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EDITORIAL

Is Residential Treatment Misunderstood?

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Residential treatment is suffering greatly from a misperception of definition. For those outside of the field, it is still widely perceived as an antiquated provision of care that does little more than warehouse children. For those working in the field, there is a lack of consensus about what constitutes residential treatment. Efficacy literature is hindered not only by the difficulties inherent in performing intervention studies, but particularly by the lack of a clear definition of subtypes of residential treatment and what they provide. Most unfortunate, however, is that these misperceptions allow for the idiosyncratic use of the term, *residential treatment*, and the personal assessment of its effectiveness. This has resulted in national and state funding reductions for a provision of care that is absolutely necessary in the continuum of services for individuals with behavioral and mental health challenges. Recognition of a more specific definition of residential treatment would provide a basis for systematic research and increase residential treatment's viability and effectiveness. This would allow for an improvement in residential treatment's reputation, and subsequently reduce ill-informed funding and policy decisions that now limit access to a much needed service for many children and families.

Funding decline

Since the mid 1990s, government policy in child welfare has become increasingly supportive of family-of-origin or kin-based alternatives for children. Federal and state dollars are being reduced for the provision of residential treatment. Maine, like other states, is aggressively promoting home-based care with outpatient and community service supports. Maine's budget is currently eliminating millions of dollars of mental health funding from its annual budget, including the closing of 170 residential treatment beds. National publications have raised

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concern about the cost and treatment effectiveness of residential care. The Surgeon General's Mental Health Report cited that while 8% of children with mental health challenges utilize residential care, 25% of the national funding is spent on these care settings (Burns, Hoagwood, & Mrazek, 1998; U.S. Dept. of Health & Human Services, 1999). This is not a surprise. Housing and caring for human beings are complex and expensive interventions. Hospitals and nursing homes can attest to this. It is logical that most types of outpatient services, by comparison, would be less expensive alternatives.

Weak body of literature

The initiative to cut funding for residential treatment is due, in part, to a lack of sufficient efficacy research on a high cost service. A decade ago, the executive summary of the U.S. General Accounting Office (1994) reported that not enough was known about residential care programs to clearly understand what worked best or what was effective. More recently, The Surgeon General's Mental Health Report stated that there is only weak evidence for the effectiveness of residential care, citing three controlled studies (U.S. Department of Health & Human Services, 1999). Examination of these studies reveals that one study found improved functioning in treated adolescents. A follow up study to this suggested that community supports might be equally effective. The third controlled study was 25 years old and found similar benefits from both foster care and residential care.

Outcome studies of residential treatment vary widely in scope and suffer from an absence of control or comparison groups, poorly defined service units, sampling problems, and improper selection or measurement of outcome criteria and, most importantly, improper aggregation of results (Bates, English, & Koudiou-Giles, 1997; Whittaker & Pfeiffer, 1994). Studies that identify a comparison group often fail to control for the acuity or complexity of initial presenting problems. Results, then, have shown a variety of findings, from one to five year maintenance of gains in clinical functioning, academic skills, and peer relationships (Blackman, Eustace, & Chowdhury, 1991; Joshi & Rosenberg, 1997; Wells, 1991), to a healthy mental health re-admittance rate (75%) and incarceration rate (30%) in a longitudinal follow-up study (Greenbaum, 1998). While it is legitimate for different studies to measure a variety of interventions and outcome variables, it is not acceptable for these studies' findings to be aggregated and referred to as *residential treatment*. These studies are measuring different interventions. Valid empirical conclusions about the effectiveness of residential treatment are not able to be made from the science of residential treatment today that suffers from methodological issues, lacks rigorous and replicated findings, and improperly groups studies into a single *residential treatment* category.

