A Renewed Perspective of Group Care and Residential Treatment: An Orientation toward Therapeutic Group/Residential Care

Part One – Setting the Context
Establishing Value in the Service System and Initiating the Construct of Therapeutic Group/Residential Care

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Abstract

In this article the writers offer a historical perspective that identifies themes of connectedness and describes the social responsibility child and youth care pioneers undertook despite the state's desire to move "underprivileged" and marginalized children out of the public eye. Additionally, five waves of group care development are described. Lastly, the authors offer some definitions of group care and residential care that are currently gaining traction within the research and practice communities in the western world. These definitions are built both on factors that differentiate programs as well as defining the separation of general group care from therapeutic group care. Therapeutic residential care or therapeutic group care are terms with an agreed upon meaning in the literature and in essence, are emerging constructs. Throughout this article the terms group care, residential care, and residential treatment are used in a broad and somewhat inclusive manner to include various group care and residential programs consistent with the literature.

Introduction

There appears to be a renewed level of optimism within the research and practice communities with respect to group and residential care services offered to young people and families. Group care and residential care are often accessed in the practice environment as a last resort (Anglin, 2002; Lee, Bright, Svoboda, Fakunmoju & Barth, 2011; Whittaker 2011). For practitioners, the debate over "last resort" versus "treatment of choice" (Whittaker, 2011) is a limited one, as many would agree that "treatment of choice" is clearly a better option. This renewed optimism is gaining momentum as service providers invest in models of care that shorten the gap between "what we know and what we do" (Holden, 2009). An emphasis on 'best practice' has resulted in group care service providers implementing program models that are utilizing 'evidence informed practice' and 'evidence based practice' within the care environment. This momentum, along with an improved understanding of child trauma

(Bloom, 1997; Perry & Szalavitz, 2006), has resulted in a desire to understand and improve upon the critical components of therapeutic group care.

Criticisms about group care and residential service have been typically focused towards the areas of high service costs, outcome limitations, and an overall concern for staff and client safety (Lee et al., 2011; Whittaker, 2012; Whittaker & Pfeiffer, 1994). Although these criticisms may have some validity, many of the empirical studies were one group design. Several of these critical studies have overgeneralized group care and residential care and do not detail the important characteristics of the group care condition (Lee et al., 2011). A recent example of an overgeneralization is found within the article by the Anne E. Casey Foundation (entitled "Right Sizing Congregate Care", 2010) (Whittaker, 2011). In this article the writers make little attempt to discriminate between the levels and types of group care and utilize confusing descriptors such as 'congregate care and institutional care', terms that have not been commonly used in group care since the 19th century (Whittaker, 2011). These criticisms have sparked a wave of interest in the use of other resources, such as earlier intervention services, kinship care, and family based services.

Few would argue that young people are served better through early intervention services and family based services. However, there is a population of young people and families where group care and residential services should be the 'treatment of choice' and in some situations the 'first choice' (Whittaker, 2011). Often children and families experience a series of failures in non-residential alternatives prior to being referred to group care and residential services (Durrant, 1993; Whittaker, 2011). These failures compound an already entrenched pessimism, while adding to the complexity of the initial referring problems (Durrant, 1993). A shift in thinking about residential service as a 'last resort' to a 'service of choice' is needed to effectively serve many of the young people and families with complex challenges. It is the authors' unwavering belief that group and residential care has an important, if not vital, role in the future of all care services. It is their hope that this article will provide a coherent and leveraged perspective into the discussion.

