Residential Care For Young People in Sweden

Homes, Staff and Residents

Jan Johansson

GÖTEBORG UNIVERSITY
Department of Psychology, 2007
Sweden

ISBN 978-91-628-7092-8
ISSN 1101-718X
ISRN GU/PSYK/AVH--185--SE

Layout och redigering: Henny Östlund
Tryck: Livréna AB, Kungälv, 2007

Abstract

Johansson, Jan (2007) Residential care for young people in Sweden – Homes, staff and residents. Department of Psychology, Göteborg University, Sweden

This thesis studies residential care for young persons (13-18 years of age) with emotional and behavioural problems. An overall aim is to examine and describe different aspects of residential care. 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. *Papers III, IV* and *V* use data from a research study concerning a single treatment home.

In *Paper I* different settings in residential care in Sweden are compared 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. In *Paper II* different approaches to residential care are identified and related to characteristics of the home, the staff and the type of care. *Paper III* explores careworkers' perceptions of treatment. *Paper IV* explores adolescents' experiences of living in residential care. *Paper V* illustrates and illuminates how relationships between careworkers and young persons in residential care can be perceived.

It was found in *Paper I* that institutions run by the public sector 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. In *Paper II* 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. 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 careworkers' general treatment perceptions. This pattern made it possible to study and compare different careworkers' perceptions of treatment. *Paper IV* shows that living in the same institution during the same time period does not mean sharing the same experiences. In retrospect, the experiences of the six young persons were very different from each other. Three of them, the girls, expressed great discontent with the stay. The three boys were more positive. *Paper V* shows that relational factors can play a great part in how young persons experience their stay in a residential institution. 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.

In conclusion, diversity in residential care was found on multiple levels in the studies in this thesis: 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".

Key words: Residential care institutions, youth, staff, settings, approaches to treatment, experiences in care

List of publications

I Johansson, J., Andersson, B., & Hwang, C.P. (in press). What difference do different settings in residential care make for young people? A comparison of family-style homes and institutions in Sweden. *International Journal of Social Welfare*.

II Andersson, B., Johansson, J. & Hwang, C.P. (pending revision). Long-term residential care for youths in Sweden - Approaches to treatment. *International Journal of Child and Family Welfare.*

III Andersson, B., Johansson, J. (in press). Personal approaches to treatment among staff in residential care – A case study. *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. (submitted). Care workers' and young persons' views on their relationships in a Swedish residential home – A case study. *Child and Youth Care Forum.*

Acknowledgements

I would like to express my sincere gratitude to the following persons who in different ways have contributed to the realisation of this thesis:

Bengt Andersson, co-worker, co-author and close friend, for everything. We finally did it!

Professor Philip Hwang, supervisor and companion during the years of research, for welcoming us to the Department of Psychology, for patience with two clinicians trying to become researcher and for encouragement and support all the way.

Professor Emeritus Gunnar Bernler for supervision during the research project at the treatment home, which resulted in papers III-V. Professor Erik Larsen, who with his great knowledge of residential care gave us support during the same time period.

Friends and former fellow students, who all got ahead, PhD Ann Frisén, PhD Malin B Olsson, PhD Emma Sorbring and PhD Lauri Nevonen for friendship and inspiring discussions in our study group.

Colleagues and fellow workers at the Child and Adolescent Outpatient Clinic (BUP), Falkenberg, and Ginsten, Varberg, for understanding and support. Former colleagues and fellow workers at the Social District, the Halland County Council, for inspiration and support at the very beginning of the research.

Directors Lars Anders Olsson, Social Welfare Services in Halmstad, the late Eva Samuelsson, Administration of Primary Care in Falkenberg, the Halland County Council, and Christina Kovac, Psychiatry in Halland, the Halland County Council, for giving practical and financial opportunities during different stages of the research.

All participants in the studies, without whom there would not have been any research at all: the staff at the treatment home for cooperation and interest in the project, the former residents of the treatment home, who during the interviews gave invaluable perspectives on residential care, and managers at all residential care homes who answered the survey.

PhD Marie Sallnäs and Professor Bo Vinnerljung for reviewing the draft of the thesis and giving valuable comments.

Last but not least: my family, Helena, Linnea and Lovisa, for love and understanding and not allowing me to be totally absorbed by research and scientific issues.