Misinformation and policy responses

The paucity of coordinated, well-defined effectiveness research has also posed a barrier to identifying best practices in residential services. This is exacerbated by federal agency and private foundation fiscal inattention to new residential treatment models (Whittaker & Maluccio, 2002). Bilchik (2005) eloquently remarked that funding foundations and the federal government unconsciously perceive residential care as a "cul de sac" in the spectrum of social services. The rhetoric of residential treatment as expensive and cumbersome is not easily dismissed. It has shaped agendas and debates, and created expectations that have

molded policies. As a result, the vicious cycle of *lack of evidence due to lack of funding* is set into motion.

Most funders and policymakers ask if residential treatment *works*. They often consider biological family reunification as the measure of success of residential treatment. This outcome is obviously narrow and Bilchik (2005) wondered if the wrong question is being asked. *Does it work* is actually a broad question wrought with generalities that immediately beg more questions (e.g., For which children? What kind of residential treatment? At what point in the spectrum of services?). Reunification status is by no means the only valid measure of residential treatment's benefits. In fact, Taussig, Clyman and Landsverk (2001) revealed that youth reunified with their biological families after foster care placement actually had more negative outcomes (i.e., behavioral and emotional health problems) than youth who did not reunify. The study cautions against presuming that children who reunify with biological parents have achieved positive outcomes simply due to reunification. For children removed from biological parents, these findings highlight that reunification should not necessarily be the ultimate goal. Other outcomes deserve attention, such as maintenance of gains from residential care in post-discharge settings. A child's functioning and health is what is important. While family empowerment and therapeutic connections with families are key to residential treatment, so is recognition that optimal solutions may not allow for every parent and child to live together (Bilchik). Similarly, gains during the course of treatment are noteworthy. During residential care and treatment, children gain greatly and are spared much trauma. Truancy decreases. Medication management is provided for mental health issues. Children avoid abuse, neglect, and the stressors of chaotic families. Hospitalizations decrease.

Challenges of residential research

Considering these laudable dependent variables in conjunction with the various types of residential treatment intervention models presents a complex, multivariate and methodological challenge. While many of these factors are measurable, many present quantifying challenges in the application of science to a social science field. This contributes to why the research field of residential treatment remains so undeveloped and unfocused. Thus, the literature does not actually reveal much helpful information as studies measure different variables, on different populations of children, at different times, receiving different interventions. Clinicians and policymakers then interpret findings idiosyncratically. Realizing this gap in information is pivotal to both efficacy research and subsequent funding support.

In fact, some outcome measures elude measurement. Consider the sign that hung in Albert Einstein's office at Princeton: *Not everything that counts can be counted, and not everything that can be counted counts*. The value and artifacts of consistency, structure, caring and nurturing, limit setting, and quiet supportive time to self-reflect and focus on mental health issues are invaluable and complicated to objectify and analyze. What a child receives from the residential treatment experience may not be known until years after discharge. A former client will reveal after 10 or 15 years that the limit setting provided during residential treatment was the only factor that helped him complete school or not live on the streets or use drugs with peers. While this former client's subjective frame of reference may not accurately represent the whole "truth" of influential treatment variables, there is a truth to his personal notion of what made a difference to him. Many people can identify that special, important person in their life—that person to whom they can reference in retrospect as a wise mentor or caregiver. Studies have shown the positive impact of mentors on factors

including psychosocial support, self-esteem and role modeling (Fagenson-Eland, Marks, & Amendola, 1997; Gilligan, 1999; Jackson, 2002). For many children, this profound kind of caring experience happens for the first time in their lives during residential treatment. This experience become integrated into a person and is not scientifically measured, but instead constitutes a developed sense of the power of relationship that a person holds inside. The field of residential treatment research would benefit from finding a way to measure such a qualitative marker.

Need for definition

What lies at the heart of its weak evidence base, changing ideology, and funding reductions, is the lack of a clear understanding of exactly what defines or constitutes residential treatment. This is not a new or novel idea, as others have echoed this same concern for years (Durkin & Durkin, 1975; Epstein, 2004). Residential treatment is not standardized. There is no sanctioned manual or protocol for delivery of residential treatment services. *Residential treatment* is used as an umbrella term to describe a plethora of different types of models of service delivery.

