



Perspectives on Residential and Community-Based Treatment for Youth and Families

Magellan Health Services
Children's Services Task Force

We would also like to acknowledge the members of the Magellan Residential Treatment Initiative task force: Rick Kamins, Pat Hunt, Jennifer Tripp, Fred Waxenberg, Evon Bergey, Kathy Dinges, Joan Discher, Murphy Leopold, Carole Matyas, Carlos Ruiz, Diane Marciano, Steve Winderbaum, Matt Miller, Bonni Hopkins and Deb Happ.

EXECUTIVE SUMMARY

The first residential treatment programs for children and adolescents appeared in the 1940s. By the 1950s, these programs began to resemble the modern day version of residential treatment: milieu therapy with specialized mental health treatment and residential school services. With few effective alternative treatment options available for children with serious emotional disturbances, more and more youth were admitted to residential treatment.

In the United States, approximately 50,000 children per year are admitted to residential treatment (Vaughn, 2005). One-fourth of the national funding on children's mental health is spent on residential treatment (U.S. Surgeon General's Report, 1999). Mental health experts agree that it is preferable to treat youth with serious mental disorders outside of institutional settings in general and outside of the correctional system in particular (Skowrya & Coccozza, 2007). These findings are echoed by the U.S. Surgeon General's Report on Mental Health (1999) which states that there is limited evidence that supports the effectiveness of residential treatment. Further, research, over the last several decades, has shown that there are effective alternative community-based services for those children who can safely be treated at home.

This paper was developed in response to concerns about the reliance on residential treatment for children and adolescents with serious emotional disturbance and the under use of evidence-based alternative treatments. It's based on reviews of the literature on the efficacy of residential treatment and alternative treatments for youth with serious emotional disturbance. We also conducted three community forums to get public input on the use of residential treatment and other alternatives. The forums were conducted in Nashville, TN on April 25, 2008, in Bucks County, PA on June 16, 2008 and in Delaware County, PA on June 17, 2008. Attendees at the forums included parents of children who had been in residential treatment as well as young adults who had received residential treatment services. Additional participants included policy makers; psychologists and psychiatrists; providers of crisis, residential and therapeutic foster care services; representatives from state child welfare, education, mental health and juvenile justice agencies; juvenile courts; Governor-appointed commissions; advocacy centers; schools and various providers. Subject matter experts included individuals with expertise in treating youth with behaviors that put themselves and others at risk, such as young people who have eating disorders or have committed sex offenses.

This paper concludes that while residential treatment remains an important component of a system of care, for most youth, community-based interventions represent a more appropriate and less costly alternative to residential placement.

One-fourth of the national funding on children's mental health is spent on residential treatment (U.S. Surgeon General Report, 1999).

While residential treatment remains an important component of a system of care, for most youth, community-based interventions represent a more appropriate, less costly alternative.

HISTORICAL PERSPECTIVE OF RESIDENTIAL TREATMENT FOR YOUTH

Inpatient services, specifically intended for adolescents, first began to appear in the United States in the 1920s (Kolko, 1992). The evolution of residential treatment is a direct result of the need to further provide services and a place of purposeful mental healing to a population of adolescents. The original concept of residential treatment was to provide services for children who were abused and neglected by placing them in a safe environment, however residential treatment for youth has taken many unique transitions since its origin.

In the late 1940s the term “residential treatment” began to be utilized more frequently as Social Security, Aid to Dependent Children and other New Deal reforms ceased being primary reasons for institutionalizing children for economic reasons. It was during this era that psychiatry and social work developed a greater respect and influence, thus allowing programs to be developed to accommodate the treatment of persons with mental illness.

By 1954, the American Orthopsychiatric Association held a major symposium on residential treatment and at its annual meeting two years later, the American Association of Children’s Residential Centers (AACRC) was established by participants in that group including Bruno Bettelheim, Edward Greenwood and Morris Fritz Mayer. Fifteen years later, a National Institute of Mental Health (1971) survey included 261 residential treatment settings. By the 1980s 125,000 children were being treated in residential treatment facilities and by the year 2000 the number of children being treated had significantly increased to a quarter million.

