

Appropriate and Effective Use of Psychiatric Residential Treatment Services

By Dave Ziegler, Ph.D.

Executive Summary

Stakeholders in a comprehensive system of care view psychiatric residential treatment as a dynamic and critical component interfacing with an effective overall mental health system for children (Butler & McPherson, 2006). To be most effective PRTS must be targeted, responsive, and individualized to the needs of the child and the family and have the following characteristics:

- Integrated into the overall system of care and includes a continuum of step-up and step-down services within the same provider organization.
- Offers a comprehensive and ecological model of multi-model treatment interventions into an integrated whole, designed to meet the individual needs of a child and the child's family.
- Commitment to national standards of excellence, a continuous commitment to quality improvement, and have an identifiable treatment philosophy and approach based upon research and empirical evidence.
- Emphasizes the environment around the child that will necessitate family interventions, partnering with families during and after residential services to best meet the child's needs.
- Makes an impact on the child's positive thoughts and perceptions, emotional self-regulation, and pro-social skills and behaviors.

Psychiatric residential treatment services can play several effective roles within the overall system including: a. intensive treatment while maintaining safety, b. a component of a step up/step down plan for a child, c. Treatment of serious disorders that require coordinated multimodal interventions, d. assessing medication level while providing a stabilizing environment, e. alternative to psychiatric hospitalization, and f. a treatment of last resort for children for whom other interventions have been ineffective.

Less appropriate uses of PRTS include: a holding place for a child waiting for a community placement, destabilizing the child by rapidly altering medications or delving into deeper psychological states without sufficient time to re-stabilize, and when the length of time in PRTS is predetermined before admission due to cost, utilization, or other factors unrelated to the needs of the child.

The commonly repeated criticisms concerning the lack of research support for the effectiveness of PRTS lack validity. The comprehensive nature of a multimodal integrated environment presents unusual challenges for isolating variables for causal research. However, considerable research exists to support the overall effectiveness and efficacy of PRTS.

When efforts are made to insure that the proper children are admitted to well designed PRTS, the child, the family, and the system of care can expect individualized, client-centered care that can result in positive outcomes for everyone.

Introduction--Efficacy and Effectiveness of PRTS

A common goal among all stakeholders in the system of care for children is to develop a comprehensive array of services that is sensitive to the needs of children and their families and provides needed care on a continuum of intensity based upon individualized needs. For over fifty years there has been a debate concerning putting children in out-of-home placements. The debate has continued whether it is the orphan asylum of the past or the psychiatric residential treatment center of the present. For a variety of reasons, some well deserved, residential care has been plagued by negative stereotypes and pessimistic sentiments (Frensch & Cameron, 2002). A persistent notion that institutional life is contrary to a child's nature (Whittaker, 2004) has led to "an archaic and inaccurate perception of residential treatment as a single type of ineffective, institutional congregate care for children" (Butler & McPherson, 2006). However, the long standing debate over residential settings has gradually given way to an acknowledgement that the best system of care includes alternatives for the needs of all children regardless of the level of required intensity (Leichtman, 2006; Butler & McPherson, 2006; Lieberman, 2004). Therefore the question has changed from whether residential treatment should be used, to what is the appropriate and effective use of residential treatment in the new system of care.

There is considerable literature and research support for the value of residential treatment of a broad variety of types and approaches, particularly for the sophisticated treatment settings that have met the highest national standards of excellence (CWLA, 2004; Lewis, 2004; Friman, 2000; Handweck, Field & Friman, 2001; Larzelere, Daly, Davis, Chmelka & Handwerk, 2004; Lipsey & Wilson, 1998; Lyman & Wilson, 1992; Pfeifer & Strelecki, 1990; U.S. Department of Health and Human Services, 1999). "Residential services are an important and integral component within the multiple systems of care and the continuum of services" (CWLA, 2005). This statement from the largest children's advocacy organization in the country outlines the new thinking coming from policy makers, system managers, advocates, families, and providers. The many arguments against the use of residential care of the past, including the comparison of one level of care over another, are out of favor due to improper comparisons and lumping divergent services (Handwerk, 2002; Butler & McPherson, 2006). In its place is a more inclusive and practical position that there will always be a number of youth who require the intensive structure and safety of the residential setting. Whether it is the Child Welfare League of America, the Building Bridges initiative, or the providers themselves (AACRC and others), there is wide support from stakeholders that residential care is an essential and important part of the overall system of care past, present and into the future.