Valuing the Wisdom of Our Child and Youth Care Pioneers

In 1601, the first Elizabethan Law was established to assign public responsibility for needy children by placing them in Alms-houses (Holden, 2009). In Ireland unwanted children were cared for in monasteries and later in workhouses (Holden, 2009). Later during this time period, similar care was provided through orphanages, reform schools, Alms-houses and apprenticeships in North America (Holden, 2009). Much of the effort during this time focused on public safety whereby the needs of children were secondary to the public need. Children were often displaced by being shipped away to emerging colonies in other continents. In North America they were given train tickets to the developing west or housed out of the public eye in strict disciplinarian facilities (Holden, 2009). It was only in the later part of the 19th and early 20th century where an interest in these children arose from some of the pioneers of child and youth care. Johann Pestalozzi was one of the first pioneers to actually live within the child's life space when he cohabitated with children from very deprived backgrounds (Brendtro, Mitchell and McCall, 2009). He created a stir in Europe as he educated young people and reclaimed them to be solid citizens. His educational techniques were grounded in relationships of love, trust, and gratitude (Brendtro et al., 2009).

Pioneers such as Mary Carpenter, Jane Addams, Anna Freud, Thomas Stephanson, Thomas Barnardo, and August Aichorn all echoed themes of humane treatment, enlightened practice, sustaining relationship, and the nurturing of competence and confidence in children (Brendtro et al.,

2009; Holden, 2009). Subsequent authors such as Becker, Bettleheim, Brendtro, Durrant, Fewster, Garfat, Hobbs, Krueger, Maier, Ness, Polsky, Treischman, Whittaker, and Wineman have written foundational works about the field.

These writers and pioneers have provided a context for the discipline of child and youth care. What is most salient in the evolution of the discipline and subsequent practice is a coherent, cohesive thread of connection. This thread binds what the pioneers discovered and what we now more richly understand from research. Today's practitioners are both student and teacher as they continue to strengthen these connections – connections that evolve, as we collectively challenge, advocate, support, research, and develop services and resources that impact the lives of the children and youth who have experienced exceptional levels of hardship, trauma, neglect, and abuse.

The Evolution of Group Care in Canada

Charles & Gabor (2009) suggested that the roots of North American group living environments for children followed five distinct waves. The first wave of residential care, referred to as the "Moralistic-Saviour Era," started in the late 18th century and continued well into the middle of the 19th century. The resource began in response to a moralistic motivation that believed society had a moral obligation to provide basic care to children who had been abandoned or orphaned. Further dispensation was offered to children who were seen to have significant mental or physical disabilities. Provision of these services was often provided within an adult population and blended without consideration of special need or circumstances. Often the motivation for these paternalistic programs was to "save the souls" of young people and this mission was served by religious organizations. By similar process, it was during this time that mission schools were beginning to be established in Aboriginal communities.

During the middle part of the 1800s and lasting until the first part of the 20th century, the second generation of residential services evolved from a "Reformation-Rescue" perspective. Within this paradigm, the moralistic motivations were still involved in the care of children. However, the difference was the desire to protect and rescue children. During this time, formal institutions such as the early Children's Aid Societies as well as preliminary, rudimentary child welfare legislation developed with a focus on protecting, reforming, and training children. It is important to note these programs were designed to replace family involvement and essentially began institutionalizing care.

A third wave of reform brought a philosophy referred to as the "Protection-Segregation Era," starting in the late 1800s and lasting until the 1940s. In this time period the inklings of service specialization were being applied to residential services. One legacy of categorization leading to segregation was the emergence of the Residential School System and its subsequent impact upon the children of many First Nation communities. Some other characteristics of specialization included the categorizing of care into distinct areas such as adult, child, insane, delinquent, orphans, and poor/homeless. The philosophy focused on the impact of one's environment setting the stage for a treatment focused perspective. There was also a growing awareness that interventions needed to be adapted to meet the emerging needs of the child.

The "Treatment-Intervention Era" arose in the 1940s and lasted throughout the 1950s and was influenced by the earlier era's specialization of client needs and a specialist approach to treatment. The greatest change during this time was the formalizing of treatment professions with greater attention to child development. A further development in the specialization movement was terminology shifting to describe children requiring treatment as being "disturbed." It was during the latter part of this era that foster care systems evolved and many orphanages were changed into treatment facilities. Treatment institutions continued to evolve

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with the development of smaller cottage settings and community-based group homes. The most important shift during this era was in the active use of the milieu as a vigorous force in the child's treatment.

