survey</li> </ul>	<p><u>Support Networks:</u></p> <ul style="list-style-type: none"> <li>•Formal support (e.g. from paid professionals and organizations) was received by nearly all families; whereas, informal support (e.g. from family, friends, parents with similar children, and community groups) was received by just over half of sample.</li> <li>•Most helpful item of support was transportation (tangible).</li> <li>•Most frequently reported source of formal organizational support were schools.</li> <li>•44% of families received support from their family doctor.</li> </ul>
Lewis (1988)	<ul style="list-style-type: none"> <li>•Cumberland House School in Nashville, TN</li> <li>•Program under umbrella of Project Re-Ed, a nationwide application of the psycho-educational model.</li> <li>•Sample consisted of 82 former residents who were voluntarily admitted to the program during 1983 and 1984.</li> </ul>	<ul style="list-style-type: none"> <li>•Follow up ratings of post-discharge adjustment made by same liaison teacher-counsellor (LTC) responsible for monitoring student's and family's progress during treatment.</li> </ul>	<p><u>Child Characteristics:</u></p> <ul style="list-style-type: none"> <li>•Average age 9.6 years old</li> <li>•26% had formal contact with juvenile court</li> <li>•27% had earlier been in residential treatment</li> <li>•Average length of stay was 7 months</li> </ul> <p><u>Family Composition:</u></p> <ul style="list-style-type: none"> <li>•24% living with natural parents</li> <li>•25% with natural parent and step-parent</li> <li>•41% with single parent</li> <li>•10% in adoptive or foster homes</li> </ul> <p><u>Clinical Factors:</u></p> <ul style="list-style-type: none"> <li>•Average family had experienced 2-3 major family disrupting problems (divorce, abuse, physical or mental illness)</li> </ul>

<p>Moore &amp; O'Connor (1991)</p>	<ul style="list-style-type: none"> <li>•Warrenstown House Children's Centre, Blanchardstown, County Dublin</li> <li>•14 beds; on-site schooling, • Program adheres to milieu therapy with an emphasis on group process</li> </ul>	<ul style="list-style-type: none"> <li>•Retrospective file review of 123 cases</li> </ul>	<p><u>Child Characteristics:</u></p> <ul style="list-style-type: none"> <li>•72% males; 28% females</li> <li>•Average age while in residence 12.4 years old</li> <li>•Most residents were diagnosed as 'conduct disorder'</li> <li>•Average length of stay 6-9 months</li> </ul> <p><u>Clinical Factors:</u></p> <ul style="list-style-type: none"> <li>•Parental or family psychiatric histories were noted in 45% of the cases reviewed</li> <li>•36% of children were not able to return home to live with their families.</li> </ul>
<p>Quinn &amp; Epstein (1998)</p>	<ul style="list-style-type: none"> <li>•238 case files of children and adolescents in large suburban county outside of Chicago referred to interagency program.</li> </ul>	<ul style="list-style-type: none"> <li>•Retrospective file review</li> </ul>	<p><u>Child Characteristics:</u></p> <ul style="list-style-type: none"> <li>• 80% of cases were school-identified special ed students, &amp; majority of these were identified as serious emotional disturbed (SED)</li> <li>•31% were clinically depressed (DSM Axis I)</li> <li>•30% experiencing moderate to severe stress (DSM Axis IV)</li> <li>•30% had major impairments in global functioning (DSM Axis V)</li> </ul> <p><u>Family Composition:</u></p> <ul style="list-style-type: none"> <li>•46% from divorced family; parental rights had been qualified in 50% of families</li> </ul> <p><u>Clinical Factors:</u></p> <ul style="list-style-type: none"> <li>•Families evidenced histories of alcohol &amp; drug abuse (61.5%), family violence (58.9%), mental illness (36.3%), and criminal activity (26.1%)</li> <li>•80% of youth had been previously placed out-side of home at least once &amp; avg. number of placement being 4.</li> </ul>

<p>Quinton &amp; Rutter (1984a)</p>	<ul style="list-style-type: none"> <li>•The sample consisted of 48 families living in an inner London borough who had children admitted into residential care from the maternal home within an 8 month period (with a minimum of 2 admissions into care for any child in the family)</li> <li>•A comparison sample of 48 families was used.</li> </ul>	<ul style="list-style-type: none"> <li>•Retrospective reporting in individual interviews.</li> <li>•Questionnaires</li> </ul>	<p><u>Financial Characteristics:</u></p> <ul style="list-style-type: none"> <li>•Frequent housing moves for in-care families were noted.</li> </ul> <p><u>Clinical Factors:</u></p> <ul style="list-style-type: none"> <li>•There was a significant difference between experimental and comparison groups in expressed warmth and sensitivity to their children.</li> <li>•60% of in-care group had at least 4 children (only 5% in comparison).</li> <li>•65% of in-care mothers had received psychiatric treatment at some point (vs. 9% for comparison).</li> <li>•Cohabitees of mothers with children in care were generally more socially deviant than control group partners with over half of the partners interviewed being in prison or on probation.</li> </ul> <p><u>Support Networks:</u></p> <ul style="list-style-type: none"> <li>•In-care group families were less likely to have close relationships with near relatives and more likely to have strained relationships with them.</li> </ul>
<p>Quinton &amp; Rutter (1984b)</p>	<ul style="list-style-type: none"> <li>•The sample consisted of 48 families in a London borough who had a child admitted to residential care during an 8 month period ('in-care' group) and a comparison group of 47 families from the same borough. Both groups had a child at home between 5 and 8 years old.</li> </ul>	<ul style="list-style-type: none"> <li>•Mothers and their current cohabitees were interviewed and data were collected on their present circumstances, life histories, marital relationships, psychiatric adjustment and parenting methods.</li> </ul>	<p><u>Clinical Factors:</u></p> <ul style="list-style-type: none"> <li>•25% of in-care mothers had been in care themselves with only 7% of comparison group.</li> <li>•3X as many in-care mothers than comparison mothers suffered harsh discipline from one or both parents during childhood.</li> <li>•Current 'fathers' of the in-care group were more likely to have had deviant histories and current psychiatric disorder than fathers in the comparison group.</li> <li>•55% of in-care group fathers had been in prison or on probation (The number of in-care fathers interviewed was small due to high proportions of single parent families and low interview success rates).</li> </ul>

<p>Savas, Epstein &amp; Grasso (1993)</p>	<ul style="list-style-type: none"> <li>•The sample of 608 males between the ages of 12 and 18 were residents of Boysville's Clinton Campus, Michigan who were released from program between Jan 1/1984 to Dec 31/1988. Boysville is committed to a family-centred therapy approach. Intensive family therapy is integral part of the treatment program.</li> </ul>	<ul style="list-style-type: none"> <li>•Retrospective file review.</li> </ul>	<p><u>Child Characteristics:</u></p> <ul style="list-style-type: none"> <li>•Average age was 15.5 yrs.</li> <li>•Average length of stay was 12.4 months.</li> <li>•48% were white, 47% were black, 3% were Hispanic.</li> <li>•50% of sample had one or two felonious adjudications prior to placement, and 37% had three or more felonies on their court record.</li> </ul> <p><u>Family Composition:</u></p> <ul style="list-style-type: none"> <li>•63% of study population were from single parent families.</li> </ul>
<p>Silver, Duchnowski, Kutash, Friedman, Eisen, Prange, Brandenburg, &amp; Greenbaum (1992)</p>	<ul style="list-style-type: none"> <li>•The sample consisted of children identified and served by the public mental health and special education systems as seriously emotionally disturbed (N=812) and their parents (N=740) from the National Adolescent and Child Treatment Study.</li> <li>•Youth were from 94 special education programs and 27 residential sites in Colorado, Wisconsin, New Jersey, Alabama, and Florida.</li> </ul>	<ul style="list-style-type: none"> <li>•At the site of placement, youth were interviewed individually, case records were reviewed, and the teacher who knew the youth best completed two behavioural checklists describing their behaviour.</li> <li>•After youth data collection, the parent or guardian was interviewed by telephone.</li> <li>•The youth's mother was the respondent of choice.</li> </ul>	<p><u>Child Characteristics:</u></p> <ul style="list-style-type: none"> <li>•The mean age of the sample was 13 yrs 11 mths.</li> <li>•The sample was 75% male and predominantly white (71%).</li> <li>•Mean age of onset for emotional or behavioural problems was 6 yrs 3 mths with boys having earlier onset than girls.</li> <li>•66.9% of the sample met diagnostic criteria for conduct disorder followed by anxiety and depression.</li> <li>•The residential group had more instances of past residential placement, foster placement, and contact with mental health and juvenile justice systems than the school group.</li> </ul>



