

# The Sounding Board

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## **Residential Treatment Services: Is it Time for a Critical Review?**

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*Over the years the full and part time group care programs that have existed in this country have fallen into disuse—an occurrence that most professionals, who saw little good and much evil in their impact on children, greeted with considerable satisfaction. As professionals withdrew their approbation the programs deteriorated, innovation ceased, and cycles of predictions of bad results and their fulfillment, spiraled the programs downward. (Wolins, 1974, p.1)*

### **The Present Context for Residential Services**

The author of these prescient words was Martin Wolins, long a distinguished professor of social welfare at the University of California, Berkeley and preeminent scholar-researcher of group child care – in all of its many forms- as a ‘powerful environment’ aiding positive growth and change. As a pre-WWII refugee from eastern Europe and a frequent commuting scholar between the U.S. and Israel, Wolins was a broad gauged investigator who continuously sought insights from residential programs and practices in other cultures to enhance and expand our judicious use of residential services, including residential treatment, within the U.S. service arena.

Group residential care<sup>1</sup>, including residential treatment for children remains a service in flux. Concerns about effectiveness, child safety and costs continue within the

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<sup>1</sup> Group residential care, or ‘group care’, includes a multiplicity of services including therapeutic group homes, shelter care, transition care, secure accommodation, residential

services research community as well as in discussions of best practices and policies for children and families (Courtney & Iwaniec, 2009; Whittaker, 2008, 2006; 2004). For example, recently expressed concerns about “deviancy training” in group treatment conditions of all kinds including group care settings for antisocial youth continue to surface, though recent rigorous analyses provide little empirical support to such claims (Dishion, McCord & Poulin, 1999; Poulin, Dishion & Burraston, 2001; Weiss et al., 2005). While it is difficult to summarize the commonalities of all of reform efforts in residential services, a general trajectory seems to be away from residential services and towards community and family-centered alternatives for those children and youth in need of intensive services. Such efforts are buttressed at least in part by a lack of consistent demonstrated effectiveness in the corpus of residential care outcome research (Barker, 1998; Kutash, Robbins & Rivera, 1996; Barth, 2002). A research review prepared for the most recent U.S. Surgeon General’s Report on Mental Health observes:

Given the limitations of current research, it is risky to reach any strong conclusions about the effectiveness of residential treatment for adolescents (Burns, Hoagwood & Mrazek 1999).

Comparable concerns are raised in a mid 1990’s report from the General Accounting Office which failed to identify a consensus on the critical ingredients in effective residential treatment (GAO, 1994). Nor are concerns about continued use of residential group care for children exclusively a U.S. preoccupation as the following observation by a leading U.K. children’s services researcher suggests: “The context of the attack on residential homes is that many people no longer believe in them” (Sinclair, 2006, p.207).

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treatment and respite care. While sharing certain common setting characteristics, these services vary greatly in treatment philosophies and practices including the intensity and duration of interventions provided. For this brief review, I will confine my remarks primarily to intensive residential treatment services for high resource using children and youth.

Many other factors such as institutional abuse and neglect, lack of clarity about who precisely needs residential treatment as opposed to therapeutic foster care or intensive family-centered alternatives, escalating costs proportionate to the small numbers served, disappointing outcome research and others have shaped the current climate for residential treatment services (Whittaker, 2004, 2008). Overriding these particular concerns, has been the central fact that for out-of-home placement as a whole, the most single stable trend line in child welfare for much of the twentieth century since the first White House Conference on Children in 1909 and the first decade of the twenty-first has been the shifting ratio of children in foster family vs. residential care as a proportion of the total number of children in out-of-home care. As Kadushin (1980) noted, from approximately the early 1930s to the mid 1970s, the percentage of children in residential care declined from 57% to 15%, while the percentage in family foster care increased from 43% to 85% for the total population of children served in out of home care. At the time of this writing, just released AFCARS estimates of the numbers of U.S. children in out-of-home care for 2010 yielded a total of 408,425 children in all forms of foster care (including residential care) in the United States on Sept. 30, 2010. This represents a 20 percent reduction since 2005 (511,000), a 19 percent reduction since 2006 (505,000) and a nearly 4 percent reduction between 2009 and 2010 (Dee Wilson, personal communication, 23 July, 2011). The latest full set of AFCARS data tables available at the time of this writing (2009) indicated the following distribution of placements:

- 48 percent in nonrelative foster family homes
- 24 percent in relative foster homes

