Data Trends
Summaries of research on mental health services for children and adolescents and their families
July, 2002
No. 61

Source: Wilmshurst, L. A. (2002). Treatment programs for youth with emotional and behavioral disorders: An outcome study of two alternate approaches. *Mental Health Services Research, 4*(2), 85-96.

This article reports on a study comparing two modes of service delivery for children with emotional and behavioral disorders (EBD): a) a community-based family preservation program (FP), and b) a five-day residential treatment program (5DR). Both programs were located in Canada. In contrast to services provided in a community setting, residential treatment centers (RTCs) serve children in a live-in, out-of-home setting. According to the author, only one controlled study comparing community-based services with RTCs has been conducted. That 1978 study found no difference in outcomes for youth served by therapeutic foster care or an RTC program. To the contrary, the current study revealed statistically significant improvement among youth who attended a community-based program when compared to youth who attended an RTC-based program. This article, therefore, makes an important contribution to children's mental health services delivery research.

The FP program is modeled upon principles common to a system of care, and the 5DR is patterned after the RTC model of service delivery. Both programs also differ in treatment approach. Whereas the FP program incorporates cognitive-behavioral methods to bring about change, the 5DR program employs a "brief solution-based" treatment methodology.

The FP program provides in-home service delivery and intensive in-home support for approximately 12 hours per week. Based on the premise that families and therapists can work together to bring relief to the child and family, the FP program includes a flexible intervention approach, operates on a family preservation model of intervention, emphasizes building upon positive family strengths, and provides crisis intervention, family counseling, asssistance with child management and skills to enhance family functioning, and provides access to other community support programs.

While the 5DR program resembles the RTC model, it has some features uncommon to typical RTC services. For example, youth stay in residence from Monday through Friday and return home on the week-ends. The 5DR brief solution-focused approach to treatment operates on the premise that the youth is the most invested of all participants (e.g., clinician, parent, teacher) in affecting positive change. Therefore, if one allows the youth to determine the "direction and purpose" (p. 89) of his or her desired change, that change will more likely be realized. Youth residing at the 5DR center are exposed to individualized and flexible programs that allow them access to Day Treatment Schools or regular, community-based schools. Also, the support and involvement of the child's parent or guardian is considered essential to the program.

Thus, both programs differed somewhat in service delivery and primary treatment approach, but they also shared some elements of a community-based approach to treatment (e.g., individualized treatment plans and family participation). The treatment goals for both programs were the same: to reduce the prevalence of externalizing and internalizing disorders and to improve functioning and prosocial behavior among youth with EBD.

Participants were youth with severe EBD who were in need of intensive services. These youth were randomly assigned to either the FP or the 5DR program to receive treatment over a three-month period. Assignation to the 5DR program was based upon the availability of beds; if there were no beds available, that particular youth was assigned to the FP program. Youth were assessed three times: at intake, at 3-months (posttreatment) and one year after discharge. Measurement instruments were the Standardized Client Information System (SCIS), an instrument developed in Ontario and based on the CBCL, and the Social Skills Rating System (SSRS). Respondents were parents, teachers, and youth. Because attrition rates were especially high among teachers and youth, analyses were based primarily on parent reports. As a result of this attrition,

Continued...

Prepared by the Research and Training Center for Children's Mental Health, Louis de la Parte Florida Mental Health Institute, University of South Florida, 13301 Bruce B. Downs Blvd. Tampa, FL 33612, (813) 974-4661
For more information, contact kutash@mirage.fmhi.usf.edu; Website: http://rtckids.fmhi.usf.edu
The Center is jointly funded by the National Institute on Disability and Rehabilitation and the Center for Mental Health Services, SAMHSA, U.S. Department of Health and Human Services.

the study sample included 38 youth assigned to the FP program, and 27 assigned to the 5DR program. Nearly all children were Caucasian, and were being raised by single mothers. There were no significant demographic differences between groups. The average age of the youth was between 10-11 years.