In the 1970s and 1980s the term “residential treatment” was identified with a type of institution and firm distinctions were made between them and hospitals. Whereas hospitals were run by doctors and nurses and designed to treat more disturbed patients, the residential treatment settings were typically operated by psychologists and social workers and provided fewer and less sophisticated therapies. During this period, residential treatment started to receive a lot of criticism by family therapists and other family advocates who were concerned about children being separated from their parents, lack of family involvement during treatment and the institutional behavior of children who had been in residential treatment.

By the 1990s many felt that residential treatment centers were overused. In response, community-based alternatives such as day hospitals, family preservation programs, wrap-around services and multisystemic treatment have become options for the treatment of children (Baldessarini, 2000). The 1990s also brought with it the use of medications to make possible the management of disruptive behaviors, affective instability, depression, anxiety, and thought disorders in outpatient settings.

1920s

Adolescent inpatient services begin to appear in the U.S.

1940s

Greater respect for psychiatry allows for development of programs to treat mental illness.

1950s

Symposium on residential treatment in 1954 and establishment of childrens residential centers in 1956.

1970-80s

Distinctions made between “residential treatment” and hospitalization.

1980s

125,000 children in residential treatment.

1990s

Community-based alternatives become options to residential treatment. Use of medication to manage disruptive behaviors.

2000

250,000 children in residential treatment.

RESIDENTIAL TREATMENT RESEARCH

Next to inpatient psychiatric hospitalization, residential treatment is the second most restrictive and costly treatment for children and adolescents. Approximately eight percent of children with mental health needs utilize residential care and 25 percent of the funding is spent for this service (Butler & McPherson, 2006). However, residential treatment is not an evidence-based practice, meaning that there is not sufficient research evidence to show that it is an effective form of treatment. According to the U.S. Surgeon General's Report (1999), "In the past, admission to residential treatment was justified on the basis of community protection, child protection and benefits of residential treatment. However, none of these justifications have stood up to research scrutiny. In particular, youth who display seriously violent and aggressive behavior do not appear to improve in such settings, according to limited evidence" (p. 170). Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald (2001) wrote that residential treatment centers and group homes are "widely used but empirically unjustified services" (p. 1185).

Because a treatment modality is not an evidence-based practice does not mean it won't be beneficial for some individuals. Residential treatment may be effective in certain circumstances. For example, Lyons, Terry, Martinovich, Peterson & Bouska (2001) confirm differential outcomes among youth in residence, and suggest that "residential treatment may be somewhat more effective with PTSD and emotional disorders rather than ADHD and behavioral disorders" (p.343). According to the research, youth often exhibit improvement for high risk behaviors, such as suicidal ideation, self-mutilation and aggression toward people in residential treatment settings. Similarly, children and adolescents who cannot be safely treated in a community setting (e.g., those who set fires or repeatedly sexually offend), are usually better treated in a residential setting (Mercer, 2008). Because every child has unique issues and needs, one has to determine what is in the best interest of each individual before making treatment decisions.

In general, however, residential treatment is not effective for many children. A survey of the literature indicates the following regarding residential treatment outcomes:

- Youth in residential treatment often make gains between admission and discharge, but many do not maintain improvement post-discharge (Burns, Hoagwood & Mrazek, 1999). Similarly, any gains made during a stay in residential treatment may not transfer well back to the youth's natural environment, creating a cycle where children are often repeatedly readmitted (Mercer, 2008). For example, Burns et al. (1999) reported that one large longitudinal six-state study of adolescents discharged from residential treatment found at a seven year follow-up that 75 percent had either been readmitted or incarcerated. Correspondingly, Asarnow, Aoki, & Elson (1996), reported that the rate of returning to placement was 32 percent after one year, 53 percent after two, and 59 percent by the end of the third year post discharge, consistent with the view that residential treatment is frequently associated with continuing placement and dependency. As cited by Surace and Canfield (2007), an analysis of Maryland youth discharged from residential placements revealed that 66 percent of youth were re-arrested within two years and 76 percent were re-arrested within three years.

Residential treatment is the second most restrictive and costly treatment for children and adolescents.

Because every child has unique issues and needs, one has to determine what is in the best interest of each individual before making treatment decisions.