The "Specialization-Intervention Era" evolved from the 1950s treatment interventional approaches and reached a peak during the 1970s. During this time the focus was to determine what aspects of the milieu were having a positive impact upon the child's life and how a negative milieu could be avoided. This thinking began to generate a shift towards individualized treatment programs that valued the client's personal needs.

A "Consumer-Community Partnership Era" began to materialize in the 1970s and continues to evolve today. Much of the early impetus for the consumer/community partnership finds its roots in the development of outpatient and aftercare services that emerged from residential treatment facilities. These early attempts at wrapping around post-care services came from the realization that there needed to be smoother and more effective transitions from the residential setting into community. Another significant development in this time was the recognition of the role the client, family, and community played in treatment success. Empowered practices, such as client and family ownership of the treatment, along with a client advocacy movement, ensured the voice of the young person and family were valued in the treatment process.

Towards a Definition of Group/Residential Care

Residential care is a broad term that encompasses many different forms of residentially based placement and treatment services provided to children and youth with a wide range of needs. It is a placement option or service at the intersection of three major child serving systems: child welfare, mental health, and justice. This 'broad stroke' definition has led to the aggregation of diverse programs under one umbrella term, as if group care were a monolithic construct. Yet, group care differs significantly along a range of dimensions including function, target population, length of stay, level of restrictiveness, and treatment approach (Leichtman, 2008). Clear operational distinctions between different group care settings do not exist in the research literature. Group care is often intended as a placement of 'last resort', and as a response to antisocial characteristics or psychosocial problems that cannot be addressed in less restrictive family-based settings. Since the emergence of a growing number of alternative family and home-based treatment options, group care has increasingly been challenged to justify its place in the treatment spectrum.

Although residential treatment is now a well-established therapeutic modality, problems in defining the concept, with which pioneers in the field struggled fifty years ago, are no less present today. We act as if there is a consensus on what the term residential treatment means, but the concept remains elusive. It has been applied to group homes, psychiatric hospitals and community based treatment centres. The range of what constitutes residential treatment also includes those offering comprehensive treatment for the most profound psychiatric disorders, to those treatment programs with widely differing philosophies and practices.

The term residential treatment began to be used in the late 1940s. As New Deal reforms such as Social Security and Aid to Dependent Children took effect, the need to institutionalize children for economic reasons diminished. At the same time, psychiatry and social work became increasingly influential disciplines (Preyde, Frensch, Cameron, Hazineh, & Burnham, 2010). As a result of these reforms institutions that formerly provided homes for neglected children, schools for the retarded, or containment for delinquents were redefined as mental health facilities. The Child Welfare League of America (as noted in Lee et al, 2011) has stated that:

> *Group care programs for youth served by public*

systems share common features, but also encompass significant variation. The purpose of residential programs can vary from care and protection to treatment, educational emphasis or detention services. Despite this enormous program variability, the terms "group care", "residential programs" and "treatment facilities" are often used interchangeably to describe settings that provide 24 hour care for youth in peer groups (CWLA, 2004).

While these terms and standards provide definition to the dynamics of modern group and residential care, what is meant by residential treatment is, in many ways, less clear now than it was fifty years ago. At that time, the term described an approach to treatment and to some degree it still does. It is, however, difficult to specify precisely what constitutes that treatment approach – largely due to residential programs being oriented around a host of disparate treatment philosophies, with little attention being given to articulating the unifying concepts that underlie them. Residential treatment has also been used to denote a type of facility, yet they differ markedly in program size, organizational structure, clientele served, and practices utilized. At times it seems residential treatment is little more than a label applied to diverse programs united only by the distinction that they all provide in-patient treatment and are not licensed as hospitals.