The psychiatric residential treatment program of today is not the same as programs of the past, including the very recent past. This fact makes most comparisons to current care and the residential treatment of the past questionable in their validity. The quality Psychiatric Residential Treatment program of today is not only integrated into the overall system of care, but includes a continuum of step-up and step-down services within the same provider organization. Such an internal system of care allows for children and families to change levels of treatment intensity without changing key staff such as psychiatrists, therapists, teachers, and mentors. For child with significant mental health needs, the level of treatment intensity will necessarily change over time if the plan of care is effective.

What Constitutes Good Psychiatric Residential Treatment Services

A quality residential program offers a comprehensive and ecological model (Stroul & Friedman, 1996; Wells, Wyatt & Hobfoll, 1991; Hooper, Murphy, Devaney & Hultman, 2000) of multi-model treatment interventions woven into an integrated whole, designed to meet the individual needs of a child and the child's family. The best programs start with a commitment to national standards of excellence, a continuous commitment to quality improvement, and have an identifiable treatment philosophy and approach based upon research and empirical evidence. Effective programs will emphasize the environment around the child that will necessitate family interventions, partnering with families to best meet the child's needs, and at times may include efforts to identify a family for children without one. Good residential programs know the target populations that they are most effective with and have evidence based approaches for these populations. Good programs make positive impacts on the child's positive thoughts and perceptions, emotional self-regulation, and pro-social skills and behaviors. The best residential programs are integrated into a community of stakeholders who have input into a continual unfolding of quality interventions in an overall environment of safety, respect and effectiveness.

The Best Use of Residential Treatment

For too long residential treatment has been relegated primarily to the placement of last resort. In some situations it may be the case that a child has been unresponsive to treatment that is less intense or insufficiently environmentally integrated, thus necessitating the strengths of a residential setting. The use of residential care as a "last resort" is still a possible role but there can be other roles as well:

Intensive treatment while maintaining safety—Some children cannot be effectively and safely treated in a family setting. Examples of this are serious violent behavior, firesetting, and significant sexual behavior.

One component of an overall treatment continuum—At times the needs of a child may warrant treatment in a variety of settings from maximal to minimal levels of intensity as treatment progresses. Residential care can be an important part of the plan including a back up to serious deterioration in levels of care in community settings.

Treatment of serious disorders that require multimodal intervention—Children with the highest acuity of psychiatric needs often require a complex array of integrated services in a single setting. An example of this are complex trauma disorders where up to a dozen specialized intervention strategies may be needed (Connor, Miller, Cunningham & Melloni, 2002).

Safely assessing psychopharmacological intervention—A child may have serious emotional or behavioral destabilization when medications are significantly altered. For children with several medications, it may be important to insure safety for the child and all concerned while the medication assessment process takes place.

Alternative to hospitalization—A well designed psychiatric residential program can be an effective alternative to hospitalization for many serious children. This can provide advantages

including: keeping the child and family in the community, intensive care in a less restrictive setting, and a significant reduction in cost allowing a length of stay appropriate for the child.

There are also ways that residential treatment should not be used. It should not be a default setting for a child who has completed treatment but is waiting for a placement. A residential setting should not be allowed to destabilize a child's mental health, such as changing medications or opening painful psychological issues without sufficient time to follow through with the ramifications. While there are children who have been shown in research to improve with short stays of six months or less in residential care (Blackman, Eustace, Chowdhury, 1991; Leichtman, Leichtman, Barker & Neese, 2001; Shapiro, Welker & Pierce, 1999), this is based upon a short-term approach of lowering the expectations of treatment through modest and selective goals such as primarily addressing the issue that caused the removal of the child from the family home (Leichtman & Leichtman, 1996). However there is still a place for longer term treatment with specific childhood disorders that are not responsive to short-term interventions (Zegers, Schuengel, van IJzendoorn & Janssens, 2006; McNeal, Handwerk, Field, Roberts, Soper, Huefner & Ringle, 2006; Greenbaum, Dedrick, Friedman, Kutash, Brown, Lardieri & Pugh, 1996). Residential treatment is improperly used when the length of intensive residential treatment is predetermined before admission due to cost, utilization or other factor unrelated to the needs of the child.

