

# **Best Practices in Children's Mental Health**

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

## **Report # 20**

### **Residential Treatment**

*A Review of the National Literature*  
**August, 2007**

**Produced by the University of Kansas**  
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## **Executive Summary: Best Practices in Residential Treatment**

As a highly restrictive form of placement, residential treatment (RT) faces a variety of changes and challenges including questions about its efficacy and effectiveness, about its place in the system of care, and its appropriateness for children and youth of different ages, gender, and ethnic backgrounds. This literature review provides the following main insights:

### **General Context**

- It is estimated that of all children in out-of-home care, RT serves anywhere between 15% to 30%. Utilized by mental health, child welfare, and juvenile justice systems, there are not yet nationally agreed upon standards to guide definitions and evaluations of “success” and thus no system for data collection across these fields.
- The vast majority of youth in RT facilities are adolescent boys whose lives have been characterized by chronic residential instability and/or difficult family relationships. Their behavioral characteristics frequently include multiple and concurrent problems in behaviors, school functioning, and relationships. Increasingly, aggressive behaviors are cited as reasons for referrals, and proper use of restraint and seclusion is a critical concern.
- Within and across programs, the mean length of time children remain in RT varies extremely from less than 2 months to more than 2 years, and only about half of placements end in planned discharges.
- RT facilities typically offer multidisciplinary treatment teams, and a combination of various treatment modalities such as cognitive-behavioral treatment, psychodynamic milieu-therapy, psychoeducation, family and group therapy, special education etc. It appears that similar set of services is provided to all RT residents regardless of their presenting problems. Staff with the most direct client contact (such as child care workers) show the highest turnover rates.

### **Effectiveness**

The current evidence base for the effectiveness of RT is still limited and lacks methodologically strong studies. Evidence for the effectiveness of RT programs is mixed:

- While most children and youth in RT make gains during treatment, 20-40% of residents show no improvements or deteriorate.

- Appropriate use of medications is not consistent, yet there is some indication that RT can help reduce the number of non-stimulant psychotropic medications youth receive.
- Issues of diversity in RT are insufficiently researched, and it remains unclear how RT could be more appropriate and effective for girls, or youth of color.
- RT seems less effective for youth with Conduct Disorder. It appears that this population may generally be better served in Therapeutic Foster Care.
- There is consistent evidence for the importance of family involvement and regular contacts with families to ensure positive outcomes. Successful engagement, involvement, and functioning of the child's family are linked to positive outcomes as are shorter lengths of stay (9 months or less), and improvements in academic achievement.
- Maintaining improvements made in RT after discharge centrally hinges on (a) the degree of family involvement during treatment, and (b) aftercare, i.e. the stability and support in the post-treatment environment to which a child or youth is discharged. Families, youth and professionals also convey the importance of respectful and consistent involvement of families in all aspects of treatment, including the sharing of training and knowledge, offering parent support and maximizing family-child contacts.

## **Recommendations**

Existing literature on best practices, including empirical studies, suggest the following strategies to improve the effectiveness residential treatment:

***1) Systematically implement family-centered strategies and policies.*** Maximize the meaningful and consistent involvement of families as partners in residential treatment and allow for regular contacts. Such policies and strategies ideally include:

- allow clients to define who counts as their “family;”
- include and involve youth and families in all planning procedures including permanency planning, goal setting, decisions regarding home visits, etc.;
- ensure regular contacts and home visits (which are not privileges to be earned);
- discuss and explain any intentions to restrict parent-child contact with youth and family;
- regularly share information with families;
- systematically share training and knowledge with families;

- plan transitions and pacing of transitions early and in detail with families;
- focus on relationship components (planned and/or spontaneous) as vitally important;
- make certain that RT policies ensure accessibility for families;
- employ strategies in treatment that can be replicated in the family environment;
- use culturally sensitive services;
- treat parents as experts and partners;
- maximize amount and quantity of family therapy;
- offer family support groups.

**2) *Link RT more closely with community-based services.*** To ensure aftercare and support a greater and clearer integration into the continuum of care is needed that allows for more permeable boundaries between in-home and out-of-home treatment. Such changes could include:

- target conduct disorder youth for diversion to community-based services, including therapeutic foster care.
- begin discharge planning on Day 1
- involve RT staff in community-based services such as wraparound;
- conceptualizing RT centers as a hub for local services for stabilization, assessment, and planning with community partners and close parent partnerships;
- establish community partnerships and locating RT in a community-service network;
- co-locate services such as family support and residential care;
- expand residential respite options, and developing more creative short term residential treatment programs;
- focus on both child well being and family functioning as outcome measures;
- develop models that serve the whole family.

**3) *Establish clear and consistent outcome measures and collect data regularly.*** In light of the much needed evidence base to monitor the effects and quality of RT, it is important for RT programs to establish clear and consistent outcome measures, and regularly evaluate their data.

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## **BEST PRACTICES IN RESIDENTIAL TREATMENT**

### **INTRODUCTION**

Over the past decades, the view and use of residential treatment facilities has undergone a variety of changes. Most importantly, policy initiatives moved residential care away from large, long-term institutional living toward smaller scale facilities that serve youth for shorter periods of time. Utilized by mental health, child welfare, and juvenile justice systems, residential care has also come under increased scrutiny as to its appropriateness, effectiveness, and its place in the system of care (Bazon Center for Mental Health Law, not dated; Whittaker, 2000). On the continuum of restrictiveness, residential care is second only to inpatient and juvenile justice facilities. Due to this highly invasive nature, RT is now considered a “last resort” for youth who cannot be served adequately in less restrictive environments through community-based programs or in foster homes (Bates, English, & Kouidou-Giles, 1997). Other issues of concern focus on how to ensure that no harm is done to residents through unnecessary or improper use of restraint or seclusion (Whittaker, 2000).

### **Definitions**

In its broadest definition, the term ‘residential treatment’ encompasses a variety of facilities in which children and youth reside out-of-home, away from their families in a non-family setting, with 24-hour care but without hospital-level medical attention (Pierpont & McGinty, 2004).

Based on Federal regulations by Medicaid, the State of Kansas (SRS, 2007, p. 4) defines its residential treatment facilities as follows (effective July 1, 2007):

Psychiatric Residential Treatment Facility (PRTF): is a facility that provides comprehensive inpatient mental health treatment and/or substance abuse services for residents with severe emotional disturbances, substance abuse, and or mental illness that meets State and Federal participation requirements, and is accredited by one of the following accrediting organizations.

1. Council on Accreditation of Rehabilitation Facilities (CARF);
2. Council on Accreditation of Services for Families and Children (COA);
3. Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or;
4. an accrediting body approved by the Kansas Health Policy Authority (KHPA), Kansas Department of Social and Rehabilitation Services (SRS) and the Kansas Juvenile Justice Authority (JJA).

A second form of residential facilities in Kansas are “Youth Residential Care” facilities (YRCs). YRCs are designed to meet the needs of youth who do not need intensive in-house mental health services. Therefore, YRCs are not funded by Medicaid (SRS, 2007b).

The following report summarizes findings from a review of the national literature to establish what can currently be considered “best practices” in residential treatment. Since it is often impossible to glean from articles whether the described program would be equivalent to a PRTF or a YRC, this review uses a broad definition of residential care and includes articles using terms such as “residential treatment,” “residential care” or “group home”. The review is restricted to peer-reviewed publications published between 1997 and 2006 that were identified in a search of national databases (PsycInfo, PubMed, Social Work Abstracts), and additional articles found in references lists, or through online Internet searches. While a major focus rests on empirical findings, selected conceptual articles are included if they demonstrated key ideas to guide the field. Excluded are publications on programs that focus solely on substance abuse treatment. (Appendix A. provides an overview of selected literature.)

## **OVERVIEW OF RESIDENTIAL TREATMENT**

Despite increased efforts and calls for national standards and data collection of RT facilities, there is currently no system for tracking data in child welfare, mental health, substance abuse and juvenile justice systems (Whittaker, 2000). As the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) points out, efforts to gather data are hampered by “the slow pace at which national consensus is being reached on appropriate performance measures for non-hospital behavioral health care settings.” (Due to these difficulties, the Commission has currently suspended the requirement for facilities to report data.) Reaching consensus remains a challenge given the different missions, traditions, and definitions of success among child welfare, mental health, and juvenile justice systems.

Some data, however, are available for children and youth served in residential treatment centers for emotionally disturbed children. According to the U.S. Department of Health and Human Services (DHHS), 30,995 children and youth lived in such RT facilities in the year 2000

(Substance Abuse and Mental Health Services Administration, DHHS, 2002; available online: <http://mentalhealth.samhsa.gov/publications/allpubs/SMA04-3938/chp18table5.asp>).

Authors estimate that of all children in out-of-home care, RT serves anywhere between 15% to 30%, while approximately 85% are placed in family foster care (Whittaker, 2000).

### **Characteristics of Children and Youth in Residential Care**

Typically, a majority of youth in RT facilities are adolescent boys (Baker, Archer, & Curtis, 2005). Their behavioral characteristics are varied but frequently include multiple and concurrent problems in behaviors, school functioning, and relationships. Young people with serious emotional disorders (SED) are in the majority at residential treatment centers and are frequently diagnosed with attention deficit disorder, conduct disorder, or anxiety disorders (Frensch, 2002). Common are chaotic behaviors, poor impulse control, tendencies to threaten or harm others, and/or destroy property. They experience strained relationships with their parents including acute and chronic conflicts as well as rejection by parents (Frensch, 2002). In addition, some youth in RT engage in inappropriate or offending sexual behaviors (Baker, Archer, & Melnick, 2004; Frensch, 2002; Lemmond & Verhaagen, 2002). Youth in RT show higher levels of internalizing and externalizing, and fewer adaptive behaviors than youth treated outside of residential settings (Foltz, 2004; Frensch, 2002).

Many young people in RT come from low income stepfamilies, single-parent families, or adoptive families. A substantial number of them are in state custody, and their lives have been characterized by chronic residential instability and difficult family relationships. They often have had a pattern of frequent out-of-home placements and repeated and unsuccessful use of other services. Many of their families also experience multiple stressors such as histories of alcohol or drug abuse, domestic violence, mental illness, or involvement in the justice system while they also have fewer social support networks (Foltz, 2004; Frensch, 2002).

### **Reasons for Admission**

Youth enter into RT via their families as well as through referrals from physicians, mental health agencies, child welfare agencies, or courts. Increasingly, aggressive behaviors are

precipitating referrals for residential treatment (Foltz, 2004). The most common reasons for admission are (Foltz, 2004, p.3):

- “*Severe Emotional Disturbance*—clinical depression, post-traumatic stress disorder, mood disorders, anxiety disorders, attachment disorder, and self-destructive behaviors.
- *Aggressive/Violent Behaviors*—oppositional and defiant aggression including self-injurious behavior.
- *Family/School/Community Problems*—inability to function at home, in school, or in the community; family dysfunction, placement failures, needing an alternative to juvenile justice, and drug abuse.
- *Abuse*—physical, sexual, or emotional abuse.”

### **Psychoactive Medications**

Youth in RT frequently receive psychotropic medication. A study by Connor et al. (1998) found not only high rates of psychotropic medication upon admission to RT (76% of SED youth received at least one medication at the time of admission) but significant patterns of multiple concurrent medication use. Forty percent of children were on more than one psychoactive medication when they were admitted. Considering their lifetime history, the numbers were even higher: 57% of children received trials of multiple concurrent psychotropic medications before admission; 52% of those treatments involved 2 psychotropic medications, 29% involved 3 drugs, 11% involved 4 drugs, and 7.9% involved 5 different medications given simultaneously (Connor & McLaughlin, 2005).

### **Length of Stay**

Both within and across programs, studies indicate an extremely high variation in the length of time children remain in residential care. Mean lengths of stay range from less than 2 months to more than 2 years. Baker, Wulczyn, and Dale (2005) explored variables associated with length of stay for 416 boys (N) in a residential child welfare facility. On average youth stayed about 1.7 years but length of stay varied significantly with type of exit. Those who were transferred to other settings (41%) stayed longer (1.98 years), while those 14% who ran away did so mostly within the first six months. Forty-five percent were discharged to parents or relatives. Mental health concerns, such as psychiatric crises, were linked significantly to longer stays

adding seven months for reunified and transferred children alike. For transferred children, prior placements, and prior hospitalization/suicidal behaviors were covariates of quicker discharge while run away status was linked to being older, substance abuse, parental incarceration and juvenile delinquency.

### **Characteristics of RT Programs**

In a survey of regulations for RT facilities for children with mental illness (Ireys, Achman, & Takyi, 2006), state officials from 38 states responded to questions on facility characteristics and programs, licensing and oversight procedures, and sources of financing. Results show as many as 71 different types of facilities with a wide range of the total number of beds associated with each type (ranging from 6 to 7,160 beds). States also varied in their methods to regulate facilities, typically including some -- but rarely all -- of the following procedures: on-site inspections; documentation of staff qualifications and training; record reviews; resident interviews; critical-incident reports; standards for resident-to-staff ratios; and educational levels of facility directors. In addition, findings indicated that often several agencies with different missions and functions are involved in licensing, overseeing, and regulating facilities making administration of RT facilities a highly complex undertaking.

Staff utilized at RTCs are typically multi-disciplinary and include child care workers, social workers, psychiatrists, nurses, teachers, recreational therapists, psychologists, and to a lesser extent family therapists (Foltz, 2004). As Connor et al. (2002) point out, staff at residential care facilities are increasingly expected to offer intensive multidisciplinary treatment and some find it difficult to meet the needs of their residents, in the face of high staff turnover, constrained resources, and increasing symptom severity. In one study of factors impacting staff retention and turnover (Connor, McIntyre, Miller, Brown, Bluestone, Daunais, & LeBeau, 2003) authors found a turnover rate of 46.1% over a 3.5 year interval which is consistent with other studies. Factors found to be correlated with longer retention included: worker is married; worker commutes 30 minutes or less to work; and worker receives positive incentives from the employer. Employees who took advantage of a tuition reimbursement program, who received positive performance evaluations, salary increases, and promotions stayed longer at the RT facility. In contrast, staff

who had the most direct daily contact with youth, namely client care workers and special education teachers, had the highest turnover rate.