The lack of clarification about what defines residential treatment helps maintain the idiosyncratic views of these services and makes residential treatment an easy target for criticism. Whittaker (2004) noted that the turn-of-the-century notion, *institutional life is contrary to a child's nature,* still exists today. This sustains the existence of an archaic and inaccurate perception of residential treatment as a single type of ineffective, institutional, congregate care for children. This negative and narrow view may be at the core of why residential care remains so unclearly defined. Simply put, it is not a popular service. Just as various outpatient treatment modalities are acknowledged as such yet studied independently, recognition and distinction of the many alternative, individualized, interdisciplinary types of residential treatment has not yet occurred.

The Surgeon General's Mental Health Report (U.S. Department of Health & Human Services, 1999) acknowledged that the types of care and treatment available in residential care settings include institutional, community-based, and home-based. Indeed, many configurations of care and treatment are labeled *residential treatment* (e.g., group homes, therapeutic foster homes, treatment foster care, campus-based homes, locked facilities, congregate care), and provide a range of care and treatment provisions. Residential treatment can be brief and intense, or longer and moderate. Some providers offer more independent living with paraprofessional oversight. Others include a full team of professionals (e.g., psychiatry, psychology, social work, occupational therapy, speech therapy) working in an integrated fashion. Others use all or some of these professionals more independently of one another. But when grouped together as residential treatment, the constellation of systems and levels of integration, the specific types of therapies provided, the milieu characteristics, and the quality of staff are lost details. Using the term *residential treatment* to describe the multitude of types of residential care and treatment provisions only does the field a disservice.

Defining elements

In an effort to more clearly articulate what constitutes residential treatment, it is useful to consider two different views of experts in the field. The American Association of Children's

Residential Centers offered a definition of a residential treatment center adapted from the Center for Mental Health Services, SAMHSA:

> An organization whose primary purpose is the provision of individually planned programs of mental health treatment, other than acute inpatient care, in conjunction with residential care for seriously emotionally disturbed children and youth, ages 17 and younger. It has a clinical program within the organization that is directed by a psychiatrist, psychologist, social worker or psychiatric nurse. . . . (AACRC, 1999)

In a more qualitatively focused manner, Whittaker (2004) stated that the government ideology that shifts funding from "service-centered" planning to "child- and family-centered planning" threatens the focus of residential treatment as a total intervention. He maintained that both types of planning are necessary to understand one of residential treatment's most important components—the power of the milieu. The therapeutic milieu offers developmental and stable caregiving, a predictable and structured environment, educated and supervised staff and professionals, maintenance of meaningful and therapeutic connections with families, opportunities for professional therapeutic work, and interaction/involvement with community and culture.

Proposed definition

As an initial step toward a consensual understanding of residential treatment, a core definition of residential treatment is needed. By definition, then, residential treatment requires components of *a therapeutic milieu*, a *multidisciplinary care team, deliberate client supervision, intense staff supervision and training,* and *consistent clinical / administrative oversight*. The notion of milieu within residential treatment began with seminal residential work and publications by Bettelheim (1950, 1955) and Redl and Wineman (1951, 1952). They recognized the need for attending to environmental features that effect physical, emotional and psychological changes in children. The challenges presented by the children needing intense interpersonal services demand a collaborative team of professionals who care for and treat from a bio-psycho-social perspective. Careful client supervision is designed and provided, staff receive formal and informal training and supervision, and senior clinical and administrative guidance is available at all times.

Definitional differentiation

The presence of these components in a defined, professionally-staffed context constitutes the core of a definition of residential treatment and provides a uniform base for research. Certainly, different modalities of therapy (e.g., Dialectical Behavior Therapy, Cognitive Behavior Therapy) may be delivered in a residential treatment program, and a therapeutic couple may care for a child instead of shift staff. But residential treatment defined in this way is decidedly different than other types of supported care. Noting these specific differences is important and needs to be articulated when researchers study child outcomes and treatment effectiveness.