Efficacy and Effectiveness of Residential Treatment

It is commonly stated that residential treatment has been shown not to be effective. A closer look at efficacy and effectiveness tells a different story. While there have been weaknesses among the providers of residential care over the years, there have also been very effective services delivered in a residential setting. This point raises an important distinction between an intervention and a setting. Too often this distinction is misunderstood resulting in 'apples and oranges' comparisons (Butler & McPherson, 2006). For example, an evidenced based intervention can be effective in a variety of settings, or the wrong evidence based intervention in a specific setting can be highly ineffective. When discussing whether a placement is the best choice, both the setting and the interventions to be used are both important considerations.

Science is informing the mental health world at an unprecedented pace. Objective research is increasingly being considered to inform decision makers, parents and providers as to what to do more of, and what to discontinue. Science considers all aspects of a situation to form an opinion, not just factors that confirm previous biases. Because there has been a fifty year debate over putting children in residential setting, both sides have presented data to enhance their argument, for or against. We must now move beyond previous biases and look toward objective science.

Whether a treatment setting works depends upon both efficacy and effectiveness. Objectively speaking there is research to support strong efficacy in residential care. At the same time there are consistent questions as to the effectiveness reflected in research on residential treatment (Hair, 2005). This apparent contradiction points to the difficulty in evaluating whether a complex setting works or not. The answer often depends upon the way the question is framed, as well as how outcomes are measured.

There has been decades of research evidence of efficacious treatment of children and adolescents in all settings. When children who receive a broad variety of treatments are compared with control groups of children receiving no treatment, the treatment group is consistently superior with an effective size from .7 to .8 (Casey & Berman, 1985; Baer & Nietzel, 1991; Burns, Hoagwood & Mrazek, 1999; Grossman & Hughes, 1992; Hazelrigg, Cooper & Borduin, 1987; Kazdin, Siegel & Bass, 1990; Shadish, Montgomery, Wilson, Wilson, Bright & Okwumabua, 1993; Weisz, 1987; Weisz, Weisz, Han, Granger & Morton, 1995). Some treatments and some settings have shown better results than others, but treatment efficacy research provides strong and consistent evidence that providing psychological treatment to child clients is much better than not doing so.

Much has been made of the scarcity of causal research on residential treatment. The reason that effectiveness research on residential settings has been either mixed or lacking is primarily due to the complex weave of multiple treatments in an ecological setting. Such an enriched setting of multi-modal treatment variables is not conducive to empirical causal research. Moreover, “the very characteristics that are likely to make (treatment) effective make them more difficult to describe and evaluate...numerous elements of family and agency life weave together with the therapeutic intervention and potentially decrease the chance of finding a positive treatment effect when there is one” (Hair, 2005). Butler and McPherson point out that this lack of empirical evidence in part is based upon the challenge of measuring what residential care does best. They report gains such as: enhanced safety, truancy reductions, consistent medication management, reduced hospitalizations, consistency, structure, caring and nurturing, limit setting, psychosocial support, self-esteem role modeling, time to self-reflect, and focus on mental health issues, all of which are invaluable to the child but are complicated to objectify and analyze. “Thus the literature does not actually reveal much helpful information” (Butler & McPherson, 2006).