- 10 percent in institutions
- 6 percent in group homes
- 5 percent on trial home visits (Situations in which the State retains supervision of a child and the child returns home on a trial basis, for an unspecified period of time, are considered a discharge from foster care after 6 months.)
- 4 percent in preadoptive homes
- 2 percent had run away
- 1 percent in supervised independent living

### **Trends**

Placement type on September 30 remained relatively unchanged between FY 2000 and FY 2009. (AFCARS, Foster Care Statistics, 2009, p.4). While the distribution above suggests a relative stability of the percentages of children in various forms of care, it sheds little light on the pathways into residential services, the nature of the programs provided or the experiences of children and youth following placement. Here, the excellent research of centers like the Chapin Hall Center for Children at the University of Chicago (Budde et. al. 2004) on the Illinois system buttress the general observation offered by Mark Courtney and Derota Iwaniec (2009) that, in many jurisdictions children need to experience multiple ‘failures’ in non-residential alternatives before they gain access to the needed residential treatment service as a ‘last resort’.

Overall and despite a brief flurry of interest in “orphanages” which surfaced in the mid 1990’s in part as the result of a growing backlash against “family preservation” and the perception that at least in public child welfare, some children were being kept far too long in unsafe family situations, policy in the main has been supportive of family based

alternatives (e.g., foster care including recent initiatives in kinship care and adoptions such as the *Fostering Connections to Success and Increasing Adoptions Act of 2008*) for children for whom there is little hope of return to parents of origin. At the level of individual states, "family group conferencing" originating in New Zealand has replaced intensive family preservation service as the "cutting edge" of practice innovation (Pennell and Anderson, 2005). Serious discussions of group residential options occur only at the margins of policy and practice debate: e.g., in the interest sparked by the Pew Memorial Trust, San Diego County, and others in "residential academies" (Whittaker, 2006).

Considering the weight of what is an increasingly skeptical consensus about the continued reliance on residential care and treatment as a major child mental health service, or as an alternative to foster care, or, largely for reasons having to do with the potential for institutional abuse, researchers and practitioners and policy makers need to direct serious attention including both theoretical and empirical analysis to the purposes, change theories, treatment protocols, expected outcomes, comparative advantages and organizational requisites for residential treatment if it is to retain its legitimacy as a viable service option for troubled children and their families. To be crystal clear: this is not an argument for expansion of residential provision, or its inappropriate use. It is an argument to understand better what highly quality residential treatment consists of, for what children and youth it is most indicated and what its desired outcomes are.

There is some particular urgency to this task, given recent developments such as the Annie E. Casey Foundation's "Rightsizing Congregate Care" initiative which quite properly seeks to reduce system overuse of group care placements, particularly in instances where children's needs can safely and properly be met in family foster care and through a variety of family and community-centered interventions ([Rightsizing Congregate Care](#), 2010). Regrettably, the initiative apparently makes little attempt to

discriminate levels or types of residential provision, including those designed to provide intensive residential treatment to children with identified serious mental health needs and uses instead the descriptors “congregate care” and “institutional care” – terms not widely heard since the late 19<sup>th</sup> century as a shorthand for all residential provision.

### **A Potential Way Forward: Determining the Highest and Best Uses of Residential Treatment**

To address some of the above concerns about residential treatment, Whittaker & Small (2011) propose an invitational working summit conference of a small number international experts representing policy, research and current practice devoted exclusively to critical reflection on the current status and future directions for intensive residential treatment services for high-resource using children and youth and their families<sup>2</sup>. The core aim is the integration of three strands of discourse which, to the extent they occur at all, most often take place in isolation:

*(1) What current cross-national research says about intensive residential treatment provision as a sub-set of out-of-home placement services including: salient child/youth/family characteristics and characteristics of the treatment settings designed to serve them.*

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<sup>2</sup> A full copy of the proposal summarized in this brief review is available from the authors:

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***(2) The current state of model program development in intensive residential treatment services in the U.S. and in selected European countries.*** Particular attention here will be given to promising practices and model programs; ‘active ingredients’ in effective residential treatment (Chorpita et. al., 2007; Jensen, et. al. 2005); program challenges; training protocols; outcome measures; organizational infra- structures which support effective practices within the treatment setting, as well as practices which aid in the continuing connection of children to families while in residential treatment; and practices which promote the seamless transition to families and communities of origin on treatment completion.