Consistent with the research, parents in Magellan focus groups stated that their children often returned to residential treatment or entered the justice system after only a few months. Some of the reasons cited for this include: lack of services in the community or lack of coordination with community supports, and children don't have the skills they need to succeed in the community. A recent analysis of Magellan utilization data supported findings from the literature and comments from the focus groups. After a youth was admitted to a residential facility for the first time, chances of a readmission within a year was 26%. In addition, community tenure was 47 days less the year after discharge compared to the year prior to admission. These data and the experience of parents of youth treated in residential facilities reveal that residential treatment is not often an effective remedy.

- The milieu in residential treatment may have serious adverse effects on many adolescents. Youth may learn antisocial or inappropriate behavior from intensive exposure to other disturbed youth (Dishion, McCord & Poulin, 1999; Loeber & Farrington, 1998 as cited in Burn et al., 1999). A document developed by Bazelon Center on the detrimental effects of group placement (<http://www.bazelon.org/pdf/Deviant-Peer-Influences-Fact-Sheet.pdf>) lists over a dozen references indicating the unintended consequence of becoming more unruly or delinquent for adolescents who are at-risk through association with peers who exhibit antisocial behavior. Instead of residential group treatment, the article recommends intensive parenting support and family-based treatments geared to the needs of individual children. Thus, the belief that it is “better to be safe than sorry” in terms of erring on the side of containment is frequently not in the best interest of the youth or society.
- Youth who engage in seriously violent and aggressive behavior have not shown statistically significant improvement from residential care; similarly, those youth diagnosed with oppositional, defiant, or conduct disorder do poorly in these settings (Joshi & Rosenberg, 1997). No change was found for aggression toward objects, disobedience, impulsivity and inappropriate sexual behavior, and anxiety and hyperactivity often worsen (Lyons et al., 2001).
- Lyons et al. (2001) found that though youth may show improvement while in residential treatment, there was no evidence that treatment was successful at improving functioning. Similarly, there is no evidence of a relationship between outcomes in residential treatment and functioning in less restrictive environments (Bickman, Lambert, Andrade & Peñaloza, 2000). Many parents in our focus groups stated that their children were not prepared or able to transfer the skills learned in residential treatment to a community setting.
- Studies comparing residential treatment to Therapeutic Foster Care (TFC) are cited by Barth (2002) in which youth in residential care did worse on developmental measures one year following placement, had higher re-admission rates after reunification, and two to three times higher costs than TFC. Similarly, Rubenstein, Armentrout, Levin, and Herald (1978) reported TFC outcomes at least equal residential treatment at one-half the costs. According to the Center for Disease Control and Prevention, TFC programs are able to reduce violent crimes by about 70 percent among young people ages 12-18 with a history of chronic delinquency compared with programs for youth in residential treatment (<http://www.thecommunityguide.org/violence/viol-int-therapeuticfostercare.htm>).

Parents in Magellan focus groups said their children often returned to residential treatment or entered the justice system after only a few months due to:

- lack of services in the community
- lack of coordination with community supports
- children lacking the skills needed to succeed in the community

- In a study by Barth, Greeson, Guo, Green, Hurley & Sisson (2007), children in intensive in-home therapy were more likely in the future to live with family, make progress in school, not have trouble with the law, and have better placement permanence than youth in residential treatment. Parents in our focus groups recommended community-based approaches such as day programs, respite and after-school programs as possible alternatives.

Effective Residential Treatment

Key Components for Treatment. Residential treatment settings vary in the treatment they provide, which accounts for why some programs are more effective than others. The facilities with more successful outcomes tend to have certain factors in common:

- *Family Involvement.* The best programs partner with families and make sure there is meaningful family involvement during residential treatment. Residential stays are shorter and outcomes are improved when families are involved (Jivanjee, Friesen, Kruzich, Robinson, & Pullmann, 2002; Leichtman, Leichtman, Barber, & Neese, 2001). Thus, it is preferred to have youth not only stay in residential programs that are family-centered in approach, but are in close proximity so as to facilitate family involvement. Echoed by parents in our focus groups, distance from home and lack of meaningful family involvement were frequently mentioned as some of the problems with residential treatment. Family members seemed more satisfied when they were actively engaged in their child's treatment.
- *Discharge Planning.* The more successful residential treatment programs begin planning discharge at the time of admission. They determine what the youth needs for successful discharge and focus on eliminating barriers and building necessary supports. Gains are more likely to be maintained and readmissions decreased when attention is paid to what services and/or placement is needed post-discharge and the plan is executed. The parents in our focus groups supported the need for adequate discharge planning and coordination with supports in the child's home community.
- *Community involvement and services.* Effective residential treatment facilitates community involvement and services while the youth are in residential treatment. Teaching youth the skills needed for reintegration into their community increases the chances of successful outcomes.