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

Contents

Introduction

This thesis studies residential care. The focus is on residential care for young persons (13-18 years of age) with emotional and behavioural problems. An overall aim is to describe and examine different aspects of residential care. Central aspects under study are settings, different approaches to care and treatment and young persons' experiences in care. Care in secure, locked facilities of young persons with extensive behavioural problems (so called paragraph 12 homes) is not included in the empirical studies.

Residential care of children and youth exists almost all over the world, with the exception of a few Muslim countries (Sallnäs, 2000). It is estimated that about eight to ten million children live in institutions (International Development Cooperation, 2001). In Europe, far more children live in institutions in the southern countries, such as Spain, Portugal and Greece, than in Sweden or the UK (Sellick, 1998). Some countries in Eastern Europe, for example Bulgaria and Romania, have a growing number of children in institutions. In contrast, the number of institutionalised children in the UK has fallen. Features that institutions for children have in common are that they offer round-the-clock residential care in which children live apart from their families. The size and organisation of these institutions and the content of institutional care vary widely.

Care for children fulfils different needs in different countries. Especially in developing countries, children live in institutions for reasons of poverty, war and AIDS (International Development Cooperation, 2001). In countries in Southern Europe, such as Greece, there are still proportionally many children who grow up in institutions because of their parents' economical and social situations (Vorria, Rutter, Pickles, Wolkind, & Hobsbaum, 1998). In Western Europe and North America, institutional care is primarily for young persons with severe emotional and behavioural problems and often with a history of abuse and/or neglect.

During the most recent decades of the twentieth century, residential care went through considerable changes in many Western countries. The role of residential care was questioned because of changes in legislation, criticism of institutional care for children and youths and development of new methods in social welfare. These changes took different directions in different countries. In the UK, placements in Children's Homes (the term describing residential care settings for children and young people in the UK) decreased from 41,000 each night in 1971 to 7,000 in 1996 (Department of Health, 1998). The number of placements in the USA remained on about the same level but the content of the care changed from long term care to shorter times of stay (Whittaker, 2004). The intention in Sweden was to reduce placements in residential care, but the result was the

opposite: placements in residential care increased during the 1980s and 1990s (Vinnerljung, Sallnäs, & Oscarsson, 1999).

Residential care is run in the context of the society in question. The content of the care is influenced by such factors as legislation, ideology, staff competence, other community resources, the setting of the residential home, the problems of the youths and the families of the youths. There is a complex interaction between many different factors. This interaction can be described in terms of the theory and model formulated by Bronfenbrenner, referred to as ecological systems theory (Bronfenbrenner, 2000) and the bioecological model (Bronfenbrenner, 2001; Bronfenbrenner & Evans, 2000). The young person develops in the context of the family and later in the context of the school and peer group. When this young person develops problematic behaviour or emotional problems, he or she may be in need of residential care. The residential setting can be seen as an ecological system in itself. The persons in the staff, with their development histories, interact with the youths, with their development histories, in a context formed by the prevailing culture and circumstances of the society. It is an environment for care and treatment but it is also the living environment for many adolescents during a large part of their youth.

Most research on residential care has been carried out in the USA and the UK (Rushton & Minnis, 2002). Because of this most of the studies referred to in this thesis were conducted in these countries. In the cases where it has been possible, results of studies done in other countries have also been included.

The focus of this thesis is residential care for young persons with emotional and behavioural difficulties. Several alternatives to residential care, especially for young persons with behavioural problems, have been developed in recent decades. These alternatives are not discussed in detail but only mentioned in relation to aspects of residential care.

The thesis begins with a description of young people in residential care and their characteristics and experiences in care. Two major sections of the thesis are entitled *Structure of residential care* and *Culture in residential care*. The concepts of structure and culture are used above all in research on residential care in the UK. Structure is referred to as the "formal" aspects of the care, i.e. the fabric of the institutions and their written aims and objectives (Brown, Bullock, Hobson, & Little, 1998). Culture is the more "informal" aspects of care. Whitaker et al. (1998) define culture by referring to Schein (1990):

"Culture can now be defined as (a) a pattern of basic assumptions, (b) invented, discovered, or developed by a given group, (c) as it learns to cope with its problems of external adaptation and internal integration, (d) that has worked well enough to be considered valid and, therefore (e) is to be taught to new members

as the (f) correct way to perceive, think, and feel in relation to those problems." (Schein, 1990 in Whitaker, Archer, & Hicks, 1998, p. 3)

In the sections following the description of culture in residential care, protection and risks in group care and the outcome of residential care are discussed. The last section describes the development of residential care in Sweden during the latest decades.

