

Diversity in residential care and treatment for young people in Sweden

Bengt Andersson



GÖTEBORG UNIVERSITY

Department of Psychology, 2007

Sweden

ISBN 978-91-628-7088-1

ISSN 1101-718X

ISRN GU/PSYK/AVH--186--SE

Layout och redigering: Henny Östlund

Tryck: Livréna AB, Kungälv, 2007

Abstract

The overall aim of this thesis was to explore and describe the diversity in residential care and treatment for young people in Sweden on the individual level, the interactional level and the contextual level. This thesis consists of five papers based on two studies. *Papers I and II* use data from a survey of residential care for young persons in Sweden. *Papers III, IV and V* are based on qualitative data from interviews with staff and residents in a single treatment home.

In *Paper I*, different residential settings were compared according to the problems of the youths in care, the mean length of stay, staff characteristics and aspects of the care and treatment provided. In *Paper II* the aim was to identify different approaches to treatment and investigate whether these approaches were related to characteristics in the home, the staff and type of care. In *Paper III* the aim was to examine whether there are personal approaches to treatment among careworkers. In *Paper IV* the adolescents' experiences of living in the treatment home were explored. The intention in *Paper V* was to describe how careworkers and young persons have perceived their relationships with each other.

According to the results reported in *Paper I*, different settings in residential care are related to differences in the care and treatment delivered. Institutions run by the public sector have better educated staff and a higher staff-resident ratio than privately run institutions. Despite this, they were found to be more restrictive in their intake and had youths with fewer problems, especially delinquency and other antisocial behaviours. There were indications that the longer time in care was related more to the setting per se than to the needs of the young persons. In *Paper II* the diversity of residential care became evident when the homes described the care they give in their own words. Despite this diversity it was possible to identify five different approaches to care and treatment that different homes agreed with to different extents. These approaches were found to be related to the variety within residential care. In *Paper III* six different intentions in the care delivered could be identified. The distribution of each careworker's statements created a pattern that illustrated the careworker's general treatment perceptions. This pattern made it possible to study and compare different careworkers' perceptions of treatment which indicated that each careworker had a rather unique and stable personal approach to treatment. In *Paper IV* interviews with the six young persons conducted two or three years after they had left the institution, revealed that living in the same institution during the same time period does not mean sharing the same experiences. *Paper V* illustrates how interactions between the young person's needs, his/her former experiences of relationships, the climate in the youth group and the psychological availability of the careworkers could influence the young person's need of support as well as experiences of support.

In conclusion, diversity in residential care was found on multiple levels: on the individual level, the interactional level and on contextual levels such as settings and approaches to treatment. It was also found that some of these differences, for example careworkers' perception of treatment and institutions' approaches to treatment, are not only possible to describe but also to "measure".

Keywords: Residential care, treatment approach, youth, staff, relationships

List of publications

- I Johansson, J., Andersson, B., & Hwang, C.P. What difference do different settings in residential care make for young people? A comparison of family-style homes and institutions in Sweden. In press, *International Journal of Social Welfare*.
- II Andersson, B., Johansson, J. & Hwang, C.P. Long-term residential care for youths in Sweden – Approaches to treatment. Pending revision, *International Journal of Child & Family Welfare*
- III Andersson, B., Johansson, J. Personal approaches to treatment among staff in residential care – A case study. In press, *The Journal of Social Work*.
- IV Johansson, J., Andersson, B. (2006). Living in residential care: Experiences in a treatment home for adolescents in Sweden. *Child and Youth Care Forum*, 35: 305-318.
- V Andersson, B., Johansson, J. Careworkers' and young persons' views on their relationships in a Swedish residential home – A case study. Submitted, *Child and Youth Care Forum*

Acknowledgements

A main theme in this thesis is the importance of our context. This has been confirmed to me in my work with this thesis. I wish to thank all the people who in one way or another have supported me during these years. I especially wish to express my sincere gratitude to the following persons.

Jan, my friend, colleague and co-author. It has always been stimulating and fun to work with you and it would not have been possible for me to accomplish this work without you. I also want to thank Jan's wife Helena and their daughters Linnea and Lovisa for making our working Mondays in their home so pleasant.

I want to express my sincere gratitude to our supervisor Professor Philip Hwang for ten years of patience and support and for guiding us through this process.

PhD Marie Sallnäs and Professor Bo Vinnerljung, for their review and valuable comments and advice

Professor Emeritus Gunnar Bernler for his help in coding the qualitative data in Paper III.

Professor Erik Larsson for sharing his knowledge about residential care and for giving valuable advice.

The six young persons in the treatment home who shared their personal experiences of living in residential care.

The staff in the treatment home under study for participating wholeheartedly, which was a prerequisite for the study.

Colleagues and fellow workers at the Child and Adolescent Psychiatric Outpatient Clinic (BUP) Varberg and the Treatment Centre Ginsten, for support, encouragement and all the fun we have had together.

PhD Ann Frisé, PhD Malin B Olsson, PhD Emma Sorbring and PhD Lauri Nevoenen, for their support and friendship.

Director Lars-Anders Olsson, the Social Welfare Service, Halmstad, who was the first to believe in our project and provided financial support for the first study.

Director Christina Kovac, Psychiatry in the Halland County Council, for providing practical and financial opportunities during the last stage of this project.

Finally I would like to thank my family, Elisabeth, Charlotte, Christine and Anna, for all your love and for being the most important persons to me. I want also to express my gratitude to my mother and my late father.

Financial support for this research was provided by: Allmänna Barnhuset, the Magnus Bergvall Foundation, the Swedish National Board of Institutional Care, the Social Welfare Service, Halmstad, the Association of Local Authorities in Halland and the Halland County Council.

Contents

Introduction.....	9
Youths in Residential Care.....	11
Youths in Residential Care in the Scandinavian Countries.....	11
Youths in Residential Care in the US.....	12
Children in Residential Care in the UK.....	12
Antisocial Behaviour	13
Approaches to Care and Treatment.....	14
Changing Approaches to Care and Treatment	17
Settings in residential care.....	19
Settings in Sweden	19
Settings in the UK.....	20
Settings in the US	20
Group care practice	22
The Complexity of Interactions in Group Care.....	22
Protection and risks in group care.....	24
The Careworker-Youth Relationship in Residential Care.....	25
Differentiation of Care and Treatment.....	28
Principles for differentiation of care.....	28
Residential Care for Whom?.....	28
Differentiation of Care and Treatment according to Different Needs.....	29
Differentiation According to Gender.....	31
Treatment outcome in residential care	33

Summary of the papers	36
General and specific aims	36
Method	37
Participants	37
Procedure	38
Results.....	39
Discussion.....	42
Concluding remarks.....	46
References.....	48

Introduction

Residential care is one of the welfare states services for helping young persons with psychosocial problems. There exists a continuum of services that are aimed to support these young persons and their families. Most of the services take place in non institutional care in the community. When out of home care is judged to be necessary, a placement in foster care is often preferred. Residential care is therefore an intervention primarily for young persons with severe emotional and behavioural problems and often with a history of abuse and/or neglect. Placement of a young person in an institution is often regarded as a “last resort” and the consequence of the failure of other services or treatments. The care strategy for these youths varies both between countries and within countries. In Sweden and several other Western countries there is now an emphasis on treatment (Sallnäs, 2000; Anglin, 2002). The National Board of Health and Welfare in Sweden (SOSFS, 2003:20 (S)) makes a distinction between care and treatment in residential care. Treatment is defined as “special measures taken in order to manage or reduce one or several problems identified in a person within the scope of social services” and care is defined as “take care of, support or bring up” (free translation by the author). Another way of describing treatment that in much is representative of the view of treatment in residential care in the UK is “anything which the home does which enables desired outcomes in the long run” (Gibbs & Sinclair, 1999, p. 1). It is not possible to examine all aspects of treatment in residential care. Some of the young persons in residential care are involved in individual, group and family therapies that are the same as those used for youths outside of residential care. Psychosocial treatments for adolescents consist of several hundreds of different techniques (Kazdin, 2000) and will not be examined in this thesis. The overall aim of this thesis is to explore and describe the diversity in treatment in residential care for young people in Sweden. The focus is on the care and treatment of young persons (13 – 18 years of age) with emotional and behavioural problems within daily living in a residential setting. In exploring treatment in residential care it is instructive to make international comparisons. It has thus been an ambition to describe relevant aspects of treatment in residential care in different countries. The studies discussed are however mainly from North America and the UK, where most of the research in this field has been carried out (Rushton & Minnis, 2002).

As little is known about what type of care or treatment will help these young persons residential care has often been guided by ideology (Little, Kohm, & Thompson, 2005). Normative descriptions of models for residential care and treatment exist (Lyman & Campbell, 1996; Zimmerman, 1990, 2004) and some countries have developed regulations and standards for the guidance and improvement of this form of care (Anglin, 2002; Watson, 2003). One important question is how

ideology or regulations are applied in residential care. There is a consensus that residential care is diverse and complex and that there is a need to define critical elements of care and treatment (Whittaker, Archer & Hicks 2004; Frensch 2002). There is also a need of detailed descriptions of residential settings as the context for treatment (Epstein, 2004). Young persons in care often live in the homes for long periods and their experiences in residential care are complex and have been found to be related to the culture of the home (Brown, Bullock, Hobson & Little, 1998; Whitaker, Archer, & Hicks, 1998). The overall aim of this thesis is to describe and explore the diversity in treatment in residential care for young people in Sweden. It is our ambition to explore treatment in residential care on different levels, namely the individual level, the interactional level and the contextual level. The first section focuses on the individual level, i.e. what is known about the young persons who enter residential care. The next section, *Approaches to Care and Treatment*, deals with one aspect of the contextual level, namely the basic ideas that constitute the ideological context of residential care. Settings in residential care are described in the subsequent section, i.e. the contexts in which the young persons are cared for. This is followed by descriptions of how researchers have tried to describe and systematise the complexity of residential group care and what care workers do in direct interaction with individual young persons and with the group of young persons. The interactional level of treatment in residential care is further illuminated with a special focus on the relation between the young person and the careworker. The section, *Differentiation of Care and Treatment*, discusses what groups of youths are appropriate for residential care and our knowledge about which residential programme is helpful for young persons with different needs and gives examples of treatment approaches for subgroups of young persons. A summary of what is known about the outcome of residential treatment is given in the last section.

Youths in Residential Care

This section provides an overview of the range of problems that young persons in residential care can experience. The variation is extensive in terms of how to define the problems that bring a young person into residential care. Different models exist for assessing needs and classifying adolescents in residential care. A material called “Looking After Children” are widely used in residential care in England and Wales to assemble essential background information about each child and data about personal development in seven areas covering health, self-esteem, communication skills, ability to care for oneself, attainments in education and work and emotional ties with family and friends (Department of Health, 1998). This material was also used in a study of 48 Children’s Homes conducted by Sinclair and Gibbs (1998). It is difficult to compare the results of this study with results of studies in the US, where a mental health perspective often is used. Some studies use the scale of Child Behaviour Checklist (CBCL) (Achenbach, 1991) and other studies apply diagnostic categories from the DSM system (American Psychiatric Association, 1994). Studies conducted in Finland (Hukkanen, Sourander, Santalahti, & Bergroth, 2005, Hukkanen Sourander, Bergroth, & Piha, 1999) and Norway (Kjelsberg & Nygren, 2004) have also utilised the CBCL scale. The Swedish National Board of Institutional Care (SiS) use the ADAD interview (Statens institutionsstyrelse, 2005) to interview youths receiving care in Youth Detention Homes.

Youths in Residential Care in the Scandinavian Countries.

There are few comprehensive studies of residential care in Sweden that have gathered information about the problems of the youths. Vinnerljung et al. (Vinnerljung, Sallnäs, & Kyhle Westermark, 2001) estimated the problems of the youths on the grounds of information in their social services acts and studied youths placed in foster care or residential care during the beginning of the 1990s. Half of them had school problems, a fourth abused alcohol or drugs and about a third were delinquent. A study by Sarnecki (1996) described the problem profiles of youths placed in youth detention homes in Stockholm 1990-94. Forty percent of the youths belonged to the criminal profile, 28 percent to the alcohol and drug abuse profile and 10 percent to the sexual (prostitution/promiscuity, sexual abuse) profile in the Youth Detention Homes. According to the information based on the results of ADAD, for example, more than half of the youths have serious school problems, about two third were involved in criminal activity during the latest three months and more than half of the youths felt that they can not control their behaviour when they were angry. According to ADAD there are clear gender differences. Boys have a higher frequency of criminal activity for example and girls a higher frequency of psychiatric problems.

Hukkanen et al. (1999) found in a Finnish material with children and youths in residential care, that 40-60 percent scored in the clinical range according to CBCL. A time-trend study (Hukkanen et al., 2005) concluded that the problems of youths, especially girls, in residential care in Finland had worsened during the 1990s. Similarly, a Norwegian study (Kjelsberg & Nygren, 2004) found that 68 percent of children and youths in residential care scored in the clinical range according to CBCL.