In order to maintain gains after discharge, three common variables have been identified:

1. the amount of family involvement in the treatment process prior to discharge,
2. placement stability post-discharge, and
3. availability of aftercare supports for youth and their families.

Effective short-term programs. There is growing evidence that most of the gains in residential treatment are made in the first six months. For example, a study cited in Hair (2005), reported that a majority of measures that assess behavioral and emotional problems including delinquency-related behavior demonstrated progress during the first six months of treatment, whereas no additional gains were noted subsequently.

Common factors for facilities with successful residential treatment outcomes:

- Family involvement
- Discharge planning
- Community involvement & services

Cognizant that residential treatment is first and foremost a place for treatment rather than simply a placement for youth, there are the beginnings of a trend to develop short-term programs. Leichtman et al. (2001) followed over 120 adolescents for four years following an intensive short-term (3-4 month) residential treatment program. Results demonstrated significant improvement at discharge and 12 months post-charge. Contributing to success were the following features:

- *Family Involvement.* Family members were involved from the beginning of treatment. Rather than being viewed as “the problem,” family members were treated as part of the solution. This resulted in “shifts in staff attitudes regarding families...” (Leichtman et al., 2001, p. 229).
- *Attending to problems precipitating admission.* Rather than focusing on curing all symptoms, the residential staff directed their attention to the specific issue(s) that were directly related to the admission.
- *Strong focus on discharge planning.* Treatment was oriented not only toward the problems that brought the adolescent into treatment, but also toward helping the adolescent and family manage and continue to work on those problems at home. Knowing that additional work would be required, the staff made sure that resources, such as outpatient providers, were available to assist the family. Family members were also given information and skills training to help deal with the adolescent post-discharge. If a placement other than at home was required, work on obtaining this began early.
- *Community Involvement.* Much attention was paid to helping the adolescent transition back into the community. Intensive work with family members and community resources such as religious organizations, schools, vocational training programs, recreational programs and self-help groups was accomplished during the admission.
- *Outcomes.* To make sure that the adolescent’s functioning was improving, the residential treatment program committed to measuring progress. If outcome measures did not indicate improvement, then the treatment plan and interventions were revised. Monitoring of outcomes allowed the program to improve its success rate.

Family members in the focus groups agreed that these were the factors for success.

Rather than being viewed as “the problem,” family members were treated as part of the solution.

ALTERNATIVES TO RESIDENTIAL TREATMENT

Therapeutic Foster Care and Group Home Care

Therapeutic Foster Care (TFC) is a viable alternative to residential treatment. In fact, according to the Surgeon General's report (1999), "youths in therapeutic foster care made significant improvements in adjustment, self-esteem, sense of identity, and aggressive behavior. In addition, gains were sustained for some time after leaving the therapeutic foster home" (p. 177). Burns et al. (1999) came to a similar conclusion, "therapeutic foster care has also been successful at encouraging discharge to less restrictive placements, increased tenure in the community and lower costs than other residential options" (p.221). The same authors also reported that youth treated in TFC showed more "rapid improvement in behavior, lower rates of reinstitutionalization and substantially lower costs" than other forms of residential care.

In more recent literature on the effectiveness of TFC for the prevention of violence, Hahn et al (2005) revealed, "Substantial positive effects have been found for the prevention of violence among adolescents with a history of chronic delinquency, with reduction of more than 70 percent for felony assaults..." (p. 83). Interestingly, the research also demonstrated that prevention of violence with adolescents who received residential group care showed no improvement.