Timbers (1990)	<ul style="list-style-type: none"> <li>•The study was conducted using data from 184 children who had been admitted to one of three therapeutic foster treatment programs, either “People Places”, “Professional Parenting”, or “PRYDE” located in Pennsylvania, USA.</li> </ul>	<ul style="list-style-type: none"> <li>•Retrospective file review</li> </ul>	<p><u>Child Characteristics:</u></p> <ul style="list-style-type: none"> <li>•Average age of first removal from home was 8.8 years combined across the three programs.</li> <li>•Child’s placement in these programs was not the first, with average number of placements being 3.8(People Places), 4.7(Professional Parenting), and 2.5(PRYDE).</li> <li>•Most children experienced multiple problems, with the average number of problems being 7.4 (People Places), 11.3 (Professional Parenting), and 6.2 (PRYDE).</li> </ul> <p><u>Clinical Factors:</u></p> <ul style="list-style-type: none"> <li>•In each of the three programs, over half of the children had been victims of physical abuse.</li> </ul>
Wells & Whittington (1993)	<ul style="list-style-type: none"> <li>•A private, non-profit mental health facility that serves 80 children considered to be severely emotionally disturbed</li> <li>•Primary treatment modality is milieu therapy</li> <li>•Sample was 111 youths referred to facility from June 1985 to May 1986 who had never been referred to the facility before and were between the ages of 10 and 17 with an IQ of 66 or higher</li> </ul>	<ul style="list-style-type: none"> <li>•Child and family functioning was assessed using CBCL, FACES III, and FILE.</li> <li>•Interviews of adult caretakers were also conducted.</li> </ul>	<p><u>Child Characteristics:</u> •Average age 14.5yrs.</p> <p><u>Financial Characteristics:</u> •Median family income: \$13,936/annual</p> <p><u>Family Composition:</u></p> <ul style="list-style-type: none"> <li>•51% of youths were crown wards; only 14% of youths lived with both biological parents.</li> </ul> <p><u>Clinical Factors:</u></p> <ul style="list-style-type: none"> <li>•Study youths had more severe problems and less competencies than comparative clinical and non-clinical samples.</li> <li>•Study youths had problems at early age, used extensive array of services over life course, and had been in “crisis” over last year.</li> <li>•32% of boys and 47% of girls could not be classified into diagnostic category using CBCL as scale scores were uniformly too high.</li> <li>•Families of study youth are less cohesive and adaptable and experience more stress than do non-clinical families.</li> <li>•56% of families said they had problems with abuse in their families.</li> </ul>

<p>Wells, Wyatt, &amp; Hobfoll (1991)</p>	<ul style="list-style-type: none"> <li>•An un-named urban multi service mental health agency for children</li> <li>•The sample consisted of 50 youths who had been in residential treatment for at least 6 months and had been discharged from the program between 1985 and 1988. Youth had been discharged from the program for a minimum of 12 months and no longer than 36 months.</li> </ul>	<ul style="list-style-type: none"> <li>•Youth were interviewed using questions with pre-structured response formats.</li> <li>•Four standardized scales were administered during the interview.</li> <li>•Data were also collected from youths' case records at the agency.</li> </ul>	<p><u>Child Characteristics:</u></p> <ul style="list-style-type: none"> <li>•58% were boys</li> <li>•86% White; 14% Black</li> <li>•Average age at admission was 14.8</li> </ul> <p><u>Family Composition:</u></p> <ul style="list-style-type: none"> <li>•1/3 had parents who were married</li> <li>•46% were in custody of a county department at the time of admission.</li> </ul>
<p>Whitaker, Archer &amp; Hicks (1998)</p>	<ul style="list-style-type: none"> <li>•A study of children's homes within the public sector of England funded by Social Services Departments, located in local authorities. From 6 to 16 children and youth were looked after in the homes located in residential neighbourhoods.</li> </ul>	<ul style="list-style-type: none"> <li>•A 3 year longitudinal study of the challenges facing those who work with and in children's homes. The study included interviews and discussions with staff and to a lesser extent residents.</li> </ul>	<p><u>Child Characteristics:</u></p> <ul style="list-style-type: none"> <li>•Children experienced a range of behavioural and emotional problems: chaotic behaviour and poor impulse control (threatening and harming others, destroying property, etc.), continual offending, and inappropriate sexual behaviour.</li> <li>•Children's "care careers" included multiple placements in a succession of children's homes, foster homes, and occasional stays with their parents.</li> </ul> <p><u>Clinical Factors:</u></p> <ul style="list-style-type: none"> <li>•Children entered homes for various reasons including: crisis situation, disturbance in living arrangements, physical and/or sexual abuse by family member.</li> <li>•Relationships with parents were described as difficult by residents (acute state of parent-child conflict, rejection by parents).</li> </ul>

<p>Whittaker &amp; Maluccio (1988)</p>	<ul style="list-style-type: none"> <li>•A review article that summarizes, among other studies, a 2 year analysis of the characteristics of 10,000 children placed in residential care in California between 1982 and 1984.</li> </ul>	<ul style="list-style-type: none"> <li>•Review Article</li> </ul>	<p><u>Child Characteristics:</u></p> <ul style="list-style-type: none"> <li>•83% of all children in out-of-home care had multiple problems at the time of placement (this included specific acts committed by the child as well as physical and psychological problems present prior to placement).</li> </ul> <p><u>Family Composition:</u></p> <ul style="list-style-type: none"> <li>•52% of these children came from single-parent families.</li> </ul> <p><u>Clinical Factors:</u></p> <ul style="list-style-type: none"> <li>•An ‘inability to control the child in the home’ accounted for 65% of all placement factors classified as ‘deficiencies in parenting’.</li> </ul>
<p>Whittaker, Tripodi &amp; Grasso(1993)</p>	<ul style="list-style-type: none"> <li>•The sample consisted of 239 youths released from Boysville’s Clinton Campus, Michigan.</li> <li>•Boysville is committed to a family-centred therapy approach.</li> <li>•Intensive family therapy is integral part of the treatment program.</li> </ul>	<ul style="list-style-type: none"> <li>•Descriptive analysis from retrospective file review.</li> </ul>	<p><u>Child Characteristics:</u></p> <ul style="list-style-type: none"> <li>•Average age 15.53 years.</li> <li>•52.7% white; 47.3% black</li> <li>•type of referral: 3.3% juvenile court; 33.9% CAR, 28.5% DSS-CCRA; 33.9% DSS-other; 3.3% public mental health facility; 1.7% group home, 3% other.</li> <li>•Mean number of previous placements was 0.99.</li> </ul> <p><u>Family Composition:</u></p> <ul style="list-style-type: none"> <li>•63.5% of sample came from single parent families (32% divorced, 9.3% separated, 9.3% widowed, 12.9% unmarried)</li> <li>•36.4% came from two parent families.</li> </ul> <p><u>Clinical Factors:</u></p> <ul style="list-style-type: none"> <li>•15.5% of sample were reported by workers as having been either physically or sexually abused (however for over 60% of the cases, this determination could not be made.)</li> </ul>

## Child and Adolescent Characteristics

A review of the literature on the characteristics of children and adolescents who use residential treatment suggests that there is a general agreement that the majority of these children are plagued by multiple and concurrent comorbid problems such as behaviour problems, school problems, and troubled relationships. In addition, there appears to be a pattern of repeated and unsuccessful use of services with frequent out-of-home placement being common among this group.

Children and adolescents with serious emotional disturbances account for a significantly disproportionate percentage of placements outside of the home (Quinn & Epstein, 1998). These youth generally have multiple problems at the time placement is made and often experience multiple placements (Jenson & Whittaker, 1989). In a sample of 184 children in three treatment homes located in Pittsburgh, PA, demographic data revealed that, with the exception of three children, all of these children had at least one prior out-of-home placement (Timbers, 1990). The average number of placements combined was 3.6 placements with the first removal from the home of origin occurring on average around 8.8 years of age. In addition, most children experienced multiple problems. The average number of problems across the three treatment programs was 6.2, 7.4, and 11.3 with verbal/physical aggression, school difficulties, and poor self-concept being among the most frequently reported.