Youths in Residential Care in the US

Connor et al. (Connor, Doerfler, Toscano, Volungis, & Steingard, 2004) studied all youths admitted to a single residential treatment centre during the period 1994 – 2001. A total of 371 youths were studied. The most common psychiatric diagnoses were disruptive behaviour disorders (e.g. conduct disorder and ADHD) (49 %) and affective and anxiety disorders (31 %). Almost all the youths (92 %) received more than one diagnosis. In this study, girls were more likely to have a primary diagnosis of affective and anxiety disorder and boys were more likely to have a primary diagnosis of disruptive behaviour disorder (Connor, et al., 2004). Hussey and Guo (2002) described a sample of children and youths in residential care from Cleveland, Ohio. These children had extensive histories of abuse and neglect, high numbers of previous placement disruptions, extensive medication histories, low average I.Q. scores and high levels of psychiatric symptomatology (Hussey & Guo, 2002). Curtis et al. (Curtis, Alexander & Lunghofer, 2001) found that, among the group of children and youth in residential care, there are high incidences of impulsiveness, aggression, truancy, sexual acting out, lying, delayed social development, interpersonal and academic problems, conduct disorder and adjustment disorder. According to Curtis et al. (2001) some studies show that the youths' problems are so extensive that nearly 90 percent of the youths scored in the clinical range on the total behaviour problem scale of CBCL (Achenbach, 1991).

Children in Residential Care in the UK

In the summary of a research programme in residential care in the UK commissioned by the Department of Health (1998) it is stated that psychiatric assessment can not comprise the range of difficulties of these youths. A study by Sinclair and Gibbs (1998) described 223 children in Children's Homes, almost all aged between 12 and 17 years. Not more than 16 percent came from families where both biological parents were living, 71 percent were suspended from school or were frequent truants, 63 percent had been involved in delinquency and 32 percent had harmed themselves or attempted suicide. About one third had been violent toward others and the same proportion had been sexually or physically abused.

In conclusion, it is known that children and youth in out-of-home care have two characteristics: first they have a high frequency of social, emotional, behavioural and educational problems (Rutter, 2000) and second they come from families in which the parents often have psychiatric problems and big difficulties with parenting (Rutter, 2000). This applies to an even greater extent to youth in residential care (Connor et al., 2004; Curtis et al. 2001; Hukkanen et al., 1999). These youths often also have been victims of different kinds of abuse and other traumas (Connor et al., 2004; Curtis et al., 2001; Hukkanen et al., 1999). Families of children in residential care often lack natural support networks and sources of help in the community (Frensch & Cameron, 2002). Relationships with close relatives are also more likely to be strained (Frensch & Cameron, 2002).

Antisocial Behaviour

One group of young person that enter residential care are now often labelled as youths with antisocial behaviour. Antisocial behaviour is a broad term with no clear definition (Rutter, Giller & Hagell 1998) and refers to different rule and law breaking behaviours that have different manifestations depending on age, gender and cultural context (Rutter, 1998; Moffitt, Caspi, Rutter & Silva, 2001). In the past two decades a great deal of empirical research has been carried out to understand the development of antisocial behaviour (Dodge & Pettit, 2003). Different patterns of risk factors and adult outcomes have been found in young persons with an early onset of antisocial behaviours compared to young persons with an onset during adolescence. Early onset of antisocial behaviour tends to persist into adulthood (life course persistent) while antisocial behaviour with onset during adolescence tends to be restricted to the adolescent period (adolescent limited) (Moffitt, 1993). The persistence of early onset antisocial behaviour is explained by interactions of risk factors over time (Moffitt, 1993; Dodge & Pettit 2003). Biological predispositions, sociocultural context and life experiences act on each other in a cyclical and cumulative way (Dodge & Pettit 2003; Rutter 1998). In transactions between the developing child and others, aggressive behaviours will reinforce the antisocial development (Dodge & Pettit 2003). Destructive and coercive parent-child interactions is an important life experience risk factor (Patterson, 2002). Other contextual risk factors are negative peer associations and school environment (Rutter, 1998, Chamberlain, 2003). The multidetermination of antisocial behaviour has prompted the development of new treatment models such as MST (Multisystemic Therapy) (Henggeler, 1998) and MTFC (Multidimensional Treatment Foster care) (Chamberlain, 2003).

Approaches to Care and Treatment

Residential care has often been described with reference to different approaches to treatment. According to Kazdin (1999) an approach in the field of psychotherapy refers to an overall orienting view with rather global concepts and can be applied to a wide range of problems and techniques. Approaches can include different theories that are not always compatible. Therapeutic approaches are often not obvious but have a pervasive influence (Kazdin 1999). It is important to remember that treatments within a single approach are frequently very different from one another even if the focus of treatment is the same (Kazdin, 2000). In residential care, the concept of approach has been used to categorise different models or programmes that have a similar view of what the critical ingredients of treatment are. This section gives descriptions of approaches in the US, UK and Sweden that have influenced treatment in residential care. This is followed by a discussion of how treatment approaches were affected by criticism during the 1970s and 1980s and the subsequent regulations and standards for the guidance of residential care.

Five different approaches to residential treatment have been described in North America: the psychodynamic milieu approach, “positive peer culture”, the behavioural model, the psycho-educational model and the cognitive-behavioural model (Zimmerman, 2004). The cognitive-behavioural model and the behavioural model have much in common and are often described as one model (Zimmermann, 2004). The psychodynamic milieu approach is an application of psychoanalytic theory to residential care and was first developed by Aichorn, Redl and Bettelheim. The focus in the early stage of the development of this approach was psychoanalytically oriented therapy with the children, and the belief was that the primary role of the milieu was to prevent deterioration between children’s individual therapeutic sessions (Abramowitz & Bloom, 2003). Psychoanalytic principles were later used to mediate the relationship between the individual and the institutional environment. Bettelheim, in his work with autistic children, emphasised the impact of the environment in promoting children’s capacity to master different situations and introduced the idea of a total environment (Zimmerman, 2004). Every detail in the environment would correspond to psychoanalytic thinking concerning the development of the child (Abramowitz, 2003). Redl worked with delinquent youths and was more concerned with group dynamics and how the group could influence the individual’s behaviour and developed techniques to manage group processes (Zimmerman, 1990, 2004). Both Redl and Bettelheim viewed the child care worker as the major agent of treatment and stressed the importance of the relation between the care worker and the child (Zimmerman, 1990). The psychodynamic milieu approach to treatment can be briefly described as a model that emphasise reliable and sustainable relationships with the young

persons in a nurturing structure of a therapeutic milieu (O'Malley, 2004). It is an approach that is common in Sweden and in other Western countries (Sallnäs, 2000, Zimmerman, 2004). A comprehensive description of milieu treatment based on psychodynamic ideas can be found in a report by Mordock (2002).

The behavioural approach was initially developed to serve youth in whom psychodynamic approaches had not achieved the desired effect, for example for children with autism or delinquent youths (Zimmerman, 1990). This model involves a specification of the behavioural problems and an analysis of what conditions are involved in the creation of the behavioural problems and what reactions strengthen or maintain them. Behavioural techniques are used to accomplish treatment goals that are formulated in behavioural terms that make it possible to measure behavioural change. The cognitive behaviour approach is based on the assumption that behaviour is determined by its consequences but also on the presumption that cognitive processes can mediate the influence. The consequence of this would be that residents are more involved in treatment and are supposed to set goals for their behaviour and evaluate progress (M. M. Johnson, 1999).

In the "positive peer culture" (Ward, 2004) processes in peer group are used to change individual behaviour and attitudes. This approach is often used for delinquents. The peer group is assumed to reinforce prosocial attitudes and behaviours and to take an active part in the control of antisocial behaviour by providing punishment for violations of rules and by confronting antisocial attitudes. The intention is to create a prosocial group climate where the individual young person will adapt to positive group norms (Zimmermann, 1990; Andreassen 2003).

In a psychoeducational model there is a focus on the young persons learning needs. The basic goal is to make it possible for the student to understand more about himself and the context around him in order to manage daily life situations. The Re-Ed project in North America (Zimmermann, 1990; Hooper, Murphy, Devaney & Hultman, 2000) was an application of a psychoeducational model. Small community based schools were combined with living in small groups. The Re-Ed philosophy saw no use for psychoanalytically oriented psychotherapy and disregarded diagnostic labels (Zimmermann, 1990). It can be described as an ecological model because it recognised the importance of different environments of the child's life space and emphasised strong links with family and school (Hooper et al., 2000).

Lyman and Campell (1996) describe two other approaches, the medical inpatient model and the wilderness therapy model. The medical inpatient originates from institutional psychiatric care and was initially influenced by dynamic psychology but has transformed into a more eclectic model with an emphasis on medical diagnosis and medical interventions. This model is adapted for shorter periods of

institutional psychiatric care. In the wilderness therapy model young persons are exposed to challenging situations where the ability to communicate and cooperate is important to cope. The aim is that the young persons will find their own abilities and develop their skills.

Another approach in residential care is based on assumptions about the need for ordinary everyday experiences. This approach has been described as the basis for much of residential practice in the UK (Ward, 2004) and has also been described in Sweden (Sallnäs, 2000). The assumption is that all children including those with severe experiences need to be treated as competent young persons not different from others (Ward, 2004). With normal expectations and with “common sense” reactions, these children are supposed to feel socially included. The daily life should resemble that of an ordinary family and the social environment should be as homelike as possible.

Some influential approaches to care and treatment in Sweden have similarities with the approaches described above. One approach, similar to the psychoeducational model and the positive peer culture model is called “Hassela pedagogy” (Hassela kollektivet & Englund, 1984; Westerberg, 2003) In 1969 the Hassela collective started institutions for drug treatment. This was a new form of residential care, where a group of youths lived together with adults. The intention of sharing the living situation was to create a sense of solidarity between youth and adults that forms the basis for upbringing and education. The focus was not on treatment or therapy but on education and upbringing. One important aim was to clearly mediate values to the young persons and make them aware of political matters. Processes in the peer group were used to change attitudes. This model now also emphasises the need to re-establish the young person’s links with the family and the network. Several institutions are still working according to the basic principles of “Hasselapedagogy” even if some adjustments have been made in the ideas.

The Children’s Village at Skå recognised early the importance of family treatment and involvement in residential care. In 1971 the Children’s Village started to integrate the whole family into residential treatment by changing the setting so that children came to live with their own families in cottages together with a “house father” and a “house mother” (Johnson, 1973). The work with the families was later transferred from the institution to the families’ homes. The Children’s Village at Skå has influenced the development of residential care in Sweden for a long period especially the involvement of families in the treatment.

Changing Approaches to Care and Treatment

For a period there was optimism in North America regarding the possibilities to help young persons with severe emotional and behavioural problems. The idea was that with new knowledge it would be possible to design residential care in a way that the young persons could be helped and even cured. An increasing number of young persons were treated in residential treatment centres in the US (Liebermann, 2003). This new focus on treatment could also be seen in other countries such as Canada (Anglin, 2002) and Sweden (Sallnäs, 2000). In the 1970s and 1980s the expectations and valuation of residential care began to change in US and UK. There were different grounds for this change. In the US the positive outcomes of residential treatment were questioned (Lieberman, 2004). A new law, The Child Welfare Act of 1980, claimed that children should not be removed from the home unless they were at risk for imminent harm and that they should be placed in the least restricted environment (Lieberman, 2004). The costs for residential care were high, with major alterations in financial support as a consequence (O'Malley, 2004). Last but not least, residential care was vilified after reports of death related to the use of restraint and seclusion (Lieberman, 2004). In the UK scandals after disclosures of physical and sexual abuse by staff led to greater attention to residential care on the part of policymakers, which generated reforms and new research (Department of Health, 1998; Rushton & Minnis, 2002). The safety of children in residential care became important. To insure safety and good quality in the care of children, regulations and standards for the guidance of residential care were developed in the US and UK (Anglin, 2002; Watson, 2003). These standards regulate among other things the activities within care and the processes of ensuring that staff fulfil these activities. In North America there was also a move among residential agencies to become nationally accredited in order to gain funding for their programs (Lieberman, 2004). These standards emphasise a risk-free environment and a careful documentation and monitoring of prescribed areas, such as number of restraints, number of parent contacts and adherence to suicide precaution procedures (Mordock 2002). In the US the result is a more eclectic nondogmatic approach to residential care and an atomistic approach to practice with a lack of coherence since programs struggle to fulfil the activities and procedures required by different standards (Whitaker, 2004). According to Liebermann (2004) the focus of discussion in the US is more focused on individualised planning designed to shorten young person's stay. In North America, milieu treatment in group care for adolescents has also been more affected by the behavioural and cognitive-behavioural models and the significance of the psychodynamic model has decreased (Zimmerman, 2004).