Multidimensional Treatment Foster Care (MTFC) is a particularly effective service for youth with severe emotional disturbance, delinquency or chronic antisocial behavior and who are in need of out-of-home placement. MTFC foster parents receive training and supervision in behavior management and other therapeutic methods. Research results have shown that youth in MTFC have significantly fewer days incarcerated or subsequent arrests, less hard drug use, quicker community placement from more restrictive settings (e.g., hospital, detention) and better school attendance and homework completion (Leve, Chamberlain, & Reid, 2005; Leve & Chamberlain, 2006). The cost per youth is from one-half to one-third less in MTFC than in residential, group or hospital placements (Chamberlain and Mihalic, 1998; Chamberlain, Leve, & DeGarmo, 2007).

Therapeutic Group Homes (TGH) is another out-of-home treatment placement alternative to residential treatment. However, the results for TGH have not demonstrated encouraging results. Youth admitted to TGH, unlike TFC, tend not to maintain improvements upon return to the community. Therefore, TGH may not be a viable treatment option for most children. (Hoagwood et al. 2001, Burns et al., 1999)

Integrated Community-Based Services

Case Management

Several studies show that case management can improve children's positive adjustment, support improved family functioning, and improve the stability of community living environments (Hoagwood et al., 2001). In addition, the use of case managers has been found to reduce future psychiatric hospitalization admissions (Burns, et al., 1996; Evans et al., 1996 as cited in Hoagwood et al., 2001), residential treatment placements (Potter

Youth in therapeutic foster care made significant improvements in adjustment, self-esteem, sense of identity, and aggressive behavior.

and Mulkern, 2004 as cited in Mercer, 2008), the number of foster care placement changes, and the number of runaway episodes (Clarke et al., 1998 as cited in Hoagwood et al., 2001). Case management is the coordination of services for individual youth and their families who require services from multiple providers. Case managers can assume a number of roles that may include service broker, advocate, providing information and referral, family and group team building and assessment. There are also various models of case management (e.g. individual, specialty, interdisciplinary team, and intensive).

Other studies have found that case management services result in lower delinquency rates and improved emotional and behavioral adjustments (Clark et al., 1996 as cited in Mercer, 2008)

Wraparound

The Wraparound approach is best defined as a “philosophy of care that includes a definable planning process involving the child and family that results in a unique set of community services and natural supports individualized for that child and family to achieve a positive set of outcomes” (SAMHSA Information Center <http://mentalhealth.samhsa.gov/cmhs/childrenscampaign/1998execsum4.asp>). The wraparound approach is team-driven, family-centered and strength-based. Fifteen studies across 10 states have shown reduced restrictiveness of living situations, reduced cost of care, lower delinquency and improvement in social, school, and community functioning (Burns & Hoagwood, 2002). Kansas, for instance, saved \$4.3 million in institutional costs which were redirected to more community-based services (Denney, 2005). Similarly, Wraparound Milwaukee has demonstrated a reduction of 60 percent in recidivism rates for delinquent youth (Pires, 2005), a decline of 60 percent in residential treatment, an 80 percent decrease in psychiatric hospitalization, and a drop of one-third in overall care costs (Bruns, 2003) since its inception.

In-Home and Community-Based Services

Multi-systemic Therapy (MST)

MST services are delivered in the natural environment (e.g., home, school, community), typically last three to five months, provide 24/7 therapist availability, and include multiple family contacts occurring weekly. Goals include separating youth from deviant peer units, improving school or vocational attendance and performance, and developing natural supports for the family to preserve therapeutic gains.

MST has been shown to reduce the number of psychiatric hospitalizations, arrest rates and out-of-home placements, and lower recidivism to juvenile correction facilities (Hoagwood et al., 2001).

Functional Family Therapy (FFT)

A research-based program for youth who are delinquent or at risk of delinquency and their families, FFT is a type of family therapy provided for three to five months in a clinic or at home. FFT focuses on family alliance, communication, parenting skills, problem solving, and reducing or eliminating problem behaviors.

Wraparound Results

Kansas

- Saved \$4.3 million in institutional costs

Milwaukee, WI

- Reduced recidivism rates for delinquent youth by 60%
- Decreased residential treatment by 60%
- Decreased psychiatric hospitalization by 80%
- Reduced overall care costs by one-third

FFT has proven highly successful in decreasing violence, drug abuse/use, conduct disorder and family conflict (Mercer, 2008) and in reducing residential treatment placements and juvenile involvement with the corrections system (Alexander et al., 2000; Aos, Barnoski and Lieb, 1998).