***(3) What is the place of residential treatment in various service systems, including mental health, child welfare and juvenile justice and how should it be designed and funded?*** This strand of inquiry will focus on a variety of policy issues relevant to state, national and local regulatory and funding entities. What is the place of residential treatment in the service systems of the future and how should it be designed and funded? Discussion will also focus on new business models for residential treatment that help agencies insure that residential treatment is an appropriate part of a spectrum of child and family social services; and how finance reform in child welfare could be used to provide the right incentives for innovation and effective services. Particular attention will be given to creative policy and administrative strategies that seek to identify the ‘active ingredients’ in intensive residential treatment and specify the highest and best uses of this intervention.

The overall goal of this working conference and the study process that informs it will be to illuminate the highest and best uses of residential treatment within a

comprehensive array of services consistent with ‘systems of care’ principles. The guiding assumption is that to achieve this goal, residential treatment must be reconceptualized and clearly perceived as a robust *family support resource*: beginning with active outreach and engagement during the pre-placement phase, continuing with multiple levels of involvement during placement, and continuing in active and supportive partnership in the post-placement period. Finally, the products from such a working conference will include:

- Identification of utilization options for intensive residential services that offer alternatives to service provided solely as a last resort.
- Identification of steps which will encourage the development and specification and rigorous evaluation of model programs & protocols—including identification of the ‘active ingredients’ in effective programs- which, ultimately, will facilitate comparative studies with widely promoted evidence-based non-residential treatment alternatives.
- Development and specification of a long overdue and updated research agenda for intensive residential treatment services focusing on key questions within the treatment milieu and in the ultimate successful re-integration of children into familial and community contexts (Whittaker & Pfeiffer, 1994). Critical to the development of this research agenda will be will studies that build on the important research of Kruzich et. al. (2003) and others in further explicating the barriers that continue to exist between families and residential treatment services and creative solutions for overcoming them.

## **Why Critical Study of Residential Treatment Services is Needed at this Time**

For a variety of reasons, the development, testing and refinement of improved models of residential treatment services have lagged seriously behind their family and community centered counterparts. For example:

1. The last Child Welfare League of America [CWLA] National Conference on Group Residential Care took place in the mid 1980's and followed a similar CWLA national study process and major conference in the mid 1970's (Balcerzak, 1989).
2. The exquisitely detailed census of 'children's residential institutions' commissioned by the Maternal and Child Health Service of the U.S. Department of Health, Education & Welfare in the mid 1960's yielded seven volumes of data on children's residential settings collected by a top-flight research team headed by Professor Donnell Pappenfort of the University of Chicago (Pappenfort, Kilpatrick & Kuby, 1970). An invitational policy conference on this data held at the University of Chicago in 1971 drew leading child welfare experts from across the U.S. and produced a timely and useful monograph on future directions in policy, practice and research in various sectors of group residential care (Pappenfort, Kilpatrick & Roberts, 1973). The census was repeated in the early 1980's, but to the disappointment of the research team, far fewer resources were available for post-survey policy and program analysis (Pappenfort, Young and Marlow, 1983). Despite the general absence of detailed national data on setting characteristics and utilization patterns of residential treatment, as noted earlier research originating from centers like the Chapin Hall Center for Children at the University of Chicago provide

excellent snapshots of contemporary uses of residential treatment services in an overall state child & family services system (Budde et. al., 2004)

3. In terms of resources for model residential program development and evaluation, one has to go back to the 1960's and 70's for examples of significant federal agency investment as in the early NIMH support for Nicholas Hobb's Project Re-ED (1969) and the support of the Center for the Study of Crime & Delinquency, NIMH for The Teaching Family Model [originally, "Achievement Place"] (Phillips, Phillips, Fixsen & Wolf, 1974) which was created at the University of Kansas and is probably best recognized in its current and enhanced form at Boys Town in Nebraska where it has been the mainstay of the treatment program and accompanying research efforts since the early 1970's. I note here that whatever one concludes about the efficacy of these innovative model approaches, there is no doubt that each has greatly enhanced our overall understanding about the components of effective and humane residential and other services for children and youth. Through Project ReED, Nicholas Hobbs pioneered the concept of an "ecological" approach to therapeutic residential intervention based on a strengths-focused, psycho-educational model with strong ties to family, school and community: well before these elements became embedded in mainstream child mental health and child welfare practice. Similarly, the Teaching Family model with its focus on skills acquisition, cross-setting monitoring of behavior and 'teaching-interaction' has continuously refined and improved over the years – most prominently, as noted earlier, at Boys Town in Nebraska- where it shares many elements in common with prominent, evidence-based non-residential

alternatives such as Multisystemic Therapy (MST) and Multidimensional Treatment Foster Care (MTFC).