Results indicate statistically significant improvement across a number of domains. For example, as shown in Table 1, FP youth made greater improvements in externalizing, and internalizing problems than did youth served by the 5DR program. Further analysis of SCIS data revealed statistically significant differences in psychopathology between each group. FP youth with ADHD showed more improvement at posttest and at follow up than did 5DR youth. Long-term improvement in internalizing disorders (e.g., anxiety and depression) was also found for FP youth when compared with 5DR youth: FP youth showed a 24% reduction in symptoms for general anxiety, as compared to 3% of 5DR youth. And while 26% of FP youth reported a decrease in clinical depression, only 11% of 5DR youth were found to have lower rates of clinical depression at posttest. Some findings were statistically significant in the direction of poor outcomes. For example, when compared with FP youth, a significant percentage of youth in the 5DR program showed worse scores for internalizing disorders at intake and follow up. Also, a greater proportion of 5DR youth reported an increase in general anxiety, separation anxiety, and depression, when compared to FP youth.

Table 1	Pretreatment		Posttreatment		1 Year Follow Up	
Outcome measure	**M**	**SD**	**M**	**SD**	**M**	**SD**
Total externalizing						
FP (SCIS)	**82.16**	19.9	**73.92**	13.2	**70.89**	12.4
5DR (SCIS)	**81.26**	9.8	**74.59**	9.6	**73.22**	12.2
Total Internalizing						
FP (SCIS)	**69.76**	13.3	**66.24**	13.4	**62.58**	11.6
5DR (SCIS)	**65.74**	11.8	**67.15**	13.3	**66.41**	12.8
Social Competence						
FP (SSRS)	**74.23**	10.59	**81.74**	14.98	**82.87**	14.98
5DR (SSRS)	**74.67**	12.02	**81.73**	13.14	**81.53**	11.91
Behavior Problems						
FP (SSRS)	**128.92**	12.62	**121.12**	13.57	**119.15**	13.78
5DR (SSRS)	**130.60**	10.25	**121.53**	12.31	**118.23**	12.19

SCIS= Standardized Client Information System; parent report (higher score = worse behavior)
SSRS= Social Skills Rating System (SSRS); parent report (lower score = worse behavior)

Limitations of this study are generally due to the small size of each group and the low response rate of youth and teachers on the SCIS and SSRS. Furthermore, at intake, most parents rated their children as being extremely impaired in all four problem areas (externalizing, internalizing, social, and behavioral), and as a result, the author could not rule out a regression toward the mean. Therefore, Wilmshurst suggests that these results be interpreted with caution. With regard to the success of the FP in comparison to the 5DR, the author notes that the FP program provided almost twice as much family contact time to youth in comparison to the 5DR program (p. 94), and that youth assigned to the 5DR in this study may have experienced increased impairment associated with their interaction with other troubled youth in residence.

In conclusion, although the 5DR in this study was not a typical RTC program (i.e., because children were allowed home on the weekends, etc.), this study suggests that relatively few gains may be expected of youth served by a residential-type treatment center in comparison to youth who are served in a community-based setting. Although both treatment options (cognitive-behavioral and brief solution-focused) included some elements of the system of care philosophy, the study lends support to community-based care over residential programs in general. The author suggests that further research on RTC services and outcomes is needed. Because youth served by the 5DR program exhibited increased internalizing symptomatology, Wilmshurst suggests that more research should also be conducted on the iatrogenic effects of residential programs.

Prepared by the Research and Training Center for Children's Mental Health, Louis de la Parte Florida Mental Health Institute, University of South Florida, 13301 Bruce B. Downs Blvd. Tampa, FL 33612, (813) 974-4661
For more information, contact kutash@mirage.fmhi.usf.edu; Website: http://rtckids.fmhi.usf.edu
The Center is jointly funded by the National Institute on Disability and Rehabilitation and the Center for Mental Health Services, SAMHSA, U.S. Department of Health and Human Services.