Assertive Community Treatment (ACT)

ACT is an evidence-based, community-based model of care for youth with serious mental illness. This model of care provides rehabilitation and treatment in addition to performing case management functions. The goals of the treatment team are to help youth live in the community, avoid hospitalization and residential admissions, and assist them in their recovery. Many states have used the ACT model to provide transition support including Arizona, Minnesota, Ohio, Pennsylvania, and Wisconsin.

Three nationally known and effective ACT programs are the Transitional Community Treatment Team in Columbus, Ohio; Allegheny County, Pennsylvania ACT Team, and the Transitional ACT Team of Clermont County, Ohio. These programs focus on young people who have been diagnosed with mental illnesses who meet the criteria for receiving mental health services and who are thought to be at highest risk for institutional placement, suicide or homelessness (Bridgeo, Davis, & Florida, 2000; Davis & Vander Stoep, 1996). Outcomes have shown increased engagement in treatment, improved housing, better social functioning, and higher employment and school attendance (Bridgeo et al., 2000).

Mentoring

The goal of mentoring is to associate healthy adult role models with high-risk youth outside their immediate families. Big Brother Big Sister of America is an example of an effective community mentoring program. A large controlled study compared outcomes of youth who participated in this program versus those on a waiting list. Results showed significantly less alcohol and drug use, better school attendance, higher grades, improved relationships with parents and peers, and less violence (Tierney et al., 1995 as cited in Burns and Hoagwood, 2002). Other effective mentoring programs include Willie M and the Blue Ridge Mentoring Program. Youth in these programs also show improved social and school functioning (Burns & Hoagwood, 2002).

ACT outcomes have shown increased engagement in treatment, improved housing, better social functioning, and higher employment and school attendance.

Results of mentoring programs show significantly less alcohol and drug use, better school attendance, higher grades, improved relationships with parents and peers, and less violence.

CONCLUSIONS

Although residential treatment is a necessary element in the spectrum of care for youth with serious emotional disturbance—particularly for youth who cannot be treated safely in the community—whenever possible, community-based programs should be considered. Over the last several decades, numerous evidence-based outpatient programs have been developed. In particular, Multisystemic Therapy (MST) and Functional Family Therapy (FFT) have shown strong positive outcomes in research and practice. In addition, case management and the wraparound approach to integrated community-based services are deemed evidence-based practices. When a child or adolescent does need 24 hour care, as an alternative to residential treatment, Therapeutic Foster Care (TFC) and, specifically, Multidimensional Treatment Foster Care (MTFC) should be considered. These two services are not only proven to be effective, they are not subject to the detrimental impact of deviant peer influences that may occur in residential treatment.

The best residential treatment programs focus on individualized treatment planning, intensive family involvement, discharge planning and reintegration back to the community. Because youth admitted to residential treatment make most of their gains in the first six months and because of the adverse impacts of extended length of stays (e.g., loss of connection to natural supports, treatment gains frequently not sustained post-discharge, and modeling of deviant peer behavior), long-term residential stays are often not in the best interest of the individual, family, or society.

In summary, many effective alternatives exist to residential treatment that are cost effective and have better clinical outcomes. When residential treatment is required, programs that focus on family involvement, discharge planning and reintegration back into the community, and average three to six months in duration should be primarily considered.

Although residential treatment is a necessary element in the spectrum of care for youth, community-based programs should be considered whenever possible.

Many effective alternatives exist to residential treatment that are cost effective and have better clinical outcomes.