Youth can enter residential treatment through multiple pathways (family, physician, Children's Aid, or court referrals) and not all residents are entering a more restrictive treatment setting as the treatment-of-last-resort would suggest. In particular, a study of 239 youths released from Boysville Michigan in 1984 and 1985, by Whittaker, Tripodi, and Grasso (1993)

revealed that 30.1% of sample youth entered residential treatment from their homes while 50.6% came from prior group home living. Similarly, in their study of prior use service characteristics of youth referred to residential treatment, Wells and Whittington (1993) reported that 96% of the study sample had used at least one service in the past, with outpatient therapy being used most frequently (83%). Furthermore, when use was restricted to out-of-home placements, only a small minority had never used out-of-home placements. In contrast, 36% had used 1-2 placements, 33% had used 3-5, and 23% had used anywhere from 6 to 23 out-of-home placements (Wells & Whittington, 1993).

Although there is no definitive classification of the children and adolescents who find themselves in residential treatment, Whitaker, Archer, and Hicks (1998) identify several characteristics of children and adolescents that residential treatment staff are likely to encounter. In their direct observation and discussion with residents in six homes ranging in size from 6 to 16 persons, Whittaker and colleagues reported chaotic behaviour and poor impulse control among residents including proneness to harm others, destroy property, and make physical threats. Difficult relations with parents, from acute states of parent-child conflict to rejection by parents, were also described by residents. Some residents were known to engage in inappropriate sexual behaviour and persistent and continual offending (Whittaker, Archer, & Hicks, 1998). Indeed, Savas, Epstein, and Grasso (1993) reported that, of their sample of 608 young men between the ages of 12 and 18 who were released from the Boysville Michigan program during a four year period, 50% had one or two felonies and 37% had three or more. Only 13% of their sample had no documented history of prior legal offenses.

In a comparison of 812 children and adolescents with serious emotional disturbance

served in 27 residential treatment programs and 94 special education programs, children in residential treatment were more likely to be diagnosed with attention deficit disorder, conduct disorder, or anxiety than children in the school settings (Silver et al. 1992). In addition, residents were more likely to have received psychotropic medication and be rated as exhibiting higher levels of internalizing and externalizing behaviours than non-residents. Residents also showed poorer adaptive behaviours than non-residents.

Most residential treatment programs have eligibility criteria in which particular behavioural or emotional problems are targeted; however, these problems tend to be defined using fairly vague terms such as school behaviour problems or peer relationship difficulties (Lyman et al. 1989). Indeed, Wurtele, Wilson, and Prentice-Dunn (1983) noted that non-compliance and academic difficulties were the most serious child behaviour problems observed upon entry into residential treatment in their study of children placed in 15 residential treatment programs in Alabama (as cited in Jenson & Whittaker, 1989). The majority of children observed by Wurtele and colleagues were functioning at least one year below their grade level and harboured serious problems in impulse control and communication skills.

### **Characteristics of Families with Children or Adolescents in Residential Treatment**

A review of the literature on families with children in residential treatment appears to indicate that there are some characteristics that generally are found to be common to these families. Children in residential treatment often come from single parent or blended families marked by poverty, residential instability, and an absence of natural support networks. In addition, the studies reviewed tend to support a generational pattern of psychiatric difficulties,

family violence, and substance abuse within families of children in residential treatment.

### Family Composition

Troubled youth often come from reconstituted families (one biological parent and the parent's current partner or relative), single-parent families, and adoptive families (Wells & Whittington, 1993). Only a small proportion of troubled youths reside with both biological parents: "intact nuclear families are a distinct minority among families served by systems of care" (Quinn & Epstein, 1998, p. 107). Many of the youths found in residential treatment are either in the custody of the county or parental custody is qualified by the local or state government (Quinn & Epstein, 1998). In their sample of 48 families with children in care, Quinton and Rutter (1984a) reported that just over half of the families were single parent households lacking any father figure. In addition, of those families with two parents, a third of the mothers' current cohabitees were not the father of any of the children (Quinton & Rutter, 1984a).

The lives and experiences of troubled youth are often characterized by long term residential instability and the resulting difficult family relationships (Quinn & Epstein, 1998). In a comparison study of children and adolescents in either residential care or special education programs, children in residential care were more likely to have come from blended families than special education children. They were also more likely to have come from low-income households, have previously lived outside the home, and to have abuse mentioned in their records (Silver et al., 1992).

### Financial Characteristics

Children and adolescents in residential treatment often come from impoverished families and frequent housing moves are a common feature of these families. In their examination of

characteristics of youth referred to residential treatment, Wells and Whittington (1993) reported a mean family income of \$13,936 for these families in comparison to \$26,720 for the average US family (1987 US Census data). In a comparison of social status and housing, Quinton and Rutter (1984a) reported 52% of families with children in care had lived in their current home for less than one year in comparison to only 12% of their comparison sample. In addition, nearly half of their sample of in-care families had overall housing disadvantages marked by unsatisfactory sleeping arrangements for their children or severe problems with structural housing deficits (poor heating, no hot water) compared with only 7% of the comparison group (Quinton & Rutter, 1984a).

### Clinical Factors

A significant proportion of families with troubled youths evidence histories of alcohol and drug abuse, family violence, mental illness, and criminal activity. These factors are widely believed to put children and adolescents at risk for poor adjustment (Quinn & Epstein, 1998). Families of troubled youths are found to be less cohesive and adaptable than nonclinical families (Wells & Whittington, 1993). In addition, these families experience more stress and report not being satisfied with how well their troubled child/adolescent can be managed at home. According to Jenson and Whittaker (1989), the most frequent condition in a family's history that led to placement was an inability to control children in the home.

According to Cates (1991), children referred to residential treatment facilities share a common set of family characteristics. Multiple foster home placements, biological father absent from the home of origin, and a biological mother experiencing a major psychiatric illness characterize this group of children (Lyman & Campbell, 1996). The rates of psychiatric disorder



among mothers with children in care are several times higher than those obtained in the general population (Quinton & Rutter, 1984a). Nearly two-thirds of their sample of mothers with children in care had been under psychiatric treatment at some time (Quinton & Rutter, 1984a). Moreover, 78% of interviewed mothers with children in care were assessed as having some form of current debilitating psychiatric problem (such as depression, anxiety, personality disorder).

In their study of parents' early adversity and current family difficulties, Quinton and Rutter (1984b) compared 48 families with a child placed in care within the last 8 months (in-care group) and 47 families with a child in the home between the ages of 5 and 8 years old (comparison group). All families lived within the same borough of London, England. One quarter of in-care group mothers had been in care themselves as children or adolescents compared with only 7% of comparison mothers. The majority of in-care mothers reported suffering harsh discipline from one or both parents as a child. Two times as many in-care mothers than comparison mothers had left home by the age of 19 and were pregnant at that age. The current fathers of children in care were more likely to have had deviant histories and current psychiatric disorders. Families with children in care were living in conditions that were socially and materially much less satisfactory than families in the comparison group. In addition, current parenting breakdown was associated with marital difficulties and marked psychiatric problems in one or both parents (Quinton & Rutter, 1984b).

### Support Networks

Children and adolescents in residential treatment are mostly individuals who cannot function in the family of origin without outside assistance or support (Whittaker & Maluccio, 1988). However, families of children in residential treatment generally lack natural helping

networks and sources of support in the community (Jenson & Whittaker, 1989). In particular, families with children in care are considerably less likely to have close relationships with near relatives and considerably more likely to have strained relationships with them (Quinton & Rutter, 1984a). In a study of 48 mothers with children in care, only 23% reported seeing their parents at least weekly and 28% reported that they felt their family was a close one. This was in comparison to 51% and 67% respectively in a matched sample of families with no child in care (Quinton & Rutter, 1984a).

In the same study, 71% of mothers with children in care reported that they wished there was someone to whom they could turn for help with practical matters (such as babysitting and lending clothing or money) compared with only 15% in a comparison sample. However, over 50% reported having someone that they could confide in (discuss personal difficulties with) such as a spouse, relative, or friend (Quinton & Rutter, 1984a). Similarly, Lehman and Irvin (1996) reported that in their sample of 100 parents of children with emotional or behavioural problems, parents most frequently relied on family members when they needed someone to talk to about their daily concerns.

### **A Review of Residential Treatment Outcomes for Children and Adolescents**

This section of our paper is an effort to summarize what is currently known about the effects of residential treatment for children and adolescents. There are several questions that are of interest to us. What can be said about the short-term and long-term effects of residential treatment? Previous research suggests that long-term effects of residential treatment tend to be diluted by time and are less encouraging than short-term patterns of success. What factors are

found to be linked with more successful child and family outcomes? And equally important, what factors remain unclear or ambiguous in the effectiveness of residential treatment? Many studies point to the positive effect that family involvement in residential treatment has on the progress children make in treatment, as well as in the maintenance of post-treatment adjustment, while characteristics of residents share a more ambiguous relationship with residential treatment outcomes. Also, are there differences in outcomes for residents of larger institutional residential treatment centres in comparison to residents of smaller group home settings? We suspect that, given the trend toward treatment in the least restrictive setting, children and adolescents treated in smaller group home settings fair better than children and adolescents serviced by larger residential treatment centres. However, does the literature support this notion or perhaps indicate an alternate pattern of effect?