Residential care in Sweden during the 1960s and 1970s was under the influence of a striving toward more professional care. Therapeutic aspects, with a stress on psychodynamic theories and models, were emphasised and the principal of work-

ing with the whole family rather than with the child alone grew in importance (Sallnäs, 2000). Standards and regulation for the guidance of residential care in Sweden (SOSFS, 2003:20 (S)) do not have the same influence on approaches to care as in US and UK. These are not as comprehensive or detailed as standards that regulate residential care in the UK and US. Residential care in Sweden has not been affected by scandals to the same extent as in the UK and US and there are no indications of change in the valuation of residential care in Sweden. The proportion of placements in residential care of children and youths increased between 1983 and 1995 at the same time as the proportion of placements in foster care decreased. (Vinnerljung et al., 1999).

Settings in residential care

Residential care can be run in very different settings. The past 40 years have seen considerable changes in the settings of residential care. One explanation is the trend toward deinstitutionalisation since the 1960s. Another is a shift in the purpose of residential care from custodial to protective (Anglin, 2002) and from care to treatment (Anglin, 2002; Sallnäs, 2002). Large institutions were considered as harmful to children and young persons and were replaced with smaller living units. (Anglin, 2002; Department of Health, 1998; Sallnäs, 2000). Differences between foster care and residential care have been reduced in different ways. There has been a tendency to make residential homes smaller with fewer beds to avoid the “contamination effect”, i.e. when antisocial youths have a negative influence on others, as well as to offer a more home like setting (Department of Health, 1998) A more homelike or familylike setting, where some of the adults live in the home, can be an alternative, especially for youths who can not be reunified with their birth parents (Sinclair & Gibbs, 1998). Other trends in Europe are the professionalisation of careworkers and community based placements that can involve the family in treatment (Rushton & Minnis, 2002). A summary of settings in Sweden, the UK and the US is given here. It is however difficult to capture all the variety in the residential settings, especially as they depend on the context with different legislation, systems of care and traditions. For example, residential settings in US tend to be segregated by income. Young persons with emotional and behavioural problems from families with financial means are often placed in mental health facilities supported by private insurance, while young persons from low income families more often are placed in residential treatment centres and correctional facilities supported by public funds (Little et al., 2005).

Settings in Sweden

A new concept came into being with the enactment of a new law for the social services (SFS 1980:620, 1980) at the beginning of the 1980s. All residential care was assembled under the heading Home for Care or Residence (Hem för Vård eller Boende, HVB). This concept includes all homes that work professionally with children, youths, adults and families. Residential care in Sweden consists of three major types – private residential care, public residential care and secure units (Detention Homes). Some of the private units are small and many are former foster homes. There has been a transformation of former foster homes into small-scale institutions (Sallnäs, 2000). Foster parents have become professionals with salaries and the right to employ staff. Some of these homes are also the residences of some of the staff and are to some extent a hybrid of foster home and institution. Homes of this kind can be described as family style homes. Public residential units are operated by local authorities and, compared to private units, take care

of a larger proportion of children in need of emergency shelter care and short term care (Sallnäs, 2000). Another setting in residential care in Sweden is here termed community home ((Hassela kollektivet & Englund, 1984). In this setting staff and youths live together for different periods of time. In some communities, staff members are on duty for a week or more and are then relieved by other staff members. In other communities some of the staff live in the community home for several years. The intention of this arrangement of the living situation is to create a sense of solidarity between youths and adults that will be the basis for upbringing and education. The majority of homes for care and treatment in Sweden (67 %) only take children for long term care (Sallnäs, 2000). Only 12 % had no age limit while 58% of the homes only took care of youths with a minimum age of 12 years (Sallnäs, 2000). Homes for younger children were more often intended for short term emergency care and sometimes took care of children and parents together for assessment (Sallnäs, 2000). Secure treatment for youths with extensive behavioural problems in need of care and treatment in locked facilities is run by the National Board of Institutional Care, a central government authority founded in 1993. The lengths of stay in Detention Homes can vary from a few weeks to two years. Today almost 700 youths are cared for in detention homes.

Settings in the UK

In the UK residential units taking care of children and youths are called Children's Homes. There are however great differences among these units. The size of the homes can vary from about three to four to about 20 beds (Department of Health, 1998; Sinclair & Gibbs, 1998) and the size of the staff can vary from about six to about 30 (Sinclair & Gibbs, 1998). It is difficult to categorize Children's Homes in unambiguous categories, however. For example, there can be similarities between homes according to size and staffing but differences according to the care delivered and children served (Department of Health, 1998). The UK also has secure units called Youth Treatment Centres that serve youths with severe behavioural problems.

Settings in the US

The Child Welfare League of America (2004) divides care into seven different types:

Supervised/staffed apartments: small living units for four youths or fewer. Supervision by staff adapted to the needs of the youths.

Group homes: detached homes housing 12 or fewer children or youths. The homes are staffed round the clock and use community resources, such as schools and recreational opportunities.

Residential treatment: homes providing a full range of therapeutic, educational, recreational and support services by a professional, interdisciplinary team.

Emergency shelter care: homes with emergency services to meet the basic needs for safety, food, shelter etc on a short term basis.

Short-term/diagnostic care: provides more intense services than shelter care, with for example an assessment/diagnostic process that evaluates each child's and family's needs.

Detention: provides short-term care, with restricted features such as locked doors, to youths under custody.

Secure treatment: provides residential treatment in a secure facility with restricted features such as locked doors. Staffing and structure make it possible to provide very close supervision of youths and a high level of physical safety.

The tendency to make residential homes smaller with fewer beds to avoid the "contamination effect" is also seen in the US. Different models of treatment in family style institutions and foster homes have been developed. Two of these are the Teaching-Family Model (Kirigin, 2001) and Multi Treatment Foster Care (Chamberlain, 2003). In the Teaching Family Model a married couple, teaching parents, are living together with 6-8 youths. The model is based on social learning theory and the purpose is to treat and reduce behaviour problems of the youths. The average length of stay is about 12 months (Kirigin, 2001). The Teaching-Family Model is also implemented in Western European countries (Little et al., 2005; Scholte & van der Ploeg, 2006). Multi Treatment Foster Care began as an alternative to residential treatment for youths with antisocial behaviour. It was started at the Oregon Social Learning Centre and is also built on social learning theory. In most cases two treatment foster parents take care of one adolescent. The program includes components directed to the foster parents, the young person, the birth parents and others in the social network. The treatment period is about a year (Chamberlain, 2003).

Group care practice

Practice is what care workers do in direct interaction with individual young persons, with the group of children and what they do on behalf of the young persons when interacting with others in the child's network, i.e. practice is behaviour (Whitaker et al., 1998). Behaviour is however related to the attitudes, feelings and values of the careworker and how he/she understands and perceives the children and what they do (Whitaker et al., 1998). In the UK several studies have focused on the "culture" in residential care, which is understood as the shared values, norms, beliefs and assumptions that develop in social groups.

The Complexity of Interactions in Group Care

There has been a lack of interest in what happens inside residential institutions (Bullock et al., 1993). Two extensive studies of group care practice have been carried out however, one in England (Whitaker et al., 1998) and one in Canada (Anglin, 2002; Anglin, 2004). Whitaker (1998) studied staff groups in six ordinary children's homes to describe what staff do and what they think about their work, themselves and the children. The purpose was to understand how staff group function and how outcomes was related to how the staff group was functioning. Anglin's study (2002) also sought to explore work in a group home but with the intention of constructing a framework for practice. This study was based on participant observation, interviews and a review of documents in ten well functioning group homes for youths. Even though these studies were carried out in different countries with different systems of care, we see similarities in their results. The complexity in residential group care practice was emphasised in both studies. To capture that complexity Anglin (2002) constructed a model of the work in a group home in the form of a three dimensional matrix. In this model one dimension refers to five different levels of work that in much correspond to the individual level, the team level, the management level and the level of organizations in wider networks that were found in the study of Children's Homes in England (Whitaker et al., 1998). The second dimension in Anglin's model describes three psychosocial processes that correspond to three tasks in residential group care. These are creating an extra familial living environment, developing a sense of normality and responding to pain and pained based behaviour. Work with the young persons were in the study of children's homes divided into three domains, containing and controlling, working with the young person's needs and seeking to provide reparative experiences. The third dimension in Anglin's model describes 11 interactional dynamics that consists of such activities as establishing structure, routine and expectations and listening and responding with respect. In the study of Children's Homes, characteristics of good practice in different arenas are described by means of illustrations. Factors that facilitate or hinder

good practice and good outcomes were identified and grouped together in clusters. Examples of clusters are relationship between residential staff and field social workers, structures and procedures within a Home and the mix of young people. One main finding was that cohesiveness and strength within staff and children groups promoted the efficient running of homes. This is in concordance with the main theme found in the Canadian study that was formulated as “the struggle for congruence”. To be a well functioning group home the 11 interactional dynamics must be present in a largely congruent manner in the work with the young persons, their families and at all levels in the organization. The philosophy and the practice orientation of the home manager in well functioning homes tended to permeate the activities, the way of thinking and the interactions in the home.

The importance of congruence in the delivery of residential care has been found in other studies and is a main conclusion drawn in the summary of research commissioned by the Department of Health (1998) in the UK. In a study based on participant observations in 12 Children’s Homes in England it was found that the quality of care was foremost related to the extent to which the manager could specify a clear theoretical and therapeutic orientation (Berridge & Brodie, 1998). Coherent culture and good outcomes were found in another study to be dependent on the level of concordance between societal, formal and belief goals (Brown et al., 1998). Societal goals correspond to the principles of the Children Act, formal goals were aims expressed by the manager and the staff and belief goals represent beliefs and values of managers and staff. Sinclair and Gibbs (1999) constructed a measure of “turbulence” defined as “involvement in delinquent behaviour, a culture marked by distrust of other residents and a perception that delinquent behaviour is common, and a lack of commitment to the establishment” (Sinclair & Gibbs, 1999 p 58). It was found that staff groups tended to have a shared perception of the home in which they worked. There was also concordance in how staff and residents perceived the homes, and the perceptions of both staff and residents were related to variations in delinquent behaviour in the home. The measure of turbulence could explain much of the variations in the quality of life that was found in 39 Children’s Homes in the UK. Difficult behaviour among the residents was related to poor morale in the staff group, which was in turn related to the residents feeling less supported. The interconnections between different aspects of the culture in a home and the children’s behaviour are parallel to what Whitaker (1998) described as good and bad patches in the homes. Three variables were found to have an independent effect on the measure of turbulence (Sinclair & Gibbs 1999). These were the size of the home, the degree to which the manager felt he/she had the power and autonomy to act and the degree of cohesiveness in the staff group. That the behaviour of the residents is strongly influenced by the culture in the home is in agreement with results of outcome studies where successful adaptation after leaving care was dependent on the stabil-

ity and support in the post treatment environment to which a child or youth had been discharged (Frensch 2002). Risks associated with negative youth culture in group care will be discussed in the next section.

Protection and risks in group care

Residential care has an important task to protect the young person from ongoing abuse and neglect, involvement in destructive peer relations and ongoing self destructive behaviour. In the case of antisocial behaviour the task can also be to protect the community from the young person's destructive behaviour.

In the worst scenario the young person falls out of the frying pan into the fire when he/she enters residential care. There is a risk of discontinuity in personal caregiving due to changes in the staff (Rutter, 2000). The young person can be bullied (Barter, 2004) and even be a victim of abuse by other residents as well as staff (Stein, 2006). Especially in the case that the young person is placed in residential care because of antisocial behaviour there is a risk of deviancy training if he/she is placed together with other antisocial young persons (Dodge, Lansford, & Dishion, 2006; Levin, 1998). The result in this scenario can be great distress and a worsening of the young person's problems. The risk of antisocial "contagion" will be discussed below.

The risk of deviancy training has been examined in several studies. Levin (1998) found in a study of a secure treatment home in Sweden that the youths developed a youth culture in the institution. In this culture criminal experiences were mediated between the youths. Levin described it as a contagion of criminal values. Dodge et al. (2006) argue that treatment of youths with antisocial behaviour in group settings can have iatrogenic effects. They give a description of youths having a tendency to negatively influence each other in group settings. Dodge et al. (2006) refer to treatment studies that show poorer results of treatments in group settings than treatments in individual settings. They conclude that if interventions have to be administered in a group context the effect is reduced by one third. If all members of the group show deviant behaviour, the results can even be adverse. This effect is called "iatrogenic deviant peer contagion effect" (Dishion, Dodge, & Lansford, 2006). These conclusions were however challenged by Weiss et al. (Weiss, Caron, Ball, Tapp, Johnson, & Weisz, 2005) They have, among other things, gone through the studies referred to by Dodge et al. (2006) and found other possible explanations for the differences in the results. For example, they identified statistical reasons and factors relating to the treatment per se that can explain the differences (Weiss et al., 2005). Weiss et al. (2005) agree with Dodge et al. (2006) on the fact that young persons with antisocial behaviour can negatively influence each other. This influence, they argue, is however much more pronounced outside treatment, in peer groups for example. A review of Lipsey

(2006) draws upon a meta-analysis of the effects of interventions on delinquency. The conclusions in this review are in concordance with those of Weiss et al. (2005) with regard to group treatments. No evidence was found for iatrogenic effects of group treatments for antisocial youths (Lipsey, 2006). Handwerk et al. (Handwerk, Field, & Friman, 2000) argue that the majority of studies of group interventions with antisocial youths have not found iatrogenic effects. They also assert that well-developed models of group interventions have produced a considerable decrease in antisocial activity among youths (Handwerk et al., 2000). Dishion et al. (2006) however draw the conclusion that residential programs should be avoided in the case of antisocial youths unless the structure of and supervision in the program is so strong that deviancy training does not occur.