One result of this resource drought, as noted earlier, has contributed to a kind of atrophy in residential treatment model development at the very same time that substantial resources from both federal and private philanthropic entities have gone to the development, model testing, refinement, evaluation and dissemination of a wide variety of novel, non-residential alternatives: see, for example Chamberlain (2003) and Henggeler & Lee, 2003. Taken in total, these efforts have added greatly to our knowledge of the ‘active ingredients’ in effective treatments as well as the strengths and limits of individual approaches. In a particularly insightful review of the evidence on residential treatment, Barth (2005) argues among other things for the use of logic models to help identify the change theories that underpin the variety of residential program approaches that presently exist. This is an excellent suggestion and indeed, it is time to reflect on both the conflicts and complementarities between varieties of ‘residential treatment’ and work towards a clearer understanding of both the critical components of each of the various options and their highest and best use in an overall continuum of services. As a step toward this goal, Lee and Thompson (2008) illuminate one promising direction in their comparison of treatment foster care and family oriented group care. A recent contribution by Sigrid James (2011) provides a detailed analysis of four current residential treatment models –*Positive Peer Culture, Teaching Family Model, Sanctuary Model and Re-ED*- guided by criteria developed by the California Evidence-Based Clearinghouse for Child Welfare and is rich in its implications for future research and practice demonstration. Continuing contributions by internationally recognized systems

researchers like Dr. John Lyons of the University of Ottawa and the Ottawa Children's Hospital of Eastern Ontario suggest promising directions in clinical measurement set in the context of total clinical outcomes management (TCOM) in a wide spectrum of child mental health services including intensive residential treatment (Lyons, 2004; Lyons and Weiner, 2009).

In my view, it is essential that any serious discussion of residential treatment service alternatives include a strong cross-national component. This reflects the fact that many developed societies are dealing with similar issues with respect to meeting the needs of high- resource using children, but are doing so from differing cultural, political and administrative bases which may offer helpful insights to a directed conversation on how to improve and sustain effective intensive residential treatment services within the U.S. context (Egelund and Lausten, 2009; Biehal, 2008; Thoburn, 2008). Despite our great size and regional variability, much U.S. thinking about residential provision has been quite insular. With advances in technology and the growing availability of reports and research studies in English, we have the opportunity to expand our horizons in services planning and research.

#### **A Note on Residential Treatment as a Family Support Resource**

Discovering the 'highest and best use' of residential treatment turns on the extent to which it can be reconceived and perceived as a true *family support resource* throughout all phases of the treatment process. In a survey published in 2003, Kruzich, Jivanjee, Robinson & Friesen report that many of the barriers to family involvement identified earlier in the 1980's continue to exist (Jenson and Whittaker, 1987). These include attitudinal, structural and financial barriers, many of which invite creative

solutions as evidenced in the pioneering work of centers and projects like the Research and Training Center on Family Support and Children's Mental Health at Portland State University (Friesen, ) supported by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, DHHS and The Carolinas Project ( Alwon et. al., 2000) which was supported by the Child Care Division of the Duke Endowment.

From early research onward, meaningful family involvement has been associated with positive outcomes for youth in residential treatment (Taylor and Alpert, 1973). That fact alone and the general thrust of progressive policy in both child mental health and child welfare over roughly the last thirty years argue strongly for renewed efforts to identify and empirically validate multiple pathways for family engagement with the residential treatment center and, indeed, its re-casting as a true family support resource (Small & Whittaker, 1979; Whittaker, 1981 and in press). This will involve a careful review and cataloguing of successful family engagement strategies from both pioneering centers and projects like those cited above and pioneering agencies, like *EMQ- Families First* in California which have successfully integrated a wide spectrum of family centered, needs driven, strengths-based services within a common agency structure which includes intensive residential treatment. It will also mean searching far and wide for those creative examples of family-centered care- such as those in Sweden cited by Barth (2005)-which involve in-home, residential and foster family applications. Finally, the continuing squeeze on budgetary resources suggests additional burdens for both families and residential treatment agencies which will require sustained, active and meaningful partnerships if they are to be overcome.

Much of contemporary and past discussion of residential treatment has been grounded in ideology and belief. The working conference, if successful, will bring an added measure of rationale discourse as well as empirical evidence to this conversation by shedding light on how successful residential services actually ‘work’ and what principles should guide future theory, research and model development of this service within an overall spectrum of service delivery. The aim is nothing less than discerning the highest and best uses of this intensive service alternative for that small but critically important segment of children who require it.