To date, knowledge about the effects of residential treatment remains largely based on a few early, yet influential, studies. Most authors agree that there has been a general lack of progress in the evaluation of residential services (Chamberlain, 1999; Curry, 1991; Lyman & Campbell, 1996; Whittaker & Pecora, 1984). The recent emphasis on treatment for children and adolescents in the least-restrictive-environment and a lack of sufficient funding for well-designed outcome studies have been said to contribute to the stagnation of residential outcome research (Curry, 1991). Moreover, studies of the effectiveness of residential treatment have been plagued by serious methodological flaws. In general investigations of residential treatment outcomes often rely on single sample studies with a small number of participants, rudimentary statistical analysis, and subjective outcome criteria with which to assess the effectiveness of treatment. A review of some of the methodological challenges unique to the study of residential treatment may help to

address these issues.

### Limitations of the Existing Research

Lyman and Campbell (1996) outline several weaknesses to the existing literature on the effectiveness of residential treatment which we have included here. According to Lyman and Campbell, studies of residential treatment often fail to adequately specify or verify components of treatment. Generally, information around the implementation of a program is scarce and descriptions that are provided can be vague, making any attempts at program replication less than accurate. Although there have been some advancements in the documentation of program descriptions and implementation procedures, what remains unclear is what constitutes intervention in residential treatment (Quay, 1986). In milieu treatment, it is difficult to specify what the service unit consists of and which element of the treatment is having a differential effect. Lyman and Campbell also suggest that treatment components are described in an ideal way with no confirmation that the actual program is carried out in this way. As a result, the effectiveness of properly implemented treatment procedures may be underestimated.

Another concern is that many evaluation designs have no identifiable feature beyond the reporting of some measure after treatment has ended or the use of pre and post measures of functioning. These types of studies tend to produce conclusions that are restricted to which children or youth within a program made improvements. Furthermore, such designs do not take into account residents' maturation during the time of treatment or the natural course of a disorder further limiting the usefulness of the evaluation (Chamberlain, 1999). In the same vein, Whittaker and Pecora (1984) argue that the selection of outcome criteria itself can be problematic in that outcomes of residential treatment are often measured using subjective clinical judgements of

success or a narrow range of criteria such as grades in school or recidivism of which the treatment program itself has little control over.

In many cases, the use of statistical methods to evaluate a residential program is inappropriate as the number of residents in any one program at one time is modest. Experimental studies often require the random assignment of individuals to various treatment conditions. In reality, residents are rarely assigned randomly to treatment programs or control groups. Assignment to a particular program is more often based on where an opening is available and the severity of a child or adolescent's difficulties. As a result of both ethical and practical concerns, residential outcome research often uses comparison group designs in which different approaches to treatment are evaluated comparatively (Whittaker & Pecora, 1984). In addition, Quay (1986) argues that studies of differential treatment for children and adolescents are lacking. In the placement of children and adolescents and in the evaluation of residential treatment, matching the type of residential treatment with child characteristics is a level of complexity not often achieved or assessed (Chamberlain, 1999; Wells, 1991).

As we acknowledge the presence of methodological flaws in the study of residential treatment, we refrain from making any definitive conclusions about the effectiveness of residential treatment and caution readers to do the same. Instead, our focus is on identifying reasonable patterns of outcomes to residential treatment for children and adolescents that emerge from the reviewed literature. We have organized the information into (1) studies of the effectiveness of group home residential treatment; and, (2) studies of the effectiveness of residential treatment delivered in a more restrictive setting, in particular, residential treatment centres. In both cases, we have attempted to summarize trends within treatment as well as patterns found in the literature

that describe post residential treatment adaptation. We have also included a discussion of several additional factors that appear to share a relationship with residential treatment outcomes crossing both short-term and long-term trends.

Table 2 provides an overview of the effects of residential treatment for children and adolescents described in each of the studies reviewed for this paper. In the sections to follow, we have incorporated previous reviews of residential treatment, as well as available reports on individual studies, placing more emphasis on studies of well-known models of residential treatment and studies with stronger scientific method.

### **Residential Treatment in a Group Home Setting**

In reviewing the literature, studies of the effectiveness of residential treatment offered in smaller group home settings appear to be outnumbered by studies available on treatment outcomes for larger residential treatment centres. The literature on group home residential treatment for children and adolescents has been largely dominated by the study of one well-known model of group home residential treatment, the teaching family model. Consequently, our review of residential treatment outcomes in group home settings focuses on the study of the teaching family model.

Residential treatment using the teaching family model utilizes a trained child care couple, known as ‘teaching parents’, who live with a small group (up to 6) of 10 to 16 year old youths (Quay, 1986). Residents of the teaching family model are generally plagued by multiple behavioural and emotional problems and often have repeated involvement with juvenile authorities. Youth exhibit a wide range of presenting problems such as severe withdrawal, non-

**Table 2: Residential Treatment Outcome Studies**

Source	Facility/Program	Method	Outcomes
Blotcky & Lichtenstein (1986)	<ul style="list-style-type: none"> <li>•An unnamed 12 bed residential facility treating children ages 7-12 years old</li> <li>•A high educational staff-to-pupil ratio is utilized (1 special education teacher and 2 child care workers for 12 students).</li> <li>•Teacher is key member of treatment team.</li> <li>•Psychoeducational</li> </ul>	<ul style="list-style-type: none"> <li>•22 children were given Peabody Individual Assessment Test (PIAT) at admission and discharge to estimate their current functioning in mathematics, reading, and spelling.</li> <li>•PIAT gain scores were used as an indicator of educational program outcome.</li> </ul>	<p><u>Short-Term:</u></p> <ul style="list-style-type: none"> <li>•The average PIAT gain score indicated the program accomplishes 1 year's academic gain over a 1 year interval.</li> </ul>
Burks (1995)	<ul style="list-style-type: none"> <li>•Edgewood Children's Centre, St. Louis, MO is a 'comprehensive child care institution serving the needs of emotionally disturbed children aged 5-17.</li> <li>•Program elements include therapy, education, and recreation.</li> </ul>	<ul style="list-style-type: none"> <li>•Information was gathered from the case records of 37 children discharged in 1991/1992.</li> <li>•Data included individual characteristics of each child, the participation of the child's family while in treatment, and the circumstances of the child's discharge.</li> <li>•Follow up telephone interviews with caregivers were conducted 6 months after the child's discharge.</li> </ul>	<p><u>Short-Term:</u></p> <ul style="list-style-type: none"> <li>•18 children were seen as having maintained a positive outcome at 6 month follow up; 19 were seen as negative outcomes.</li> <li>•An outcome was positive if a child was still placed at the location to which s/he was discharged and was not involved in trouble with peers or authority figures.</li> </ul> <p><u>Long-Term:</u></p> <ul style="list-style-type: none"> <li>•Post discharge placement (either family, foster/adoptive home, or other) was the only variable found to be significantly related to outcomes.</li> </ul>

<p>Day, Pal &amp; Goldberg (1994)</p>	<ul style="list-style-type: none"> <li>•Earls court Child &amp; Family Centre, Toronto, ON is an 8 bed residence serving conduct disordered children ages 6-12.</li> <li>•The program is based on social learning and a behavioural systems model of treatment.</li> </ul>	<ul style="list-style-type: none"> <li>•Questionnaire data was obtained from 37 children who were residents between 1986-1990. Data consisted of demographic information, child and parent functioning, and the Child Behaviour Checklist (CBCL).</li> </ul>	<p><u>Short-Term:</u></p> <ul style="list-style-type: none"> <li>•There was a significant decrease in the number of children within the clinical range on the CBCL at discharge (80% of the children were in the clinical range at admission).</li> </ul> <p><u>Long-Term:</u></p> <ul style="list-style-type: none"> <li>•At 6, 12, and 24 month follow ups, CBCL scores were significantly lower than at admission, although scores remained comparable to those at discharge.</li> </ul>
<p>Garrett (1985)</p>	<ul style="list-style-type: none"> <li>•Institutional and community residential programs.</li> <li>•The majority of treatments took place in institutional settings accounting for 81.1% of the studies included.</li> </ul>	<ul style="list-style-type: none"> <li>•A meta-analysis of 111 controlled studies that assessed the effectiveness of residential treatment for delinquents completed between 1960 and 1983.</li> </ul>	<p><u>Short-Term:</u></p> <ul style="list-style-type: none"> <li>•Across treatments, settings, and outcome measures, the treated group performed at a level +.37 standard deviations above the untreated group.</li> <li>•Recidivism was modestly reduced.</li> <li>•Institutional adjustment, psychological adjustment, and academic performance were all improved following treatment.</li> <li>•Cognitive-behavioural interventions, family therapy, and 'Outward Bound' programs showed notable positive changes.</li> </ul>