The program variations for group care programs present significant challenges and implications for both the practice and research communities. From a practice perspective, group care programs are at times used as a 'last resort' often in instances when a family setting is deemed inappropriate or not available (Lee et al., 2011). Butler and McPherson (2007) argue for the importance of definition for residential treatment and identify components that include: therapeutic milieu, a multidisciplinary team, deliberate client supervision, intense staff supervision and training, and consistent clinical and administrative oversight. These components require further definition as they incorporate a broad range of group care programs. Lee et al. (2011) propose reporting standards that further identify program differences in residential and group care programs. These reporting components include: outcomes (program goal), size of facility and residences, populations served, setting and location, program model, practice elements, staffing, system influences, and restrictiveness of setting.

Whittaker (2011, 2012) views group care and residential care as suffering from what he terms 'benign neglect' in the understanding of how successful residential services operate. This neglect fails to fully understand the critical components or "active ingredients" of residential/group care, such as principles, program models, funding, performance measurement, and research. Recent work from Australia (Versa Consulting, 2011) has addressed this 'neglect' by identifying key provisions and features of successful therapeutic group care. This includes the conclusion that therapeutic residential care (TRC) leads to better outcomes than general group care when there is a program model applying particular program elements that underpin practice. This work also concluded that a therapeutic specialist providing direct clinical oversight is essential to program success. Clinical oversight is provided to front-line staff by a psychologist, clinical social worker, or other registered clinical staff. Some other key features identified in their conclusions included enhanced staff training, a practice theory, and an augmented staffing model that reduces staff/client ratios. Their final conclusion stated that therapeutic residential care has a clear and definitive economic and cost benefit.

A foundational child and youth care belief proposes that children have an innate capacity to grow and develop (Bernard, 2004; Holden, 2009). It is from this developmental perspective Henry Maier (1987) defines first order and second order of change, within group care environments. First order of change provides conditions for children

to progress on a normal path of development (Holden, 2009; Maier, 1987) while second order of change is much more intense and complex. In a second order of change process, children are not only provided with environments that create conditions for normal development, but also to behave, think, feel and learn differently (Holden, 2009; Maier, 1987). Programs with a second order of change focus must have greater competence and be more adaptive to carry out meaningful interventions that go beyond supporting normative child development (Holden, 2009). Therapeutic Group Care must, by definition, be focused on the second order of change. Maier (1987) emphatically states that it is essential for group care programs to be clear about what order of change they are focused upon. Given the need for congruence across systems of care (Anglin, 2002) it is crucial that macro systems be focused on this need for specialized developmental care as well.

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Three Broad Definitions for Constructing Practice and Practice Language

As previously stated, the definitions for what comprises a group/residential care spectrum of services is dynamic, variant, and may even be somewhat arbitrary. This lack of overall clarity in definition provided challenges to the writers of this article and lead to definitions being shaped by both research and practice experience. There may be other resources that do not fit neatly into the definitions that have been crafted, and they are certainly valid in their own right. For the purposes of discussion these definitions are where the authors "landed" in their practice grounded analysis. These definitions are offered in a broad context and as a start to organize our thinking and language as the profession delves further into specific differences.

Campus-Based Therapeutic Care

Generally, the goal of campus-based therapeutic care is to return the young person to a community based setting (family, independent living, or community group living). In a campus-based facility the group size varies. Usually their population is 20 to 100 children or youth housed in a number of residences with each residence having 4 to 12 occupants. The client characteristics are typically young people who have a chronic history of abuse and neglect and multiple diagnoses (both psychiatric and psychological). Many have challenges forming attachments and engaging the intimacy of a family with their overall function ranging from mental retardation to average intelligence. Young people placed in this setting require programming that is targeted at what Maier refers to as a second order of change (1987). Typically, the youth in this type of program have struggled in community settings and require a setting that promotes efficacy and regulation through the program's ecology. The program ecology is the strength of a campus based resource as it has its own internal ecology or community that is modified for children to be successful and offers a significant greater amount of attachment opportunities. These programs may be specialized in their treatment approach or have a developmental orientation, with the setting being either rural or urban. Rural programs may include an agricultural, wilderness, or ranch component to their service.