The risks discussed can be counteracted in several ways. As mentioned, the risk of deviancy training can be minimised through well-structured programs that supervise the interaction between the youths (Dishion et al., 2006; Handwerk et al., 2000). There are also general ways to meet the different risks. Sinclair and Gibbs (1998) conclude that an important task for an institution is to gain an acceptance among the residents of what is and what is not reasonable behaviour. This task is easier to achieve if the institution is small, the leader is clear about what he/she is doing and the staff are on good terms with each other and agree on how the home should be run (Sinclair & Gibbs, 1998). A stable staff group is a prerequisite for the opportunity to create trustful relationships between young persons and staff. The staff should foster a prosocial culture and the residents should have a say about their situation in the home (Brown et al., 1998).

The Careworker-Youth Relationship in Residential Care

Traditional residential treatment has emphasised the importance of reliable and sustainable relationships in the nurturing structure of a social and therapeutic milieu (Rosen, 1999, O'Malley, 2004). A general assumption underlying residential treatment is that all interactions in a home have therapeutic potential. The concepts "corrective emotional experience" (Moses, 2000) or "reparative experience" (Whitaker, 1998) are used to describe youths' need for support and encouragement in order to counter their earlier experiences and their current expectations of others. The importance placed on relationships is mainly based on theories inspired by psychoanalysis. According to attachment theory early experiences of relations with caregivers are conceptualised as cognitive "working models" that form the basis for perceptions of self and others (Moses, 2000, Schuengel & Van IJzendoorn, 2001). Youth in residential care often have difficult relations with parents ranging from acute conflicts to parental rejections (Frensch & Cameron, 2002). High levels of insecure attachment representations have been found among young persons in residential care (Zegers, Schuengel, Van IJzendoorn,

Jansens, 2006; Wallis & Steele, 2001). Offering these youths reliable and sustainable relations can be a way to compensate for earlier deficits. It has been shown that the therapeutic process is affected by the attachment representations of both the young persons and the care workers in a prospective study of therapeutic relations in a youth treatment institution in Netherlands (Zegers et al., 2006). That attachment relationships develop between careworkers and youth within institutional settings has however, not yet been proven, though there is some evidence to support this (Schuengel & Van Ijzendoorn, 2001). Other roles of the youth-careworker relation are described in a review of assumptions and clinical implications of attachment in mental health institutions (Schuengel & Van Ijzendoorn, 2001). Supportive youth-careworker relationship can reduce some of the negative effects following separation from attachment figures and can function as a secure base and help the young person to cope with different forms of stress associated with residential care. The intention can also be to improve the youth's interpersonal and social skills within structured relationships with careworkers (Mordock, 2002).

Despite much of the focus in residential treatment being on the careworker-youth relationship there is a lack of research in this field. The significance of some aspects of the relationship has been studied however, and put in relation to youths' experiences of treatment and to outcome.

Studies have been made of the role of the working alliance between careworker and youth. (Florsheim, Shotorbani, Guest Warnick, Barratt, & Hwang, 2000). While the definition of this concept varies, two core aspects are personal attachments and collaboration or willingness to invest in the therapy process (Horvath & Luborsky, 1993). The working alliance has chiefly been studied in traditional outpatient treatment settings. It is not easy to study and assess the working alliance in a residential treatment setting where each young person may have a working alliance with each one of the careworkers. In a study of the role of working alliance in a residential treatment program (Florsheim et al., 2000), this problem was solved by asking each youth to indicate which careworker was most involved in his/her treatment. The hypothesis that was tested was whether a positive working alliance between careworker and youth would predict psychological and behavioural change in delinquent boys and whether the working alliance would be relevant for treatment outcome regardless of different approaches to treatment. Results showed that a positive working alliance after three months in treatment was related to a positive psychological change and to lower rates of recidivism in the year following placement. A positive working alliance after three to four weeks in treatment was however related to a negative psychological change and higher rates of recidivism and was interpreted as a false alliance. Further analyses showed that whether the working alliance improved or declined over time was more important

for reducing delinquent behaviour than the absolute value of working alliance scores early in treatment. There was a bidirectional relation between working alliance and progress of treatment; when progress was made in treatment working alliance was strengthened, and as the working alliance develops, treatment progress occurs. Other findings from this study were that delinquent boys with deviant peer relations were more resistant to developing a working alliance and that staff were less likely to establish a positive relation with severely delinquent boys.

This finding is supported by a study of staff-client relationships in a residential treatment facility in California (Moses, 2000). Residents who were well liked and easy to work with received more individual attention and encouragement than youths who were difficult to treat. Differences in involvement were also found in a study of staff perceptions towards children in Children's Homes in Scotland (Heron & Chakrabarti, 2003). Careworkers were more involved in trying to understand some of the youths while their avoidance strategies with others was not considered to be good practice. The low level of involvement with some of the youths was suggested to be a reflection of the disempowered position of staff. There are probably considerable variations among careworkers in how they take care of and treat young persons within the home. There is however insufficient information on how these variations are related to the development of young people in residential care (Little et al. 2005).

Surveys of youths' experiences in residential care point to the importance of the relationships with careworkers (Little et al. 2005). An Israeli study found the careworker-youth relation to be the best predictor of life satisfaction during the residential stay (Schiff, Nebe & Gilman, 2006). Good relations with staff were associated with the youth's assessment of being helped in a study of Children's Homes (Gibbs & Sinclair, 1999). In that study, however, it was found that good relationships with careworkers were relatively ineffective in helping youths with the stress associated with being friendless, harassed or bullied.

Little is known about the long term effects of good careworker-youth relationships. Gibbs & Sinclair (1999) found no long term effects in their study of Children's Homes. Results of a longitudinal Dutch study (Scholte & Van Der Ploeg 2000) indicate that a supporting relationship in a firm but not harsh therapeutic climate together with cognitive-behavioural training have long term effects in youths with severe behavioural difficulties. The efficacy of cognitive-behavioural training was interpreted as being dependent on supporting relationships.

Differentiation of Care and Treatment

Principles for differentiation of care

Traditionally a differentiation of residential care has primarily been made according to age, sex, and different needs or difficulties (Andreassen, 2003). Differentiation according to age has almost always been central in residential care. Today the greatest part of residential care for children and young persons in Western countries are directed to adolescents (Sallnäs, 2000). Younger children are preferably placed in foster care. Rearing younger children in residential settings has been found to predispose to problems such as hyperactivity, inattention and a lack of selective social attachment relationships (Roy, Rutter, & Pickles, 2000, 2004). According to the Swedish National Board of Health and Welfare children and young persons with essential differences in their basic problems, in age or in maturity should not be cared for or treated together in the same home and it is also mentioned that there can be a need for a differentiation due to gender (SOSFS 2003:20 (S)). Other grounds for differentiation of care exist. A principle that guides the system of care in the US and Canada is that “children with emotional disturbances should receive services within the least restrictive, most normative environment that is clinically appropriate” (Hair, 2005, p. 554). As a consequence, residential care should only be a service for a small and challenging group of children and adolescents. The principle of least restricted also guides placements in residential care in the US (Child Welfare League of America, 2004). Differentiation of placement is done in the continuum of care, where young persons with the least challenging problems are placed in the most normative environment and young persons with the most challenging problems are placed in the most restricted settings. An adverse effect of this principle is that entry to more restricted and specialised care may require that earlier placements have failed (Lieberman, 2004). In the UK, Sinclair and Gibbs (1998) proposed a differentiation of residential care according to different purposes of the care. In their study of 48 Children’s Homes they found that one group of youths was in need of short-term emergency care, another group was in need of a period of reflection and perhaps treatment and a third group was in need of long term care in a stable environment.

Residential Care for Whom?

Related to the question of differentiation of care is the question concerning what groups of youths is residential care appropriate and what groups of youths are accepted for placement. Is the placement an active choice or is it the last resort because there are no other alternatives (Frensch & Cameron, 2002)? In the Nether-

lands youths can only obtain residential care on the basis of a written document called an indication for treatment statement (IFT) (Metselaar, Knorth, Noom & Van Yperen, 2004). This document includes an assessment of the problems, an analysis of the needs of the young person, a consensus between the young person and the professional about the goals of the care and a consensus on the means that will lead to the goals. The IFT gives the young person a statutory right to the care that is recommended and is the basis for all treatment plans. In a follow up of the recommendations given in the IFT it was found that youths with externalising behaviour were more often recommended residential care while youths with internalising problems were recommended different forms of ambulatory youth care (Metselaar et al., 2004). One project in the US used a need based assessment of youths to differentiate between those in need of residential care and those suitable for community based services (Lyons, 1998). Youths in need of residential care were defined as having mental health problems of a kind that constitute a potential risk for themselves or others. According to this definition one third of the youths in different forms of residential placements were regarded as low risk youths that could have been better served in a community setting.

Differentiation of Care and Treatment according to Different Needs

There is a considerable heterogeneity in the needs and problems of young persons in residential care (Connor, et al., 2004; Curtis, 2001; Department of Health, 1998; Rutter, 2000). The question of what works for whom has its base in the assumption that youths in residential care have different needs and difficulties and that different interventions are needed for different youths. In order to differentiate care and treatment there is a need for assessment and classification of the youths in a meaningful way, i.e. that has implications for decisions about care and treatment. In the summary of a research programme on residential care in the UK commissioned by the Department of Health (1998) one conclusion is that psychiatric assessment can not comprise the range of difficulties of these youths. Specialised treatment approaches are not required within the home itself. Children with special treatment needs can receive support from external professionals.

In a summary of what is known about child development in residential care Little et al. (2005) conclude that little is known about what impairments for which residential care is appropriate and the knowledge about what residential programme is helpful for which children is extremely poor. Some results however indicate that certain symptoms are reduced more during placement than others. Lyons et al. (Lyons, Terry, Martinovich, Peterson & Bouska, 2001) studied the outcome trajectories of 285 adolescents that had received residential treatment in a state

in the western US. They concluded that there was a reduction of depression and of risk behaviours such as suicidality, self-mutilation and aggression. It appeared however that residential treatment had an adverse effect on anxiety and hyperactivity. When it comes to the question of what treatment type is helpful for which youth, there is some evidence that youths with behavioural problems (conduct disorders) are best helped with treatments using cognitive-behavioural strategies (Andreassen, 2003; Frensch & Cameron, 2002; Lipsey & Wilson, 1998).

Novel models for differentiating treatment have been developed especially for youths with antisocial behaviour Andreassen (2003). Predictions of outcomes of different interventions could be related to three different principles: the risk principle, the need principle and the principle of responsibility. (Dowden & Andrews, 2000; Andrews et al., 2006). According to the risk principle high risk youths are those most suitable for institutional care. The need principle implies that the targets of the interventions should be risk factors known to be important for the development and maintenance of criminal behaviour, called criminogenic needs. Interventions should target the criminogenic needs of the youths, in the family, in the school and in relation to friends. The third principle, responsibility, states that certain strategies i.e. behavioural, social learning and cognitive-behavioural strategies are more powerful for the treatment of antisocial behaviour. Specific responsibility suggests that there is a need for different interventions according to individual differences, for example in age, motivation, gender and ability. The importance of all three principles for treatment outcomes has received support in meta studies, and the best outcomes were found in programs that applied all the principles (Andreassen, 2003).

Differentiation according to different needs is related to which groups of youths can live together in the same home. Whitaker (1998) describes favourable and unfavourable mixes of young persons. Too much diversity in the needs of the youths made it difficult for staff to establish a suitable approach. An approach that is firm enough for hard to handle youths can be intimidating to more fearful ones. Some youths that display acting out behaviour can be threatening to others. Sexually abused children have been found to be at risk of abusing other children in care (Farmer & Pollock, 1999) and young perpetrators require controlled settings (Farmer & Pollock, 1999).

Some recently developed models for residential treatment have adapted to the criticism that treatment must be tailored to the needs of the young persons. One example of an approach for a subgroup of youths is the Sanctuary Model (Abramowitz & Bloom, 2003) which is an approach developed to work with disturbed children and youth with experiences of trauma. The aim is to create a coherent conceptual approach that can guide the work with youths in living units, school and treatment sessions. Trauma exposure is seen as a central organising life expe-

rience. The conceptual framework is called SAGE that stands for Safety, Affect Management, Grieving, and Emancipation. There is a strong focus on creating an environment free from violence. With reference to social learning theory the entire environment is seen as a therapeutic agent of change. This approach tries to identify critical elements in the care and to define their characteristics by using manuals and training materials. Assessments of the therapeutic environment and of the youths are parts of an evaluation process (Rivard, Bloom, Abramoovitz, Pasquale, Duncan, McCorkle & Gelman, 2003).