Some of the research showing marginal or no positive efficacy makes the conceptual error of comparing some new type of treatment intervention with the traditional treatment setting of residential care. There are studies that indicate poor outcomes with residential care (Burns et.al., 1999; Greenbaum et.al., 1996; Friman, 2000; Ruhle, 2005). Some of these studies again address a setting, not specific treatment interventions. Research on essentially all settings can find poor outcomes (families, hospitals, foster care, schools, etc.). For example, while there is considerable evidence of effectiveness for some uses of family based treatment foster care, other uses have been found to be contraindicated (Farmer, Wagner, Burns & Richards, 2003), or less effective for some populations than residential care (Drais-Parrillo, 2005). Treatment settings in themselves do not insure effectiveness, this can only be done by quality interventions within a treatment setting.

When treatment interventions are the subject of research residential settings the results often show strong improvement (Landsman, Groza, Tyler & Malone, 2001; Hooper et. al., 2000; Weiner & Kupermintz, 2001; Burns et.al., 1999). Research has shown long-term maintenance of gains in clinical functioning, academic skills and peer relationships (Blackman, Eustace & Chowdhury, 1991; Joshi & Rosenberg, 1997; Wells, 1991).

Two predictors of long-term positive outcomes deserve to be specifically mentioned. The quality of the therapeutic relationship in therapy has been found to be one of the most important

predictors of long-term success (Pfeifer & Strzelecki, 1990; Scholte & Van der Ploeg, 2000). In a recent study on attachment representations, children in residential treatment improved in their forming secure attachments and decreasing their avoidance and hostile behavior. However this finding was true only for children with longer stays in residential treatment. The study reported, “When the duration of treatment is extended, the personal attachment backgrounds of clients and treatment staff increase in importance (Zegers, Schuengel, van IJzendoorn & Janssens, 2006). The other long-term predictor of success is positive outlook, life satisfaction and hopefulness. In a 2006 study children in residential treatment increased their hopeful thinking and general well-being, while decreasing psychopathology (McNeal, Handwerk, Field, Roberts, Soper, Huefner & Ringle, 2006). Attitudinal and cognitive variables such as hope have been found to predict outcomes above and beyond psychopathology (Hagen, Myers & MacKintosh, 2005). This study on hope found the children with the highest levels of psychopathology made the most gains after 6 months of residential care.

Therefore a quick statement on the general findings of research indicate: strong support for providing treatment services to child over no treatment, mixed results when evaluating the setting, and strong support for effectiveness with specific treatments in residential settings. It can therefore be said that, in general, treatment provided to the child will be better than none at all, and it is the treatment interventions used in the residential setting that are the determining factor of efficacy and not the setting itself.

The Right Target Population for Psychiatric Residential Treatment

Intensive treatment services in a residential setting are restrictive and potent and should only be a part of the plan of care for a child if needed. There is common agreement that care should be taken before placing a child out of a family setting and particularly when placing the child in a PRTS program. It is important that guidelines exist concerning the right target population while not being so prescriptive that children ‘fall through the cracks.’ To avoid legislating children out of a needed service, it is essential that the individual child’s needs must come first, and the child matched to the proper level of care intensity. The overall criteria for such a restrictive setting is to include only those children who cannot receive the treatment they need while remaining in a family setting.

The historical criteria for admission to PRTS have been:

1. Other treatment resources available in the community do not meet the treatment needs of the child.
2. Proper treatment of the child’s psychiatric condition requires services in a psychiatric residential treatment setting under the direction of the psychiatrist.
3. The services can be reasonably expected to improve the child’s condition or prevent further regression so that psychiatric residential services may no longer be needed
4. The child has a principal diagnosis of Axis I of a completed 5-Axis DSM diagnosis that is not solely a result of mental retardation or other developmental disabilities, epilepsy, drug abuse, or alcoholism.

These criteria have provided guidelines while allowing for individual needs to be considered. If proper treatment resources exist in the community, if the child does not need psychiatric oversight, if the treatment can help or prevent further deterioration and if they child has a mental health diagnosis, then the child can be considered. As the system focuses on improving community resources, more children would be screened out due to the first criteria.