Over the past decades, the predominance of traditional psychodynamically informed residential treatment models that employed “milieu-therapy” has given way to a broader range of theoretical orientations (Epstein, 2004). The American Association of Residential Treatment Centers (AACRC) compiled a national survey (2000) which indicated that of the 96 surveyed RTCs from 33 states cognitive-behavioral orientations were indicated most frequently (31% of RTCs), followed by “eclectic” (30%). Nine percent or fewer indicated an orientation at behavioral, psychodynamic, psychoeducational, family systems and attachment theories. Surveyed treatment centers typically offered a combination of various treatment modalities and special education services: 96% offered medication assessment and individual therapy; psychiatric assessment (95%); family assessment (92%); special education services (91%); academic testing (89%); group therapy (88%); recreational therapy (86%); family therapy (85%); milieu therapy (83%); and psychological testing (81%) (Foltz, 2004).

How much of these services are provided to which kind of youth was the subject of a survey study involving Clinical and Executive Directors of 40 RTCs in Colorado (Libby, Coen, Price, Silverman, & Orton, 2005). Surveys asked participants to estimate the types and amount of services that a young person would receive in a typical week for youth presenting with either internalizing, externalizing, low functioning, or high needs serious emotional disturbances. Authors analyzed if the intensity of particular services differed according to the type of problem and found that within each RTC most services were relatively uniform across case types. With a few exceptions, “a similar set of services is provided to all young people regardless of their major problem” (Libby et al., 2005, p. 181). While interviews with key informants suggested there are important differences and specialization in services depending on youth profiles, data showed that over the course of a week young people are engaged in very similar activities for similar periods of time. It is plausible that differences and individualization in services occurs on the most individual level of how treatment is delivered, which could not be captured in this study. One indication of such individualization was the wide range of one-on-one supervision provided to youth (ranging from as little as one hour/week for all case types to 78 hours/week for

low functioning youth). Youth typically spent about half of their day in school or doing school-related work (which points to school as an important yet rarely emphasized outcome area); and only about 13 % of their week is spent in group, individual or family therapy. The majority of this special service time was spent in group therapy while family therapy took up only about one hour a week. As the authors point out, youth spent far more time in expressive therapies than in family therapy, even though research evidence suggests that family therapy is important to the outcomes of residential care.

### **Placement Stability and Permanency**

A large sample of 8,933 (N) children and adolescents in residential treatment facilities in California was examined as to placement stability (i.e. planned versus unplanned discharge) (Sunseri, 2005). Overall, 46.3 % of cases were deemed planned discharges, i.e. there was mutual agreement between parties that RT should end. Treatment goals had been reached in 24.5% of cases; for 15.1% treatment goals had been partially reached, and in 6.7% of cases there was mutual agreement that treatment goals had not been met. Unplanned discharges (43.3%) consisted of cases in which youth had run away (treatment goals partially reached: 11.7%; no improvement: 16.5%); 12.1% of cases in which the program made a unilateral decision of ending placement, including placement breakdown; and 3% of placements ended due to incarceration of the youth. Results of data analysis indicated that more intensive residential programs achieved greater placement stability. Even though youth admitted to these programs had significantly more problematic behaviors at the time of admission, they made greater behavioral improvements over the course of treatment than residents in lower intensity programs. Youth in high level programs also had significantly fewer unplanned discharges regardless of the amount of prior residential/ group home placements. Those young people who were placed into high level programs as their first time placement, stayed a shorter length of time than those placed into lower levels of care, and 67.6% returned to home or home-like settings if discharged in a planned manner. In contrast, of youth who were discharged in an unplanned way 74.8% were discharged either to another residential care program or to more restrictive settings. In addition, results showed that youth who eventually experienced placement instability already exhibited a worsening of behavioral symptoms between the period of admission and discharge. Therefore,

Sunseri (2005) calls for better assessment procedures to place youth in appropriate RTC level rather than simply in lowest intensity program from where they “fail up” the system ladder.

### **Current Trends and Issues**

Whittaker (2000) and Lieberman (2004) outline current trends in RT, and note

- a growth of the numbers of residential facilities with smaller sized living units;
- increased demand because more children enter into the child welfare system;
- children are older at intake and stay for shorter lengths of time;
- children in RT show higher needs than previously because (a) children with lesser needs are served in less restrictive environment, and (b) children who previously would have been remained/placed in hospitals are now placed in RT;
- in certain sectors, facilities become more specialized (e.g., serving youth with substance abuse problems, problems related to sexual offending etc.);
- among residential centers there are more mergers, more closures and less stability in funding; there is an increased business orientation with corporate structures;
- new partnerships on local, regional and state levels have emerged;
- there is a growing emphasis on specification of standardized child and family outcomes as well as on specifying treatment and care protocols; however, there is yet no national set of indicators;
- increased standardization toward individualized, observable plans to return youth to community as quickly as possible;
- information technology, i.e. electronic files and plans are increasingly streamlining work
- managed care as an increasingly common factor;
- an increased focus on mental health issues.

Among the challenges Whittaker (2000) and Lieberman (2004) count:

- residential care often lacks clear diagnostic indicators;
- there are concerns that within some service systems children are placed in RT without first attempting community and family based interventions;
- the framework of continuum of care is a valuable but linear concept and often leads to a better/worse dichotomy in which RT requires “failure” at lower levels;

- there are concerns about the disruption of attachment through RT;
- there are fears of abuse and neglect within residential settings;
- the body of evidence about the effectiveness of residential treatment is questionable;
- there is a lack of consensus on critical intervention components;
- there is a lack of residential treatment theory development;
- high cost of care are reasons for concern;
- there may be biases in service selection;
- turnover and training problems for child care workers who are often not involved in planning, and remain poorly paid.

### **VOICES FROM THE FIELD – WHAT FAMILIES, YOUTH, AND PROFESSIONALS SAY**

Among the reviewed sources, several articles reflected specifically the insights from families, youth, and professionals in residential facilities. A qualitative study on permanency outcomes and planning (Freundlich & Avery, 2005) involved interviews with 77 (N) participants, including 56 professionals (family court judges and referees, private child welfare agencies, children’s lawyers, social workers, and advocacy group representatives), 21 former clients and two focus groups with 10 former consumers. Professionals’ views varied on how central permanency goals are especially with older youth. Professional respondents seemed divided over the question if adoption or independent living was an appropriate permanency goal for older youth. They were also critical of the quality of permanency planning and noted the enduring misconception by staff that families are either unimportant or uninterested. Similarly, they found that connections to relatives or other important adults are rarely explored. In addition, geographic distance of RT facilities from families’ homes made it more difficult to keep connections. Only two former clients reported having had reunification as their official permanency goal; one reported “independent living” an official goal as although she herself wanted to go home. Consumers varied as to the extent of maintaining connections to family while at RTCs, whether they liked visiting with family or whether their family had taken up the opportunity to stay in contact. Clients also reported they had often been at odds with staff perceptions about who counted as their “family;” some wanted to maintain contact with a former foster family or another relative

but were not supported in their efforts. As to their involvement in planning, their experiences, again, differed widely, and clients emphasized the need to be assertive with caseworkers if they wanted to be included regularly.

Which therapeutic components adolescents and staff found most helpful in RT was the subject of a study examining involving 73 (n) adolescents and 39 (n) mental health workers (MHWs) (Abraham, Reddy, & Furr, 2000). Relationship components of treatment, whether formalized or informal, were identified by clients and staff as the most helpful dimensions of RT. Planned and/or spontaneous social interactions between staff and clients were perceived as highly valuable and important. Among the formal relationships, both groups found individual psychotherapy to be the most helpful intervention. Family involvement (including telephone contacts, letters, and visits) and informal relationships with adult were also viewed as highly valuable and important by both groups. Adolescents felt that specialty group therapy, a focused short-term intervention, was more helpful than ongoing process group therapy. And while adolescents thought the level system was only “sometimes helpful,” MHWs found it “often helpful”.

Results of youth focus groups in a Canadian group home (Pazaratz, 1999) underscored the importance of relationships with staff. Youth reported finding control more acceptable from staff with whom they had a positive relationship. Youth who had positive relations to staff exhibited fewer problems, were better at school and had better friendships. Focus groups with staff indicated that they, too, emphasized relationships and the development of values, such as trust, respect, etc.

In an interview, Sandra Spencer, currently Executive Director of the Federation of Families for Children’s Mental Health ([www.ffcmh.org](http://www.ffcmh.org)) and mother of a child who has been in residential services, outlines her experiences and recommendations from a parent’s perspective (Spencer & Powell, 2000). Spencer’s main points include

(a) Accessibility policies

*“The hardest part of placement in most residential homes is that they have a rule that during the first week or so they don’t want visitation because they want the kids to adjust*

*... I pleaded with them because Stephen was so young [4.5 years]. But I thought even if he were fifteen I would have had a hard time with that...*

(b) Sharing information

*"I found out that families had to continue to go [to staff] and continue to ask. ... how [Stephen] was getting along at the group home; how he was getting along with the other kids; ... They were really hesitant sometimes about sharing all the information with me. Finally we made up a little behavior report card... It was validating for me because he was in a treatment group home and he was still having difficulties with his behaviors all during the day..."*

(c) Sharing training and knowledge with parents

*"I said to them that if they would teach family members the techniques they were using and how they worked, then we could continue to use them on the weekends and even when they left the residential care. ... Not teaching me what they discovered would be defeating the purpose of placement.... Sharing that kind of training and knowledge with family members is critical. Children in residential treatment settings learn wonderful ways to control their behaviors, and the staff should also teach the family new ways to respond when their child comes home."*

(d) Transition planning and pacing

*"I wanted them to have a more extensive transition process for us... we had a meeting with the staff from the group home and some teachers at the school he was transitioning into, and we developed a plan for him to begin visiting the school. One of the staff from the residential center went with him... It took three or four weeks to completely transition him into public school, but I think that was critical. At the same time he was spending more and more time at home... I think that the transition period made it successful. But here again, this wasn't something that was initiated by the residential home."*

(e) Matching family resources

*"One of the things that I continue to advocate for is to make sure that they are not putting the kids in situations that are impossible for families to keep up with at home. We didn't have shift workers at my house that could come in and sit up with him all night. Because it is so structured at the residential home, they never gave the children independent time where they had to be on their own. They never sent them to their room to play by themselves or to be by themselves and create things to do to occupy their time."*

(f) Family-Centered/ Culturally sensitive services

*"[During an inpatient time at a hospital] they really respected our relationship and our culture and the way we did things. They asked how we did things. They asked about our religious preferences. They asked permission for Stephen to participate in some religious services there since they knew we did that at home. Mutual respect and believing that learning and discovery is two ways, was helpful. Families need to be given a voice--what are their hopes, dreams, and aspirations? Then you try to help them get there."*

(g) Family support

*"We've found that support groups have been really helpful for families. ... I would meet other family members who were visiting. Somehow we would congregate and start talking, and it was so supportive. I wish that would happen as a planned activity in all residential placements... because it is a critical time for families--when their child is*

*away from home. Why not plan a time when all the families could talk and support one another? ... The residential treatment staff could serve as facilitators and resource people. Also, some families might like to be assigned a mentor or a special family support person who has been through the experience.”*

Spencer’s themes are mirrored in a qualitative study by Demmitt and Joanning (1998) who conducted interviews with 17 parents eliciting their description of experiences with RT. Again, the main theme emerging from interviews was parents’ desire for increased *involvement of parents as experts and partners in their child’s treatment*. A majority reported they had not been asked about goals for the child, and attitudes of RT staff were a frequently named as an obstacle to involvement. Parents wanted more sharing of information about day-to-day activities, behaviors and disciplinary activities. Triangulation was a frequently occurring behavior in children but often remained unaddressed. In cases of divorced families, parents often felt that staff was taking sides. Parents often felt sidelined by staff precluding them from partaking in decision making. They wished staff would make efforts to get to know the families, and maybe visit their homes. Pre-visits to the RTC were also seen as helpful. While parents generally considered meetings as important and helpful most reported having missed a *quarterly staffing/meeting* due to not being informed or because meetings had been scheduled at inconvenient times. When parents were separated, they were particularly sensitive about the need of both parents being informed and they preferred information over the phone. Families also wished that all key professionals (therapist, nurse, etc.) be present at such meetings to give whole picture of the child. Parents wished for *more home visits, more involvement in decisions about home visits* or their cancellations, and wanted to receive *feedback* to the forms they had to fill out after a visit. Parents found the phase system used at the RT confusing, wanted more information, and wished to be part of the phase treatment goals. Many parents had found *family therapy* helpful and thought that if family problems are identified as key issue, than family should be the focus of treatment. Parents wished family therapy had continued as an *aftercare* services. At the same time, parents wanted family therapists to be more assertive about goals and attendance, and wished that sessions should reflect the parents’ agenda and not just the child’s. Sometimes meetings should occur without child to allow for discussions between involved adults. Parents also wished for *parent support* groups. Their *advice to other parents* is that families need to be involved in treatment, know what is expected of them and their child, need to know how to be “pushy” and “play the game” of professionals, try to develop a relationship with staff, and need

to learn the labels staff uses. *Parents' advice to professionals* is to remember how difficult it is for parents to leave a child in someone else's care; to be respectful, and not talk down to parents, take them seriously, respect parents' expertise on the child, spend more time building a relationship with parents; and be cautious with labels.

Geographic distance frequently poses problems in rural areas (Spencer & Powell, 2000) and may preclude frequent face-to-face family therapy sessions. Results of a study by Springer and Stahmann (1998) indicate that parents also value family therapy over the telephone. Parents found phone interventions effective for helping family functioning and communication. The more frequently parents spoke with youth and therapists together, the more they perceived conversations as helpful. Speaking only with youth or only with therapists did not correlate with better scores in functioning, communication or satisfaction.

Parent-child contacts are also the subject of national accreditation standards by accrediting bodies such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Council on Accreditation for Children and Family Services (COA). As Robinson et al. (2005) point out, these regulatory bodies insist that any restrictions to parent-child contact have to be fully explained, have to be disclosed prior to placement, have to benefit the individual served, and should be determined with the participation of the youth and the family whenever possible. In addition, the COA requires regular reviews to establish if restrictions on contact are indeed therapeutically effective. Generally, restrictions on parent-child contact should be imposed only under three conditions: judicial orders, potential for child endangerment, and the possibility of adverse effects on the child's mental health and development.