For example, by simply using the defining elements noted above, an essential difference between residential treatment and other types of treatment (e.g., kinship, family foster, or family teaching) is that the therapeutic milieu offers a consistent plan of care and treatment, without compromise, due to the level of supervision and monitoring in a system where all

parties adhere to a specific plan of care and treatment. Residential treatment that employs clinicians and care workers, and owns/rents homes or facilities of care, is decidedly different than family care options. Residential treatment, newly defined, can maintain control of the multitude of variables that would otherwise inevitably occur due to familial preference and resources. This defined residential treatment model has the advantage of sustaining a focus on what is clinically best for a child, while a familial model of care may not be able to manage the strain or duration of distress that inevitably arises.

Kinship care is inherently subjective, and thus more vulnerable to family dynamics that may not be in a child's best interest. Carefully designed and delivered team treatment is not typically a part of kinship care. A child in a client/family-owned and managed home will fare differently than a child in an agency-owned and managed residential home. Residential treatment offers the power of an integrated treatment team and attention to a milieu that it develops, supervises and maintains. While many children do not require the level of structure and support that this defined residential treatment provides, it is important to distinguish the difference between the provisions of residential treatment and the various family-care options.

Benefit of definition

Although practitioners long to see the day when youngsters with serious psychiatric disorders can be treated quickly and effectively in outpatient or in-home settings, that time has not, and may never, come. Plans of increased outpatient clinics thwarting the need for hospitalizations were shown to be unrealistic (Grob, 1991). The same is true for community supports replacing residential treatment. There is a place for residential treatment—although it needs to be clearly defined and studied. Residential treatment belongs on a horizontal axis along with other social service options, to be considered as an appropriate placement at any time a child may need it (Bilchik, 2005). In fact, residential treatment continues to be perceived by many as a dynamic and critical component in the continuum of care model, interfacing with a variety of other linked services (CWLA, 2004; Durrant, 1993; Lewis, 2004; Lieberman, 2004).

Although lacking sound empirical evidence, clinical experience indicates that youngsters can smoothly and effectively move in and out of short and long-term residential treatment as needed, as they do with other service provisions in the mental health system. Despite the overwhelming challenges facing residential treatment, prominent child mental health experts maintain that, "... the field has continued to progress" (Leventhal & Zimmerman, 2004, p. xvi). Residential treatment in children and adolescents is "alive and well, quietly advancing in the shadows of the perilously functioning children's health care system" (Leventhal & Zimmerman, p. xv). Perhaps this is due to data that indicates that in the United States, four million children and youth suffer from a major mental illness that significantly impairs their functioning at home, school and with peers (U.S. Public Health Service, 2000). Furthermore, between 75% and 80% of children and youth do not receive mental health services that they need (U.S. Department of Health & Human Services, 1999).

Logic implores policymakers and funders to not dismiss residential treatment as ineffective, but rather to recognize that its ambiguous definition and historical rhetoric have resulted in studies reporting idiosyncratic findings that result in incorrect policy conclusions. By employing a shared definition with unambiguous terminology, a common understanding of residential treatment can be reached and its effectiveness better understood. This will allow for articulation of children's progress both during and post-discharge from treatment, and

provide evidence for a service that is consciously utilized on horizontal spectrum of services rather than as a last resort. Clearly defined interventions and outcomes can advance the field and inform clinicians, funders, and policymakers in a manner that increases the utility and improves the reputation of residential treatment as a viable and necessary treatment. Yet, while this is in process, and despite political and economic pressures to the contrary, practitioners have a clinical and ethical obligation to provide effective and meaningful residential treatment as a component within a full continuum of care to meet youngsters' and families' needs.

While residential treatment suffers from a misperception of definition and is still regarded by many as archaic, it remains a widely used and necessary care provision. The challenge of the field is to recognize and utilize a common definition of residential treatment to provide a base for more systematic comparison and replication studies of effectiveness. With more rigorous evidence of its value, residential treatment's funding competitiveness can then increase, and policy decisions and resources can provide greater access to this important service.

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