<p>Giacobbe &amp; Traynelis-Yurek (1992)</p>	<ul style="list-style-type: none"> <li>•Elk Hill Farm, Virginia is a private institution for boys ages 13-17 which employs a peer group model based on Bendtro's Positive Peer Culture.</li> <li>•Program components include peer group process, parent involvement, special education, physical fitness, and adventure/challenge activities.</li> </ul>	<ul style="list-style-type: none"> <li>•Changes in attitudes of 130 boys at Elk Hill Farm were measured using the Jesness Behaviour Checklist (JBC) at admission and discharge.</li> <li>•The JBC assesses self perception of change and measures 14 bipolar behavioural tendencies to produce a composite attitude score.</li> </ul>	<p><u>Short-Term:</u></p> <ul style="list-style-type: none"> <li>•All of the 14 factor scores on the checklist were reported as having a statistically significant change in the direction of healthy growth (e.g. friendliness, responsibility, sociability) from admission to discharge.</li> <li>•The greatest differences between admission and discharge scores were observed on obtrusiveness, conformity, and rapport.</li> </ul>
<p>Hoagwood &amp; Cunningham (1992)</p>	<ul style="list-style-type: none"> <li>•A study of 114 children and adolescents with serious emotional disturbance who had been placed by school districts in 36 residential facilities for educational purposes over a 3 year period.</li> </ul>	<ul style="list-style-type: none"> <li>•Data were collected on the discharge status/outcomes of these students to analyse the relationship between outcomes and several predictive factors including characteristics of the residential placement, students, school districts and severity of functioning at intake.</li> </ul>	<p><u>Short-Term:</u></p> <ul style="list-style-type: none"> <li>•63% of students had made either no or minimal progress, had been discharged with a negative outcome, or had run away.</li> <li>•Positive outcomes were significantly associated with shorter lengths of stay (&lt; 15 months).</li> </ul> <p><u>Long-Term:</u></p> <ul style="list-style-type: none"> <li>•Availability of community based services for children returning to the community was reason most likely reported for positive discharge.</li> </ul> <p><u>Additional Factors:</u></p> <ul style="list-style-type: none"> <li>•Students in the positive outcome category had more severe functioning deficits at intake.</li> </ul>

<p>Lewis (1984)</p>	<ul style="list-style-type: none"> <li>•Crockett Academy, TN is an educationally oriented residential treatment program for adolescents who are moderately to severely disturbed.</li> <li>•The program is fashioned after Project Re-Ed and reflects an emphasis on ecological change and personal growth.</li> </ul>	<ul style="list-style-type: none"> <li>•Of 89 consecutive admissions, comparisons were made between the 20% who had improved the most and the 20% who had improved the least (18 students in each group).</li> <li>•Differences between the sum of 4 adjustment ratings (school academics, school behaviour, home &amp; family life, and community settings) at admission and 6 weeks after discharge were used as the index of improvement.</li> </ul>	<p><u>Short-Term:</u></p> <ul style="list-style-type: none"> <li>•At discharge, the top 20% group had gained significantly more ecological support than their peers.</li> </ul> <p><u>Long-Term:</u></p> <ul style="list-style-type: none"> <li>•All but one of the top 20% group was living in community settings (e.g. family home, group home, or foster home) 6 weeks following discharge.</li> <li>•At the same time, almost half of the low improvement group was living in corrections or mental health institutions.</li> </ul>
<p>Lewis (1988)</p>	<ul style="list-style-type: none"> <li>•Cumberland House, Nashville, TN serves latency-aged children with a serious accumulation of behaviour problems (both at home and school).</li> <li>•The program includes educational and cognitive-behavioural interventions for students and ecological interventions for families, schools, and communities.</li> <li>•Cumberland House serves 40 children in groups of 8 and is staffed principally by educators.</li> <li>•Children return home each weekend.</li> </ul>	<ul style="list-style-type: none"> <li>•Data on admission, discharge, and 6 month follow up were analysed for 82 former students who were voluntary admissions to the program during 1983-1984.</li> <li>•Personal and ecological data at admission and discharge were used to predict 6 month follow up adjustment status.</li> </ul>	<p><u>Long-Term:</u></p> <ul style="list-style-type: none"> <li>• # of family problems at admission was related to follow up measures of home and school adjustment.</li> <li>•If a child had been referred for professional help more than 2 yrs prior to admission, the child was likely to have low ratings on follow up measures of school adjustment, presenting problems, and new problems.</li> </ul> <p><u>Additional Factors:</u></p> <ul style="list-style-type: none"> <li>•High family SES was related to high scores on school adjustment.</li> </ul>

<p>Moore &amp; O'Connor (1991)</p>	<ul style="list-style-type: none"> <li>•Warrenstown House, Ireland is a 14 bed unit for children ages 6-16 with a variety of severe emotional and behavioural difficulties.</li> <li>•The program emphasizes group process and residents are encouraged to participate in social skills groups, community meetings, and sports activities.</li> <li>•Warrenstown House provides on site schooling for residents.</li> </ul>	<ul style="list-style-type: none"> <li>•A retrospective file review of 123 cases.</li> </ul>	<p><u>Short-Term:</u></p> <ul style="list-style-type: none"> <li>•The majority of the sample had poor skills in peer relationships at admission. Over half of these children improved to adequate of better skill level by discharge.</li> <li>•Over 60% of children having poor interactions with authority at admission improved to adequate levels or better at discharge.</li> </ul> <p><u>Additional Factors:</u></p> <ul style="list-style-type: none"> <li>•36% of residents were not able to return home to live with their families after discharge.</li> </ul>
<p>Taylor &amp; Alpert (1973)</p>	<ul style="list-style-type: none"> <li>•Children's Village residential treatment program of Children and Family Services of Connecticut is one of three programs in the agency designed to provide social work, psychiatric and psychological treatment, child care, and special education to emotionally disturbed children in placement.</li> </ul>	<ul style="list-style-type: none"> <li>•Questionnaire data was obtained from 75 children who were residents of Children's Village between 1955 and 1967.</li> <li>•Data included measures of adaptation at admission, post-discharge adaptation (as measured by the Community Adaptation Schedule), degree of change during treatment, supports, and continuity following treatment.</li> </ul>	<p><u>Long-Term:</u></p> <ul style="list-style-type: none"> <li>•Improvement within treatment was not predictive of adaptation at follow up.</li> <li>•Adaptation after discharge was related to a child's perception of available support from significant others (e.g. help was available from parents and others in the community).</li> <li>•Adaptation after discharge was also related to indices of participation by a child and her/his parents during treatment.</li> </ul>

<p>Wells, Wyatt &amp; Hobfoll (1991)</p>	<ul style="list-style-type: none"> <li>•An unnamed urban multiservice mental health agency for children offering a residential treatment program.</li> </ul>	<ul style="list-style-type: none"> <li>•Data were drawn from treatment records and interviews with 50 youths who were 1-3 years postdischarge.</li> <li>•Structured interviews included 4 standardized measures assessing social support, stress, continuity in living situation, and their relationship to adaptation of former residents after treatment.</li> </ul>	<p><u>Long-Term:</u></p> <ul style="list-style-type: none"> <li>•Family support (as measured by the Social Support Questionnaire) was significantly correlated to 3 indices of adaptation (self esteem, mastery, and psychopathology).</li> <li>•Greater residential stability was predictive of lower anti social behaviour and lower substance use.</li> <li>•More stress was predictive of more frequent use of restrictive psychiatric services.</li> </ul>
<p>Friman, Toner, Soper, Sinclair &amp; Shanahan (1996)</p>	<ul style="list-style-type: none"> <li>•Father Flanagan’s Boys’ Home is a family style residential program which uses an adaptation of the teaching family model.</li> <li>•Traditionally residents live in group homes containing 8 children and one teaching couple.</li> <li>•Reduced Ratio Homes with 4 residents and 1 teaching couple have been introduced to treat residents who have ‘failed’ the regular ratio homes and are at-risk of terminating the program.</li> </ul>	<ul style="list-style-type: none"> <li>•The study compared 23 youth in reduced ratio homes (RRH) with a residential sample (N=812) and psychiatric sample (N=87).</li> <li>•Groups were compared on the CBCL, aggressive behaviours, length of stay (LOS), cost of stay, and status at discharge.</li> </ul>	<p><u>Short-Term:</u></p> <ul style="list-style-type: none"> <li>•RRH increased the chance of in-program success for the study sample to a level equivalent to that for the much less troubled comparison group.</li> <li>•Placement in RRH resulted in an additional mean LOS of 920 days without an increase in program restrictiveness.</li> </ul> <p><u>Additional Factors:</u></p> <ul style="list-style-type: none"> <li>•The estimated per diem cost of stay per youth is \$154 for regular ratio homes, \$308 for reduced ratio homes, and \$1150 for psychiatric hospital stays.</li> </ul>