In spite of these standards, a cross-sectional study by Robinson et al. (2005) found that restricted contact to their children is a common experience for parents. Of 102 (n) parents in the study, almost 60 % reported that contact was limited during the initial 1–8 weeks following admission. Such restrictions during the initial placement period were frequently presented as necessary to help the child's adjustment, and were applied regardless of children's age. As the authors point out, there is no empirical evidence that supports the idea; rather, contemporary child welfare literature underscores "the importance of preserving children's attachment to their

parents and minimizing the stress and trauma of separation.” (p. 639). Beyond the initial time in RT, 79.4% of parents reported at least one type of restriction for contact. Almost 40% reported restrictions on telephone calls; 35.6% on day visits at the facility; 46.9% on day visits away from the facility; and 60 % restrictions on home visits. About half of the respondents reported that a point and level system interfered with contacts since such contacts were constructed as a privilege to be earned by youth. Sixteen percent of parents indicated that contact was made contingent on the behaviors of other youth in the RT. In addition, analysis of results revealed statistical difference for contact restrictions for parents of girls and single parents who were more likely to report restrictions. Also, parents who did not have legal custody of their children were also more likely to report restrictions.

#### **Summary: What Families, Youth and Professionals Say**

- ✓ Resist the misconception that families are unimportant or uninterested
- ✓ Remember that relationship components (planned and/or spontaneous) are deemed most important
- ✓ Allow clients to define who counts as their “family”
- ✓ Include and involve youth and families in all planning procedures including permanency planning, goal setting, etc.
- ✓ Ensure regular home visits and involvement in decisions re. home visits
- ✓ Share information regularly
- ✓ Share training and knowledge with families
- ✓ Plan transitions and pacing of transitions early and in detail with families
- ✓ Make certain that RT policies ensure accessibility for families
- ✓ Visits and contacts with families are not privileges to be earned but necessary and useful rights
- ✓ Restrictions to parent-child contact must be fully explained prior to placement, have to benefit the child, and should be determined with the participation of youth and family
- ✓ Only judicial orders, potential for child endangerment, and the possibility of adverse effects on the child’s mental health and development necessitate restrictions for contacts.
- ✓ Employ strategies in treatment that can be replicated in the family environment (matching family resources)
- ✓ Use family-centered and culturally sensitive services
- ✓ Treat parents as experts and partners
- ✓ Maximize family therapy
- ✓ Ensure and offer aftercare
- ✓ Offer family support groups

## EFFECTIVENESS RESEARCH

The current evidence base for the effectiveness of RT is still rather limited and lacks methodologically strong studies. Studies frequently employ single sample, pretest-posttest, or posttest-only designs without control or comparison groups. In addition, they often provide only minimal information on interventions or sample, and encounter high attrition (Hair, 2005). Therefore all findings on residential treatment should be considered cautiously.

### Systematic Reviews of Empirical Literature

The most current systematic review of outcome studies on residential care for children and youth with emotional and behavioral disorders is provided by Hair (2005) who reviewed 18 studies of programs for children and/or adolescents with severe emotional and/or behavioral problems, which employed trained staff, provided some on-site schooling for at least some residents, and had as a goal the return to family members, alternate caregivers, or independent living. The author distinguished outcomes at discharge from outcomes after discharge. For outcomes measured at the time of discharge, research evidence shows that *frequent family visits and participation in family therapy is associated with successful outcomes*. In addition, at-risk behaviors typically reduced during the first six months of residential care suggesting that a shorter length of stay may very well allow for major treatment gains and leave more bed availability when structured, predictable containment is needed. No particular diagnosis had a notable impact on outcomes. While some RTs resulted in positive results for youth with anti-social/ conduct disorders (if they completed treatment), family/foster care settings seem to lead to better outcomes. Ongoing success after discharge from residential treatment was associated with three key factors: (a) the *extent to which the family was involved* in the treatment process before discharge, (b) the *stability of the place where the child or adolescent goes to live* after discharge, and (c) *the availability of aftercare support* for the child or youth and their families. Among those three, family involvement and support had the most significant and consistent effect on successful discharge and continued adaptation to life after RT.

Other authors who reviewed previously published studies (Bates, English, & Kouidou-Giles, 1997; Epstein, 2004; Frensch & Cameron, 2002) arrive at very similar conclusions. While 20-40% of residents show no improvements or deteriorate while in RT (Bates et al., 1997), most children and youth make gains during treatment. Yet, improvements are not easily maintained

and tend to dissipate over time. Factors predicting positive outcomes include shorter lengths of stay, improvements in academic achievement, and better results in clinical work with a child's family. Successful patterns of adjustment after discharge again hinged on two factors: the stability and support in the post-treatment environment to which a child or youth is discharged, and the degree of family involvement during treatment.

### **Longitudinal Follow-Up**

Longitudinal follow-up studies that examine outcomes years after discharge from RT are few and far between.

- Kaminsky (1998) evaluated the psychological, behavioral, and educational functioning of 30 young men who left residential treatment between 1986 and 1993. The author found that a large majority (83%) of former residents lived independently in the community in their own apartment or with significant others. Good outcomes were related to good social functioning and achieving treatment goals (such as improved social functioning, lower substance abuse, and the completion of more education after discharge.) Those who had poor outcomes had previously experienced dysfunctional early home environment, early substance abuse, had displayed antisocial behavior or personality disorders. The author concludes that all participants, except those young men with the most extreme antisocial behaviors and substance use, benefited from residential treatment particularly from the opportunity to experience academic achievements.
- A qualitative follow-up study (Asarnow, Aoki, & Elson, 1996) involved primary caregivers of 51 male youth up to three years after being discharged to their families. Findings during the first year post-discharge indicated that 32% of youth ran a risk of out-of-home placement; by the end of the third year the number had increased to a 59% risk. Eventual re-placement to a residential facility or group home was mainly due to violent behaviors toward others or property, and/or running away. There also appeared to be an underutilization of aftercare services by families which may have contributed to need for more structured settings. Families of children with SED, who also had few resources, seemed to experience residential treatment as a "single shot" intervention with no follow-up provided. Thus, the author concluded that residential treatment is not yet understood as part of a system of care, which poses a barrier to access other services.

- A retrospective study (Lyons, Terry, Martinovich, Peterson, & Bouska, 2001) reviewed the clinical status of 285 adolescents over a 2-year period after placement in an RT facility. Results suggest that the effectiveness of residential treatment may be limited to reducing risk behaviors and depression (such as reducing suicidality, self-mutilation, aggression towards others) and to improve management of psychotic episodes. It remains unknown if these gains persist after discharge and there was little evidence that RT improved other functioning. Rather, it appeared that RT may have unintended adverse outcomes for anxiety and hyperactivity. The authors conclude that RT may be somewhat more effective with PTSD and emotional disorders rather than ADHD and behavioral disorders. A lack of details about interventions, the reliance on file review measures, and the absence of control/comparison groups limit this study.

### **Individual Studies**

Findings in individual studies with short-term follow-up include insights such as:

- If the resident and her or his family participated in family therapy the odds were about 8 to 1 that the resident would be discharged to a less restrictive setting. Family therapy was the only significant predictor of successful discharge to a less restrictive setting (Stage, 1999).
- Children who did not go on home visits while in RT were 8.1 times more likely not to complete treatment (Sunseri, 2001). Conversely, children with frequent visits to or from families were 5.7 times more likely and even those with minimal visits were 2.6 times more likely to complete treatment. It may also be possible to predict whether or not a child will be visited by family in the current placement by assessing if the child has been visited in the past: Children with a history of visiting were 10.5 times more likely to have visitors than those without such a history. The likelihood of not completing treatment also increased for youth who do not talk easily with adults (3.6 times); children who tease others (2.9 times); children who use substances (2.2 times); and children with prior residential care placement (2.1) (Sunseri, 2001).
- Family involvement, and viewing the family as a unit was associated with higher success in a study of 150 (N) predominantly female residents (Gorske, Srebalus, & Walls, 2003). Again, discharges deemed successful (64%) were due to family support and

involvement with treatment. Youth who received a combination of various modalities were also more likely to be successful. In contrast, children and adolescents with significant antisocial behaviors, those lacking stable family supports were at risk for unsuccessful outcomes.

- Comparing outcomes for children in RT to those served in Family Preservation Program, Wilmshurst (2002) found that children in family preservation reduced symptoms for internalizing behaviors, ADHD, generalized anxiety, and depression and maintained these gains one year post-treatment. On the other hand, children in RT appeared to experience clinical deterioration for all internalizing symptoms. As a possible explanation, the author points to the much higher amount of family contact in family preservation than in the residential program.
- Going beyond involvement of families, Sunseri (2004a) suggests the need to develop RT program components geared to increase family functioning (akin to Patricia Chamberlain's Treatment Foster Care Model). The author bases his assertion on the robust association of family functioning with treatment outcomes. Children from high functioning families were seven times more likely to complete treatment than those from low functioning families, and five times more likely than counterparts from families with intermediate functioning. Improvement in behavior scores also correlated with higher family functioning. Youth from low functioning families had the worst outcomes in lower intensity programs (only 20.5% completion). The best outcomes (93.9% completion) were noted for children with high functioning families placed into high level programs. As family functioning increases, the probability of being discharged into less restrictive settings also increases. Therefore, the author recommends early and regular assessment of family functioning as guide for placement and inclusion of treatment components to improve family functioning.
- Similarly, an exploratory study of 89 children and adolescents from 5 to 17 years in New Mexico supports family-centered care that emphasizes not only parents' interactions with RT staff, but involvement in all aspects of treatment (Lakin, Brambila, & Sigda, 2004). Such involvement seems to significantly impact families' level of functioning at discharge, which in turn serves to protect young people from later re-admissions. Beyond

participation in family therapy, parents who frequently visited their children had the opportunity to observe and learn from the staff, and could practice skills and strategies.

- Hussey and Guo (2002) suggest that rather than conceptualizing RT placement as a “once and for all cure,” opportunities for shorter and repeatable periods in a residential facility may aid treatment gains and educational achievement for children with less severe disturbances. Examining outcomes for 57 (n) young residential children (ages 5 to 13 years), the authors found little evidence of overall behavioral change during the course of residential treatment. Shorter lengths of stay combined with less severe psychopathology was associated with more positive outcomes suggesting that length of stay may be a proxy for severity of symptoms.
- Two cohorts (N=46) of highly disturbed youth showed positive results following residence in a program initiated by the Texas child welfare agency (Armour, & Schwab, 2005). Most of those youth who successfully completed the project did so in 3 to 7 months. The program offers a highly structured, individualized, behavior modification approach, with no-reject/ no-eject policies, and close staff-youth ratios. A majority of youth moved to less restrictive RTs and stabilized their placement situation and improved functioning. At the 2nd-year evaluation (for cohort 1 only), the percent of children deemed to show benefits had dropped from 85% to 66%.
- Two studies examined changes in life satisfaction in RT (Gilman, & Barry, 2003; Gilman, & Handwerk, 2001) and found mixed results. Results of the first study showed that children were relatively satisfied with their lives upon first arriving at the residential treatment facility and over time significant increases were noted. In the second study, there was a high variability of satisfaction, and global satisfaction actually decreased between in the first month in placement. Adaptation to the new environment was neither immediate nor linear. Beginning with the second month satisfaction increased for a majority of children.
- Employment was associated with positive effects on behavior problems and reading performance (Cone, & Glenwick, 2001). Compared to a non-employed group, youth who worked a moderate 9-13 hours a week showed positive behavioral outcomes, and greatest benefit were reached at about 52 weeks of work.

## Medication in RT

Three studies specifically examined the role and use of medication in RT:

- Foltz (2004) reviewed the efficacy of RT focusing on the use of medication and some psychotherapies. He found that disruptive behavior disorders (including Conduct Disorder, Oppositional Defiant Disorder, and ADHD) and affective disorders, (such as Bipolar Disorder and Major Depression) are increasingly diagnosed and that psychotropic treatment follows adult regimens even though the appropriateness of such protocols and medications for children is uncertain. In particular, the author warns that the common use of SSRIs to treat depression is ill advised given an FDA report which states that only 3 in 15 studies involving children showed favorable outcomes. Also little is known about the effectiveness of psychopharmacology and psychotherapy approaches with PTSD in an adolescent population. Therefore the author advocates judicious use medication and suggests use of strengths based approaches with a focus on the role of therapeutic relationships and building of pro-social skills.
- A study of randomly selected charts compared data from four states (N=732) to determine off-label use of anti-psychotic medication in RTCs (Rawal, Lyons, MacIntyre, & Hunter, 2004). The authors found that anti-psychotic medications are frequently prescribed in RTCs and that 42.9% of children receiving anti-psychotic medications had neither a history of psychoses nor current symptoms of psychosis. Although off-label prescription was inconsistent across various states, most frequently these medications were used with youth who exhibited impulsive behaviors (ADHD), ran away, were physically aggressive, sexually abusive, or showed criminal behaviors.
- At the same time, a small naturalistic study by Connor and McLaughlin (2005) indicates that structured RT and relatively long lengths of stay may help reduce the number of medications youth receive. Of 141 (N) youth in the study only 29 had been admitted on no medication. At discharge, 40 were off medication and 66% were discharged on less medication than at admission. The number of children on multiple concurrent medications dropped substantially, from 78% (87 of 112) of subjects at admission to 48% (48 of 101) at discharge. Correlates of reduced medication use were: reduced psychopathology and lessening symptoms; having an intact biological or adoptive family; and being on non-stimulant medication. Neuroleptic and antipsychotic, antidepressant,

anticonvulsant, lithium, and clonidine use significantly diminished, while stimulant medication use did not decrease. Nonetheless a majority of youth remained on medication.

### **Targeted Programs to Enhance Family Involvement and Build on Family Strengths**

The evidence base for successful strategies to increase family involvement, by engaging families in treatment, becoming more family-centered, or building on individual and family strengths (Lietz, 2004), is still rather limited. However, several studies highlight emerging insights into such practices and their effects:

- The Carolinas Project is a comprehensive intervention designed to help 37 residential providers in North and South Carolina become more family-centered (Alwon et al., 2000). The authors also report on outcomes and outline lessons learned from the two-phased implementation. Data showed that agencies made significant improvements in the levels of parent involvement and decision making in their programs, as well as regarding the overall availability of service aiming directly at families and family members. In addition, agencies achieved specific goals targeted in the action planning process including creating a family-friendly admissions handbook, establishing a parent advisory committee or adding parents to the board, changing policies to create a more family friendly environments, producing newsletters for families, and adding space to allow for family services. Among the lessons learned, authors list the following insights:
  - 1) Importance of Core Values and Principles: project staff initially overestimated the level of awareness and level of commitment to the project by many participants; an orientation packet prior to the initial site-visit by the project coordinator was added.
  - 2) Resistance: participants demonstrated more resistance to family-centered practice principles than anticipated. A revised training curriculum added more empathy building activities in an attempt to facilitate changes in participants' attitudes.
  - 3) More Direction: Early in the consultation process some CEOs expressed the need for more direction from their consultant. They felt that staff and consultants were overly deferential to the feelings of agency administrators and not prescriptive enough about what was or was not family-centered practice.