The one screening tool that has been used in the past is the Childhood Acuity of Psychiatric Illness. It has been used to inform the admission and discharge decisions but has not been the sole criteria. Like the CASII, where it is possible to have an overall low acuity score yet be appropriate for intensive treatment due to high risk behavior, the CAPI scores do not address all areas of need or interest when making admission decisions. Therefore it cannot be used solely as an indication of proper or improper placement decisions.

There is general agreement that treatment should be individualized, strength-based, and integrated. Therefore it is important to insure that admission and discharge decisions are individualized and not based upon a score or single or multiple indicators not related to the needs of the child.

It is important that the child have a serious mental health issue to be appropriate for PRTS. However, the treatment needs of the child should be the primary consideration and not the diagnostic category, which often varies by practitioner. Frequently a child's diagnosis changes when the provider changes. Diagnostic categories are not discreet in many cases and children needing PRTS care typically have multiple Axis I diagnoses. The diagnosis of a child at admission has been found to be a negligible factor in success at discharge (Hair, 2005), thus the specific diagnosis should not be used as a factor to screen a child in or out of PRTS. For example, If a child is dangerous due to a mental health diagnosis, the child should not be screened out due to which diagnosis the child has been given. Using another example, if a child is suicidal and has a serious oppositional defiant diagnosis, the child should receive the treatment needed in a safe setting, which could necessitate a PRTS level of care, regardless of the diagnosis.

Research consistently indicates that children with supportive families do better in general, do better in school, do better in treatment, and do better coming out of PRTS. This makes logical sense. However, true trauma informed care necessitates that a child who is unlucky enough to receive poor family support or who has lost his or her biological family, should not be further neglected by the system and prevented from receiving PRTS care if that is the indicated need. Developing an aftercare resource becomes an important part of the plan of care. Trauma informed care also requires that the treatment reflects the child's past, provides effective trauma treatment, and insures safety, predictability, and stability of placement while intensive trauma treatment is provided. For a seriously traumatized child, focusing solely on stabilizing a child's behavior without providing intensive trauma treatment is not individualized, nor is it responsive to the needs of the child and family.

Summary

Psychiatric residential treatment is an important and essential component of the mental health system of care. The best treatment programs are ecological in orientation and combine all the needed components to best help the child and family. Despite the fact that ecological treatment settings are not conducive to quantitative causal research designs, they have been shown to be some of the most effective services for children with multiple needs. Psychological treatment has shown decades of strong support across settings and has been shown effective when interventions in residential settings are considered rather than the setting itself. The family must be involved in both decision making and intensive treatment along with the child. If a child has lost his or her family for whatever reason, the child should not be further neglected by not receiving the level of intensive treatment services needed. The right target population should be afforded PRTS. Adhering to the historical criteria has shown that the right children receive the right level of care. Reliance on any one score, instrument or factor alone is contraindicated for PRTS as it is for any placement decision for a child. The admission decision on a child must be individualized with the needs of the family taken into consideration. The treatment must conform to the child and family and not expect the child to conform to the treatment. This includes both treatment programs as well as the overall system of care. When a PRTS program is carefully designed with multimodal treatments to address the complex needs of the child, and individualized in partnership with the family, this intervention can turn the most seriously challenging children in the system of care into some of the most improved consumers. Such an outcome is one that is desirable to all stakeholders in the system of care.

References

- Baer, R.A. & Nietzel, M.T. (1991). Cognitive and behavioral treatment of impulsivity in children: a meta-analytic review of the outcome literature. Journal of Clinical Child Psychology, 20, 400-412.
- Burns, B.J., Hoagwood, K. & Mrazek, P.J. (1999). Effective treatment for mental disorders in children and adolescents. Clinical Child and Family Review, 2, 199-254.
- Butler, L.S. & McPherson, P.M. (2006). Is Residential Treatment Misunderstood? Journal of Child and Family Studies.
- Blackman, M., Eustace, J. & Chowdhury, T. (1991). Adolescent residential treatment: A one to three year follow-up. Canadian Journal of Psychiatry, 36, 472-479.
- Casey, R.J. & Berman, J.S. (1985). The outcome of psychotherapy with children. Psychological Bulletin, 98, 388-400.
- Connor, D.F., Miller, .P., Cunningham, J.A. & Melloni, R.H. (2002). What does getting better mean? Child improvement and measure of outcome in residential treatment. American Journal of Orthopsychiatry, 72, 110-117.

