

Residential Treatment Centers

Residential treatment centers (RTCs) usually house youths with significant psychiatric, psychological, behavioral, or substance abuse problems who have been unsuccessful in outpatient treatment or have proved too ill or unruly to be housed in foster care, day treatment programs, and other nonsecure environments but who do not yet merit commitment to a psychiatric hospital or secure correctional facility. These facilities frequently offer a combination of substance abuse and mental health treatment programs, such as psychoanalytic therapy, psychoeducational counseling, special education, behavioral management, group counseling, family therapy, and medication management, along with 24-hour supervision in a highly structured (often staff-secure) environment. These facilities typically are less restrictive than an inpatient psychiatric unit, and they are not licensed as hospitals (Bettman and Jaspersen 2009).

The American Association of Children’s Residential Centers defined a residential treatment center as “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” (AACRC 1999). In addition, when exploring residential treatment and the alternatives, Bates, English, and Kouidou–Giles (1997) differentiated between RTCs and group homes—two terms often used interchangeably when discussing residential treatment. Group homes provide for the basic needs of residents, which include food, shelter, and assistance with daily care. There is no primary emphasis on providing residents with treatment for mental health problems. However, the authors noted that RTCs specifically concentrate on delivering therapeutic treatment services to residents, in addition to also providing for their basic needs (Bates, English, and Kouidou–Giles 1997).

Lack of a Standard Definition

Like most other residential programs, however, RTCs suffer from a lack of a standard definition. A 2007 report by the Government Accountability Office (GAO) noted that it was difficult to develop an “overall picture” of RTCs and other residential treatment programs because there were no standardized definitions to differentiate residential programs (please see the Residential literature for further information on the GAO findings from the investigation that looked at cases and allegations of child abuse and neglect that were uncovered in residential treatment programs). Though the GAO report investigated allegations of abuse that youths experienced during their time in residential programs, the report ended up concentrating primarily on unregulated, privately run residential facilities such as wilderness therapy programs and boot camps, which were mistakenly labeled as residential treatment centers in a news article. Nevertheless, there are distinct differences between

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these types of residential programs (Lee 2008).

Changes in Program Theory

There have been calls in the literature to re-envision the model of the RTC. McCurdy and McIntyre (2004), for example, argue that RTCs need to adopt a “stop-gap model,” the goals of which are to interrupt the downward spiral of youth in crisis and prepare youth for reintegration. Chance and colleagues (2010) likewise encourage a model that brings together short-term, intensive residential treatment with aftercare services delivered in the community’s continuum of care. Lyons and colleagues (2009) similarly recognize the special importance of community resources, noting that length-of-stay decisions should be determined in part by what is available to the youth and family postdischarge.

Characteristics of RTCs

The Juvenile Residential Facility Census, a biennial survey conducted by the Office of Juvenile Justice and Delinquency Prevention (OJJDP), found that more than 900 facilities identified themselves as residential treatment centers. RTCs constituted 35 percent of all reporting facilities and held 32 percent of juvenile offenders in placement on the census date (Hockenberry, Sickmund, and Sladky 2009). RTCs and group homes outnumbered all other types of facilities included on the survey (though this finding may be misleading, as residential facilities are asked to self-report which type of facility they are and the survey does not provide definitions to differentiate between the various facility types listed, including RTCs, detention centers, training schools, group homes, ranch/wilderness camps, boot camps, reception or diagnostic centers, and runaway and homeless shelters).

The number of residents held in facilities that self-identified as RTCs varied. Only 18 percent of RTCs reported currently holding 10 or fewer residents. Most (57 percent) reported currently holding 11 to 50 residents in the facility. About one third of RTCs reported being at their standard bed capacity; only 3 percent reported being over capacity of their standard beds. Security features also varied across RTCs. Fewer than half (43 percent) reported using one or more confinement features, such as locked doors or gates, to restrict youth (Hockenberry, Sickmund, and Sladky 2009).

The survey asked facilities about the counseling and therapy services that were provided to youth. Of the 919 self-identified RTCs, 532 (about 58 percent) reported providing counseling services to youth in residence. Of those providing therapy, 89 percent provided individual therapy, 91 percent provided group therapy, and only half provided family therapy. In addition, of the 919 RTCs, 658 (about 72 percent) reported providing therapy services. Ninety-three percent provided individual therapy, 92 percent provided group therapy, and 58 percent provided family therapy. The survey did not differentiate between therapy and counseling services (Hockenberry, Sickmund, and Sladky 2009).