Another approach has been developed for youths with antisocial behaviour. Multiple risk factors that interact and reinforce each other over time necessitate that interventions be directed toward all or several of the risk factors in multiple settings (Chamberlain, 2003; Dodge & Pettit, 2003). Interventions that for example focus on only the individual or on family interactions may otherwise be counteracted by other risk factors. Multimodal interventions in multiple systems i.e. family, peer group and school are used in treatment of antisocial behaviour in non institutional care, in Multisystemic Treatment MST (Henggeler 1998) and in Multidimensional Treatment Foster Care, MTFC (Chamberlain, 2003). A project, including six institutions in Norway and two in Sweden are testing a treatment model for young persons aged 14-18 with severe behavioural problems based on the principles of multimodal interventions in multiple settings.

Differentiation According to Gender

Treatment models in residential care have usually been constructed according to the needs of boys (Andersson, 1996, Överlien, 2004). Girls have been a minority group in residential care and tend not to be referred to social services or educational delivery service as often as boys (Chamberlain, 2003). In comparisons between boys and girls in residential care, girls have been found to exhibit higher levels of psychopathology (Connor et al., 2004; Hussey & Guo, 2002; Baker, 2005). There are many indications that girls in residential care are more traumatized and have grown up under worse circumstances than boys (Chamberlain & Moore, 2002; Odgers & Moretti, 2002; Wood, Foy, Goguen, Pynoos, & James, 2002). In a comparison between boys and girls incarcerated for delinquency it was found for example that a third of the girls had injuries from physical punishment. This was twice as frequent as among the boys (Wood et al., 2002). Among youths who had been placed in Treatment Foster Care it was found that the girls in mean had experienced 14 transitions of parental figures compared to four transitions among the boys (Chamberlain & Moore, 2002). Transitions were counted as every time a parent figure entered or left the young person's life or the young person was placed in for example foster care or residential care. These results is in concordance with results from ADAD (Statens institusjonsstyrelse, 2005) show-

ing that 41 percent of girls have made more than seven moves during their lives compared to 23 percent of boys. A state-wide screening in Massachusetts, US, studied 18607 juvenile offenders in detention (Cauffman, 2004). The girls in this study showed more externalizing and internalizing problems (Cauffman, 2004). One explanation for these differences could be that girls must demonstrate more difficulties to be considered for placement.

We have less knowledge about the interplay between risk and protective factors for the development of antisocial development in girls than in boys (Chamberlain, 2003). There are indications that similar risk factors such as maltreatment, family dysfunction and low socio economic status, are important for both high risk boys and girls (Moffit et al., 2001; Odgers & Moretti, 2002). The difference is that girls in comparison with boys are more likely to have higher levels of these risk factors co-occurring across several domains (Odgers & Moretti, 2002). Differences in the social perception of self and others and different styles of attachments have been found between boys and girls with behaviour problems. Girls have a more negative evaluation of themselves and view others as more hostile (Connor et al., 2004; Moretti et al., 2001). Experiences from MTFC indicate that girls are more difficult to treat than boys, probably depending on social aggressive behaviours that are difficult for the MTFC parents to handle (Chamberlain, 2003). Youths with a history of sexual and/or physical abuse were found at discharge from a residential treatment facility found to show more psychopathology compared to youths without a history of abuse (Connor et al., 2002). Results of a follow up of youths placed in secure units in Sweden support these findings. Youths with sexual problems i.e. prostitution and/or victims of sexual abuse, attempted suicide more often and were more often treated in psychiatric care than delinquent youths, youths with drug and alcohol abuse and youths with psychiatric problems during a 24 month follow up (Sarnecki 1996). Consistency with these findings Odgers (2002) proposed that treatment of girls should be focused on the effects of trauma and the difficulties with attachment. We have not found any approach or model designed for the special needs of girls in residential care. The Oregon MTFC model (Chamberlain, 2003) has interventions targeting girls' specific needs. The Oregon MTFC model (Chamberlain, 2003) uses mentorship by the female foster parent as a positive female adult. This relation is given special attention to prevent negative escalating confrontations in order to stop a pattern of disrupted relations with adults and an accompanying breakdown of placement. Girls who avoid social-relational aggression are given reinforcements and they are taught strategies for avoiding social-relational aggression (Leve & Chamberlain, 2005). Girls are offered individual therapy in which it is possible to work with issues related to sexual and physical abuse. There is also an emphasis on preventing contacts with delinquent peers and on planning for the girls' future (Chamberlain, 2003).

Treatment outcome in residential care

Although residential care is a common intervention for children and adolescents there has been long standing controversy in opinions about the benefit of separating children and adolescents from their parents as well as the considerable cost of the care (Hair, 2005). Residential care is an invasive intervention that has an influence not only on the child but on the entire family. Because of the high costs, the risk of negative effects, public policy and professional preferences, residential care and treatment have been regarded a “last resort” intervention (Frensch & Cameron, 2002).

Frensch & Cameron (2002) and Hair (2005) reviewed studies of outcomes of residential treatment. Frensch & Cameron included studies of residential treatment and group homes in the US, England and Ireland. Hair included studies of residential treatment in the US. In these reviews there is agreement in several conclusions. Youths who have been in residential care can generally be in a much better position when they leave the institution compared to their status at admission. A large problem is however the difficulties of maintaining these positive effects after discharge. Youths leaving care are vulnerable and are very dependent on the post treatment environment. There is a need for after care services, such as support to the family, in school and at work. The studies reviewed consistently show the importance of contact and work with the young person’s family during the period of residential treatment. Working with the families is a way to improve these youths’ the post treatment environment. This is a challenging task however, due to the often multiple and chronic problems of the families. In many cases the family may not be a realistic support system for a young person to return to. It has however been shown that an important factor for a positive outcome is that parents or parental substitutes can be helped to provide a consistent structure and support for the young person, similar to what he or she took part of in residential care (Chamberlain, 2003). Failure to include parents in the treatment seems to represent the single largest barrier to generalisation of treatment effects from residential care to living at home (Chamberlain, 2003).

There are few studies of the results of residential care in Sweden. One hundred boys cared for at the Children’s Village at Skå during the 1950’s and 222 ordinary boys from Stockholm were followed up 20 years later (Andersson 1976). Only one third of the former boys at Skå were classified as having adapted to society compared to 90 percent of the control group. Levin (Levin, 1998) studied the situation of 208 youth (143 boys and 65 girls) placed in the Råby youth detention home during the period 1983 – 1993. The most common reasons for placements were criminal behaviour and drug abuse. According to Levin (1998) almost 80 percent of the youths reverted to some kind of criminal activity within four years

after they had left the institution. Only 13 percent had completely left criminality. The same was seen for drug abuse. About 70 percent of the youths continued to abuse drugs after they had left the institution. Sarnecki (1996) studied youths in detention homes in the Stockholm area. Two years after discharged 75 percent of the young persons still had such problems as drug abuse and psychiatric problems and 57 percent were still under treatment (Sarnecki, 1996).

There is still little knowledge about what works for whom and why in residential treatment (Little et al., 2005; Frensch & Cameron, 2002). One of the methodological shortcomings in outcome research is poor descriptions of treatment components and a lack of research methods that can reflect the complexities of the intervention process. (Frensch & Cameron, 2002; Epstein, 2004; Hair, 2005). The treatment approach is often described in general terms by referring to a theoretical approach such as the psychodynamic, behavioural, psychoeducational or others but, there is a lack of descriptions of how these approaches are put into practice (Epstein, 2004; Andreassen 2003; Frensch, 2002). Without a clear and precise description of the treatment, knowledge about what treatment is effective will be insufficient (Epstein, 2004; Frensch, 2002). Another problem is that in a single outcome study there is often so much variation in data depending on chance factors, such that treatment effect is overwhelmed (Lipsey, 1995). By means of meta-analyses, results of several studies can be analysed collectively and the influence of chance factors can better be controlled (Lipsey, 1995). This makes it possible to estimate average treatment effects and to study differential effects that are dependent on different approaches and variations in program characteristics i.e. how the treatment was implemented. In meta-analyses of 83 studies of treatment effects of institutionalised young delinquents ten – 22 years old, Lipsey & Wilson (Lipsey & Wilson, 1998) found that treatment reduced the rate of recidivism from 50% to 45%, i.e. by 10% as compared to the control group, six months subsequent to treatment. There was however a large variability in treatment effects. The variation was related to program characteristics and types of treatment. The best programmes reduced recidivism rates by nearly 40% while others had no effect. Program characteristics related more to treatment effects than was the type of treatment. The most important program characteristics were the age of the program and whether the treatment was administrated by mental health or juvenile justice personnel. Lipsey & Wilson (1995) also found variations in effectiveness among different types of treatment. Social skill training and Teaching Family Home were the most effective types of treatment for serious offenders. In the Teaching Family Model a married couple develop positive teaching relationships with the youths with a focus on behavioural and social skill training. Programs defined as multiple services and behavioural programs were also effective but the outcomes were not as consistent as for social skill training and for Teaching Family Home. Weak or no effects were found in treatments based on milieu therapy

and wilderness therapy. Andreassen (Andreassen, 2003) compiled ten meta-analyses of treatment outcomes for young persons with serious conduct disorders. His conclusion was that a behavioural approach with a cognitive component and with a focus on social skill training is effective. Treatments based on psychodynamic approach or on other unstructured approaches have not proved to be effective in the treatment of behavioural problems. Approaches defined as unstructured were those that did not utilise practical training. Lipsey estimated that an optimal combination of program elements had the capacity to reduce recidivism by 40-50 % (Lipsey, 1999). This was the case when (1) the treatment (program) had been established for more than two years, (2) staffed were treatment oriented, (3) behaviour modification interventions were used, (4) treatment duration was more than six months and (5) there was a good implementation of treatment. Each of these factors contributes to reduce recidivism. This example demonstrates the necessity of descriptions of treatment components and how outcome studies can be misleading if the outcomes not are related to different aspects of treatment and how treatment is delivered.

Results of meta-analyses have changed the view that nothing works in the treatment of institutionalised young offenders (Grietens, 2004). These results have also made a contribution to identifying which treatment approaches are most effective and under which circumstances they are effective. This knowledge is restricted to treatment of delinquency in residential care, however. The support for different approaches in the treatment of other problems in residential care is poor (Little et al., 2005). There is also little information on how variations in single residential contexts affect aspects of development (Little et al., 2005).

Summary of the papers

General and specific aims

The general aim of this thesis was to describe and explore the diversity in treatment in residential care for young people (13-18 years of age) in Sweden. The focus was on care and treatment of the young persons within daily living in a residential setting. Detention Homes (so called § 12 hem) were not included in the empirical studies. The thesis consists of five papers based on two different studies. Papers I and II use data from a survey of residential care for young persons in Sweden. Paper III, IV and IV are based on qualitative data from interviews with staff and residents in a single treatment home. The aims of the various papers were as follows:

Paper I. To compare the three settings of privately run institutions, institutions run by the public sector and family style homes, according to the problems of the youths in care, the mean length of stay in care, staff characteristics and aspects of the care and treatment provided. The questions were: Are there any differences between privately run institutions and institutions in the public sector with respect to the problems of the youths, the educational level of the staff and other aspects of the care delivered? Are there any differences between institutions (both privately run and in the public sector) and family style homes in terms of to the youths' problems and how long they stay in care? Are there any differences between the settings in their use of external psychiatric services? How can possible differences be understood?

Paper II. To describe the basis for long term residential care for youths in Sweden and to investigate what therapeutic underpinnings are involved in that care and in the creation of the residential environment. The issue was to identify different approaches and investigate whether these approaches were related to characteristics of the home, the staff and the type of care.

Paper III. To explore careworkers' perceptions of treatment and to illustrate these views about treatment in a way that would facilitate comparisons of treatment perceptions between careworkers. The aim was to make it possible to examine whether there are personal styles or approaches to treatment and the stability of these approaches among the staff and to explore the consistency and individualisation in perceptions of the treatment of each young person in care.

Paper IV. To explore adolescents' experiences of living in residential care and examine how differences in their experiences can be understood.

Paper V. To illustrate and illuminate how relationships between careworkers and young persons in residential care can be perceived. The intention was to describe

how both careworkers and young persons have perceived their relationships with each other and to discuss these examples in relation to different aspects of the treatment process.