Young people in residential care

Characteristics

From a general point of view it is known that children and youth in out-of-home care tend to show 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 great difficulty with parenting (Rutter, 2000). This applies to an even greater extent to youth in residential care (Connor, Doerfler, Toscano, Volungis, & Steingard, 2004; Curtis, Alexander, & Lunghofer, 2001; Hukkanen, Sourander, Bergroth, & Piha, 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 supporting networks and sources of help in the community (Frensch & Cameron, 2002). Relationships to close relatives are also more likely to be restrained (Frensch & Cameron, 2002).

One group of young persons that enters residential care is now often labelled youths with antisocial behaviour. Antisocial behaviour is a broad term without any 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 et al., 1998). In the past two decades a great deal of empirical research has been carried out to gain an understand of the development of antisocial behaviour (Dodge & Pettit, 2003). Different patterns of risk factors and adult outcomes have been found in young persons with early onset of antisocial behaviour compared to young persons with onset during adolescence (Moffitt, 1993). 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 period of adolescence (adolescent limited).The persistence of early onset antisocial behaviour is explained by interactions of risk factors over time (Dodge & Pettit, 2003; Moffitt, 1993). Biological predispositions, sociocultural context and life experiences will work on each other in a cyclical and cumulative way (Dodge & Pettit, 2003; Rutter et al., 1998). In transactions between the developing child and others, aggressive behaviours will

reinforce the antisocial development (Dodge & Pettit, 2003). Destructive and coercive parent-child interaction is an important life experience risk factor (Patterson, 2002). Other contextual risk factors seem to be negative peer associations and school environment (Chamberlain, 2003).

There is no agreed upon system for defining the problems of youths in residential care. A difference can be seen for example between the UK and the USA in the way that the youths' problems are defined. "Looking After Children" is a material 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 the 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 from the USA, where a mental health perspective is often used. Some studies use the scale of the Child Behaviour Checklist (CBCL) (Achenbach, 1991), and other studies apply diagnostic categories from the DSM system (American Psychiatric Association, 1994). In still other studies, other systems are used. This makes it difficult to compare different studies with respect to youths' problems.

The summary of a research program on residential care in the UK commissioned by the Department of Health (1998) states that psychiatric assessment can not comprise the range of difficulties of the young persons in care. A study by Sinclair and Gibbs (1998) described 223 children in children's homes, almost all aged between 12 and 17. Not more than 16 percent came from families where both biological parents were living, 71 percent had been expelled from school or were frequent truants, 63 percent had been involved in delinquent acts and 32 percent had harmed themselves or attempted suicide. About one third had been violent to others and the same proportion had been sexually or physically abused.

Connor et al. (2004) studied all youths admitted to a single residential treatment center during the period 1994 – 2001. A total of 371 youths was 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 (Hussey & Guo, 2002) described a sample of children and youths in residential care in Cleveland, Ohio. These children had extensive histories of abuse and neglect, high numbers of previous placement disruptions, extensive medication histories, low average IQ scores and high levels of psychiatric symptomatology (Hussey & Guo, 2002). Curtis et al.

(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 scored in the clinical range on the total behaviour problem scale of CBCL (Achenbach, 1991). Hukkanen et al. (1999) found, in a Finish material with children and youth in residential care, that 40-60 percent scored in the clinical range according to CBCL. A time-trend study (Hukkanen, Sourander, Santalahti, & Bergroth, 2005) concluded that the problems of youths, especially girls, in residential care in Finland had worsened during the 1990s. In a comparison between 1993 and 1999 internalizing symptoms had especially increased significantly (Hukkanen et al., 2005). 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.

There are few comprehensive studies of residential care in Sweden that have gathered information about the problems of youths. Vinnerljung et al. (Vinnerljung, Sallnäs, & Kyhle Westermark, 2001) estimated the problems of the youths grounded in information in their social services acts and studied youths placed in foster care or residential care at the beginning of the 1990s. Half 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. As in the study by Vinnerljung et al. (2001), it was found that the youths to a high degree were delinquent or abused alcohol or drugs. 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. The Swedish National Board of Institutional Care (SiS) uses the ADAD interview (Statens institutionsstyrelse, 2005) to interview youths receiving care in 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 thirds were involved in criminal activity during the latest three months and more than half of the youths felt that they could not control their behaviour when they were angry. According to ADAD there are clear gender differences. Boys have a higher frequency of criminal activity and girls a higher frequency of psychiatric problems (Statens institutionsstyrelse, 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 that a third of the girls had injuries incurred by physical punishment. This was