In addition, the survey found the RTCs and group homes were more likely than other residential placements to have in-house mental health professionals who evaluate all youths for mental health needs. Seventy-three percent of RTCs reported having in-house mental health professional available to evaluate youths’ mental health needs (Hockenberry, Sickmund, and Sladky 2009).

Variation in Treatment Centers

Though there are some common characteristics among facilities, RTCs can dramatically differ on numerous factors. For example, there are variations in staff education and qualifications, treatment organization, site theoretical orientation, and client psychopathology. In addition, individual and parental participation, family therapy involvement, vocational training components, and postdischarge

support can also vary among programs. For example, some residential treatment programs function from an ecological perspective, addressing individual problems with youths and concentrating on the interaction between youths and their environments. Other programs may take a therapeutic community approach, addressing problem behaviors through peer influence. However, there is a lack of research that measures or examines the influence of these factors on the success of treatment, so it remains unclear what program elements are important and beneficial to the treatment process (Bettman and Jaspersen 2009).

Target Population

In 2004, Federal funding supported the placement of 200,000 youths in government or private residential facilities, which include youths not involved in the juvenile justice system (GAO 2008b). Between 15 percent and 30 percent of youths in out-of-home care reside in RTCs (Whittaker 2004). The Survey of Youth in Residential Placement, another survey conducted by OJJDP, found that in 2003 approximately 14,070 juveniles were in a residential treatment program, which includes RTCs and other types of residential programs (Sedlak and McPherson 2010). Youths in residential treatment made up 14 percent of the total population of youths in placement.

There appears to be a general acceptance that the youths being sent to RTCs present increasingly intense and severe behavioral and emotional problems, academic problems, and substance use problems (Baker, Fulmore, and Collins 2008; Baker, Ashare, and Charvat 2009; Lyons et al. 2009). The 2000 American Association of Children's Residential Centers National Survey identified four main reasons for admission into an RTC:

- Severe emotional disturbance
- Aggressive/violent behaviors
- Family/school/community problems
- Abuse (Foltz 2004)

However, there is almost no research on the best target population for this type of facility and treatment. As Whittaker (2004) points out, because this treatment option is so expensive and radical, it must be used where it will be most effective. Mental health and substance abuse professionals have also repeatedly called for clearer admission criteria for RTCs, to avoid incarcerating youths in inappropriate settings or with inappropriate and potentially dangerous peer groups.

Outcome Evidence

As with most treatment options where there is enormous diversity in the type and quality of services being offered, the literature regarding RTCs shows mixed results. Bettmann and Jaspersen (2009) conducted a review of the outcome literature on adolescent residential treatment programs, including RTCs. Examining 13 studies they found to fit their review criteria, they concluded that "the outcome literature of adolescent residential and inpatient treatment indicates that these therapeutic settings are successful interventions for many clients" (2009, 174). However, they also observed several significant deficits in the existing literature that limit any definitive conclusions about the effectiveness of residential treatment programs. They note that there is a lack of research that assesses the effectiveness of specific program elements; there is no consensus in the research on a definition of residential treatment and little agreement on what constitutes treatment success; insufficient details and descriptions are provided in evaluation studies that look at the effectiveness of specific programs (making it difficult to replicate a particular treatment approach); and there is a need for outcome research to examine the cultural sensitivity of child and adolescent residential treatment (Bettman and Jaspersen 2009). (See the Residential literature for further information on the limitations of research.)

In addition to these limitations, many of the treatments and services, whether psychotropic or psychosocial, delivered to youth in RTCs lack a foundation in research (Foltz 2004). For instance, Foltz calls attention to the widespread use of medications that have largely been tested only on adult populations and are prescribed “off label” to adolescents in treatment. Few evidence-based practices have been tested in RTCs, because of, in part, issues such as the lack of fit between Medicaid reimbursement and many evidence-based interventions (Bright et al. 2010). Moreover, a lack of funding can mean that inadequate services are available. In a survey of New York State RTCs, it was found that, because of budget constraints, facilities were forced to hire staff with limited formal education (Baker, Fulmore, and Collins 2008).