REFERENCES

- Alexander, J., Pugh, C., Parsons, B., & Sexton, T. (2000). Functional Family Therapy. In D. S. Elliott (Ed.), *Blueprints for Violence Prevention* (Vol. 3). Boulder, CO: Venture Publishing.
- Aos, S., Barnoski, R., and Lieb, R. 1998. *Watching the Bottom Line: Cost-Effective Interventions for Reducing Crime in Washington*. Olympia, WA: Washington State Institute for Public Policy.
- Asarnow, J.R., Aoki, W., & Elson, S. (1996). Children in residential treatment: A follow-up study. *Journal of Clinical Child Psychology*, 25 (2), 209 – 214.
- Baldessarini, R.J. (2000). American biological psychiatry and psycho-pharmacology, 1944-1994. In R.W. Menninger & J.C. Nemiah (Eds.), *American psychiatry after World War II: 1944-1994* (p. 371-14120). Washington, D.C.: American Psychiatric Press.
- Barth, R. P. (2002). Institutions vs. foster homes: *The empirical base for a century of action*. Chapel Hill: University of North Carolina, School of Social Work, Jordan Institute for families.
- Barth, R. P., Greeson, J. K., Guo, S., Green, R. L., Hurley, S., Sisson, J. (2007). Outcomes for youth receiving intensive in-home therapy or residential care: A comparison using propensity scores. *American Journal of Orthopsychiatry*, 77 (4) 497-505.
- Bazon Center for Mental Health Law. (2006) *The Detrimental Effects of Group Placements/Services for Youth with Behavioral Health Problems*. Available through the Bazon Center for Mental Health Law [Online]. Available: (<http://www.bazon.org/pdf/Deviant-Peer-Influences-Fact-Sheet.pdf>)
- Bickman, L., Lambert, E. W., Andrade, A. R., & Peñaloza, R. V. (2000). The Fort Bragg continuum of care for children and adolescents: Mental health outcomes over 5 years. *Journal of Consulting and Clinical Psychology*, 68(4), 710-716.
- Bridgeo, D., Davis, M., & Florida, Y. (2000). Transition coordination: Helping young people pull it all together (pp.155-178). In H.B. Clark & M. Davis (Eds.). *Transition to adulthood: A resource for assisting young people with emotional or behavioral difficulties*. Baltimore: Paul H. Brookes Publishing Co.
- Bruns, E. J. (2003). *Serving youth with emotional and behavioral problems in Maryland: Opportunities for the use of the wraparound approach*. University of Maryland, School of Medicine, Department of Psychiatry.
- Burns, B.J., Farmer, E.M.Z., Angold, A., Costello, E. J. & Behar, L. (1996). A randomized trial of case management for youths with serious emotional disturbance. *Journal of Clinical Child Psychology*, 25, 476–486.
- Burns, B.J., Hoagwood, K., & Mrazek, P. (1999). Effective treatment for mental disorders in children and adolescents. *Clinical Child and Family Psychology Review*, 2, 199-254.
- Burns, B. J. & Hoagwood, K. (2002). *Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders*. New York: Oxford University Press.
- Butler & McPherson, 2006 Butler, L.S. & McPherson, P.M. (2007). Is Residential Treatment Misunderstood? *Journal of Child and Family Studies*. 465-472.
- Chamberlain, P., & Mihalic, S.F. (1998). *Multidimensional Treatment Foster Care: Blueprints for Violence Prevention, Book Eight*. Blueprints for Violence Prevention Series (D.S. Elliott, Series Editor). Boulder, CO: Center for the Study and Prevention of Violence, Institute of Behavioral Science, University of Colorado.
- Chamberlain, P., Leve, L., & DeGarmo, D. (2007). Multidimensional Treatment Foster Care for Girls in the Juvenile Justice System: Two Year Follow-up of a Randomized Clinical Trial. *Journal of Consulting and Clinical Psychology*, 75 (1), 187-193.
- Child Welfare League of America, Inc. (2005). *Position Statement on Residential Services*. Washington, D.C. [Online]. Available: www.cwla.org/programs/groupcare/rgcqpositionstatement.pdf
- Davis, M., and Vander Stoep, A. (1996). *The Transition to Adulthood Among Adolescents Who Have Serious Emotional Disturbance*. Rockville, MD: Center for Mental Health Services.