twice the frequency as among the boys (Wood et al., 2002). Among youths who had been placed in Treatment Foster Care it was found that girls in mean had experienced 14 transitions of parent figures compared to four transitions among boys (Chamberlain & Moore, 2002). Transitions were counted every time a parent figure came in or out of the young person's life or they themselves were placed in foster care or residential care. These results agree with results from ADAD showing that 41 percent of girls have made more than seven moves during their lives as compared to 23 percent of the boys (Statens institutionsstyrelse, 2005). A state-wide screening in Massachusetts, USA, studied 18 607 juvenile offenders in detention (Cauffman, 2004). The girls in this study showed more externalizing and internalizing problems (Cauffman, 2004).

Experiences in care

Several surveys have shown that children and adolescents are often quite satisfied with their living situation in out-of-home care. Children and adolescents who live in foster homes are generally more satisfied than those who live in some kind of residential care (Chapman, Wall, & Barth, 2004; Delfabbro, Barber, & Bentham, 2002; Wilson & Conroy, 1999). Children and youths living in residential care feel, for example, less safe and secure than children and youth who live in foster care (Chapman et al., 2004; Wilson & Conroy, 1999). Living in a residential care situation can give greater opportunity for activities outside the home, however, such as shopping and sports activities (Chapman et al., 2004).

How children and adolescents in residential care feel about their living situation has to do with many factors. In a study of 48 Children's Homes in England and Wales, 223 children and adolescents were interviewed about their experiences in living in residential care (Sinclair & Gibbs, 1998). The way in which residents valued different aspects of living in the residential home differed between homes. Important factors were the extent to which they felt involved, the behaviour of the other youths in the home and perceived morale, that is the degree to which residents were proud of the home and felt that being there was worthwhile. The perceived morale among the residents was highly correlated to the way the staff valued the same factors (Sinclair & Gibbs, 1998, 1999a).

Many results of surveys of youths' experiences from residential care point to the importance of relationships with careworkers (Little, Kohm, & Thompson, 2005). The careworker-youth relation was found to be the best predictor of life satisfaction during the stay in an Israeli study (Schiff, Nebe, & Gilman, 2006). Good relations with staff were associated with the youth's assessment of being helped in a study of Gibbs and Sinclair (1999). In this 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.

Youths who have been bullied in the institution often evaluate their stay negatively (Gibbs & Sinclair, 2000; Sinclair & Gibbs, 1998). A study of peer violence in residential care in the UK (Barter, 2004) showed that nearly all young people in the Children's Homes under study had experienced verbal attacks and that this was a common feature of life in residential care. Almost half of the young persons had also been victims of physical attack or attacks on their properties. A quarter of the girls reported that they had been targets of unwanted sexual behaviours (Barter, 2004). Young people living in care are more vulnerable to abuse than others because they have also often been victims to abuse earlier (Barter, 2003).

Young people in residential care can also be victims of abuse by staff working in the institutions. During the 1990s attention was paid in the UK to abuse in residential care. The time period from the mid-1960s to the mid-1980s was studied. Several investigations and reports about scandals in Children's Homes were published (Colton, 2002; Stein, 2006). Stein (2006) discusses different factors that contributed to the abuse of young people in residential care. Firstly, the status of being a child in general and a child in need of care in particular contribute to powerlessness and a risk of being in an exposed position. Secondly, during the time period in question, there were treatment methods, grounded in both psychodynamic and behaviour therapy, that in various ways sanctioned violations of the young persons' rights. These methods, in combination with staff with low education and no supervision, led to attitudes that made abuse possible. Thirdly, managerial, organizational and inspection systems failed to discover and pay attention to ongoing abuse. Fourthly, the institutional criticism that was voiced during the 1960s and 1970s condemned all institutions and in that way did not offer any help in developing residential care (Stein, 2006).

In recent years investigations of abuse in residential care during the time period from the 1950s to the 1980s have been initiated in Norway (NOU, 2004) and now also in Sweden (Socialstyrelsen, 2006).