By nature of definition, campus based facilities are usually quite comprehensive with an on-site school, recreational facilities, intensive activity program using recreation, and adventure based experiential learning. Common practice elements may include family therapy and clinical oversight (e.g. a minimum ratio of one graduate level clinical staff to 14 young people) and access to a consulting psychiatrist. They operate within a specific program model that is practice informed and supported by evidence. Another important element of campus-based treatment includes appropriately educated and trained caregivers. Staff ratios will typically range from 1 staff-1 client to 1 staff-4 clients. Facilities are generally highly structured and may be open or closed.

Therapeutic Community Group Care

The typical goal of therapeutic community group care is to return the young person to a family, kinship family, foster family, or to prepare them for independent living. Program sizes will vary and are usually between three and six young people who live in a residential setting. One of the features of smaller, community situated programs is they are located within closer proximity of the client's family and community. Additionally, the program may target the needs of particular populations and provide a therapeutic program that is tailored to these needs. Due to the smaller population of clients the programs can be fluid in service parameters such as age, gender, and developmental capacity and be able to adapt to emerging system needs. One of the key capacities of this program milieu is the smaller number of clients and staff the young person will encounter when compared to the larger residential campus-based treatment program. The smaller group living environment can strengthen their relational capabilities while providing opportunities for intensive connections. Another feature of this service environment is the overall access to the community including neighbours, local school, stores, and other situations that can be used to assess their functioning capacity, while building their competence within a community.

Similar to campus-based treatment, client characteristics may include a history of trauma, abuse and neglect, multiple diagnoses (both psychiatric and psychological). They may also have challenges forming attachments and struggle to handle the intimacy of a family. As with the clients in campus-based treatment, the young people being served in a therapeutic community group care setting require what Maier calls second ordered change (Maier, 1987). Additionally, there are qualifications similar to those required in campus-based treatment, with staff ratios ranging from 1 staff-2 clients to 1 staff-4 clients.

Community Group Care

The overarching goal of community group care is to prepare children and youth to live in either a home or independent living situation. These programs provide a supportive, nurturing environment, while maintaining a structured milieu. While similar in overall program structure to a therapeutic community group care program, the difference lies largely within the orientation. A community group care program focuses on the overall nurturing, safety, and security of a child without an overt emphasis on therapeutic intervention. The focus of this program model highlights role modelling and teaching using the day to day routines, experiences, and structures as the catalyst for learning. In many ways the program functions as a surrogate home providing opportunity for parental involvement. The young people placed within this setting require programming that is at the first order of change (Maier, 1987).

Concluding Statements/Insights

The pioneers of group care sparked a quest for excellence which continues today as the field embraces a continuous quality improvement commitment, driven by a desire to produce the right outcomes for children served. Group care programs have had a significant, if not auspicious history, along with a rich role caring for children over the past two centuries. From the beginning of formalized group care the role has undergone several significant iterations. Change continues to be an important theme for group care as the current climate of political will has placed group care programs squarely in the sights of change. Fortunately, the historical experience of group care has demonstrated that this resource can and will change.

The relevance of the group care resource is not where this debate lies. There are deeper and perhaps more important considerations to be explored, such as what constitutes the critical components of group care and how these important ingredients of care can be enhanced. What are the overall

system benefits of a healthy spectrum of group care resources? And finally, what would optimum care, care that includes group and residential care, look like?

Group care and residential care programs are becoming more sophisticated in their delivery of services through aligning with evidence informed and evidence based practice. The research is also providing evidence that higher-level group care and therapeutic residential care are producing some promising results for children and families. Defining higher-level care in the context of therapeutic group care or therapeutic residential care through describing critical components or active ingredients of the service promises to provide the practice community a framework to explore their own services. The challenges will be to establish congruence across the service system in shifting the services to be utilized as 'treatment of choice' or 'treatment of first choice' and not as a 'last resort.'

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