Some individual RTC programs have been evaluated and were shown to make a positive impact on youth who received treatment services. For instance, the treatment model used by the Phoenix House Academy (a therapeutic community for substance-abusing adolescents) was associated with better outcomes than the average expected outcome of alternative probation dispositions. In an evaluation using a quasi-experimental nonequivalent comparison group design, the outcome results over a 1-year follow-up period for 125 youths who were enrolled in the Phoenix Academy were compared with 274 control youths who received alternative probation dispositions. Compared with the control group, Phoenix House Academy youths had significantly better outcomes for most substance use and psychological functioning outcomes (Morral, McCaffrey, and Ridgeway 2004). However, a recent study that looked at a 7- to 8-year follow-up period found no evidence of positive effects on the outcomes measuring substance use problems, criminal activity, and psychological functioning. Although Phoenix Academy appeared to have short-term effects, no long-term effects were evident.

Moreover, an evaluation of the Mendota Juvenile Treatment Center (MJTC), an intensive treatment program designed for serious and violent juvenile offenders, found positive effects on youths who received treatment in the program. Caldwell and Rybroeck (2005) compared 101 youths who were treated through MJTC with 147 youths who were briefly assessed at MJTC but who then returned to a secured correctional institution for the remainder of their sentence. Using propensity scores to control for nonrandom group assignment, the study found that youths treated at MJTC were only one sixth as likely to commit felony violent offenses as the comparison group youths were. MJTC treatment, in addition to reducing the number of youths involved in offending, increased the time youths were in the community before they reoffended.

Finally, the Residential Student Assistance Program (RSAP) was shown to make positive impacts on the alcohol, marijuana, and tobacco use of youths. The program, which provides culturally sensitive alcohol and drug prevention and intervention services to mostly African American and Latino youth, was evaluated using a quasi-experimental design with two nonequivalent groups: the treatment group, consisting of 125 youths who participated in RSAP, and the control group, consisting of 211 youths who either chose not to participate in RSAP or participated in another residential facility that did not use the RSAP model (Morehouse and Tobler 2000). The results showed reductions in measures of alcohol, marijuana, and tobacco use for youths who participated in RSAP, compared with youths in the control group.

Alternatives to Residential Placement

Critics of residential placement often express concerns about decisions to remove youths from their homes and communities to treat them in settings such as RTCs. Some argue that placing youths with psychiatric or behavioral problems together in a residential environment may cause more harm to an individual’s treatment process. Youths may be traumatized by the experience of being removed from

their home and placed in a residential program, hindering their chances of treatment success. In addition, the costs of placing youths in residential programs such as RTCs can be substantial to the juvenile justice system (Bettman and Jaspersen 2009). A report from the Justice Policy Institute (2009) estimates that reporting States spend an average of \$7.1 million a day keeping youths in residential facilities. Thus, many jurisdictions across the country have implemented alternative options to secure residential placements and confinement for youths who could be served better in community-based treatment programs, instead of receiving treatment in residential settings such as RTCs (though these alternatives may not be appropriate for all youths).

Alternatives to secure corrections or confinement, including residential placements, are special programming approaches designed to prevent youths from being placed out of the home environment for any significant length of time. The concept follows from the premise that time spent in out-of-home placement may do more harm than good for these youths. Further, these alternatives give such youths the benefit of remaining in their communities with greater access to needed resources (i.e., necessary treatment and medical services) without endangering the community and at much less expense than secure residential placement (OJJDP 2001). In addition, the many problems associated with reentry are avoided because the youth is never entirely estranged from the community for a lengthy period of time. Finally, this approach keeps less serious or nonviolent offenders at home or in their home communities, thus increasing the availability of secure beds for the most serious and violent offenders (OJJDP 2001).

There are several different types of secure confinement and placement alternatives, including home confinement or house arrest, day or evening reporting centers, shelter care, specialized foster care, and intensive supervision programs. Wraparound/case management is another program type designed to keep youth at home and out of institutions or residential placements whenever possible. The strategy involves “wrapping” a comprehensive array of individualized services and support networks “around” young people, rather than forcing them to enroll in inflexible treatment programs. Many of the wraparound initiatives and programs that have been evaluated, including Wraparound Milwaukee and Connections, have concentrated on youths with mental health needs. The research on these programs finds that youths who receive wraparound/case management services show improvements in behavior and everyday functioning, as well as reduced risks of delinquency, compared with youths who do not receive those services.

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