Structure of residential care

Settings

Residential care can be run in very different settings. There is a wide range of settings, from family style homes, with relatively few persons, involving both adults and young persons living together, to large, locked, institutions with several departments and staff working according to a schedule. In the USA residential care is divided in different levels, from less to more intensive (Child Welfare League of America, 2004). The Child Welfare League of America (2004) divides care into seven different types:

Supervised/staffed apartments: small living units for four or fewer youths. 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 given 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: providing more intensive services than shelter care, with for example an assessment/diagnostic process that evaluates each child's and family's needs.

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

Secure treatment: providing residential treatment within in a secure facility with restricted features such as locked doors. Staffing and structure make it possible to provide intensive supervision of youths and a high degree of physical safety.

In practice the distinctions between the different settings mentioned above are not entirely clear. Institutions can be combinations of different kinds of settings, such as emergency shelter care and short-term diagnostic care.

In the UK residential units taking care of children and youths are called Children's Homes. There are great differences among these units, however. The size of the homes can vary from accommodating about three to four youths 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 categorise Children's Homes in unambiguous categories. For example, there can be similarities between homes according to size and staffing but differences in 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.

The structure of residential care is dependent on factors such as which youths should be served and what the aim of the care should be. Efforts have generally been made to make institutions smaller, with fewer beds. In this way differences between residential care and foster care have been reduced. Residential care and foster care have been the two main alternatives for out-of-home care for children and youths during at least the last century (Rushton & Minnis, 2002). There is traditionally a clear difference between foster care and residential care (Rushton

& Minnis, 2002). In foster care, the young person lives together with two foster parents and a few other children/young persons, as well other foster children, as the foster parents' biological or adoptive children. This is a home-like environment where life is structured as in a normal family. The more caring aspects are emphasised. In residential care, care workers work according to a schedule. No adults live in the home. In this setting more young people live together and they are often closer in age than children in foster care. The living environment is more like that of an institution than a home. There is often a stronger emphasise on treatment of behavioural and emotional difficulties. Traditionally, long term placements have preferably been made to foster care to reduce the harmful effects of residential care (Rushton & Minnis, 2002). There has however also been a tendency to long term treatment in residential care. The long-term perspective has been predominant in psychodynamic and relational approaches to treatment (O'Malley, 2004; Rosen, 1999).

As mentioned above 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", where antisocial youths have a negative influence on other youths, and to offer a more home-like setting (Department of Health, 1998). A more home-like or family-like setting, with some adults living in the home, can be an alternative, especially for youths who can not be reunited with their birth parents (Sinclair & Gibbs, 1998). Some parts of foster care develop in the direction of treating behavioural and emotional problems. Different models of treatment in family style institutions and foster homes have been developed in the USA. Two of these are the Teaching-Family Model (Kirigin, 2001) and Multidimensional Treatment Foster Care (MTFC) (Chamberlain, 2003). In the Teaching-Family Model, a married couple, teaching-parents, live together with between six and eight youths. The model is based on social learning theory and the purpose is to treat and reduce youths' behaviour problems by developing positive teaching relationships. The average length of stay is about 12 months (Kirigin, 2001). The Teaching-Family Model is also implemented in some Western European countries, such as England and the Netherlands (Little, Kohm, & Thompson, 2005; E.M. Scholte & van der Ploeg, 2006). MTFC started as an alternative to residential treatment for youths with antisocial behaviour. It was initiated at the Oregon Social Learning Centre and is built on social learning theory. A couple of treatment foster parents take care of, in most cases, one adolescent. The program contains components directed to the foster parents, the young person, the birth parents and others in the social network. The treatment period is about one year (Chamberlain, 2003). This model has now also been implemented in Sweden (Hansson, Olsson, Balldin, Kristoffersson, & Schüller, 2001).

Differentiation of care

Traditionally a differentiation of residential care has been made primarily according to age, sex and different needs or difficulties (Andreassen, 2003). Differentiation according to age has almost always been central in residential care. The greatest part of residential care for children and young persons in the Western countries today is directed toward 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 lack of selective social attachment relationships (Roy, Rutter, & Pickles, 2000, 2004). In many cases younger children are placed together with their parents in residential care (Sallnäs, 2000).

Research on girls situation in residential care is limited (Chamberlain & Moore, 2002). Treatment models are often designed to meet the needs of boys (Andersson, 1996; Överlien, 2004). Girls have been a minority group in residential care and girls 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 (Baker, Archer, & Curtis, 2005; Connor, Miller, Cunningham, & Melloni Jr, 2002; Hussey & Guo, 2002). 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 (Moffitt, Caspi, Rutter, & Silva, 2001; Odgers & Moretti, 2002). In comparison with boys, girls are however more likely to have higher levels of these risk factors co-occurring across several domains (Odgers & Moretti, 2002).