Child Welfare League of America. (2004). Standards of excellence for residential services (revised). Washington, DC.

Child Welfare League of America. (2005). Position Statement on Residential Services. Washington, D.C.

Drais-Parrillo, A.A. (2005). The Odyssey Project: a descriptive and prospective study of children and youth in residential group care and therapeutic foster care. Child Welfare League of America, Washington D.C.

Farmer, E.M., Wagner, H.R., Burns, B. J. & Richards, J.T. (2003) Treatment foster care in a system of care: Sequences and correlates of residential placement. Journal of Child and Family Studies, 12, 11-25.

Frensch K.M. & Cameron, G. (2002). Treatment of choice or a last resort? A review of residential mental health placements for children and youth. Child and Youth Care Forum, 31, 307-339.

Friman, P.C. (2000). Behavioral, family-style residential care for troubled out-of-home adolescents: Recent findings. In J. Austin & J.E. Carr (Eds.), Handbook of applied behavior analysis. Reno NV: Context Press.

Greenbaum, P.E., Dedrick, R.F., Friedman, R.M., Kutash, K., Brown, E.C., Lardieri, S.P. & Pugh, A.M. (1996). National adolescent and child treatment study (NACTS): Outcomes for children with serious emotional and behavioral disturbance. Journal of Emotional and Behavioral Disorders, 4, 130-146.

Grossman, P.B. & Hughes, J.N. (1992). Self-control interventions with internalizing disorders: A review and analyses. School Psychology Review, 21, 229-245.

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. 219.

Hagen, K.A., Myers, B.J. & MacKintosh, V.H. (2005). Hope, social support, and behavioral problems in at-risk children. American Journal of Orthopsychiatry, 75, 211-219.

Handweck, M.L., Field, C. & Friman, P.C. (2001). The iatrogenic effects of group intervention for anti-social youth: Premature extrapolations? Journal of Behavioral Education, 10, 223-238.

Handwerk, M.L. (2002). Least restrictive alternative: Challenging assumptions and further implications. Children's Services: Social Policy, Research & Practice, 5, 99-103.

Hazelrigg, M.D., Cooper, H.M. & Borduin, C.M. (1987). Evaluating the effectiveness of family therapies: an integrative review and analysis. Psychological Bulletin, 101, 428-442.

Hooper, S. R., Murphy, J., Devaney, A. & Hultman, T. (2000). Ecological outcomes of adolescents in psychoeducational residential treatment facility. American Journal of Orthopsychiatry, 70, 491-500.

Joshi, P.K. & Rosenberg, L.A. (1997). Children's behavioral response to residential treatment. Journal of Clinical Psychology, 53, 567-573.

Kazdin, A.E., Siegel, T.C. & Bass, D. (1990). Drawing on clinical practice to inform research on child and adolescent psychotherapy: Survey to practitioners. Professional Psychology: Research and Practice, 21, 189-198.

Landsman, M.J., Groza, V., Tyler, M. & Malone, K. (2001). Outcomes of family-centered residential treatment. Child Welfare, 80, 351-379.

Larzelere, R.E., Daly, D.L., Davis, J.L., Chmelka, M.B. & Handwerk, M.L. (2004). Outcome evaluation of the Birls and Boys Town Family Home Program. Education & Treatment of Children, 27, 131-148.

Leiberman, R.E. (2004). Future directions in residential treatment. Child and Adolescent Psychiatric Clinics of North America, 13, 279-294.

Leichtman, M. (2006). Residential treatment of children and adolescents: Past, present and future. American Journal of Orthopsychiatry, 76, 285-294.

Leichtman, M. & Leichtman, M.L. (1996). A model of short-term residential treatment: General Principles and Changing Roles. In W. Castro (Ed.), Contributions to residential treatment, 1996. Alexandria, VA: American Association of Children's Residential Centers.