- 4) Critical Role of Motivation for Change: agencies' trust in and long-standing relationship with the supporting organization increased motivation for change in the absence of other pressures.
- Pierpont and McGinty (2004) describe initial results of a small (N=10) pilot study about a family-oriented RTC in North Carolina. The small program consists of a five-day/week treatment (four beds, plus three for day treatment) as part of local mental health center. It employs behavioral, psychoeducational, individual, group and family therapy approaches, and included existing community services providers such as teachers, therapists etc. Parents had to commit to weekly involvement and work on treatment plans with the child (first with staff assistance/supervision and later alone). Six and 12 months after discharge 7 (70%) children still lived at home. Better outcomes were associated with participation of family and child in all phases of treatment, with families having and using social supports, and continuing with mental health treatment. Authors strongly recommend that RT implement in-home family programming to provide family therapy, individual supports, and arrange group support.
  - A family-centered residential treatment program, REPARE, found positive effects on stability of placement after discharge (Landsman, Groza, Tyler, & Malone, 2001). The program consisted of ongoing parental contact and involvement, shorter stay in the residence (on average 8 months compared to 14 months in the control group), and the availability of supportive aftercare services. For the mostly male Caucasian participants (N=82) in the experimental group, permanency improved by 18 months after discharge as. Youth in the family-centered RT group had a greater likelihood that their post-discharge placement remained stable than their counterparts in the comparison group. The authors conclude that RT is able to maintain a dual focus on children and families and can achieve better permanency.
  - A description and qualitative evaluation of a family-centered, strength-based process model was tested in two children's residential settings in Western North Carolina (Bass, Dosser, & Powell, 2000). Content analysis of interviews with parents, children, and agency staff confirmed that the program appeared to help family members and children achieve a greater level of involvement, and may assist in providing focus and intensity to placement processes as well as a sense of satisfaction with services.

- Nickerson, Salamone, Brooks, and Colby (2004) reviewed existing theoretical and empirical support for strategies to engage families in various contexts. Based on their review, the authors conclude that a strengths-based family systems perspective should guide all interventions in RT. Upon intake, family members and other important figures in the child's social network should be identified and included in the initial assessment. Existing strengths and resources of the child and his or her family should be assessed with standardized strength-based measures. Extensive interviews with the child and family should identify natural mentors as well as interests in work or services. Working with the family from the beginning also allows for identifying interactions and patterns that may become barriers to the transfer of skills learned in placement and makes it possible to address these barriers in the treatment plan. In addition, authors recommend involving youth in activity-based learning, including such as adventure-based learning, work, or service learning activities in the community. Inviting families to work alongside their children might also serve to nurture family bonds and strengths. Being involved throughout the child's time in treatment can be encouraged by an "open door" policy for parents and other significant others. Structured educational and therapeutic activities, such as parent training or support groups, family therapy, as well as social events would be useful. To ease transition back to the family requires that plans be made for children to visit their families for increasing lengths of time.
- An innovative example for an RT program striving to become more family-centered is the description of the "Familyworks" program at River Oak Center for children ages 5 to 12 years in Sacramento, CA (Knecht & Hargrave, 2002). Beginning with an advisory council on how to make RT more family-centered, Familyworks re-designed its program hiring clinical, program and parent advocacy staff to create an intensive family-centered program with a full continuum of parent-centered interventions. Underlying these program changes was an ideological shift toward family-centered attitudes. Program components include
  1. a 6-week orientation for the family to the RT
  2. having parents participate in the education and after-school programs,
  3. offering intensive family therapy that continues through aftercare,
  4. hiring family advocacy supports,
  5. support the family in their natural environment,

6. facilitating the transfer of learning from RT facilities to family and community settings by allowing RT staff to go into the family homes on weekend visits or to community events,
7. participating of the RT in wraparound services, and
8. outreach by family advocate and social worker to build bridges to those parents who felt they had previously been blamed by the system for their child's problems.

A particular challenge pose those children who arrive at RT with little or no family resources. They require intense “detective work involved with locating kinship resources or other connected people” (p. 33) which is unlike typical discharge planning. Although data should be regarded with caution due to a lack of clear research parameters, the authors note that since its implementation in 1999 the average length of stay declined from 14 months to 9 months.

### **Addressing Diversity**

Neither gender, nor age, nor ethnic differences in residential care have yet received much systematic attention (Handwerk, et al. 2006). A study of child welfare data (Baker, Archer, & Curtis 2005) examined a national child welfare sample of 1,167 young people in residential treatment to explore whether the behavioral problems exhibited during the transition to residential treatment varied depending upon the age and gender. They found only 2% of youth in RT were girls under the age of 12, compared with 10% boys in the same age group. The vast majority of youth in RT are older boys (63%) and 24% are girls age 12 and above. The authors suggest that either older boys are more likely to have the kind of mental health problems that lead to placement in RT or that other children with similar problems are placed and/ or treated elsewhere, either in lower levels of the child welfare system or outside the child welfare system altogether. Younger children were found to be less likely to be in the clinical range on somatic complaints and more likely to be in the clinical range on aggression and social problems, were more demanding of attention, hot-tempered, attacking others and destroying property. Older girls were less likely to be in the clinical range on withdrawn and more likely to be exhibit delinquency and externalizing behaviors.

A qualitative study (Okamoto, 2004) examined the concept of relational aggression and its application to high-risk girls in RT. Semi-structured interviews with 16 male practitioners from 9 different agencies in Arizona suggest that relational aggression and victimization can extend beyond peer-to-peer relationships, and play part in the practitioner/client relationship. The author found that girls' anger toward their male practitioners manifested itself often in sexual abuse allegations. Professional respondents described needing to be "cautious," "sensitive, and "hyper-vigilant" to situations that could put them at risk for such allegations.

Examining results for the Teaching Family Model at Boys' and Girls' Town, Larzelere et al. (2004) found that girls improved more than boys in perceived success at discharge and in the restrictiveness of their subsequent living situation. The Teaching Family Model is among the dominant models in the literature and is associated, for instance, with Father Flanagan's Boys' and Girls' Home in Nebraska. TFM utilizes a trained child care couple, known as 'Teaching Parents,' who live with a small group (up to 6) of youth. With a focus on behavior modification, cognitive-behavioral approaches, individual, group, and family psychotherapy, and special education Teaching Parents are trained to teach social, academic, and independent living skills necessary for the successful transition of adolescents to their communities (Lazerele, et al. 2002). The model is used in over 250 group homes across the United States and Canada (Frensch & Cameron, 2002). Studies of TFM's effectiveness support modest in-program gains, particularly in the area of education. However, the model seems to fall short in regards to long-term maintenance of effects and in the post-treatment reduction of delinquent and criminal behavior (Frensch & Cameron, 2002). Perhaps in response to such findings, TFM has expanded on older versions (Lazerele et al., 2002), and now also focuses on pro-social skill building, attempts to incorporate family members, as well as community representatives into the treatment team process, and provides ongoing discharge and aftercare service planning.

The only study specifically presenting a program for girls presents the use of Dialectical Behavior Therapy (DBT) to reduce hospitalization among 68 (N) female youth between the ages of 12 and 18 (Sunseri, 2004b). Preliminary outcomes showed that since implementing DBT there were no premature terminations, and a significant reduction in the number of inpatient days. The author suggests that the implementation of DBT may have been effective in increasing the

clients' motivation to remain in treatment and is likely to have increased girls' skills to cope with stressful periods without engaging in parasuicidal behavior. Based on their experience, the authors caution that youth with conduct disorder may be poor DBT candidates because they often show little or inconsistent remorse or reflective capacities. Authors found that without this capacity, clients have little motivation to make use of skills or engage in other DBT tasks. Data in this study are preliminary, and findings are limited by the small sample, the use of non-equivalent groups for comparison, and shifts in admissions policy from avoiding suicidal clients to seeking them out.

### **Youth with Conduct Disorder**

A number of studies involved primarily or exclusively youth with conduct disorder or those involved in the Juvenile Justice system. Results as to the effectiveness of RT with this population are mixed at best (Underwood et al., 2004). By comparison, the literature on Therapeutic Foster Care provides a good evidence base for successful treatment of this population using the Multidimensional TFC model of the Oregon Social Learning Center (Chamberlain, 2003; Chamberlain, Fisher, & Moore, 2002; Chamberlain & Moore, 1998) (See also Reports # 8 and # 15 available at [www.socwel.ku.edu/occ/projects/cmh/bestPractices.html](http://www.socwel.ku.edu/occ/projects/cmh/bestPractices.html)).

- A study by Shapiro, Welker, and Pierce (1999) examined the effectiveness of RT for 27 mostly male adolescents aged 11-15. Youth in the sample showed high levels of past out-of-home placements and high levels of disrupted family relationships (75% were in state custody). On average, youth remained in RT for a mean length of 12 months. Results did not show consistent findings. There was some evidence of improved functioning for some measures of delinquency-related problems, and almost all of those improvements occurred within the first six months. Only marginally significant improvement was evident in symptomatic behaviors. Most clients did not demonstrate improvement for behavior problems in the eyes of cottage staff, or teachers, nor in their satisfaction with group therapy.
- Peterson and Scanlan (2002) examined outcomes for 37 (n) male youth six and 12 months post-discharge and found that youth who had co-morbid conditions of conduct disorder fared significantly worse than those who did not exhibit such difficulties. Despite the small sample the authors conclude that family home environments are the treatment of choice for youth who have disorders of conduct as their primary or secondary diagnoses.

- Frankfort-Howard and Romm (2002) reviewed records of 42 adolescents identified with antisocial behaviors who had been admitted with a diagnosis of Conduct Disorder, or a juvenile court finding of delinquency, and who had remained in RT for at least eleven months. On average, youth stayed in treatment for 18.7 months. The authors note that compared to the national average of this population, fewer continued in their antisocial behavior into adulthood (28.6%) and none of those who completed treatment were found to be re-offenders in adulthood. Yet, the small sample, lack of control or comparison group and reliance on a record review only severely limits this study.
- A cross-sectional follow-up study involved 111 (N) adolescents (Hooper, Murphy, Devaney, & Hultman, 2000) most of whom were male Caucasian youth (mean age 15 years) with histories of abuse/neglect and diagnosis of conduct disorder. These youth had been discharged from the Whittaker School, in North Carolina, which employs a re-education model with an emphasis on community involvement prior to, during, and after treatment. Specifically, the program offers: community/family-oriented wraparound services (beginning while the student is still in residence); service coordination with local mental health centers; family liaisons to work with families/guardians; psychoeducation; individual education plans; behavior management; community-based individual and family therapies; recreation and leisure skills exposure/ training; pre-vocational development; and ongoing community consultation. During the 24 months after discharge nearly 58% of the students received “satisfactory” ratings from their case managers. However, these outcome measures were rather crude and success rates varied from over 69% at six months post-discharge to about 29% at 24 months. Notably, about 80% of students did not engage (or get caught engaging) in any new illegal activity and most did not require more restrictive levels of care. Successful participants tended to be younger, female, had higher intelligence, higher reading and writing skills, and more internalizing symptoms upon admission into the program. With its single-sample cross-sectional design, the study lacked control/comparison groups.
- A quasi-experimental study by Weis, Wilson, and Whitemarsh (2005) evaluated the effectiveness of a voluntary military-style residential treatment (“boot camp”) program for 242 (N) adolescents with academic and conduct problems. Youth in the program were mostly male adolescents (mean age 17). The treatment group consisted of 192 youth of which 130 (68%) completed the program. Compared to youth who did not complete the program (32%)

or those 47 who were in the wait-list comparison group those who completed the 22-week program showed statistically significant reductions in externalizing and internalizing symptoms from pretreatment to 6-month follow-up and significant increases in adaptive skills, were more likely to earn a high school degree, to be employed full-time, displayed fewer substance use problems and fewer arrests. However, the study lacks longer-term follow up, random assignment, relied on parental reports only for outcomes, and used self-reports by adolescents about their pre-treatment behaviors.

### **Summary: Effectiveness Research**

Evidence for the effectiveness of RT programs is mixed. While most children and youth in RT make gains during treatment, 20-40% of residents show no improvements or deteriorate. There is some indication that medications can be inappropriately utilized, but that RT can also help reduce the number of non-stimulant psychotropic medications youth receive. Issues of diversity in RT are insufficiently researched, and it remains unclear how RT could be more appropriate and effective for girls, or youth of color. RT seems less effective for youth with Conduct Disorder. It appears that this population may generally be better served in Therapeutic Foster Care.

Existing empirical studies on RT, although often methodologically weak, provide consistent evidence for the importance of family involvement and regular contacts with families to ensure positive outcomes. Other factors predicting positive outcomes include shorter lengths of stay (9 months or less), improvements in academic achievement, as well as successful engagement, involvement, and functioning of the child's family.

Improvements made in RT are not easily maintained and tend to dissipate over time. Maintaining improvements after discharge hinges centrally on (a) the degree of family involvement during treatment, and (b) aftercare, i.e. the stability and support in the post-treatment environment to which a child or youth is discharged. To these ends, family-centered approaches and efforts that link RT more closely with community-based services to ensure aftercare are gaining empirical support.

## Special Issue: Restraint and Seclusion

A specific area of concern is the use of restraint and seclusion practices in RT. In a position paper, the **American Association of Children's Residential Centers** (AACRC, 2007) recommends the following practices concerning therapeutic holds, restraint and seclusion:

- That organizations develop a clearly defined behavior management policy which articulates: the organization's philosophy for behavior management; the interventions and maximum duration permitted; and the criteria and authorizations required for utilization of the interventions.
- That organization policy specify that such interventions only be used when the child's behavior presents a danger to self or others; that contraindications, especially physical conditions which may place a child at greater risk be identified; that all incidents be documented; and that all incidents be debriefed with the child.
- That organizations review each intervention for necessity, alternatives considered, alternatives overlooked, effectiveness, procedures utilized, and follow-up action indicated.
- That organizations review these interventions individually and in aggregate to ascertain trends and discover opportunities to reduce their implementation.
- That organizations train staff who work directly with youth in care in a nationally approved regime of non-violent crisis intervention and ensure that the training is updated regularly.
- That organizations provide ongoing training for staff in verbal de-escalation techniques.
- That organizations utilizing these interventions undergo regular reviews of their use by accrediting bodies or state regulatory agencies. Additionally, AACRC recommends the following national initiatives:
  - That national accrediting bodies such as the Joint Commission on Accreditation of Healthcare Organizations and/or Council on Accreditation establish a certification and approval process for non-violent intervention regimes.
  - That accreditation surveys or other regulatory reviews include thorough individual and aggregate review of the documentation of restraint and seclusion.