Method

Participants

Papers I and II used a questionnaire that was sent to all Homes for Care or Residence that fulfilled the inclusion criterion of offering long term residential care for more than five months. Homes that were not included took care of youths in emergency situations and for assessment. Thirty-seven secure units that were operated by the state and had the legal authority to incarcerate were excluded owing to their special character. The study group in Paper II consisted of 195 homes, of the original 261 that received the questionnaire, which gives a response rate of 75 percent. A majority of these homes, 75 percent, were private and 11 percent were run by the public sector. The remaining homes were operated by different foundations. The response rate among the public homes was 87 percent as compared to 76 percent among the private homes. Paper I concentrated on 150 homes. These homes, according to the questionnaire, defined themselves either as institutions or family style homes and were run either privately or by the public sector. The family style home is the residence of some persons in the staff and functions in a way that is something between a foster homes and an institution. All staff in an institution work according to a schedule or daytime work hours and have their residence outside the institution. According to this definition, all the public homes and more than half of all the homes in the study defined themselves as institutions. In all, 174 homes were defined either as institutions or family style homes.

Papers III, IV and V are based on a study carried out in a treatment home run by the social services in a mid-size Swedish city. The home took care of young persons with “psychosocial problems” for long term treatment, i.e. approximately one to two years. The home had just opened at the beginning of the study. It accommodated six young persons, three girls and three boys between 15 and 18 years of age, who were the first to be referred to the home. In the part of the study described in Paper III, all eight residential careworkers were participants. They had college degrees or higher education in social work or social pedagogy (Cameron, 2004), and all except one had prior experience of working in residential care. The participants in the part of the study described in Paper IV were the six youths, three girls and three boys, who were the first to live at the treatment home when it opened. They were between 15 and 18 years of age at the time of referral and were interviewed two to three years later.

Procedure

Papers I and II. This study is based on a postal questionnaire directed to managers of Homes for Care or Residence. The responses were collected at the beginning of 2000. The questionnaire contained items about formal aspects of the homes, the youths, the staff and treatment and care in the home. The aim was to capture the basis of the care and treatment delivered. Items about the youths were answered on a “home level”, meaning that the homes had to state how many of the youths corresponded to different items. Data were subjected to multivariate analyses, ANOVA with the Tukey Post Hoc test. Some data were subjected to Pearson bivariate correlation analysis. Two linear regressions were carried out in Paper I and a factor analysis of statements related to treatment approaches was made in Paper II.

Paper III. Study data were collected in interviews with eight residential careworkers in a treatment home. The intention was to interview every careworker about each of the six youths on two occasions. This would have been a total of 96 interviews. Because of a vacancy in the staff group and because one of the youths left the home before the second interview was held, 81 interviews were carried out. The first set of interviews (43) was conducted when the youths had been at the treatment home for about two to four months. The second set (38) took place seven to ten months after the first interviews. All interviews were conducted by the two authors, both of whom were clinical psychologists with several years of interview experience. The interviewers took notes during the interviews, which lasted for 0.5 – 1.5 hours. The notes were typed as soon as possible after the interview. The content of the interviews was analysed in a stepwise fashion. In the first step, all “meaning units” (Giorgi & Giorgi, 2003) that referred to problems and treatment were sorted out – 869 from the first set of interviews and 607 from the second set. In the next step, all of these meaning units were coded and grouped into descriptive categories. This categorisation resulted in 13 categories, six describing the needs and problems of the youths and seven describing ideas about treatment. Three categories that concerned treatment were further analysed and resulted in the formation of six new categories describing careworkers’ intentions in the treatment. The distribution of each careworkers’ statements within different categories created a pattern that illustrated the careworker’s general treatment perceptions. This pattern made it possible to compare different careworkers’ perception of treatment.

Paper IV. Study data were collected in interviews with the six young persons who had been living together in the treatment home since it opened. The young persons were interviewed two to three years after they had left the treatment home. All interviews were carried out with two interviewers, both experienced clinical child psychologists. Both interviewers took notes. The notes were later compared

and typed. With two interviewers, it was possible to simultaneously collect information, create and maintain an alliance with the interviewed youth, and summarise what had been said. All the interviews were initially read by both authors in order to form a global sense of the contents of each interview. The next step of the analysis was to identify the meaning units in the interviews. The units were then categorised to form a meaningful structure. Other aspects not captured by the interview schedule also came to light during the interviews.

Paper V. This paper used data from Paper III and Paper IV. In all, material from 13 interviews, ten with careworkers and three with young persons, was used. The material concerned the three young persons who had the same careworkers as key workers throughout their stay at Pine Grove and who completed the interview after their stay, Elias, Frida and Carl. There were clear differences between the interviews with the key workers and the interviews with the young persons. The interviews with the key workers were carried out during the time when the young persons were living in the treatment home. The interviews with the young persons were retrospective and were conducted two to three years after their stay at Pine Grove. There were also differences in the focus in the interviews. The interviews with the key workers were more detailed and clearly focused on aspects of the care and treatment delivered to the young person in question. The interviews with the young persons focused on how they in retrospect remembered how they experienced their stay at the treatment home. Because of these differences, the interviews with the key workers contained more material and details. The point of departure for this study was material from the interviews with the young persons that was reflected in the material from the interviews with the key workers. Aspects that were only present in the interviews with the key workers were not used.

Results

Paper I. Here, institutions run by the public sector were found to have better educated staff and a higher staff-resident ratio than privately run institutions. Despite this, they were more restrictive in their intake and had youths with fewer problems, especially delinquency and other antisocial behaviours. Private homes, both institutions and family style homes, seemed to use psychiatric services more than institutions in the public sector. It was found however that this difference could be explained to a high degree by the educational level of the staff. Homes with few university educated persons in the staff seemed to use psychiatric services more than homes with staff who to a higher degree had university educations. There was a clear difference in the mean length of stay in the different settings, where youths stayed much longer in family style homes than in institutions. It was not possible to conclude whether these differences in the length of stay were related to

the youths' problems. There was however a tendency for residents to stay longer in homes with a relatively larger proportion of youths who had been sexually abused and youths with mentally ill parents and a relatively smaller proportion of delinquent youths.

Paper II. According to this paper, the psychosocial problems of youths in long term residential care in Sweden seem to resemble those of youths in other Western countries. Some basic ideas about care and treatment were widespread. The youths' problems and symptoms were seen as being based in deficient relations early in life that could be compensated for by stable and secure relationships during adolescence. There was also a consensus among the homes concerning the need to mediate values to the young persons and the necessity of long term treatment. The diversity in long term residential care became evident when the homes described the basis for the care they give in their own words. Despite this diversity it was possible to identify five different approaches to care and treatment. These approaches did not exclude each other but were agreed with to different extents by different homes. The approaches were found to be related to the variety within residential care.

Paper III. The analyses of careworkers' statements included seven descriptive categories covering treatment. These categories can be understood as a summary of what the careworker considered to be the critical ingredients in the treatment. Structure included statements about the norms, roles, routines and procedures of the home. Relation indicated that aspects of the relation between a careworker and the young person were seen as essential in treatment. Conversation indicated the need of structured conversation individually or in a group. Work with family/and network contained statements about the need to include members of the family or important persons in the network in the treatment. Skill training was related to the need of training or other activities to strengthen the young person's competence and skills. Experience/adventure contained statements about the need for adventures, e.g. skiing or excursions. Assessment included comments about the need to know more about the young person's needs or physical/mental health. The statements in these categories were reread, as were the protocols from the interviews. In this analysis it became clear that every statement within the categories of Structure, Relation and Conversation contained an intention. These categories can be understood as different domains in which different treatment intentions can be carried out. Six different intentions could be identified: Control/Protection, Holding/Containing, Conflict management, Learning, Working through and Organising the work. The distribution of each careworker's statements within the different domains and intentions created a pattern that illustrated the careworker's general treatment perceptions. This pattern made it possible to study and compare different careworkers' perceptions of treatment. Each

careworker had a rather unique and stable pattern of treatment perceptions i.e. a personal approach to treatment. Despite different approaches to treatment among the careworkers, there was enough consistency in the perceptions of treatment of each young person in the home to create individualised approaches to treatment. That treatment plans were discussed during weekly meetings was probably vital to the achievement of consistency in treatment perceptions of the young persons.

Paper IV. Living in the same institution during the same time period does not mean sharing the same experiences. The six youths had lived in the same environment and met the same staff during a shorter or longer period of their adolescence. In retrospect, their experiences were very different from each other. The different individuals had interacted with the environment in their own unique ways. Three of the young persons, the girls, expressed great discontent with the stay. They said that they should not have lived at the treatment home at all. One described that she had been bullied and that she had not received the love that she needed. The other two stated that they had been incorrectly treated and that the stay at the treatment home had not brought anything good. The three boys were more positive. One saw both positive and negative aspects of the stay. He said that the staff had not been able to handle his acting out. On the other hand he described many positive experiences during the stay. The other two boys were essentially positive and both described positive relationships with persons in the staff. One of them described the stay at the treatment home as almost having saved his life.

Paper V. Several factors contributed to the relationship between Elias and his male key worker becoming so important. Elias felt that the staff understood that it was difficult for him to live in a group together with other youths and he also felt that they tried to protect him. The relationship with one particular person, which he himself experienced as the most important factor during his stay, was supported by others in the staff. He also sensed a personal commitment on the part of his male key worker. Despite great strains on the male key worker during a certain period, the relationship still was very important to Elias two years after his stay at Pine Grove. Elias had experience of another institution at which it seems that he had not had the opportunity to form a relationship with an important adult. It is not possible to know why this was so. The picture of Elias is that he was a lonely young person who was quite afraid of contacts with others. In the context of the treatment home, however, it was possible for him to establish a very important relationship with his male key worker.

Frida expressed two great sorrows in connection with the stay at Pine Grove: she had been bullied and threatened and she had not received the love and affection that she needed. The key workers were aware of her need for love. They experienced however that it was difficult to mediate positive feelings to Frida in a way that they thought was adequate. It is also obvious that they could not protect

Frida from being bullied even though they saw that she was exposed to harassment by the other youths.

Carl said that he had felt trusted and that he had had an important relationship with the male key worker during his stay at Pine Grove. He had felt safe and secure and had not needed any protection from the youth group. On the contrary, he was a leading figure in the group and the one that the other youths had looked up to. In retrospect he saw his time at Pine Grove as important and almost having saved his life.

Discussion

Paper I. The differences between private institutions and institutions in the public sector found in this study can partly be explained in relation to the development in the residential care sector in Sweden. Cutbacks were made in residential care during the post-war period. In the institutions that remained the ambition was to reduce the number of beds and to make the milieu more therapeutic (Sallnäs, 2000). Care was professionalised and staff with higher education were employed. One possible explanation is that, in this process, the institutions became more and more exclusive and started to sort out youths that best 'fit the model'. The most difficult youths, especially those with different kinds of antisocial behaviours, were excluded. These youths were referred to secure units or were not offered any residential care at all. When the residential care sector changed during the 1980s and 1990s, the new private institutions could find a 'market share' among this group of youths. Many social workers do not willingly place adolescents in secure units, especially younger ones. The risk for 'contamination' from older, antisocial youths is often taken into consideration. There may have been an opportunity to place these young antisocial adolescents in private institutions.

A possible explanation for the differences in the use of psychiatric services that were found in this study is that many private institutions and family style homes emphasised the more caring aspects and, as in many Children's Homes in the UK and group homes in the USA, use external resources for treating the youths' emotional and behavioural problems. Many institutions in the public sector, on the other hand, seemed to be more like residential treatment centres in the USA in the way that they emphasised treatment within the home. This explanation is supported by the fact that the two tasks that institutions in the public sector in mean evaluated highest were those that focused most on treating emotional and relational problems. There was thus a connection between high educational level among the staff, a focus on treatment of emotional and relational problems and not using psychiatric services outside the home. There was also a connection between low educational level among the staff, a focus on more caring aspects and use of psychiatric services outside the home. These differences can be considered

from different perspectives. Homes with highly educated staff and a high ambition to treat emotional and relational problems can seem to have better quality than homes with the primary ambition of offering good care and upbringing. However, if the homes with the more caring ambitions use services outside the home for treatment of emotional and relational problems, this could be a good complement. It would also give the youths an opportunity to meet professionals outside the homes and to talk about things that may be difficult to discuss with the staff in the home.

According to this study there seems to be a tendency for youths to stay in family style homes for much longer periods of time than in institutions. The family style homes also stated an ideal length of stay that was longer than the ideal length of stay given by institutions. The idea that several years in care is good for youths in need of out-of-home placements is probably grounded in the foster care tradition. It is also possible that many of the youths who live in family style homes have few opportunities to move back to their parents because of difficulties in the home environment. In the UK it has been said that there is a need for small family style homes for youths who cannot return to their parents (Sinclair & Gibbs, 1998). One risk factor in residential care is discontinuity in personalised caregiving (Rutter, 2000). Many persons are involved in the care situation and there is a risk of many disruptions in relations between youths and caregivers. In a family style home, where adults live in the home, this risk can be reduced. It is important however to be aware that youths who live in family style homes still in many cases have to relate to ten to 20 persons or more in their living environment during their years in the home. According to this study, the main focus in the family style homes was on caring aspects. A development towards structured treatment programs, such as those described in the USA (Chamberlain, 2003; Kirigin, 2001), could not be seen.