- Denney, R., VanAllen, E. & Cowger, K. (2005). Kansas HCBS-SED Waiver. Paper presented at the National health Policy Forum, Washington D.C., October 7th, 2005.
- Dishion T. J., McCord J., & Poulin F. (1999). *When Interventions Harm: Peer Groups and Problem Behavior*, *American Psychologist*, 54, 755 – 764.
- Francis, G. & Hart, K.J. (1992). Depression and suicide. In V.B. Van Hasselt & D.J. Kolko (Eds.), *Inpatient Behavior Therapy for Children and Adolescents* (pp. 93-111). New York: Plenum Press.
- Hahn, R.A., Bilukha, O., Lowy, J., Crosby, A., Fullilove, M.T., Liberman, A., Moscicki, E., Snyder, S., Tuma, F., Corso, P., & Schofield, A.(2005). The effectiveness of therapeutic foster care for the prevention of violence: a systematic review. *American Journal of Preventive Medicine*, 28 (2S1), 72-90.
- Hair, H. J. (2005) Outcomes for Children and Adolescents After Residential Treatment: A Review of Research from 1993 to 2003. *Journal of Child and Family Studies*, 14 (4), 551–575
- Hoagwood, K., Burns, B., Kiser, L., Ringeisen, H. & Schoenwald, S. K. (2001). Evidence-Based Practice in Child and Adolescent Mental Health Services. *Psychiatric Services*, 52 (9), 1179-1189.
- Hoagwood, K. & Cunningham, M. (1992). Outcomes of children with emotional disturbance in residential treatment for educational purposes. *Journal of Child and Family Studies*, 1, 129-140.
- Jivanjee, P., Friesen, B. J., Kruzich, J. M., Robinson, A., & Pullmann, M. (2002). Family Participation in system of care: Frequently asked questions (and some answers). *Portland, OR: Portland State University, Research and Training Center on Family Support and Children's Mental Health*. Published originally in CWTAC Updates: Series on Family and Professional Partnerships, Issue#2, Volume 5(1), January/February 2002. [Online]. Available: www.dhh.louisiana.gov/offices/publications/pubs-142/Family%20Participation%20FAQ.pdf. [November 2007].
- Joshi, P. K., & Rosenberg L. A. (1997). Children's behavioral response to residential treatment. *Journal of Clinical Psychology*, 53, 567–573.
- Leichtman, M., Leichtman, M. L., Barber, C. C., & Neese, D. T. (2001). Effectiveness of Intensive Short-term residential treatment with severely disturbed adolescents. *American Journal of Orthopsychiatry*, 71 (2), 227-235.
- Leve, L.D., & Chamberlain, P. (2006). A randomized evaluation of Multidimensional Treatment Foster Care: Effects on school attendance and homework completion in juvenile justice girls. *Research on Social Work Practice*, Vol. X No. X, July 2006 1–7.
- Leve, L.D., Chamberlain, P., & Reid, J.B. (2005). Intervention outcomes for girls referred from juvenile justice: Effects on delinquency. *Journal of Consulting and Clinical Psychology*, 73(6), 1181–1185.
- Lyons, J. S., Terry, P., Martinovich, Z., Peterson, J., & Bouska, B. (2001). Outcome trajectories for adolescents in residential treatment: a statewide evaluation. *Journal of Child and Family Studies*, 10:333–345.
- Mercer Government Human Services Consulting. (2008). *White Paper Community Alternatives to Psychiatric Residential Treatment Facility Services* Commonwealth of Pennsylvania, Office of Mental Health and Substance Abuse Services.
- Rubenstein, J. S., Armentrout, J. A., Levin, S., & Herald, D. (1978). The parent-therapist program: Alternative care for emotionally disturbed children. *American Journal of Orthopsychiatry*, 48, 654-662.
- Pires, S. (2005). Comprehensive and coordinated systems of care: Addressing financing challenges. Office on Disability, U.S. Department of Health and Human Services, Rockville, Maryland. [On-line] Available: <http://www.hhs.gov/od/documents/OfficeonDisabilitySummit.pp#256,1,Slide1>
- Skowrya, K. R. & Coccozza, J. J. (2007). *Blueprint for change: A comprehensive model for the identification and treatment of youth with mental health needs in contact with the juvenile justice system*. The National Center for Mental Health and Juvenile Justice. [On-line] Available: www.ncmhij.com/Blueprint/pdfs/Blueprint.pdf

- Surace, C. S. & Canfield, E. (2007). *Evidence-based practices for delinquent youth with mental illness in Maryland: Medicaid must cover these cost effective services*. A Public Report by the Maryland Disability Law Center.
- Vaughn, C. F. (2005). Residential treatment centers: Not a solution for children with mental health needs. *Clearinghouse Review Journal of Poverty Law and Policy*, 39 (3-4), 274.
- U.S. Surgeon General (1999). *Mental health: A report of the surgeon general*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.