AACRC, online <http://www.aacrc-dc.org>

Although in-depth review of strategies to reduce seclusion and restraint cannot be provided here, programs showing promise to reduce critical incidents at RTCs, including those leading to restraint or seclusion, are the Therapeutic Crisis Intervention (TCI) developed and promoted by Cornell University since the 1980s (Nunno, Holden & Leidy, 2003), the skill-based components of the Teaching Family Model (Jones & Timbers, 2003), and other system-wide efforts (Farragher, 2002; Miller, Hunt, & Georges, 2006).

## **CONCLUSION: BEST PRACTICES AND FUTURE DIRECTIONS**

This review of what can currently be considered “best practices” in the field of Residential Treatment for youth with emotional and/or behavioral disorders revealed a high level of consistency among the insights from families, youth, professionals and empirical evidence around two central factors: (1) Involvement of families in RT and maximizing regular contacts between child and family; (2) Ongoing support and aftercare once the child returns home. Best Practices therefore include a shift to family-centered strategies and policies that maximize the meaningful and consistent involvement of families as partners in residential treatment and allow for regular contacts. Such policies and strategies ideally include:

- allowing clients to define who counts as their “family;”
- including and involving youth and families in all planning procedures including permanency planning, goal setting, decisions regarding home visits, etc.;
- ensuring regular contacts and home visits (which are not privileges to be earned);
- discussing and explaining any intentions to restrict parent-child contact with youth and family;
- regularly sharing information with families;
- systematically sharing training and knowledge with families;
- planning transitions and pacing of transitions early and in detail with families;
- focusing on relationship components (planned and/or spontaneous) are deemed most important;
- making certain that RT policies ensure accessibility for families;
- employing strategies in treatment that can be replicated in the family environment;
- using culturally sensitive services;
- treating parents as experts and partners;
- maximizing amount and quantity of family therapy;
- offering family support groups.

Other characteristics that, with less consistent evidence, seem to emerge as best practices include (Abraham et al., 2000; Pazaratz, 1999; Whittaker, 2000):

- focusing on positive relational aspects in formal and informal treatment components (which may also be linked to reduced restraint and seclusion);

- individual treatment plans,
- teaching social, coping and living skills,
- and ensuring positive peer influence and interaction.

Since what happens *outside* of residential treatment is of equal or greater importance than what happened during RT (Nickerson et al. 2004), ensuring and offering support and aftercare is essential to help youth maintain gains made. To this end, RT will require a greater and clearer integration into the continuum of care replete with more permeability (Lieberman, 2004; McCurdy, & McIntyre, 2004). Whittaker (2000, p. 27) calls for “a new service continuum that softens the differences and blurs the boundaries between in-home and out-of-home options such as shared care, respite care, and partial placements.” Related suggestions (Leichtman & Leichtman, 2002; Lieberman, 2004; Whittaker, 2000) include

- involving RT staff in community-based services such as wraparound;
- conceptualizing RT centers as a hub for local services for stabilization, assessment, and planning with community partners and close parent partnerships;
- establishing community partnerships and locating RT in a community-service network;
- co-locating services such as family support and residential care;
- expanding residential respite options, developing more creative short term residential treatment programs, or step-down group care of lesser intensity (Baker, Archer, & Melnick, 2004; Baker & Calderon 2004);
- focusing on both child well being and family functioning as outcome measures;
- developing models that serve the whole family.

Finally, in light of the much needed evidence base to monitor the effects and quality of RT, it is important for RT programs to establish clear and consistent outcome measures, and collect data regularly (Davidson-Methot, 2004; Connor, et al., 2002; Lyons & McCullough, 2006; Zimmerman, 2004).

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## Appendix A: Matrix of Selected Literature

#	Author(s) & Date	Type of Article	Key Variables/Components	Main Conclusions
1	Abraham, P.P., Reddy, L., & Furr, M. (2000). Adolescents' and Mental Health Workers' Perceptions of Helpfulness in a Residential Treatment Setting, <i>Residential Treatment for Children &amp; Youth</i> , 17 (4), 55-66.	Study examining 73 (n) adolescents' and 39 mental health workers' (MHWs) perceptions of helpfulness on 16 therapeutic components and services using self-report questionnaires.	<b>Sample:</b> <u>Adolescents:</u> 26 females, 47 males (mean age 16.4 years), 72% Caucasian, 21% African American, 6% Latino American; <u>Diagnoses:</u> mood disorders, disruptive behavior, anxiety, psychotic disorders, and personality disorders with over 50% comorbidity. Mean length of stay 18 months. <u>MHWs:</u> 19 females and 20 males, full-time employees; 74% Caucasian, 18.5% African American, average age was 24.48 years. All with bachelor degrees, average length of employment was 2.8 years. <b>Measures:</b> self-report questionnaire <b>Intervention/Program:</b> psycho-dynamic and cognitive behavioral interventions provided individual therapy for the adolescents two times a week.	<b>Results:</b> Relationship components of treatment, whether formalized or informal, were found to be the most helpful dimensions of residential treatment by adolescents and MHWs. Therefore, planned and/or spontaneous social interactions between staff and clients were perceived as highly valuable and important to both groups. Both groups rated individual psychotherapy as the most helpful formal relationship intervention. One-to-one relationship interventions with opportunities to interact and engage in affective exchanges were highly valued by both groups. Family involvement (i.e., telephone contacts, letters, and visits) and adult informal relationships were also viewed by both adolescents and MHWs as extremely valuable and important. Adolescents indicated that a focused short-term intervention was more helpful than an ongoing process group therapy intervention. In contrast, MHWs rated both group interventions as equally helpful. Both groups found highly structured programs (recreation and school), with clearly defined levels of involvement and peer group activities, as helpful.
2	Alwon, F. J., Cunningham, L. A., Phillips, J., Reitz, A. L., Small, R. W., & Waldron, V. M., (2000). The Carolinas Project: A Comprehensive Intervention to Support Family-Centered Group Care Practice, <i>Residential Treatment for Children &amp; Youth</i> , 17 (3), 47-62.	Describes a strategic change intervention designed to help a large number of residential providers in North and South Carolina become more family-centered. The article also reports on the project's outcomes and outlines lessons learned from this experience.	The Carolinas Project (TCP) began with a comprehensive staff development program and technical assistance for 37 participating RT centers. The project later focused on facilitating closer collaboration between private providers and public agencies: <b>Phase I</b> began in early 1994 with establishing relationships and credibility with influential leaders; developing curricula and devising a program evaluation model. <b>Phase II</b> (starting in 1997) increased collaboration in family-centered service provision between participating care providers and the public sector. Additional goals included: ongoing basic training and advanced training in family-centered practice; training-for-trainers; supporting continued collaboration; producing a newsletter. <b>Measures:</b> Trieschman Family Centered Group Care Instrument (TFCGCI) a self-assessment instrument to measure an organization's level of family-centered practice in four areas: family participation in program; family involvement in decision making; availability of services to families; and staff attitudes to families.	<b>Results:</b> TFCGCI data showed that agencies made significant improvements in the levels of parent involvement and decision making in their programs, as well as in the overall availability of services directly targeting families and family members. In addition, agencies achieved a large number of specific goals targeted in the action planning process including: 70% created or revised a family-friendly admissions handbook; 25% established a parent advisory committee, or added parent(s) to the governing board; 30% made significant policy changes to create a more family friendly environment; 30% produced newsletters for families; 15% built new structures or remodeled existing buildings to provide services for families. <b>Lessons Learned:</b> <ol style="list-style-type: none"> <li>1) Orientation to Core Values and Principles</li> <li>2) Resistance: participants demonstrated more resistance to family-centered practice principles than anticipated.</li> <li>3) More Direction: Early in the consultation process a few CEOs expressed the need for more direction from their consultant. They felt that staff and consultants were overly deferential to the feelings of agency administrators and not prescriptive enough about what was or was not family-centered practice.</li> <li>4) Critical Role of Motivation for Change:</li> <li>5) CEO involvement: better results were noted for agencies whose CEOs clearly supported the effort.</li> </ol>

				<p>6) Positive peer influence: The strengthening of collaborative relationships was a positive by-product</p> <p>7) Multiple Exposures/ Facets: There is a need to provide multiple exposures to a core set of critical themes that support the project's primary goals.</p>
3	<p>Armour, M. P. &amp; Schwab, J. (2005). Reintegrating Children Into the System of Substitute Care: Evaluation of the Exceptional Care Pilot Project, <i>Research on Social Work Practice</i> 15 (5); 404-417.</p>	<p>Pilot study</p> <p>Texas Department of Protective and Regulatory Services (TDPRS) initiated the Exceptional Care Pilot Project (E6)</p>	<p><b>Sample:</b> 61% female; age 9 to 18 years (M = 15 years), 43% White, 30% African-Americans, 11% Hispanic; all with extensive histories of severe comorbid diagnoses and inpatient psychiatric hospitalizations; 97.8% of children (n = 45) disrupted multiple placements; 95.6% (n = 44) histories of aggression toward adults.</p> <p><b>Measures</b> data available for cohort 1 (n=27): years 1 and 2; for cohort 2 (n=19): year 1 only. (a) Level of Care (LOC) status, (b) domains (<i>i.e.</i> safety socialization, education etc.) (c) Children's Global Assessment of Functioning (CGAS), (d) audiotaped assessment interviews.</p> <p><b>Program/Intervention:</b> two facilities, no-reject, no-eject policy, both using highly structured, individualized behavior modification programs.</p>	<p><b>Results:</b> As far as comparable both cohorts showed similar results. A majority of youth moved to less restrictive RTs and stabilized their placement situation and improved functioning. Most of those successfully completing the project, did so in 3 to 7 months. At the 2nd-year evaluation (for cohort 1 only), the percent of children deemed to show benefits had dropped from 85% to 66% . Staff attributed children's progress to continual one-on-one monitoring, individualized attention and programming, consistency in limit setting, behavioral management, and a highly structured environment. At the same time interviewed staff expected many of the children who completed E6 placements to cycle back again due to the children's erratic and volatile behaviors.</p> <p><b>Limitations:</b> small sample, no control/comparison, limited measures, changes in workers' attitudes and behavior may have contributed to changes</p>
4	<p>Asarnow, J. R., Aoki, W., &amp; Elson, S. (1996). Children in residential treatment: A follow-up study, <i>Journal of Clinical Child Psychology</i>, 25, 209–214.</p>	<p>Qualitative follow-up study using interviews with primary caregivers of 51 (n) male youth up to three years after being discharged to their families</p>	<p><b>Sample:</b> 100% male, 63% Caucasian, 22% African-American, 45% single working parent, 49% admitted from parental home, 24% from group home; 46% CW funded; 49% MH funded; discharged to parent (80%) or relative (20%); mean length of tx: 16.7 months</p> <p><b>Measures:</b> semi-structured telephone interview follow up 2 months to 3 years after discharge</p> <p><b>Intervention/Program:</b> RTC in greater L.A.area. No further details provided.</p>	<p><b>Results:</b> After first year post-discharge, 32% of the youth ran a risk of out-of-home placement, by the end of the third year the number increased to a 59% risk. Placement to a residential facility or group home was due to assaultive behaviors towards others or property and/or running away. There was an underutilization of aftercare services by the families that may have contributed to need for more structured settings. Children and families did participate in required special education services which the residential treatment staff had helped to set up. One barrier to other services is that residential treatment is not understood as part of a system of care. Families with few resources and SED children experience residential treatment as a "single shot" intervention with no follow-up provided.</p>
5	<p>Baker, A.J.L., Archer, M., &amp; Curtis, P.A. (2005). Age and gender differences in emotional and behavioural problems during the transition to residential treatment: the Odyssey Project. <i>International Journal of Social Welfare</i>, 14 (4), 184–194.</p>	<p>Utilizing a national child welfare sample of 1,167 young people in residential treatment, this study explored whether the behavioral problems exhibited during the transition to</p>	<p><b>Sample:</b> 74% male, 40% Caucasian, 37% African-American, 16% Hispanic, mean age 14, 35% neglect/abuse, 66% with reunification goal. Only 2 % were girls under the age of 12, compared with 24 % older girls, 10 % younger boys and 63 % older boys.</p> <p><b>Measures:</b> Age, gender, CBCL scales as reported shortly after admission.</p>	<p><b>Results:</b> Either older boys are more likely to have the types of MH problems that result in placement in a residential treatment centre or other children with similar problems are placed and/or treated elsewhere, in lower levels of the child welfare system or outside the child welfare system. Across all gender and age groups the proportion of youth in the clinical range was well above community norms. Age and gender were both significant variables. Younger children were found to be less likely to be in the clinical range on somatic complaints and more likely to be in the clinical range on aggression and social problems. Girls (mostly being older) were less likely to be in the clinical range on withdrawn and more likely to be in the clinical range on delinquency and externalizing. Younger</p>