Experience from MTFC indicates that girls are more difficult to treat than boys, probably depending on socially aggressive behaviours that are difficult for the MTFC parents to handle (Chamberlain, 2003). Still, Chamberlain (2003) found no differences in outcomes related to gender. Youths with a history of sexual and/or physical abuse were 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 (Sarnecki, 1996). Youths with sexual problems, i.e. prostitution and/or victims of sexual abuse, made more suicide attempts 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 months follow up (Sarnecki, 1996). Owing to the differences found, it is proposed that institutions for girls should focus to a higher degree on effects of trauma and difficulties with attachment (Odgers & Moretti, 2002). Another reason for unisexual institutions for girls is the need to protect girls from further abuse from boys.

Differentiation according to different needs is related to which youths can live together in the same home. There can be favourable and unfavourable mixes of

young persons in residential care. Too much diversity in the needs of the youths makes it difficult for staff to establish a suitable approach (Whitaker et al., 1998). An approach that is firm enough for hard to handle youths can be intimidating to more fearful ones (Whitaker et al., 1998). Sexually abused children have been found to be at risk of abusing other children in care, and young perpetrators require controlled settings (Farmer & Pollock, 1999).

Staff

Staff is the most important resource in the care and treatment delivered in residential settings. Members of staff are there to create a caring and growth-promoting environment for the children in their care (Whitaker et al., 1998). Even if the philosophy of the home is set by managers, it is the staff who must implement that philosophy and convey through their actions to the children and young persons in their care what the true culture of the home is (Sinclair & Gibbs, 1998).

There are few data in research on residential care in the USA about educational levels among staff and staff resident ratios in homes and no data exists about the relation between staff characteristics and outcome of the care (Lique Naitove, 2002). However, some information about staff in group homes are available from the National Survey of Child and Adolescent Wellbeing (NSCAW) (Children's Bureau of the Administration on Children, 2005). Most group home caregivers are between the ages of 24 and 45. The majority of staff has a Bachelor's degree or higher, most likely because of employment requirements (Children's Bureau of the Administration on Children, 2005). Research in the UK has focused to a greater extent on aspects relating to staff. In a review of research on residential care in the UK it was concluded that the staff-resident ratio has risen and that a large part of all Children's Homes have a greater number of persons in the staff than residents living in the home (Department of Health, 1998). Sinclair and Gibbs (1998) describe the staff situation in the 48 Children's Homes that were under study in the following way: of the roughly 500 staff persons, 63 percent were women and the mean age was 38.5 years. About 40 percent had worked in their current post for at least five years. About 80 percent had no special educational qualifications for their work (Sinclair & Gibbs, 1998). No relation was found between staff resident ratio or staff qualification and the quality of the home (Sinclair & Gibbs, 1999b). Good quality of the homes was however strongly related to measures concerning staff unity and the degree to which the head of home felt that he or she had an adequate autonomy and a clear remit (Sinclair & Gibbs, 1999b).

Working in residential care is a challenging task. Work of staff groups in residential care was extensively investigated in two different qualitative studies, one in the UK (Whitaker et al., 1998) and one in Canada (Anglin, 2002, 2004). Whitaker et al. (1998) studied staff groups in six ordinary Children's Homes for the purpose of describing what staff do, how they think about their work and how they