Paper II. There are evident similarities between the approaches identified in this study and descriptions of different approaches in residential care in other countries. The approaches described here are also related to some of the critical issues in long term residential care. One issue is what is thought to be the mediator of treatment (Chamberlain, 1996). A major difference between the fostering approach and the re-educational approach is who the mediator of socialisation is. The re-educational approach uses the peer group culture, while the adults or the family are the mediators in the fostering approach. The aim in the systemic approach is to use the young person's family and network as mediators to achieve treatment goals. Another critical issue is whether there is a need for developing a sense of normality (Anglin, 2004; Ward, 2004), as in the fostering approach, or a need for therapeutic treatment and an environment adapted to youths with special needs (Lieberman, 2004; Ward, 2004), which is most obvious in the psy-

chodynamic and behavioural approaches. The relation between approach and aspects of the residential setting supports the view that it is not sufficient to describe treatment methods within residential care without relating these to the context (Epstein, 2004). There is a need of descriptions of what treatment type is provided (Curry, 1995) and of the therapeutic underpinnings involved in the residential care. Some of the variety within residential care can be the basis for a differentiation of residential care and can be used to compare outcomes (Bullock, Little, & Millham, 1993).

Paper III. Working in residential group care is a complex task. There is a wide gap between principles or guidelines and daily practice. The existence of different personal approaches to treatment among careworkers confirms assumptions and observations made in residential care (Abramovitz & Bloom, 2003; Watson, 2003; Whitaker et al. 1998). If these approaches are as stable as these results suggest, more attention should be paid to the individual careworkers perceptions of treatment. Extensive differences in treatment approaches among careworkers in a home can lead to problems in interaction within staff groups and to incongruence in the delivery of care. Consistency is highly valued among the staff (Watson, 2003). One important aspect of the high evaluation of consistency may be the careworkers' need for support. Careworkers may feel unsure about what to do with youths that are hard to manage in the complexity that exists in residential care (Anglin, 2002; Whitaker et al., 1998). They have a need of support and confirmation that consistency in treatment perception among the staff can fulfil. With significant similarities in descriptions of group care practice (Anglin, 2002; Whitaker et al., 1998), it may be possible to find a systematisation of treatment that is meaningful for residential group care. A well functioning system or model of treatment ideas could be helpful for careworkers in their task of putting all the ideas about care and treatment into practice. It could also be a means for the defining of treatment components and measuring of treatment fidelity that are required in treatment outcome research.

Paper IV. The stories described in this paper convey that the period of life during which the youths had lived at the treatment home was important. In spite of the fact that the interviews were conducted two to three years after the young persons had lived at Pine Grove, feelings, situations and persons were vividly remembered. They referred less to the experience of treatment than to the experience of living in an institution. It was the relationships with the adults and the other youths and the experiences in the living environment that were most important to these youths. The main conclusion was that it is of great importance to be observant of the individual experiences of youths living in residential care. Youths in residential care are vulnerable and often live in the institution for a year or more. Although young persons live in the same institution and meet the same staff dur-

ing the same time period, the environment is in great part nonshared. There is a complex interaction between the youths' experiences earlier in their lives, conditions and relationships in the institution throughout the treatment period, and special events during the stay. The relationships, both between the youths and between youths and staff, are of great importance for how the stay is experienced.

Paper V. The three young persons' views on their relationships with the careworkers were quite different. They expressed different needs for relationships and they made different evaluations of their relations to their key workers. Two to three years after they had left the home they described experiences in relation to careworkers that can be seen as illustrations of the importance of relationships in residential care. It was possible to find a considerable amount of material in the interviews with careworkers that dealt with the same experiences in the treatment home that the young persons described in retrospect.

Three aspects of the relationships were studied and clear differences were found. Elias and Frida needed protection against the stress that living in a residential home can entail. Elias felt that he had gotten that protection but Frida did not. The key workers saw both Elias' and Frida's need for protection but could not protect Frida in a way that made her feel safe. Carl was not in need of protection and was the one that most clearly described a working alliance with his key workers. He was the only one that expressed ideas about what the treatment consisted of. The boys, Elias and Carl, described positive therapeutic relationships with their key workers. This was in concordance with their key workers' views. The relation between Elias and his male key worker had a clear character of an attachment relationship. Frida's key workers described difficulties working with Frida, and she herself described that she had not gotten the help that she needed.

The relationships between these young persons and their key workers can be seen as an illustration of the complexity of treatment in residential care. Interactions between the young person's needs, his/her former experiences of relationships, the climate in the youth group and the psychological availability of the careworkers influence the young person's need of support, as well as his or her perception and experience of support. Experiences of support from careworkers are related to the young person's evaluation of care (Gibbs & Sinclair, 1999) and are important to being able to sustain the working alliance between the young person and the careworker (Florsheim et al., 2000) These three cases can also be seen as an illustration of how the youth-careworker relationship in residential care can influence the risk of dropout and how it can motivate both careworkers and young persons to accomplish treatment goals (Florsheim et al., 2000; Scholte & van der Ploeg, 2000)

Concluding remarks

This thesis has examined and described the complexity and diversity in residential care. Different levels, from individual experiences to structural issues, were studied.

Young persons living in the same institution can experience their stay in very different ways (Paper IV). Although young persons live in the same institution and meet the same staff during the same time period, the environment is in large part not the same for each. There is a complex interaction between the youth's experiences earlier in their lives, conditions and relationships in the institution throughout the treatment period, and special events during the stay. Relational factors also play a great part in how young persons experience their stay in a residential institution (Paper V). The mutual trust between the young person and the careworker can be an important foundation for the treatment process. Likewise, difficulties in the relationship between the young person and the careworker can contribute to mistrust and dropout from care.

There can be different personal approaches to treatment among careworkers in an institution (Paper III). To identify these differences, it is not sufficient to ask the careworkers about their general ideas about how to treat young persons in residential care. It is for each careworker to be engaged in the task of treating a real young person at a specific time. It is probably also important that there is a supportive climate during the interviews and that there are questions that stimulate reflection and aim for as concrete answers as possible. Under these circumstances it is possible to obtain personal ideas and statements about treatment that can be categorised in a meaningful way.

A major problem in descriptions of the basic grounds for treatment is the variation in the use of concepts and the confusion of ideas that exists (Dartington social research unit, 1998). To overcome some of these difficulties, it is possible to create operational definitions for general approaches to care and treatment in residential care (Paper II). With the use of a few statements about aims, beliefs, staff roles and values it is possible to identify different approaches and to differentiate between groups of homes that emphasise these approaches to different extents.

Different settings in residential care are related to differences in the care and treatment delivered (Paper I). In Sweden, staff in institutions in the public sector have a higher educational level and have longer experience of working in residential care than staff in private institutions. Despite this, private institutions take care of young persons with more behavioural problems than institutions in the public sector do. Young persons stay longer in family style homes than they do in institutions. There are indications that the longer time in care is related more to the

setting per se than to the needs of the young persons. The differences in care and treatment between settings can be related to the development in the social welfare sector in Sweden but are not grounded in knowledge about what is best for the young persons in need of residential care.

In the studies contained in this thesis diversity in residential care was found on multiple levels: on the individual level, the interactional level and on contextual levels such as settings and approaches to treatment. It was also found that some of these differences, for example careworkers' perception of treatment and institutions' approaches to treatment, are not only possible to describe but also to "measure". These measures can for example be valuable in development work in residential care done to achieve congruence in the care and treatment delivered. Very little is known today about treatment outcome in residential care in Sweden and there is thus a need for outcome studies in the residential care sector. When outcome is studied, however, it is important to define and describe the parts of the care and treatment that are supposed to have an effect on the outcome among the young persons served (Frensch & Cameron, 2002). In outcome research it is crucial to distinguish the part played by the problems of the youths and that played by contextual factors, such as treatment approaches and settings (Lyons & McCulloch, 2006).

References

- Abramovitz, R., & Bloom, S. L. (2003). Creating sanctuary in residential treatment for youth: From the "well-ordered asylum" to a "living-learning environment". *Psychiatric Quarterly*, 74(2), 119-135.
- Achenbach, T. M. (1991). *Manual for the Child Behavior Checklist/4-18 and 1991 profile*. Burlington, VT: University of Vermont, Department of Psychiatry.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4 ed.). Washington DC: American Psychiatric Association.
- Andersson, C. (1996). Om struliga flickor – beteende och bemötande. In B. Å. Armelius, S. Bengtsson, P.-A. Rydelius, J. Sarnecki & K. Söderholm Carpelan (Eds.), *Vård av ungdomar med sociala problem – en forskningsöversikt*. Stockholm: Statens institutionsstyrelse, Liber Utbildning.
- Andersson, M. (1976). Hur går det för 50-talets Stockholmspojkar. En uppföljning av 222 vanliga skolpojkar och 100 Skå-pojkar. Stockholm: Monografier utgivna av Stockholms kommunalförvaltning, nr 38.
- Andreassen, T. (2003). *Institutionsbehandling av ungdomar – Vad säger forskningen?* Stockholm: Centrum för utvärdering av socialt arbete (CUS), Statens institutionsstyrelse (SiS), Förlagshuset Gothia.
- Anglin, J. P. (2002). *Pain, normality and the struggle for congruence: Reinterpreting residential care for children and youth*. New York: The Haworth Press.
- Baker, A. J. L., Archer, M., & Curtis, P. A. (2005). Age and gender differences in emotional and behavioural problems during the transition to residential treatment: the Odyssey Project. *International Journal of Social Welfare*, 14(3), 184-194.
- Barter, C. (2004). *Peer violence in children's residential care*. Gordonsville, VA, USA: Palgrave Macmillan.
- Berridge, D., & Brodie, I. (1998). *Children's homes revisited*. London: Jessica Kingsley Publishers.
- Brown, E., Bullock, R., Hobson, C., & Little, M. (1998). *Making residential care work – Structure and culture in children's homes*. Aldershot: Ashgate.
- Cauffman, E. (2004). A statewide screening of mental health symptoms among juvenile offenders in detention. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43(4), 430-439.
- Chamberlain, P. (2003). *Treating chronic juvenile offenders: Advances made through the Oregon multi-dimensional treatment foster care model*. Washington, DC: American Psychological Association.
- Chamberlain, P., & Moore, K. J. (2002). Chaos and trauma in the lives of adolescent females with antisocial behavior and delinquency. *Journal of Aggression, Maltreatment and Trauma*, 6(1), 79-108.
- Child Welfare League of America. (2004). *Standards of excellence for residential services*. Washington DC: CWLA press.
- Connor, D. F., Doerfler, L. A., Toscano, J., Peter F., Volungis, A. M., & Steingard, R. J. (2004). Characteristics of children and adolescents admitted to a Residential Treatment Center. *Journal of Child and Family Studies*, 13(4), 497-510.
- Connor, D. F., Miller, K. P., Cunningham, J. A., & Melloni Jr, R. H. (2002). What does getting better mean? Child improvement and measure of outcome in residential treatment. *American Journal of Orthopsychiatry*, 72(1), 110-117.
- Curtis, P. A., Alexander, G., & Lunghofer, L. A. (2001). A literature review comparing the outcomes of residential group care and therapeutic foster care. *Child and Adolescent Social Work Journal*, 18(5), 377-392.

- Dartington social research unit. (1998). *Towards a common language*. Dartington: Dartington social research unit.
- Department of Health. (1998). *Caring for children away from home – Messages from research*. Chichester: John Wiley & Sons.
- Dishion, T. J., McCord, J., & Poulin, F. o. (1999). When interventions harm: Peer groups and problem behavior. *American Psychologist*, *54*(9), 755-764.
- Dishion, T. J., Dodge, K. A., & Lansford, J. E. (2006). Findings and recommendations: A blueprint to minimize deviant peer influence in youth interventions and programs. In K. A. Dodge, T. J. Dishion & J. E. Lansford (Eds.), *Deviant peer influences in programs for youth – Problems and solutions*. New York: Guilford Press.
- Dodge, K. A., & Pettit, G. S. (2003). A biopsychosocial model of the development of chronic conduct problems in adolescence. *Developmental Psychology*, *39*(2), 349-371.
- Dodge, K. A., Lansford, J. E., & Dishion, T. J. (2006). The problem of deviant peer influences in intervention programs. In K. A. Dodge, T. J. Dishion & J. E. Lansford (Eds.), *Deviant peer influences in programs for youth – Problems and solutions*. New York: Guilford Press.
- Epstein, R. A., Jr. (2004). Inpatient and residential treatment effects for children and adolescents: a review and critique. *Child and Adolescent Psychiatric Clinics of North America*, *13*(2), 411-428
- Farmer, E., & Pollock, S. (1999). Mix and match: Planning to keep looked after children safe. *Child Abuse Review. Special Children in public care*, *8*(6), 377-391.
- Florsheim, P., Shotorbani, S., Guest Warnick, G., Barratt, T., & Hwang, W. C. (2000). Role of the working alliance in the treatment of delinquent boys in community-based programs. *Journal of Clinical Child Psychology*, *29*(1), 94-107.
- 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*(5), 307-339.
- Gibbs, I., & Sinclair, I. (1999). Treatment and treatment outcomes in children's homes. *Child and Family Social Work*, *4*, 1-8.
- Grietens H, Hellinckx W (2004). Evaluating effects of residential treatment for juvenile offenders by statistical metaanalysis: a review. *Aggression and Violent Behavior* *9*(4): 401–415
- Hair, H. (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.
- Handwerk, M. L., Field, C. E., & Friman, P. C. (2000). The iatrogenic effects of group intervention for antisocial youth: Premature extrapolations? *Journal of Behavioral Education*, *10*(4), 223-238.
- Hassela kollektivet, & Englund, G. (1984). *Fostran för framtiden*. Stockholm: Tidens förlag.
- Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (1998). *Multisystemic treatment of antisocial behavior in children and adolescents*. New York, NY, US: The Guilford Press.
- Heron, G., & Chakrabarti, M. (2003). Exploring the perceptions of staff towards children and young people living in community-based children's homes. *Journal of Social Work*, *3*(1), 81-98.
- Hooper, S. R., Murphy, J., Devaney, A., & Hultman, T. (2000). Ecological outcomes of adolescents in a psychoeducational residential treatment facility. *American Journal of Orthopsychiatry*, *70*(4), 491-500.
- Horvath, A. O., & Luborsky, L. (1993). The role of the therapeutic alliance in psychotherapy. *Journal of Consulting & Clinical Psychology*, *61*(4), 561-573.
- Hukkanen, R., Sourander, A., Bergroth, L., & Piha, J. (1999). Psychosocial factors and adequacy of services for children in children's homes. *European Child and Adolescent Psychiatry*, *8*, 268-275.