<p>Oswalt, Daly &amp; Richter (1990)</p>	<ul style="list-style-type: none"> <li>•Father Flanagan’s Boys’ Home (Boys’ Town) is a family style residential program which uses an adaptation of the teaching family model to treat ‘at-risk’ adolescents.</li> <li>•Residents live in group homes containing 8 children and one teaching couple.</li> </ul>	<ul style="list-style-type: none"> <li>•A 2 year longitudinal study of 498 residential youth and 84 comparison youth.</li> <li>•Youth were interviewed and administered questionnaires every 3 months for 24 months.</li> <li>•Measures included psychological indices, employment, criminal activity, and placement measures.</li> </ul>	<p><u>Long-Term:</u></p> <ul style="list-style-type: none"> <li>•There was a significant difference in education level attained between groups. 83% of residents graduated from highschool or received their GED in comparison to 69% of non-residents.</li> <li>•When controlling for age, residents had completed more years of schooling than non-residents.</li> <li>•No long term differences were reported in the following areas: delinquency and criminal activity, placements, employment, and psychological indices.</li> </ul>
<p>Thompson, Smith, Osgood, Dowd, Friman &amp; Daly (1996)</p>	<ul style="list-style-type: none"> <li>•Father Flanagan’s Boys’ Home, Boys Town, NE operates under the teaching family model with a strong emphasis on academic performance in the program.</li> <li>•Residents live in group homes containing 8 children and one teaching couple.</li> </ul>	<ul style="list-style-type: none"> <li>•503 residents and 84 comparison youth who did not enter the program were interviewed every 3 months for 4 years.</li> <li>•Data collected included grade point average (GPA), years of school completed, whether or not high school diploma/GED had been completed, the importance of college, and help with homework.</li> </ul>	<p><u>Short-Term:</u></p> <ul style="list-style-type: none"> <li>•Initial increase in GPA for Boys Town (BT) youth was observed. Their GPA dropped after 6 months; however, it was still higher than the GPA of the comparison group.</li> </ul> <p><u>Long-Term:</u></p> <ul style="list-style-type: none"> <li>•BT youth completed years of school at a faster rate than the comparison group.</li> <li>•83% of BT youth and 69% of comparison youth completed highschool.</li> </ul>

compliance, verbal aggression, and poor impulse control.

The teaching family model began with the opening of Achievement Place in Lawrence, KA as a research project in 1967. There are now well over 250 group homes in Canada and the U.S. that have met the requirements to be designated 'teaching family homes'. The teaching family model is grounded in behaviour modification and incorporates a point system to monitor and reward appropriate behaviours. The main focus of treatment is the pro-active teaching by 'teaching parents'. Teaching parents teach social, academic, and independent living skills necessary for the successful integration of residents back into the community. The teaching family model has generally been somewhat successful in changing in-program behaviour. Improvements have been made in residents' educational progress and in the reduction of criminal behaviour.

From the original site, the teaching family model expanded to a number of group homes across the country, one of the more well-known being Father Flanagan's Boys' Home, Boys Town, NE. An overall analysis of the effectiveness of these homes by Weinrott, Jones, and Howard (1982 as cited in Quay, 1986) indicated no observed differences between the teaching family model and comparison groups in the reduction of deviant behaviour, occupational status, or social and personality adjustment. However, the model did have a modest but significant effect on educational progress. Similarly, Thompson, Smith, Osgood, Dowd, Friman, and Daly (1996) monitored the academic progress of boys treated using the teaching family model at Boys Town for four years following treatment. Residents were compared to a group of youth who were admitted to Boys Town but never attended, and consequently received treatment in alternative settings. Thompson and his colleagues noted an initial increase in grade point average for Boys Town residents. The initial gains in grade point average made by Boys Town youth dropped off

after six months; however, residents' average was still higher than that of the comparison group. Thompson et al. (1996) also reported that Boys Town residents completed years of school at a faster rate than the comparison group. Eighty-three per cent of youth treated using the teaching family model completed high school. In contrast only 69% of the comparison youth completed high school.

Oswalt, Daly, and Richter (1990) also offer support for the modest effectiveness of the teaching family model on educational progress. Oswalt et al followed the progress of 340 residents of Boys Town and 59 non-residents with an average of six years between initial and follow up interviews. Significant differences were noted in education level attained with more Boys Town residents graduating from high school than non-residents. When controlling for age, residents had completed more years of schooling than non-residents (Oswalt et al. 1990). There were no significant long term differences noted in delinquency and criminal activity, employment (proportions of full time, part time, and unemployed individuals), psychological indices such as self esteem and locus of control, and use of placements. Twenty-one per cent of Boys Town residents and 24% of non-residents had spent at least one day in a corrections or psychiatric facility in the six months preceding the follow up interview.

In their examination of 13 Achievement Place homes and 9 comparison group homes, Kirigin, Baukman, Atwater, and Wolf (1982 as cited in Quay, 1986) offer support for in-program change but offer little evidence that would suggest the maintenance of post-program change. The only significant difference between Achievement Place homes and comparison group homes, in a comparison of the number of youth involved in recorded offenses, occurred while in treatment and favoured Achievement Place homes. There were no significant differences in the

number of youth involved in recorded offenses at post-treatment follow up. Kirigin and colleagues also noted this pattern for the number of recorded offenses per youth.

Typical residents of residential treatment are highly troubled and disruptive youth who consequently have an increased risk of treatment failure. In an attempt to maintain placement of these highly troubled youth, Father Flanagan's Boys' Home offers residents continued residential treatment in reduced youth-to-staff ratio homes. In reduced ratio homes, teaching parents care for four youth instead of the regular number of eight youth per home. Friman, Toner, Soper, Sinclair, and Shanahan (1996) assessed the effectiveness of these reduced ratio homes in maintaining placement for highly troubled youth by comparing 23 youth in reduced ratio homes to a residential and psychiatric sample. Placement in reduced ratio homes increased the chance of in-program success for the study sample to a level equivalent to that of the less troubled comparison residential sample. Furthermore, placement in these homes resulted in an additional mean length of stay of 920 days without an increase in program restrictiveness (Friman, Toner, Soper, Sinclair, & Shanahan, 1996).

The popularity of the teaching family model as a treatment option, as well as a program of choice for evaluation and study, is evident in a review of the literature on residential treatment in group home settings. Studies of the effectiveness of this model appear to support modest in-program gains, particularly in the area of educational progress. In addition, reducing the number of youth per teaching family home has the potential for extending treatment for highly troubled youth. However, the teaching family model appears to fall short in the long-term maintenance of in-program effects and in the post-treatment reduction of delinquent and criminal behaviour.



## **Residential Treatment Centres**

Similar to the literature on the effects of group home residential treatment, outcome studies of residential treatment centres tend to produce mixed results. Repeatedly, investigators have attempted to identify predictors of positive treatment outcomes for children and adolescents with only minimal success. In most cases, demographic information such as age, race, and IQ have been found to not be predictive of post discharge adaptation. However, several treatment factors and child characteristics have been found to share some association, albeit without much consistency, to positive outcomes including shorter length of stay, greater academic ability, and clinical work with a child's family. Indeed, outcome studies of residential treatment offered in larger centres tend to offer further support for the significant effect of family involvement in treatment on positive outcomes for children and adolescents.

Our review of the literature suggests that outcome studies of residential treatment centres are more numerous and varied than studies of group home outcomes. We have included a sampling of those studies here. However, similar to the group home literature, there is one particular treatment model that dominates the outcome research landscape.