### **Summary**

Is residential treatment to be viewed as a service remedy of ‘last resort’ as research from Chapin Hall determined in Illinois (Budde et. al. 2004), or are there situations where intensive residential services may be the service of first choice? What promising programmatic innovations are on the horizon? How is the variety of residential services best thought of in an overall spectrum of child and youth services? Such questions follow the recent recommendations of Professors Mark Courtney of the University of Chicago and Dorota Iwaniec of Queen’s University of Belfast (2009) who, along with others, call for a more fulsome discussion of the current state and future development of intensive residential services for troubled youth viewed in cross-national perspective. Such calls reflect the previously noted reality that in the U.S. as well as in many other developed countries, residential services have suffered from what might be thought of as a kind of ‘benign neglect’ with respect to public sector and private philanthropic funding particularly in such key areas as development and testing of new and innovative model programs, research on the critical components (‘active

ingredients’) in effective residential treatment, development of creative training and management protocols and refinement of sensitive outcome indicators appropriate to the services offered.

The field of child and family services – crosscutting child welfare, child mental health and juvenile justice- needs to bring several strands of conversation concerning residential treatment together in one place: *research, clinical practice and policy*. A hoped for outcome is to shed light on pathways for exploring how successful residential services actually ‘work’ and what principles should guide future theory, model development, funding, performance measurement, and research in this critical area of practice. The overall aim remains the identification of the highest and best uses of well specified and empirically supported residential treatment as a component of a comprehensive array of services and as a family support resource.

The cross-national nature of such a discussion reflects the fact that many developed societies are dealing with similar issues with respect to meeting the needs of high- resource using children, but are doing so from differing cultural, political and administrative bases which may offer helpful insights to a directed conversation on how to improve and sustain effective intensive residential treatment services within the U.S. context (Egelund and Lausten, 2009; Biehal, 2008). The questions enumerated above suggest a national response: no single agency, state or professional association – particularly those engaged in meeting the immediate service needs of troubled children and their families- can address the complex issues surrounding the future for residential treatment. That said, many pioneering agencies and integrative projects like the very promising “Building Bridges” initiative originating from the Center for Mental Health

Services, SAMHSA along with family and youth consumer groups and academic research centers dedicated to services research all have vital roles to play. In an era of reduced government funding at all levels, it is critical that America's singular and vibrant philanthropic community – particularly those institutions that have exercised great leadership in relentless pursuit of the overarching goals of permanency and treatment efficacy for vulnerable children and families- become involved in meaningful ways. In an insightful closing essay [“Looking backward to see forward clearly”] to the previously cited volume on residential care in international perspective by Courtney and Iwaniec, three of the contributors Mark Courtney (U.S.), Talal Dolev (Israel) and Robbie Gilligan (Ireland) set the direction for the work that lies ahead:

*As the role of residential care within the child welfare systems in each country continues to evolve, the authors raise a number of questions about the efficacy both of residential care and its alternatives.....As we search internationally for models of care appropriate to meeting the needs of at-risk children, this volume tells us that many of the dilemmas we confront and the solutions we imagine are shared across cultural and geographic boundaries, and across time. It highlights the importance of developing a body of evidence to support our care choices..... (Courtney & Iwaniec, 2009 p.208).*

One hopes that fresh insights garnered from empirical research and careful analysis of residential treatment services here and elsewhere will constitute a portion of that ‘body of evidence’ and will thus inform future policy and practice decisions in this vital, yet contested area of service.

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Dr. Whittaker began his career as a child care worker at the Walker School in Needham, MA in 1962 where he later served as Assistant Director under founding director, Dr. Al Trieschman. In October 2010, he joined present director, Dr. Rick Small and 200 colleagues in a special symposium - "*The Other 23 Hours Then and Now: Lessons learned and future directions in fostering resilience and building competence with troubled children and their families*" - celebrating Walker's 50<sup>th</sup> anniversary and the 40<sup>th</sup> anniversary of the publication of *The Other 23 Hours: Child Care Work with Emotionally Disturbed Children in a Therapeutic Milieu* (Trieschman, Whittaker & Brendtro, 1969) which remains in print and has also been published in Danish, Dutch, German & Japanese. Earlier in September 2010, he served as moderator and presenter of a symposium entitled - *Residential Services for At-Risk Youth: Is it Time for a Critical Review?*- which included papers from the U.K., Israel, Belgium, the U.S. and the Netherlands at the 11<sup>th</sup> Biennial EUSARF Conference @ the University of Groningen, The Netherlands. He may be contacted at: [jimw@uw.edu](mailto:jimw@uw.edu)