- Hukkanen, R., Sourander, A., Santalahti, P. i., & Bergroth, L. (2005). Have psychiatric problems of children in children's homes increased? *Nordic Journal of Psychiatry*, 59(6), 481-485.
- Hussey, D. L., & Guo, S. (2002). Profile characteristics and behavioral change trajectories of young residential children. *Journal of Child and Family Studies*, 11(4), 401-410.
- Johnson, G. (1973). *Att bryta det sociala arvet*. Stockholm: Tiden/Folksam.
- Johnson, M. M. (1999). Managing perceptions: A new paradigm for residential group care. *Child and Youth Care Forum*, 28(3), 165-179.
- Kazdin, A. E. (1999). Current (lack of) status of theory in child and adolescent psychotherapy research. *Journal of Clinical Child Psychology*, 28(4), 533-543.
- Kazdin, A. E. (2000). *Psychotherapy for children and adolescents: Directions for research and practice*. New York, NY, US: Oxford University Press.
- Kirigin, K. A. (2001). The teaching-family model: A replicable system of care. *Residential Treatment for Children and Youth*, 18(3), 99-110.
- Kjelsberg, E., & Nygren, P. (2004). The prevalence of emotional and behavioural problems in institutionalized childcare clients. *Nordic Journal of Psychiatry*, 58(4), 319-325.
- Leve, L. D., & Chamberlain, P. (2005). Girls in the juvenile justice system: Risk factors and clinical implications. In D. J. Pepler, K. C. Madsen, C. Webster & K. S. Levene (Eds.), *The development and treatment of girlhood aggression* (pp. 191-216). Mahwah, NJ: Lawrence Erlbaum Associates, Publishers
- Levin, C. (1998). *Uppfostringsanstalten – Om tvång i föräldrars ställe*. Lund: Arkiv förlag.
- Lieberman, R. E. (2004). Future directions in residential treatment. *Child and Adolescent Psychiatric Clinics of North America*, 13(2), 279-294.
- Lipsey, M. W., (1995). What do we learn from 400 research studies on the effectiveness of treatment with juvenile delinquents? In McGuire, James (Eds.). *What works: Reducing reoffending: Guidelines from research and practice* (pp. 63-78). Oxford, England: John Wiley & Sons
- Lipsey, M. W., & Wilson, D. B. (1998). Effective intervention for serious juvenile offenders: A synthesis of research. In R Loeber & D. P. Farrington (Eds.), *Serious and violent juvenile offenders* (pp. 313-345). Thousand Oaks, CA: Sage
- Lipsey, M. W. (1999). Can intervention rehabilitate serious delinquents? *Annals of the American Academy of political and Social Science*, 564, (pp. 142-166).
- Lipsey, M. W. (2006). The effects of community-based group treatment for delinquency: A meta-analytic search for cross-study generalizations. In K. A. Dodge, T. J. Dishion & J. E. Lansford (Eds.), *Deviant peer influences in programs for youth – Problems and solutions*. New York: Guilford Press.
- Little, M., Kohm, A., & Thompson, R. (2005). The impact of residential placement on child development: research and policy implications. *International Journal of Social Welfare*, 14(3), 200-209.
- Lyman, R. D., & Campbell, N. R. (1996). *Treating children and adolescents in residential and inpatient settings*. Thousand Oaks: Sage Publications.
- Lyons, J.S. (1998). *Severity and Acuity of Psychiatric Illness Manual—Child and Adolescent Version*. The Psychological Corporation, Harcourt Brace Jovanovich, San Antonio, Texas.
- 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(3), 333-345.
- Lyons, J. S., & McCulloch, J. R. (2006). Monitoring and managing outcomes in residential treatment: practice-based evidence in search of evidence-based practice. *Journal of the American Academy of Child & Adolescent Psychiatry*, 45(2), 247-251.

- Metselaar, J., Knorth, E. J., Noom, M. J., Van Yperen, T. A., & Konijn, C. (2004). Treatment planning for residential and non-residential care: A study on indication-for-treatment statements as input to the care process. *Child and Youth Care Forum, 33*(3), 151-173.
- Moffitt, T. E. (1993). Adolescence-limited and life-course-persistent antisocial behavior: A developmental taxonomy. *Psychological Review, 100*(4), 674-701.
- Moffitt, T. E., Caspi, A., Rutter, M., & Silva, P. A. (2001). *Sex differences in antisocial behaviour: Conduct disorder, delinquency, and violence in the Dunedin Longitudinal Study*. New York, NY, US: Cambridge University Press.
- Mordock, J. B. (2002). A model of milieu treatment: Its implementation and factors contributing to "drift" from the model over a 30-year period: Part 1: Implementation of the model. *Residential Treatment for Children and Youth, 19*(3), 17-42.
- Moses, T. (2000). Attachment theory and residential treatment: A study of staff-client relationships. *American Journal of Orthopsychiatry, 70*(4), 474-490.
- Ogders, C. L., & Moretti, M. M. (2002). Aggressive and antisocial girls: Research update and challenges. *International Journal of Forensic Mental Health, 1*(2), 103-119.
- O'Malley, F. (2004). Contemporary issues in the psychiatric residential treatment of disturbed adolescents. *Child and Adolescent Psychiatric Clinics of North America, 13*(2), 255-266.
- Patterson, G. R. (2002). The early development of coercive family process. In J. B. Reid, G. R. Patterson & J. Snyder (Eds.), *Antisocial behavior in children and adolescents: A developmental analysis and model for intervention* (pp. 25-44). Washington, DC: American Psychological Association.
- Rivard, J. C., Bloom, S. L., Abramovitz, R., Pasquale, L. E., Duncan, M., McCorkle, D., et al. (2003). Assessing the implementation and effects of a trauma-focused intervention for youths in residential treatment. *Psychiatric Quarterly, 74*(2), 137-154.
- Rosen, M. (1999). Treating child welfare children in residential settings. *Children and Youth Services Review, 21*(8), 657-676.
- Roy, P., Rutter, M., & Pickles, A. (2000). Institutional care: Risk from family background or pattern of rearing? *Journal of Child Psychology and Psychiatry, 41*(2), 139-149.
- Roy, P., Rutter, M., & Pickles, A. (2004). Institutional care: Associations between overactivity and lack of selectivity in social relationships. *Journal Child Psychology and Psychiatry and allied disciplines, 45*(4), 866-873.
- Rushton, A., & Minnis, H. (2002). Residential and foster family care. In M. Rutter & E. Taylor (Eds.), *Child and adolescent psychiatry* (Fourth ed.). Oxford: Blackwell.
- Rutter, M. (2000). Children in substitute care: Some conceptual considerations and research implications. *Children and Youth Services Review, 22*(9/10), 685-703.
- Rutter, M., Giller, H., & Hagell, A. (1998). *Antisocial behavior by young people*. Cambridge: Cambridge University Press.
- Sallnäs, M. (2000). *Barnavårdens institutioner – framväxt, ideologi och struktur*. Stockholms universitet, Stockholm.
- Sarnecki, J. (1996). Problemprofiler hos ungdomar på särskilda ungdomshem i Stockholms län 1990-1994. In B. Å. Armelius, S. Bengtzon, P.-A. Rydelius, J. Sarnecki & K. Söderholm Carpelan (Eds.), *Vård av ungdomar med sociala problem – en forskningsöversikt*. Stockholm: Statens institutionsstyrelse, Liber Utbildning.
- Schiff, M., Nebe, S. W., Gilman, R. (2006). Life satisfaction among Israeli youth in residential treatment care. *British Journal of Social Work, 36*, 1325-1343.
- Scholte, E. M., & van der Ploeg, J. D. (2006). Residential treatment of adolescents with severe behavioural problems. *Journal of Adolescence, 29*(4), 641-654.

- Schuengel, C., & van IJzendoorn, M. H. (2001). Attachment in mental health institutions: A critical review of assumptions, clinical implications, and research strategies. *Attachment & Human Development. Special Attachment in mental health institutions*, 3(3), 304-323.
- SFS 1980:620. (1980). *Socialtjänstlag [Social Service Act]*.
- Sinclair, I., & Gibbs, I. (1998). *Children's homes – A study in diversity*. Chichester: John Wiley & Sons.
- Sinclair, I., & Gibbs, I. (1999). Measuring the turbulence of English children's homes. *Children and Youth Services Review*, 21(1), 57-74.
- Socialstyrelsen. *Föreskrifter och allmänna råd SOSFS 2003:20 (S) (Board's Code of Statutes) 2003*. Stockholm: Socialstyrelsen.
- Statens institutionsstyrelse. (2005). *Årsrapport ADAD 2004 (Allmän SiS-rapport No. 2005:9)*. Stockholm: Statens institutionsstyrelse.
- Stein, M. (2006). Missing years of abuse in children's homes. *Child & Family Social Work*, 11(1), 11-21.
- Wallis, P., & Steele, H. (2001). Attachment representations in adolescence: Further evidence from psychiatric residential settings. *Attachment & Human Development*, 3(3), 259-268.
- Ward, A. (2004). Towards a theory of the everyday: The ordinary and the special in daily living in residential care. *Child and Youth Care Forum*, 33(3), 209-225.
- Watson, D. (2003). Defining quality care for looked after children: Frontline workers' perspectives on standards and all that? *Child and Family Social Work*, 8(1), 67-77.
- Weiss, B., Caron, A., Ball, S., Tapp, J., Johnson, M., & Weisz, J. R. (2005). Iatrogenic effects of group treatment for antisocial youths. *Journal of Consulting and Clinical Psychology*, 73(6), 1036-1044.
- Westerberg, K.-A. (2003). *Hassela, beroenden och politik – istället för memoarer*. Stockholm: Égalité.
- Whitaker, D., Archer, L., & Hicks, L. (1998). *Working in children's homes – Challenges and complexities*. Chichester: John Wiley & Sons.
- Whittaker, J. K. (2004). The re-invention of residential treatment: an agenda for research and practice. *Child and Adolescent Psychiatric Clinics of North America*, 13(2), 267-278.
- Vinnerljung, B., Sallnäs, M., & Kyhle Westermarck, P. (2001). *Sammanbrott vid tonårsplaceringar – om ungdomar i fosterhem och på institution*. Stockholm: Socialstyrelsen.
- Vinnerljung, B., Sallnäs, M., & Oscarsson, L. (1999). Dygnsvård för barn och ungdom 1983-1995. *Socionomen*, 11(2), 1-20.
- Wood, J., Foy, D. W., Goguen, C. A., Pynoos, R., & James, C. B. (2002). Violence exposure and PTSD among delinquent girls. *Journal of Aggression, Maltreatment and Trauma*, 6(1), 109-126.
- Zegers, M. A. M., Schuengel, C., van IJzendoorn, M. H., & Janssens, J. M. A. M. (2006). Attachment representations of institutionalized adolescents and their professional caregivers: Predicting the development of therapeutic relationships. *American Journal of Orthopsychiatry*, 76(3), 325-334.
- Zimmerman, D. P. (1990). Notes on the history of adolescent inpatient and residential treatment. *Adolescence*, 25(97), 9-38.
- Zimmerman, D. P. (2004). Psychotherapy in residential treatment: historical development and critical issues. *Child and Adolescent Psychiatric Clinics of North America*, 13(2), 347-361.
- Överlien, C. (2004). *Girls on the verge of exploding? Voices on sexual abuse, agency and sexuality at a youth detention home*. Linköping University, Linköping.