Project Re-Ed is a short term psycho-educational residential treatment program designed and implemented by specially trained teachers that works with not only children but families, schools, and community agencies to help a child's ecology meet his or her needs better. In an early, yet influential and frequently cited study of the long term effects of Project Re-Ed, Weinstein (1974 as cited in Curry, 1991) compared 122 Re-Ed children with a sample of 128 untreated disturbed children and a sample of 128 non-problem children on long term academic adjustment. Children were assessed at the time of discharge, 6 months, and 18 months following

discharge.

At discharge, Project Re-Ed children showed improvement in social behaviour, attitudes toward and motivation for learning, and academic skill acquisition as judged by referring agencies. In addition, data suggested that this form of treatment led to a more positive self concept, more internal locus of control, decreased motor and cognitive impulsivity, and more constructive family relationships as perceived by the child. Weinstein noted that there were no significant improvements in these areas for children in the two comparison groups. While both Project Re-Ed children and untreated children were judged by regular school teachers to have shown improvements in academic adjustment, improvements were greater for the Project Re-Ed children. Furthermore, Project Re-Ed children were seen as having fewer academic problems than comparison children at both the 6 month and 18 month follow up. However, it should be noted that only half of the Project Re-Ed children were considered to be no longer 'severely behaviourally impaired' in school.

Lewis (1988) offers additional outcome research on Project Re-Ed in a follow up study of 82 former residents admitted to Cumberland House, Nashville, TN during 1983 and 1984. Cumberland House serves 40 children in smaller groups of 8 children and the program itself follows educational, behavioural, and ecological biases. Each group has their own living unit and classroom with three teacher-counsellors and one dorm aide. In addition to schooling, children engage in arts and crafts, physical education, outdoor education, and educational testing. Treatment interventions employed by Cumberland House include group processes, contingency contracting, levels systems, and academic interventions. Educators are the principle agents in implementing treatment.

According to Lewis (1988), most child admission data did not predict student follow up status. Age, IQ, race, prior contact with the juvenile system, and how much a child's family made use of community resources were not predictive of any follow up ratings. However, sex of the resident was significant, in that females were more likely than males to develop new problems after discharge. Also, if a child had been referred for professional help more than two years prior to admission, that child was likely to have low ratings on several of the follow up measures: school adjustment, presenting problem (to what extent the child still exhibited an initial presenting problem), and new problems. Family data revealed that higher socioeconomic status was related to higher scores for children on school adjustment and presenting problem. In addition, the number of family problems at admission, such as abuse, mental illness, divorce, was associated with follow up measures of home and school adjustment. The direction of the association could not be determined due to statistical limitations; however, inferences from the raw data suggested an inverse association between the number of family problems at admission and follow up measures of home and school adjustment (Lewis, 1988).

In a frequently cited study of continuity and aftercare following residential treatment, Taylor and Alpert (1973) followed 75 children discharged from Children's Village of Family and Children's Services of Connecticut from 1955 to 1967. Children's Village offers "comprehensive social work, psychiatric and psychological treatment, child care and special education services to emotionally disturbed children in placement" (Taylor & Alpert, 1973, p. 11) Using a measure of adaptation to the community environment as the criterion for success at follow up, Taylor and Alpert found no significant relationships between any treatment variables and adaptation after discharge, except for the number of parent contacts with a child or with staff while the child was

in treatment. More specifically, adaptation after discharge was related to the degree to which a child perceived support to be available from significant others.

Similarly, in a comparison study of successful and unsuccessful former students of Cumberland House, a residential treatment program for elementary school children and junior high school youth, Lewis (1982) reported that parents of successful children made more contact with their children and the residential staff during treatment than parents of less successful children. In addition, contacts made by parents of successful children were more positive in nature. Lewis also noted that the reduction of stress and the increase of support in a child's post-treatment environment was significantly greater on discharge for successful children. Findings from both Taylor and Alpert (1973) and Lewis (1982) suggest that the ecological setting may be of greater importance in determining a child's adjustment than changes made by a resident during treatment.

In addition to the study of Project Re-Ed, there are several studies we have included in our review that further capture the mixed effects of treatment in residential treatment centres. Hoagwood and Cunningham (1992) investigated the global school functioning of 114 students classified as seriously emotionally disturbed (SED) who were placed in residential programs by school districts between 1987 and 1990. Reasons for placement were categorized as follows (1) student behaviour-related reasons (violence, assaultiveness, and serious suicide attempts; (2) family-related reasons (neglect, concern for family's safety, and sexual abuse); and, (3) school-related reasons such as persistent school failure. The majority of the sample was male (75%) with a mean age of 13 years old. The average length of stay was 18.2 months. Outcome measures included severity of functioning as assessed through the use of a modified version of the Global

Assessment of Functioning (from Axis V of the DSM III-R) and students were placed at one of five levels of functioning from discharged with a positive or negative outcome to still in placement with significant, minimal, or no progress.

In 63% of the cases, either no or minimal progress had been made in treatment or the student was discharged with a negative outcome. Twenty-five per cent of students had a positive outcome status of being discharged back into school or into school-related vocational training and 11% of students were still in placement with substantial treatment progress. Hoagwood and Cunningham concluded that positive outcomes were significantly associated with a shorter length of stay. A positive outcome was most likely to occur if the student was discharged prior to 15 months. Students in the positive outcome categories received initial severity of functioning ratings indicative of more disturbance than students in the negative outcome categories. They also noted that the availability of community-based services with which to transition a student from residential placement back into the community was the reason most likely reported by educational administrators for positive discharge status (Hoagwood & Cunningham, 1992).

In a study of 37 children discharged between 1991-92 from Edgewood Children's Centre in St. Louis, MO, Burks (1995) found that a child's post discharge placement was the only variable significantly related to outcomes at six months. If a child was discharged to a family placement, either family of origin, foster family, or adoptive family, the chances of a positive outcome were enhanced. Edgewood Children's Centre treats emotionally disturbed children aged 5 to 17 using a 'comprehensive' program emphasizing education and recreation. An outcome was considered to be positive if a child was still placed at the location to which he or she was discharged and was not involved in trouble with peers or authority figures. There were no

significant relationships found between outcomes at six months and severity of emotional disturbance, family participation in treatment, and characteristics of children in treatment (Burks, 1995).

In contrast, Well's (1991) review of the placement criteria of emotionally disturbed children in residential treatment identified several child characteristics and treatment factors said to be associated with positive status at follow up. Child characteristics included a less severe dysfunction, the onset of an acute problem rather than an ongoing one, greater academic ability, and a greater capacity for relationships. Treatment factors that were associated with positive follow up status included the involvement of a child with their peers, staff, and academic tasks, a child's attainment of treatment goals, and clinical work with a child's family. The use of after care services and family and community support were also associated with positive status at follow up (Wells, 1991).

To understand the ways in which differing sources of social support, stress, and continuity in children's living situation are associated with the adaptation of former residents after treatment, Wells, Wyatt, and Hobfoll (1991) interviewed 50 youths who had been in residential treatment at an urban multi-service mental health agency for children. Residents were discharged between 1985-1988 and had a minimum six month length of stay. Results indicated that family support, as measured by the Social Support Questionnaire, was significantly correlated to three indices of post treatment adaptation: self esteem, mastery, and psychopathology. Children's residential stability was significantly correlated with self esteem, anti-social behaviour, and substance abuse. More specifically, greater residential stability was associated with lower levels of anti-social behaviour and substance use. Wells et al (1991) concluded that adolescent residents of long-term

residential treatment who have little to no family support, who experience high levels of stress, and have little residential stability after treatment are unlikely to successfully adapt after discharge.

## **Additional Treatment Outcome Factors**

### The Effects of Family Involvement

Common to both group home and residential treatment centre outcome studies summarized herein is the consistent and significant effect of parental involvement and family support during treatment on within treatment progress, as well as children and adolescents' ability to successfully adapt to the community following discharge. As an illustration, Day, Pal, and Goldberg (1994) examined the post-discharge functioning of conduct disordered children in a treatment program with an emphasis on family involvement. Parents participated in family therapy, parent training groups, and their child's treatment on a daily basis. At an assessment six months following discharge, improvements were found on the Child Behaviour Checklist (CBCL), with significantly fewer children being in the clinical range on both the internalizing and externalizing scales (Day, Pal, & Goldberg, 1994).