		residential treatment varied depending upon the age and gender.		children were found to be demanding of attention, hot-tempered, attacking others, fighting, screaming, and destroying their own and other's property. These types of behaviors are likely to put the younger children as well as their peers at risk of harm, and require clinical expertise in crisis intervention and de-escalation techniques.
6	Baker, A.J.L., Archer, M., & Melnick, D. (2004). An Alternative to Hospitalizing Youth in Psychiatric Crises: The Children's Village Crisis Residence Model, <i>Residential Treatment for Children &amp; Youth</i> , 22 (1), 55-74.	Description and study of a hospital diversion program for treating (103 N) young persons who are in psychiatric crisis. Data for one fiscal year are presented.	<p><b>Sample</b> referred from RTC (n = 32): 100% male, mostly ethnic minority, 75% prior hospitalizations, mean age 14.6, Mean LOS = 6.86 weeks  Outside agency referral (n = 71): 42% male, mostly ethnic minority, 58.5% prior hospitalizations, mean age 13.5.  Outside Referrals from Biological Families Mean LOS = 4.17, Outside Referrals from Foster Homes Mean LOS = 3.77</p> <p><b>Measures</b>  History of Maltreatment and Behavior Problems, Precipitating Events and Behaviors, Presenting Problems</p> <p><b>Program/Intervention:</b>  The Crisis Residence program was developed to avert psychiatric hospitalization of residents and expanded to serve community young people. The resident to staff ratio is 3:1. Behavioral level system, individual psychotherapy, family therapy, group therapy</p>	<p><b>Results:</b> For the majority of residents served in the Crisis Residence, the program functioned as a respite and/or a short-term treatment setting that allowed them to regain stability and return to their residence. For the subset of residents who went to a higher level of care, the Crisis Residence functioned as an intermediary "step-up" in the continuum of care between the prior residence and the discharge destination. In general, the residents exhibited a range of problem behaviors across several functional areas. The authors note that with a few exceptions, much less was known about the events that precipitated the admission to the Crisis Residence than the behaviors of the young person. Pattern of discharge was similar for the three groups: About two-thirds of the residents in each sample was discharged to the residence they were living at prior to the admission to the Crisis Residence (67.7% of the Agency RTC residents went back to the agency RTC, 66.7% of the residents who came from a biological family returned to their biological family and 67.5% of the residents living with a foster family prior to the admission went back to a foster home). A small proportion was discharged to a lower level of care (between 3% and 4% in each sample), and about one-third of the sample was discharged to a higher level of care.</p> <p><b>Limitations:</b> small sample, no comparison/control, no follow up.</p>
7	Baker, A.J.L., Wulczyn, F., & Dale, N. (2005). Covariates of Length of Stay in Residential Treatment, <i>Child Welfare</i> , 84 (3), 363-386.	Study exploring variables associated with length of stay for 416 boys (N) in RTC.	<p><b>Sample:</b> all male, ages 5-17 (m=12); 96% Black or Hispanic; 83% abuse/neglect or voluntary placements, 31% history of running away, 58% parental substance abuse, 47% previous psychiatric hospitalization/suicidality, 62% previous CW placement.</p> <p><b>Measures:</b> discharge status, length of stay</p> <p><b>Program/Intervention</b> not specified</p>	<p><b>Results:</b> discharged to parents or relatives (45%), transfer to other setting (41%- mostly within first six months or after 4 years in RT, majority to less restrictive settings), run away (14%- mostly within first 6 months); median duration 1.7 years but length of stay varied significantly with type of exit (transferred 1.98 years; run away 0.78 years) . MH concerns (like psychiatric crisis) were linked significantly to longer stays (adding 7 months) for reunified and transferred children alike. The author points out that such crisis can be brought on by external factors in the RT system or family. For transferred children, prior placements, and prior hospitalization/ suicidal behaviors were covariates of quicker discharge. Run away status was linked to being older, substance abuse, parental incarceration and juvenile delinquency.</p>
8	Bass, L.L., Dosser, D.A., & Powell, J.Y., (2000). Celebrating	Description and qualitative evaluation of a	<p><b>Sample:</b> family members and staff at two RTCs. No further details given</p> <p><b>Measures/Methods</b></p>	<p><b>Results:</b> Content analysis of interviews with parents, children, and agency staff confirmed that the schema did help family members and children achieve a greater level of involvement;</p>

	Change: A Schema for Family-Centered Practice in Residential Settings, <i>Residential Treatment for Children &amp; Youth</i> , 17 (3), 123-137.	family-centered, strength-based helping process model tested in two children's residential settings.	Qualitative interviews were conducted with family members and staff at the conclusion of the study at both test sites. <b>Intervention/Program:</b> two residential homes for children in Western North Carolina implemented the "schema," which is based on family-centered principles and aims to increase hope and expectancy for change.	that using the schema could help provide focus and intensity to placement processes; tended to indicate using the "Schema" helped to create a sense of satisfaction with services. It remained unclear if the family story/ narrative aspects of the Schema helped family members to have a greater appreciation of their family heritage, ethnicity and culture
9	Bates, B. C., English, D. J., & Kouidou-Giles, S. (1997). Residential treatment and its alternatives: A review of the literature. <i>Child &amp; Youth Care Forum</i> , 26 (1), 7-51.	Review	treatment modalities characteristics of youth <u>effectiveness</u> aftercare comparison to alternatives	<b>Findings</b> as to effectiveness are mixed at best and riddled with methodological limitations. This finding holds across modalities. While positive changes can be found at discharge, gains often dissipate quickly especially for youth with substance abuse, SED, or conduct disorder/ juvenile delinquency. In addition, 20-40% of residents show no improvements or deteriorate while in RTC. Studies lack control/ comparison group, samples are small and often involve only one site, measures used are often not standardized. Limitation: inclusion/exclusion criteria of reviewed publications not given.
10	Connor, D.F. M.D., & McLaughlin, T.J. (2005). A Naturalistic Study of Medication Reduction in a Residential Treatment Setting, <i>Journal of Child and Adolescent Psychopharmacology</i> , 15 (2), 302-310.	A review study of the treatment of 141 SED patients (N) admitted to, and discharged from, a residential treatment setting between 1992 and 2001 to ascertain factors in reducing psychiatric medications.	<b>Sample:</b> 112 (n) admitted on medication and 29 (n) admitted on no medication, in both groups: majority male from biological or adoptive homes, most with previous placements, history of abuse, and similarly high externalizing scores. The no-medication group was on average a year older (m=14) and had lower internalizing scores. Mean length of stay not significantly different; for medication group 662 days; non-med group 506 days (wide ranges in both groups). <b>Measures:</b> psychiatric history, family history, Devereux Scale of functioning, medication use Reduction of medication use was not the explicit aim of the study, and participating psychiatrists were not aware of this interest. Thus the study explores the "naturally occurring" rate and circumstances of reduced medication at one RT facility.	<b>Results</b> suggest that multiple and complex medication regimens can be reduced in therapeutic and structured treatment environments and relatively long lengths of stay. Since the majority of youth were discharged on some medication, psychopharmacology continues to be an important component of treatment. Correlates of less med use: (1) children who showed reduced psychopathology and lessening symptoms; (2) children with a biological or adoptive parent caregiver, and (3) those on non-stimulant medication. Also there was a strong trend in the data for abused children to be less likely to have medication reductions at discharge than nonabused children. Of all children 40 were on no medication at discharge as compared to 29 on no meds when they were admitted. 19 children were discharged off all medications. Of the 29 children admitted on no medications, 21 children were discharged on no medications. Of those who entered RT on meds, 74 children (66.1%) were discharged from residential treatment on less medication than at admission, and 38 children (33.9%) did not. Only stimulant medication use did not decrease. The number of children on multiple concurrent medications dropped substantially, from 78% (87 of 112) of subjects at admission to 48% (48 of 101) at discharge.
11	Demmitt, A.D., & Joanning, H. (1998). A Parent-based description of residential treatment, <i>Journal of Family Psychotherapy</i> ,	Qualitative interview study of 17 parents.	<b>Sample:</b> 17 (n) parents, 13 women, 4 men, mostly Caucasian, age 29-58, majority HS graduates. <b>Methods:</b> Focus groups with emergent design, beginning with a general question about families' experiences. Domain analysis.	<b>Results:</b> Main theme was desire for increased involvement of parents as experts and partners in child's treatment. Most parents reported having missed a meeting due to not being informed or meetings being scheduled at inconvenient times. A majority reported they were not asked about goals for the child, cottage staff attitudes were a frequently named obstacle

	9 (1), 47-66.		<b>Program/Intervention:</b> RTC in the Midwest with goal of reunification. No further details provided.	to involvement, parents were concerned about peers' influence; one mother found it particularly helpful to be part of cottage activities. Triangulation was a frequently occurring behavior and often not addressed. Parents wanted more sharing of information about day-to-day activities, behaviors and disciplinary activities; in cases of divorced families parents often felt that staff was taking sides. Parents wished for more home visits, more involvement in decisions about home visits or their cancellations, and wanted to received feedback to the forms they had to fill out after a visit. Parents found phase systems confusing, wanted more information, and wished to be part of the phase treatment goals. Professionals should spend more time building a relationship with parents and be cautious with labels. Family therapists should be more assertive re. goals and attendance. Many found FT helpful and wished it had continued as aftercare. Parents wanted parent support groups. Parents wished staff would make efforts to get to know the families, maybe visit their homes. Previsits to the RTC were seen as helpful.
12	Foltz, R.(2004). The Efficacy of Residential Treatment: An Overview of the Evidence, <i>Residential Treatment for Children &amp; Youth</i> , 22 (2), 1-19.	Review of evidence of medication (and some psychotherapy) and by type of disorder	<ul style="list-style-type: none"> <li>• Findings of efficacy research</li> <li>• findings from a RTC survey</li> <li>• conclusions and recommendations</li> </ul>	Author notes a trend for RTCs to become more characteristic of inpatient psychiatric units. The severity of behaviors that RTCs are expected to control is ever increasing. RTCs are expected to deal with behaviors that were previously managed within a hospitalization. Disruptive behavior disorders (including Conduct Disorder, Oppositional Defiant Disorder, and ADHD), and affective disorders are increasingly diagnosed in young people and tx follows adult regimens even though the appropriateness of such protocols and medications for children is uncertain. At the same time a study revealed considerable diagnostic overlap between bipolar disorder and ADHD, conduct disorder, oppositional defiant disorder, and substance use disorder, which confound the accuracy of any "true" diagnostic category. The common use of SSRIs to treat depression seems ill advised in light of an FDA report which found that in 15 studies, involving children aged 6 to 18 years old, only 3 studies showed favorable outcomes when compared to placebo. Anxiety/PTSD: Over an extended period of time, very little is known about the effectiveness of psychopharmacology and psychotherapy approaches with PTSD in an adolescent population. Author advocates judicious use medication and suggests use of strengths based approaches with a focus on the role of therapeutic relationships and building of pro-social skills.
13	Frankfort-Howard, R., & Romm, S. (2002). Outcomes of residential treatment of antisocial	Retrospective record review of 42 adolescents who were	<b>Sample:</b> 14 to 18 years (m=15), 90.5% males, 45% African American, 31% Caucasian, 19% Hispanic, and 4.8% had one Caucasian parent and one African American parent. Remained in	<b>Result:</b> Fewer young persons persisted in their antisocial behavior into adulthood (28.6%) as compared to the national average (40-50%) of this population. None of those who completed treatment were re-offenders in adulthood. Adult

	youth: Development of or cessation from adult antisocial behavior. <i>Residential Treatment for Children and Youth, 19, 53–70.</i>	identified with antisocial behaviors.	RT for at least 11 months. Mean length of time in treatment 18.7 months, at time of review discharged from residence for an average of six years.  <b>Measures:</b> record review  <b>Program/Intervention:</b> “eclectic therapeutic milieu model” including individual and group therapy, family therapy, community meetings, cognitive and behavioral programs, tutoring, volunteer activities, etc.	antisocial and adult non-antisocial groups look relatively similar across most variables. The antisocial group was more likely than the non-antisocial group to have a diagnosis of Conduct Disorder; be placed in a chemical dependency treatment facility; have a learning disability or attention problems; experience abuse or neglect; abuse drugs or alcohol; have more arrests for juvenile and adult crimes against persons, adult crimes against property, adult drug related crimes, and adult disorderly conduct; be separated from their family before the age of 10; and receive a fair/good rating in individual and family therapy. <b>Limitations:</b> small sample, no control/comparison, record review only.
14	Frensch, K.M & Cameron, G. (2002). Treatment of Choice or a Last Resort ? A Review of Residential Mental Health Placements for Children and Youth, <i>Child &amp; Youth Care Forum, 31</i> (5), 307- 339.	Review of 14 (N) outcome studies	Characteristics of youth and families outcomes for group home and larger RTCs	Residential services have been found to improve functioning for some children. At the same time, any success or gains made by children and youth during treatment are not easily maintained and tend to dissipate over time. Successful patterns of adjustment appear to hinge on two factors: the posttreatment environment to which a child or youth is discharged, and the degree of family involvement during treatment. <b>Group homes:</b> dominated by studies of the teaching family model which 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 youth and teach social, academic, and independent living skills necessary for the successful integration of residents back into the community. Studies of the effectiveness of this model appear to support modest in-program gains, particularly in the area of educational progress. 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. <b>Larger RTCs:</b> Outcome studies of residential treatment centers have produced mixed results. Factors predicting positive outcomes include shorter length of stay, improved academic achievement, and better outcomes from clinical work with a child’s family. Outcome studies offer support for the significant effect of family involvement in treatment.
15	Freundlich, M. & Avery, R. (2005). Planning for permanency for youth in congregate care. <i>Children and Youth Services Review, 27</i> (2), 115-134.	Qualitative Study on permanency outcomes	<b>Sample:</b> 77 participants including family court judges and referees (7), private child welfare agencies (14), children’s lawyers (11), social workers (10), advocacy group representatives (14), former consumers (n=21, mostly female, 18-25 years), plus two focus groups with 10 former consumers  <b>Measures/Domains:</b> permanency, youth	<b>Results:</b> <u>Professionals</u> were critical of quality of permanency planning, noted enduring misconceptions of staff about families being unimportant or uninterested, too little exploration of links to relatives or other important adults; views varied on how central permanency goals are for work with youth, especially teens; divided over appropriateness of adoption or independent living as permanency goal for youth. Keeping connections is made more difficult when RTCs are geographically distant from families’ residences. <u>Former</u>