Leichtman, M., Leichtman, M.L., Barker, C.B. & Neese, D.T. (2001). Effectiveness of intensive short-term residential treatment with severely disturbed adolescents. American Journal of Orthopsychiatry, 71, 227-235.

Lipsey, M.W. & Wilson, D. (1998). Effective intervention for serious juvenile offenders: A synthesis of research. In R. Loeber & D.P. Farrington (Eds.), Serious & violent juvenile offenders: Risk factors and successful interventions. Thousand Oaks, CA: Sage Publishing.

Lewis, M. (2004). Residential treatment: Forward. Child and Adolescent Psychiatric Clinics of North America, 13.

Lyman, R.D. & Wilson, D.R. (1992). Residential and inpatient treatment of emotionally disturbed children and adolescents. In C.E. Walker & M.C. Roberts (Eds.), Handbook for clinical child psychology (2nd ed.), Oxford, UK: Wiley Publishing.

McNeal, R., Handwerk, M.L., Field, C.E., Roberts, M.C. Soper, S., Huefner, J.C. & Ringle, J.L. (2006). Hope as an outcome variable among youth in a residential care setting. American Journal of Orthopsychiatry, 76, 304-311.

Pfeifer, S.I. & Strelecki, S.C. (1990). Inpatient psychiatric treatment of children and adolescents: A review of outcome studies. Journal of the American Academy of Child & Adolescent Psychiatry, 29, 847-853.

Ruhle, D.M. (2005). Take care to do no harm: Harmful interventions for youth problem behavior. Professional Psychology: Research and Practice, 36(6), 618-625.

Scholte, E.M. & Van der Ploeg, J.D. (2000). Exploring factors governing successful residential treatment of youngsters with serious behavioral difficulties: Findings from a longitudinal study in Holland. Childhood: A Global Journal of Child Research, 7, 129-153.

Shadish, W.R., Montgomery, L.M., Wilson, P., Wilson, M.R., Bright, I & Okwumabua, T. (1993). Effects of family and marital psychotherapies: A meta-analysis. Journal of Consulting and Clinical Psychology, 61, 992-1002.

Shapiro, J.P., Welker, C.J. & Pierce, J.L. (1999). An evaluation of residential treatment for youth with mental health and delinquency-related problems. Residential treatment for Children and Youth, 17, 33-48.

Stroul, B.A. & Friedman, R.M. (1996). The system of care concept and philosophy. In B.A. Stroul (Ed.), Children's mental health: Creating systems of care in a changing society. Baltimore: Paul H. Brookes.

U.S. Department of Health and Human Services, (1999). Mental health: A report of the Surgeon General. Rockville, MD.

Weiner, A. & Kupermintz, H. (2001). Facing adulthood alone: The long-term impact of family break-up and infant institutions: A longitudinal study. British Journal of Social Work, 31, 213-234.

Weisz, J.R. (1987). Effectiveness of psychotherapy with children and adolescents: A meta-analysis for clinicians. Journal of Consulting and Clinical Psychology, 55(4), 542-549.

Weisz, J.R., Weiss, B., Han, S.S., Granger, D.A. & Morton, T. (1995). Effects of psychotherapy with children and adolescents revisited: A meta-analysis of treatment outcome studies. Psychological Bulletin, 117, 450-468.

Wells, K. (1991). Placement of emotionally disturbed children in residential treatment: A review of placement criteria. American Journal of Orthopsychiatry, 61, 339-347.

Wells, K., Wyatt, E. & Hobfoll, S. (1991). Factors associated with adaptation of youths discharged from residential treatment. Children and youth Services Review, 13.

Whitaker, J.D. (2004). The re-invention of residential treatment: An agenda for research and practice. Child and Adolescent Psychiatric Clinics of North America, 13, 267-278.

Zegers, A.M., Schuengel, C., van IJzendoorn, M.H. & Janssens, J.M. (2006). Attachment representations of institutionalized adolescents and their professional caregivers: Predicting the development of therapeutic relationships. *American Journal of Orthopsychiatry*, 76, 325-334.