Despite the promising effects of family involvement in treatment, historically parents have had little encouragement or assistance from residential treatment centres in becoming actively involved in their child's treatment (Jensen & Whittaker, 1989). Efforts to include families in treatment have been marred by program customs and culture which may restrict family visits by neither encouraging nor discouraging them. In addition, the tendency to see families as guilty for a child's problems and a lack of financial resources to work with families have further contributed to limited family involvement (Jenson & Whittaker, 1989). Including families in treatment can be

challenging when children are often removed from highly dysfunctional families, many of whom are not able or willing to be involved in their child's' treatment (Burks, 1995). Moreover, children and youth of residential treatment possess characteristics that can make them particularly susceptible to high risk elements in the post treatment environment (Oswalt et al., 1990). Furthermore, including the family in treatment challenges a program's traditional focus of dealing with one client, the child, to dealing with two clients, the child and family. This duality of clients has the potential to raise professional concerns around balancing the needs of each client which may or may not be complementary. For example, programs that serve children are committed to protecting the best interest of children which at times may not include family connectedness (Noble & Gibson, 1994). However, the separation from one's biological family can be a painful and damaging experience for children. Similarly parents frequently feel depression, guilt, or feelings of failure around placing their child in residential treatment. Ignoring the contribution of a family to treatment may intensify these feelings for both children and their families (Jenson & Whittaker, 1989).

#### Matching Child Characteristics and Treatment Type

Currently, matching child characteristics with treatment type is a level of sophistication rarely undertaken in both the practice and research of residential treatment. Early conclusions of the limited application of matching child characteristics and treatment suggest that such a strategy holds promise for the successful treatment of specific groups of children and adolescents. The study of residential treatment for conduct disordered children and adolescents is one area where evidence for matching children to programs can be seen.

Conduct disorder is the most frequently applied diagnoses to troubled children and



adolescents (Garrett & Marler, 1989). Children with conduct disorder are likely to have educational deficits, mental health difficulties, drug and alcohol involvement, and dysfunctional or abusive families. These children and adolescents can be further characterized by disruptive behaviour problems with antisocial and aggressive symptoms. Conduct disordered youth are among the most difficult populations to treat in residential treatment in that they tend to benefit the least in comparison to non-antisocial counterparts in treatment (Zoccolillo & Rogers, 1991 as cited in Chamberlain, 1999). Unique to the treatment of conduct disordered children is the negative impact of the inclusion of children and youth with conduct disorder on the therapeutic milieu. There appears to be a negative emotional cost to staff and other residents in the treatment of conduct disordered youth. Previous research indicates that the association with delinquent peers strongly contributes to continued and escalating patterns of anti-social and criminal behaviour (Buysse, 1997). Yet, these youth make up a growing number of children and adolescents referred to residential services (Chamberlain, 1999).

Using meta-analysis, Garrett (1985) examined the efficacy of treatment for conduct disordered youths in 111 studies of adjudicated delinquents in institutional and community residential settings completed between 1960 and 1983. More restrictive institutional settings accounted for 81.1% of the studies reviewed. The remaining 18.9% were community residential programs. The analysis revealed that treatment based on behavioral theory produced the greatest amount of positive change across delinquent types and outcome measures including psychological adjustment, recidivism, community adjustment, and academic improvement. Cognitive-behavioural interventions, family therapy, and wilderness programs also yielded large positive changes (Garrett, 1985). Similarly, Chamberlain (1999) concluded that successful treatment

strategies for youth with conduct disorder include the use of a highly structured reward levels system as a behavioural management tool and immediate feedback about positive and negative behaviours.

## **Conclusion**

Despite methodological shortcomings and variability in programming, residential services have been found to improve functioning for some children. At the same time, any success or gains made by children and adolescents during treatment are not easily maintained and tend to dissipate over time. Successful post treatment patterns of adjustment appear to hinge on post treatment environmental factors such as available support, reduction of stress, and residential stability. Less encouraging are early studies of long term outcomes to residential treatment which generally indicate that improvement within treatment is not predictive of adaptation at follow-up (Taylor & Alpert, 1973). Child admission data and within treatment variables are at best minimal to poor predictors of post treatment adjustment. However, the degree of family involvement in treatment is generally regarded as predictive of post treatment patterns of adjustment.

Pecora, Whittaker and Maluccio (1992) draw similar conclusions regarding the current knowledge on the effectiveness of residential treatment. They conclude that (1) the quality of supports available in post discharge environment appears to be associated with a youth's subsequent community adjustment irrespective of status at discharge; (2) contact and involvement with a child's family appears to be positively correlated with post placement success; (3) neither the severity of a youth's presenting problem nor the specific treatment modality employed appears to be strongly associated with post discharge adjustment; and (4) youth with supportive community networks are more likely to maintain their treatment gains than those who lack such

supports.

The most consistently supported post treatment effects appears to be the link between working with families during treatment and children's successful post-discharge adaptation. However, the difficulties that led to residential placement are frequently still present in the family upon return of the child or youth, and as such, many families cannot be seen as a reasonable post-treatment environment. Oswald et al (1990) emphasize that, in their long term study of Boys Town residents, "virtually all families of Boys Town residents received family treatment and prevention services prior to Boys Town placement. This, coupled with a history of multiple out-of-home placements, frequently signals that natural family or surrogate family resources...are not readily available to maintain treatment effects" (p. 160). Families with multiple chronic problems may not be realistic support systems to return these children and youth to and expect them to maintain progress made in the treatment environment. "A failure to respond in some way to conditions in the environments in which youth are discharged may well undo the hard-won gains youths make in treatment. Minimally we need... to evaluate the potential stressors and stability of the environments to which youth are returned" (Wells et al. 1991, p. 214).

Admittedly there are challenges to working with families of children in residential treatment; nonetheless, we cannot ignore the evidence that clearly suggests parental and family involvement play a pivotal role in the success of residential treatment for children and youth. More specifically, parental contact within treatment is related to successful adaptation after discharge (Taylor & Alpert, 1973); at discharge, successful children had more contact with parents during treatment and this contact was more positive in nature (Lewis, 1982); and, increased family support following discharge is related to successful post treatment adaptation by

children and youth (Wells et al , 1991). Consistently, and early on, studies have documented the positive effects of increased family involvement. “Minimally we need to heed the often-repeated calls for the reconceptualization of residential treatment as a family support system...” (Wells et al., 1991, p. 214). Similarly Burks (1995) concludes, “whatever the residential treatment centre can do to direct its efforts as a family support system, rather than as a place where the child is removed from family and community, should work in this direction” (p. 38).

According to Wells (1991), too little is known as yet about the critical combinations of child and family characteristics, program characteristics, and post-discharge status for research findings to be useful in making placement decisions. Because the decision to place a child is often rooted in crisis, the choice of residential treatment is often based on availability rather than on an appropriate match of its program to the recipient. Indeed, Durrant (1993) has argued that children placed along the continuum of residential services are not all that different from one another. Clinical and long term follow up of children in residential treatment will enhance our understanding of the types of individuals for whom residential settings are a particularly good fit. Equally important is an understanding of which treatment approaches work best with specific populations. For example, what levels of severity of youth and family problems appear to justify a temporary loss of community connectedness that tends to accompany placement (Whittaker & Pfeiffer, 1994)? Are there particular groups of children and youth for whom residential treatment is a first rather than last resort?

There will continue to be children who require highly restrictive placements and as such residential treatment will remain an integral component of a comprehensive system of care for children with serious emotional disorders (Kutash & Rivera, 1996). However, reframing

residential treatment as a ‘first resort’ for some children and adolescents runs counter to the trend toward treatment of children and adolescents in the ‘least restrictive setting’. Treatment in the ‘least restrictive setting’ also appears to intuitively suggest that treatment in smaller settings, which are more akin to home-like conditions, holds more promise in successfully treating children and adolescents than treatment in larger residential centres. Currently there is insufficient information to address this suspicion. Direct comparison studies between group homes and residential treatment centres are few in number and when undertaken require a level of analysis beyond the level demonstrated thus far in studies of residential treatment.

Unfortunately, any gains made by reconceptualizing the practice of residential treatment will be overshadowed at present by the limitations of current methods for studying residential treatment. Research in this area continues to be plagued by serious methodological flaws. Generating more useful treatment outcome research lies in clearly defining and operationalizing treatment components, rethinking the selection of outcome measures, and working toward clarifying when residential treatment is warranted. Unless current methods of studying and documenting residential treatment outcomes are improved, research in this area will continue to struggle with poor credibility and limited application.

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## Partnerships for Children and Families Project

Wilfrid Laurier University  
Waterloo, Canada N2L 3C5

Email: [partnerships@wlu.ca](mailto:partnerships@wlu.ca)

Local: (519) 884-0710 ext.3636

Toll Free: 1-866-239-1558

Fax: (519) 888-9732