			<p>involvement in decision making, recommendations for improvement</p> <p><b>Programs/Intervention:</b> foster care youth in “congregate care” in NY including group homes, RT (child welfare only, not MH-run RTCs), maternity facilities, mother-child homes</p>	<p><b>Clients:</b> only two reported having had reunification as their official permanency goal; another reported an official goal as “independent living” while she herself wanted to go home. They varied as to the extent of maintaining connections to family while at RTCs, whether they liked visiting with family or whether their family had taken up the opportunity. Clients were often at odds with staff perceptions of who counted as “family;” some wished to maintain contact with a former foster family or another relative but were not supported in their efforts. As to their involvement in planning, their experiences, again, differed widely, and clients emphasized the need to be assertive with caseworkers if they wanted to be included regularly.</p>
16	<p>Gorske, T.T., Srebalus, D.J., &amp; Walls, R.T. (2003). Adolescents in residential centers: characteristics and treatment outcomes, <i>Child and Youth Services Review</i>, 25 (4), 317-326.</p>	<p>Study of characteristics in 150 randomly sampled charts.</p>	<p><b>Sample:</b> 150 (n) 13-20 year olds (mean age = 16 years); predominantly female (two thirds), 45% Caucasian. 46% African American; 52% with a history of running away;</p> <p><b>Measures:</b> CAFAS, success rating</p> <p><b>Intervention/Program</b></p> <p>62% received a combination of individual, group, and family therapy, 76% were (also) seen without family members. Average length of tx: 77 days or 28 sessions.</p>	<p><b>Results:</b> 64% were deemed successful discharges due to family support and involvement with treatment. 26% were prematurely terminated, 7% deemed unsuccessful. Family involvement, viewing family as a unit was associated with higher success in RT. Youth who received a combination of tx modalities was more likely to be successful. Children and adolescents with severe antisocial behaviors, living outside the family, lacking stable family support and receiving only one form of treatment were at risk for unsuccessful outcomes in RT.</p>
17	<p>Hair, H.J. (2005). Outcomes for Children and Adolescents After Residential Treatment: A Review of Research from 1993 to 2003, <i>Journal of Child and Family Studies</i>, 14 (4), 551–575.</p>	<p>Review of outcome studies.</p>	<p><b>Sample:</b> 18 (N) outcomes studies (published 1993 – 2003), criteria for inclusion: RTC study must (a) have a treatment program for children and/or adolescents with severe emotional and/or behavioral problems, (b) employ trained staff, (c) provide some on-site schooling for at least some residents, and (d) have as a goal the return of residents back with family members, alternate caregivers, or independent living.</p> <p>Excluded: group foster homes, psychiatric hospital settings, open or closed facilities for young offenders, and settings designed specifically for substance abuse treatment.</p> <p><b>Definition of successful discharge:</b> (a) the staff agreed the resident attained desired emotional and behavioral changes during her or his stay; (b) the resident completed the program; and (c) the resident moved to a less restrictive setting.</p>	<p><b>Results:</b> Residential treatment appears to be a valuable intervention as part of a system of care for severely emotionally and behaviorally troubled youth. Outcome research demonstrated that post-discharge changes depend on family involvement, community supports, and aftercare services. Overall, research is limited and suggests that no one particular discharge diagnosis has a notable impact on post-discharge outcome. However, outcome studies demonstrate that residential treatment which include family involvement and that is combined with accessible aftercare programs and continued academic participation are associated with ongoing success after discharge. Moreover, as part of a continuum of care <i>shorter</i> residential stays can contribute to long-term gains. Some findings suggest that day programs which include intense family involvement are a potentially less intrusive alternative as long as families are able and willing to keep the child or adolescent at home. Maintaining gains after discharge appear to be associated with three key factors: (a) the extent that the resident’s family is involved in the treatment process before discharge (for example, in family therapy), (b) the stability of the place where the child or adolescent goes to live after discharge, and (c) the availability of aftercare support for</p>

				the child or youth and their families.
18	Handwerk, M.L., Clopton, K., Huefner, J.C., Smith, G.L., Hoff, K.E., & Lucas, C.P. (2006). Gender Differences in Adolescents in Residential Treatment, <i>American Journal of Orthopsychiatry</i> 76 (3), 312–324.	Study of gender differences in 2,067 (N) youth at a residential facility (Boys Town?).	<p><b>Sample:</b> 63% males, 61% Caucasian, 19% African American, 9% Hispanic, 6% multiethnic, 5% Native American, mean age 15; referred by their family (33%), by court or juvenile justice sources (27%), by other mental health facilities (23%), by other social service agencies (18)%. Most youths came from single-parent homes.</p> <p><b>Measures:</b> Problem behaviors, DISC (prevalence of psychiatric disorders); Suicide Probability Scale CBCL and YSR, Daily Incident Report (DIR), Departure and Follow-Up Scales (3-6 months after discharge).</p> <p><b>Program/Intervention:</b> Teaching–family model (TFM)</p>	<p><b>Results</b> indicate that girls generally exhibited more behavioral and emotional problems than their male cohorts, had more psychiatric diagnoses at admission, had higher scores on standardized behavior checklists at admissions, and demonstrated more in-program problem behaviors than boys. Consistent with many prior reports, girls demonstrated more internalizing problems than their male peers. On reports of problem behaviors at admission, girls had higher rates of depression, suicide threats and attempts, self-injurious behavior, history of sexual abuse, and eating disorders identified as problems at the time of admission. At admission, girls were 3 times more likely than boys to have a depressive disorder and twice as likely to have an anxiety disorder. A small but growing body of evidence suggests that at least a subset of at-risk girls demonstrates persistent antisocial behavior at rates equivalent or higher than those of their male counterparts. At 1 year, girls demonstrated declining but still significantly higher rates of internalizing diagnoses, For externalizing problems, rates decreased substantially from the first 6 months to the second 6 months for the entire sample, regardless of gender. However, for internalizing problems, girls demonstrated significantly greater improvement relative to boys. Girls’ average length of stay (m 18.8 months) was approximately 2 months longer than that of boys. At follow-up there were no differences between genders. Only ratings of program success at departure made by clinical staff were higher for girls than boys but the clinical significance of this finding should be interpreted with some caution.</p> <p><b>Limitations:</b> one residential facility only</p>
19	Hussey, D. L., & Guo, S. (2002). Profile characteristics and behavioral change trajectories of young residential children. <i>Journal of Child and Family Studies</i> , 11, 401–410.	Exploratory study of 142 (N) children ages 5-13, (M=10) in Ohio RTC	<p><b>Subsample</b> of 57 (n) (similar to larger sample): predominately preadolescent male children (age 5 to 13 years; m=10 years), 95% Medicaid, 56%Caucasian, mean age at first out-of-home placement 5 ; mean number of placements 8; 92% on meds. Mean length of stay: 533 days.</p> <p><b>Measures:</b> Devereux Scale behavior ratings</p> <p><b>Intervention/ Program:</b> Not provided</p>	<p><b>Results:</b> There was little evidence of overall behavioral change during the course of residential treatment; shorter length-of stay combined with less severe psychopathology that was associated with more positive outcomes suggesting that length of stay may be a proxy for severity of symptoms. Opportunities of shorter, repeatable periods of stability in a residential facility may foster treatment gains and educational achievement for children with less severe psychopathology rather than using out-of-home placements as a “once and for all cure.”</p> <p><b>Limitations:</b> no control group</p>
20	Lakin, B.L., Brambila, A.D., & Sigda, K.B. (2004). Parental Involvement as a Factor in the Readmission to a	Exploratory study of 89 children and adolescents from 5 to 17 years old	<p><b>Sample:</b> 66% males; 51% Caucasian, 45% Hispanic, mean age 11.7. A majority of the subjects came from divorced families, many from families with histories of mental illness, alcohol abuse, and drug abuse. Mean length of stay</p>	<p><b>Results</b> support parental involvement as a factor but emphasize a broader definition to incorporate not only parents’ interactions with RT staff, but involvement in all aspects of RTC. Such involvement appears to significantly impact families’ level of functioning at discharge (the main predictor of</p>

	Residential Treatment Center, <i>Residential Treatment for Children &amp; Youth</i> , 22 (2), 37-52.	from the University of New Mexico's Children's Psychiatric Center.	58.6 days with a wide range (7-243). Excluding outliers: the average length of stay was 54.6 days (range 7-119). <b>Measures</b> frequency of weekly parent phone calls and visits, frequency of weekly therapeutic absences (passes), participation in weekly family therapy sessions, family functioning (APGAR), Children's Functioning (CFARS, and CAFAS) <b>Intervention/Program:</b> two family-like cottage settings, multi-disciplinary treatment, The staff member to child ratio is 1:4. Treatment includes group therapy, family therapy, individual therapy, psychopharmacology services when needed, milieu therapies, and a public school with special education teachers.	recidivism) and in turn can protect young people from future readmissions. Residents with parents who consistently called, visited, went on planned therapeutic absences, and attended weekly family therapy sessions had a better prognosis of maintaining therapeutic gains in the community. This suggests that parental involvement is multi-faceted and includes more elements than simply the level of participation in family therapy. It also includes weekly visits, phone calls, and planned therapeutic absences. Parental involvement is an important factor not only for externalizing problems but also for youth with mood disorders, anxiety disorders, and psychotic disorders. Parents who frequently came to visit their children had the opportunity to learn from and work with the RTC staff members in the milieu. They were able to practice important skills such as limit setting, learning to modify unwanted behaviors and how to deal with their children in a firm but therapeutic way. <b>Limitations:</b> no control/comparison.
21	Landsman, M.L., Groza, V., Tyler, M., & Malone, K. (2001). Outcomes of family-centered residential treatment, <i>Child Welfare</i> , 80 (3) 351-379.	Quasi-experimental study of a family-centered residential tx model (REPARE) and its effects of permanency	<b>Sample:</b> 82 children (mostly male Caucasian) in the experimental group vs. 57 in comparison group. <b>Measures</b> file data, staff observations and standardized measures completed by staff, parents and children during and after residential treatment. <b>Intervention:</b> (a) ongoing parental contact and involvement, (b) shorter stay in the residence (on average 8 months compared to 14 months), (c) the availability of supportive aftercare services.	<b>Results:</b> At six months post-discharge only a shorter length of stay had a significantly positive effect; however, at 18 months REPARE group status along with length of stay had a greater likelihood that post-discharge placement had remained uninterrupted. Residential treatment can maintain a dual focus on children and families and that treatment time does not need to be lengthy to achieve outcome success.  <b>Limitation:</b> small study.
22	Larzelere, R. E., Dinges, K., Schmidt, M. D., Spellman, D. F., Criste, T. R., & Connell, P. (2001). Outcomes of residential treatment: A study of the adolescent clients of Girls and Boys Town, <i>Child and Youth Care Forum</i> , 30, 175-185.	Pre-Posttest Study of 43 (N) youth in TFM Boys and Girls Town	<b>Sample:</b> 51% girls, (6-17 years, m = 13), 72% Caucasian; primary diagnoses at intake depressive disorders (51%), disruptive disorders (21%). On average, they had four different placements during the 6 months before admission. LOS 18 to 505 days, with a mean of 181 days. <b>Measures</b> at intake, discharge, and/or as part of a follow-up survey. The follow-up surveys occurred at an average of 10 months after discharge: CBCL, Children's Global Assessment Scale (C-GAS); Restrictiveness of Living Environments Scale (ROLES) Youth Satisfaction Survey; telephone follow-up survey with caregivers. <b>Program/ Intervention:</b> Boys and Girls town	<b>Results:</b> Youth showed improvement on most outcome variables that were generally maintained at the follow-up. Most youth were in a less restrictive environment following discharge. (67% came from a more restrictive setting and 9% were discharged to a more restrictive setting). Placement stability also improved. Youth satisfaction at discharge was an 6.4 on a 7-point scale. Almost all youth were attending school and getting along at least fairly well with their current adult caregiver. Overall, caregivers reported that 76% of the youth now had a quality of life that was better than prior to RTC. The authors suggest that success may be due to the comprehensive program offered during and participation of most youth in individual psychotherapy and/or medication follow-up after RTC. <b>Limitations:</b> no control group, attrition
23	Larzelere, R.L., Daly, D.L., Davis, J.L.,	Study exploring gender as a	<b>Sample:</b> 38% girls. 60% Caucasian, 20% African-American. Primary referral sources:	<b>Results:</b> Most youth improved from intake to discharge and

	Chmelka, M.B. & Handwerk, M.L. (2004). Outcome Evaluation of Girls and Boys Town's Family Home Program, <i>Education and Treatment of Children</i> , 27 (2), 130-149.	factor in outcomes at Girls and Boys Town.	juvenile justice (34%), social services (21%), mental health (17%), family or self (17%). Age at admission ranged from 8.6 to 18.6 years (M = 14.9). Length of stay ranged from 31 days to 9.7 years (M = 1.8 years) <b>Measures at Intake and discharge:</b> ROLES. The Restrictiveness of Living Environments Scale, CBCL, DISC; departure success, Percentage of Problems Improved, follow up functioning (3 months after discharge). <b>Program/ Intervention:</b> modification of the Teaching Family Model, emphasizing relationship	were functioning at levels similar to national norms at a three-month follow-up. Girls improved as much as boys on both DISC diagnoses and CBCL scores. Girls improved more than boys in perceived success at discharge and in the restrictiveness of their subsequent living situation, which were the only areas of differential improvement by gender. 59% of youth were discharged positively due to program completion or high school graduation. Nineteen percent were discharged negatively due to non-compliance with the program. The remaining 22% left for other reasons. <b>Limitations:</b> no control group, 33% attrition, only short term follow-up
24	Lyons, J.S., Terry, P., Martinovich, Z., Peterson, J. & Bouska, B. (2001). Outcome Trajectories for Adolescents in Residential Treatment: A Statewide Evaluation, <i>Journal of Child and Family Studies</i> , 10 (3), 333-345.	Retrospective study of clinical status of 285 adolescents over a 2-year period after placement in residential treatment by the Department of Mental Health in a western state.	<b>Sample:</b> 63% male, 12 to 17. placed in one of eight residential treatment centers; primary diagnosis-related group (DRG) at admission was post-traumatic stress disorder (PTSD, 27%), followed by attention-deficit hyperactivity disorder (ADHD, 21%), depressive spectrum disorder (17%), oppositional-defiant disorder (ODD, 11%) <b>Measures</b> (3 periods within 2 years of admission; spanned a range of approximately nine months to two years): Acuity of Psychiatric Illness (CAPI) encompassing four domains: High Risk Behaviors, symptoms, functioning, and social support. <b>Program/ Interventions:</b> not specified	<b>Results</b> suggest that the effectiveness of residential treatment may be limited to the reduction of risk behaviors and depression and improved management of psychosis. There is little evidence that the facilities in this study were successful at improving functioning. In addition, it appears that residential treatment may have unintended adverse outcomes on anxiety and hyperactivity. Benefits of treatment were apparent primarily in reducing suicidality, and to some extent in reducing self-mutilation, and aggression towards others. It remains unknown if these gains persist beyond treatment. RT may be somewhat more effective with PTSD and emotional disorders rather than ADHD and behavioral disorders. <b>Limitations:</b> no details about interventions, retrospective file review measures, no control/comparison group
25	Pazaratz, D. (1999). An Impressionistic Evaluation of the Efficacy of a Residential Treatment Facility for Emotionally Disturbed Youth, <i>Residential Treatment for Children &amp; Youth</i> , 16 (3), 15-35.	Qualitative study using questionnaires, and interviews in an "in-house" program evaluation to elicit adolescents' and staff and perceptions of the program.	<b>Sample:</b> Questionnaires administered to one hundred adolescents, mostly male Caucasian <b>Method:</b> questionnaires administered over a four year period. Focus group discussions and some individual interviews to discuss youths' feelings about the treatment process; focus groups with staff.	<b>Results</b> of youth focus grouped underscored the importance of relationships with staff: They found control more acceptable from staff they had a relationship with. They tended to get into power struggles with staff they disliked. Those youth who were positive with staff had fewer problems, were better at school and had better friendships than those who constantly defied staff. Staff felt that the milieu worked when an atmosphere of fellowship was developed. Staff saw their role as emphasizing relationships and the development of values, such as trust, respect, etc. Programming structure was deemed essential to develop group cohesiveness and cooperation. Staff did not feel that the milieu worked for all adolescents; about two thirds of youth changed due to the positive effect of the milieu; while a third were viewed as not changing. Some staff believed that some residents merely matured or grew up.
26	Pierpont, J. & McGinty, K. (2004). Using Family-oriented treatment to improve placement outcomes for children	Description and initial results of a small (N=10) pilot study of a family-oriented	<b>Sample:</b> 8 boys, 2 girls; 50% Caucasian, 50% African-American; mean age 7; most common dx: disruptive behaviors. <b>Measures</b> at intake, 3,6,12 months and 3 months post discharge (by telephone)	<b>Results:</b> Three months post discharge 8 (80%) children lived at home, at 6 and 12 months: 7 (70%). Those who did not live at home were moved soon after discharge due to behavior problems. Better outcomes were associated with family and child participation in all phases of treatment, as was

	and youth in residential treatment, <i>Journal of Human Behavior and the Social Environment</i> , 9 (1/2), 147-163	RTC in North Carolina.	<b>Program/Intervention:</b> Five-day/week Eastern Area Residential Treatment Home (EARTH) as part of local MH center. Uses behavioral, psychoeducational models plus individual, group and family therapy, SpEd classes.	medication stabilization and educational status of the child. For families who had and used social supports, and continued with MH treatments it was more likely that their child was still at home at 12 months post discharge and continued making behavioral progress. Authors strongly recommend RT to implement in-home family programming to provide family therapy, individual supports, and arrange group support, and integrating RT and the systems of care approach. <b>Limitations:</b> small sample, no comparison, measures not detailed.
27	Robinson, A.D. , Kruzich, J.M., Friesen, B.J. Jivanjee, P., & Pullmann, M.D. (2005). Preserving Family Bonds: Examining Parent Perspectives in the Light of Practice Standards for Out-of-Home Treatment, <i>American Journal of Orthopsychiatry</i> 75 (4), 632–643.	Cross-sectional study examining the experiences of families (N=102) regarding parent– child contact in relation to examples of national accreditation standards.	<b>Sample:</b> parents or other caregivers, recruited through family support organizations, with primary responsibility for youth aged 0 to 20 years who had received 3 months or more of treatment while living at home or 30 or more continuous days of out-of-home treatment. This analysis focuses on a subset of a larger sample, the responses from 102 parents whose children received out-of-home treatment in one of three settings: residential treatment centers (66.7%), psychiatric hospitals/ units (20.6%), and group homes (12.7%). Respondents: Female 92%, Caucasian 90%; mean age 45, 53% with college degree; 87% biological mothers. <b>Method:</b> mail-questionnaire	<b>Results:</b> Findings indicate that many organizations still restrict contact between children and their parents. Nearly 60.0% of parents reported contact was limited for a period of 1–8 weeks. Contact during the initial period after placement is ostensibly limited to assist in the child's adjustment or because programs constructed visits as a privilege to be earned by youth. Initial restrictions on contact were applied equally to children regardless of age and setting. Reported reasons for limiting contact throughout placement fell primarily into four main categories: individual staff discretion, restrictive facility policies, behavior modification programs, and maintenance of the “therapeutic” environment. Responses revealed the perception on the part of some parents that limits were imposed arbitrarily. 79.4% of parents reported at least one type of restriction on contact. Almost 40% of respondents reported restrictions on telephone calls, 35.6% restrictions on day visits at the facility, 46.9% restrictions on day visits away from the facility, and 60.0% of respondents reported restrictions on home visits. Approximately half of the respondents reported restrictions on parent– child contact on the basis of a point and level system. Sixteen percent of parents reported that parent– child contact was contingent on the behavior of peers in the living or treatment unit. Parents of girls and single parents were more likely to report restrictions on contact. Parents who did not have legal custody of their children were also more likely to report restrictions.
28	Shapiro, J.P., Welker, C.J. & Pierce, J.L. (1999). An Evaluation of Residential Treatment for Youth with Mental Health and Delinquency-Related Problems, <i>Residential Treatment for Children &amp; Youth</i> , 17 (2), 33-48.	Longitudinal study investigating the effectiveness of residential treatment for 27 adolescents aged 11-15 with histories of mental health	<b>Sample:</b> 79% male; 24% African American, 72% Caucasian, 11-15 years Average of 4.74 past out-of-home placements; 60% some past involvement in the juvenile justice system. Most prevalent diagnoses: 92% conduct disorder, and 28% ADD. High level of disrupted family relationships; 75% in state custody. <b>Measures</b> (baseline 4-6 weeks after intake, 3 months, 7.5 months, and 12 months): CBCL, youth self-report, teacher report; Personality	<b>Results:</b> mean length of treatment 12.05 months; results were not consistent, but there was evidence of improved functioning for some measures such as delinquency-related problems, the youth self-report of behavior problems, cottage staff ratings of development-related behaviors (TBRS), and therapist ratings of ability to engage in therapy and treatment progress. The clients showed marginally significant evidence of improvement in staff-rated frequency of symptomatic behaviors (TBRS), number of critical incidents, and satisfaction with individual therapy. The clients did not demonstrate improvement on

		and delinquency-related problems.	Inventory (for delinquent youth), Target Behavior Rating Scale; critical incidents. <b>Program:</b> weekly individual, group and music therapy, social skills training, problem-solving, developing self-control, and working toward positive personal goals	measures of behavior problems completed by cottage staff (CBCL) or teachers (TRF), nor in satisfaction with group therapy. Almost all of the improvements occurred within the first six months, there was no measure on which improvement was concentrated late in treatment (after 7.5 months). <b>Limitations:</b> No control/comparison group, high attrition, small sample
29	Spencer, S. & Powell, J.Y. (2000). Family-Centered Practice in Residential Treatment Settings: A Parent's Perspective, <i>Residential Treatment for Children &amp; Youth</i> , 17 (3), 33-43.	Interview with Sandra Spencer,	mother of a bipolar child who was in RTC and inpatient hospitals, Children's MH advocate	<b>Main themes:</b> <ul style="list-style-type: none"> <li>• Accessibility policies.</li> <li>• Geographic accessibility</li> <li>• Access to information</li> <li>• Sharing training and knowledge</li> <li>• Transition planning and pacing</li> <li>• Matching family resources</li> <li>• Family-Centered/ Culturally sensitive</li> <li>• Family support</li> </ul>
30	Stage, S.A. (1999). Predicting Adolescents' Discharge Status Following Residential Treatment, <i>Residential Treatment for Children and Youth</i> , 16 (3), 37-56.	Study exploring records on 130 (N) adolescents for predictors of discharge status from RTC.	<b>Sample:</b> 86 males, average age 14 years, mean length of stay 8 months; majority African-American. Most in state custody. <b>Measures:</b> victimization, family dysfunction, antisocial behavior, type of therapy, discharge status <b>Program/Intervention:</b> Behavioral management, different types pf therapy.	<b>Results:</b> participation by the resident and her or his family members in family therapy was the only significant predictor of successful discharge to a less restrictive setting. The odds were about 8: 1 that the resident would be discharged to a less restrictive setting if they received family therapy. Of the 57 who received family therapy, 49 were discharged home or to a group home. A history of anti-social behaviors, victimization, and family dysfunction did not predict discharge status. <b>Limitations:</b> no control/comparison, long-term maintenance of their gains is unknown.
31	Sunseri, P.A. (2001). The Prediction of Unplanned Discharge from Residential Treatment, <i>Child &amp; Youth Care Forum</i> , 30 (5), 283-303.	Study exploring data on 313 (N) children placed in RTC to determine if risk for noncompletion could reliably be identified at the time of referral.	<b>Sample:</b> 77% male; 57% Caucasian, 17% African American, ages 9-17, completers: 71%; 58% voluntary MH placement, 27% probation wards; single mother homes 40%; previous placement 41%. <b>Measures:</b> completers/noncompleters; client demographics (e.g., age, sex, family characteristics) client characteristics (e.g., placement history, presenting behaviors, diagnosis). Follow-up data were collected 12 months after the date of placement. <b>Program/Intervention:</b> not specified	<b>Results:</b> Likelihood of <u>not</u> completing treatment increased for children who did not receive home visits (8.1 times more likely not to complete treatment); children who do not talk easily with adults (3.6 times); children who tease others were (2.9 times); children who use substances (2.2 times); and children with prior residential care placement (2.1). Conversely, children with frequent visits were 5.7 times more likely to complete treatment than those with no visits and even those with minimal visits were 2.6 times more likely to complete treatment than children with no visits. In addition, children with a history of visitation were 10.5 times more likely to have visitors. Similarly, previous histories of running away from home or from RTC, previous use of restraint, and psychiatric hospitalization predict a significantly higher likelihood of the same incidents happening again.
32	Sunseri, P.A. (2004a). Family Functioning and Residential Treatment Outcomes, <i>Residential Treatment for Children</i>	Study examining data on 8,933 (N) children and adolescents in residential	<b>Sample</b> (see above #32)  <b>Measures:</b> family functioning restrictiveness of discharge environment	<b>Results</b> suggest robust association of family functioning to treatment outcomes. Children with high functioning families were seven times more likely to complete treatment than children with low functioning families, and five times more likely to complete treatment than children with intermediate

	& Youth, 22 (1), 33-53.	treatment programs as to association of treatment outcomes with family functioning.	behaviors child functioning RTC intensity level program completion	functioning families. Improvement in behavior scores was correlated with higher family functioning. 30.9% had families that were high functioning, 46.5% had families that were of intermediate functioning, and 22.5% had families that were low functioning. Eighty-three percent of the children with high functioning families completed treatment, compared to 42% of those with intermediate functioning families, and 31% of those with low functioning families. Children from low functioning families had the worst outcomes in lower level programs (only 20.5% completion); conversely, children from high functioning families placed into high level programs had the best outcomes (93.9% completion). As family functioning increases, the probability of being discharged into less restrictive settings also increases. Author recommends early and regular assessment of family functioning as guide for placement and inclusion of treatment components to increase family functioning (not just family involvement) akin to Chamberlain's MTFC Treatment Foster Care model.
33	Sunseri, P.A. (2005). Children Referred to Residential Care: Reducing Multiple Placements, Managing Costs and Improving Treatment Outcomes, <i>Residential Treatment for Children &amp; Youth</i> , 22 (3), 55-66.	Study examining placement stability (planned discharge) among 8,933 (N) children and adolescents admitted into residential treatment facilities in California.	<b>Sample:</b> (see above # 32)  <b>Measures</b> at admission and at discharge: planned/unplanned discharge Intensity level of RT services (low, medium, high-according to a CA. Level system) previous placements, behaviors  <b>Programs/Interventions:</b> RTCs of different intensity levels	<b>Results:</b> More intensive residential programs achieve greater placement stability, despite the fact that the young persons admitted to these programs have significantly more problematic behavior at the time of admission and make greater behavioral improvements over the course of treatment than residents in lower level facilities. Clients with and without prior residential/ group home placements admitted into high level programs had significantly fewer unplanned discharges. When young people are placed for the first time into high level programs, the mean length of stay is shorter than when placed into lower levels of care. For those youth who had been at RTC for the first time and who were discharged in a planned way 67.6% returned to home or home-like settings. In contrast, for residents who were discharged in an unplanned way, 74.8% were discharged either to another residential care program or to even more restrictive settings. Residents who experience placement instability exhibit a worsening of behavioral symptoms between the period of admission and discharge. Authors calls for better assessment procedures to place youth in appropriate RTCs (not simply lowest intensity), so youth don't have to "fail up" the system ladder. <b>Limitations:</b> actual treatment processes/intervention not known, properties of measures not validated, no comparison group
34	Weis, R., Wilson, N.L., & Whitemarsh, S.M. (2005). Evaluation of a Voluntary, Military-Style Residential Treatment	Quasi-experimental study evaluating the effectiveness of a military-style	<b>Sample:</b> 242 (N) adolescents (197 boys, 45 girls); 67% age 17, Caucasian (67%), African American (13%), Hispanic (12%), multiple behavior problems prompting referral. <b>Measures:</b> Behavior Assessment System for	<b>Results:</b> Adolescents who completed program displayed statistically significant reductions in externalizing and internalizing symptoms from pretreatment to 6-month follow-up and significant increases in adaptive skills No such changes in functioning were seen in adolescents who did not attend the

	Program for Adolescents With Academic and Conduct Problems, <i>Journal of Clinical Child and Adolescent Psychology</i> , 34 (4), 692–705.	residential treatment program for 242 (N) adolescents with academic and conduct problems.	Children (BASC) <b>Program/ Intervention:</b> 22-week-long voluntary Boot Camp “Wisconsin Challenge Academy” for 16-18 year old delinquent adolescents, core components include (a) educational attainment; (b) job-skill development; (c) physical fitness; (d) leadership skills; (e) health, sex, and nutrition education; (f) life coping skills; (g) citizenship; and (h) community service.	program. Graduates were more likely to earn a high school degree and to be employed full-time than controls, displayed fewer substance use problems and fewer arrests.  <b>Limitations:</b> no random assignment, parental outcome reports only, and unreliable self-reports about pre-treatment behaviors by adolescents, no longer-term follow up
35	Wilmshurst, L. A. (2002). Treatment programs for youth with emotional and behavioural disorders: An outcome study of two alternative approaches. <i>Mental Health Services Research</i> , 4 (2), 85–96.	Quasi-experimental study comparing treatment outcomes from a five-day residential program and a family preservation alternative	<b>Sample:</b> 82 (N) latency aged children who were randomly assigned 38 (n) youth in the family preservation and 27 (n) youth in residential program <b>Measures:</b> Parent ratings of emotional disturbance and social skills at intake, discharge and one year after discharge. Teacher and youth responses were also sought but with such limited success <b>Intervention/Program:</b> Residential: brief solution-focused therapy models; Family-Preservation comparison.	<b>Results:</b> Children from the FP reduced symptoms for total internalizing, ADHD, generalized anxiety, and depression and these gains were maintained one year post-treatment. On the other hand, children in the residential program appeared to experience clinical deterioration for all internalizing symptom clusters (separation anxiety, general anxiety, and depression). The author points out that FP participants had almost twice the family contact time compared to the residential program. Consequently, the children in residential treatment could have experienced iatrogenic effects due to removal from their homes. Alternating from a five-day-a-week intensive live-in residential program to living with family for two days could have potentially increased worry and anxiety.