feel about themselves and the children in their care. The aim was to understand how staff group functioning was related to the outcome of care. The Canadian study (Anglin, 2002, 2004) also sought to explore work in a group home but with the intention to construct a framework for practice. This study was based on participant observations, 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, there are similarities in their results. The complexity in residential group care practice was emphasised in both studies. Anglin (2002, 2004) constructed, with a grounded theory approach, a three-dimensional model with the dimensions of psychosocial processes, interactional dynamics and levels of home operation. The three basic psychosocial processes which with worked, were defined as: (1) creating an extrafamilial living environment, (2) responding to pain and pain-based behaviour and (3) developing a sense of normality. These three processes were seen as the basis in "the struggle for congruence in service of the children's best interest" (Anglin, 2004, p. 177-178). In the study 11 interactional dynamics (for example listening and responding with respect and establishing structure, routine and expectations) were identified as the key relational ingredients of group home life. Anglin (2002, 2004) described the work in group homes as being carried out on five different levels, from (I) the youth resident and family level to (V) the extra-agency level. Whitaker et al. (1998) described five different areas of work in Children's Homes. These areas were described as: (1) working with the group of young people, (2) working with individual young people, (3) surviving as a staff team which meets the needs of children, (4) working with, and being managed by the department and (5) working with others in the network. Characteristics of good practice in the five main areas were identified in the study. On the positive side, it was found that staff drew strength and encouragement from working in a cohesive staff team in a distinctive home, from the progress of residents and their relationship with them, from organising special events and treats, from the variety of the work and the sense that they themselves did it well, and from a sense that their management listened to them and gave them resources. Conversely, staff felt stressed by difficult relationships with young people, violence or abuse from them, fear of allegations and worry about the residents' safety and progress. These stresses could be compounded by a feeling that they lacked control over admissions, a lack of resources, a lack of support from senior staff, high turnover or a lack of cohesiveness in their own staff team, and the intrusiveness of the work into their own lives and those of their colleagues. In both these studies, staff characteristics that facilitated good practice, such as the staff's sensitivity to young persons' needs and its capacity to respond to rather than react to the young persons' behaviour, were identified. Both studies, however, emphasised the importance of the whole context, the culture of the homes.

Summary of structural aspects

Residential care can be run in very different settings, from small, family style homes to large institutions with several departments. In the latest decades there has been a tendency to make institutions smaller, with fewer beds. This has reduced the differences between residential care and foster care. Residential care is often differentiated according to age, sex and different needs and problems. Staff is a very important resource in residential care, and a well functioning staff group is a prerequisite for care and treatment of good quality.

Culture in residential care

Approaches to care and treatment

Residential care has often been described with reference to different approaches to treatment. According to Kazdin (1999), an approach within 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 nonetheless have a pervasive influence. It is important to remember that treatments within a single approach are frequently very different from one another, even though the focus of treatment is the same (Kazdin, 2000). In residential care, the concept of approach has been used to categorise different models or programs that have a similar view about what the critical ingredients of treatment are.

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 (Zimmerman, 2004).

The psychodynamic milieu approach is an application of psychoanalytic theory to residential care. It was first developed by Aichorn, Redl and Bettelheim (Zimmerman, 1990). 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 (Abramovitz & 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 notion of a total environment (Zimmerman, 2004). Every detail in the environment would correspond to psychoanalytic

thinking concerning the development of the child (Abramovitz & Bloom, 2003). Redl worked with delinquent youths and concentrated on group dynamics and how the group could influence an individual's behaviour. In this work techniques were developed for the management of group processes (Zimmerman, 1990, 2004). Both Redl and Bettelheim viewed the child careworker as the major agent of treatment and stressed the importance of the relation between the careworker and the child (Zimmerman, 1990).

The behavioural approach was initially developed to serve youth in whom psychodynamic approaches had not attained the desired effect, such as children with autism and delinquent youths (Zimmerman, 1990). This model involves a specification of 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 measurable 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 and on the presumption that cognitive processes can mediate 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 (Johnson, 1999).

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

In the psychoeducational model there is a focus on the young person's 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 (Zimmerman, 1990). The Re-Ed project in North America was an application of the psychoeducational model (Hooper, Murphy, Devaney, & Hultman, 2000; Zimmerman, 1990). Small community based schools were combined with living in small groups. The Re-Ed philosophy saw no use of psychoanalytically oriented psychotherapy and disregarded diagnostic labels (Zimmerman, 1990). It can be described as an ecological model because it recognised the importance of different environments in 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 model origi-

nates 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 be able to cope. The aim is for the young persons to 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 who are 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.

Relationships and working alliance

Traditional residential treatment has emphasised the importance of reliable and sustainable relationships in a nurturing structure of a social and therapeutic milieu (O'Malley, 2004; Rosen, 1999). A general assumption underlying residential treatment is that all interactions in a home have therapeutic potential. The concepts of "corrective emotional experience" (Moses, 2000) or "reparative experience" (Whitaker et al., 1998) are used to describe the youth's need for support and encouragement in order to be able to counter their earlier experiences and their current expectations of others. The importance of relationships is mainly based on psychoanalytically inspired theories. According to attachment theory, early experiences of relations with caregivers are conceptualised as cognitive "working models" that are the basis for perception 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 rejection by their parents (Frensch & Cameron, 2002). Offering these youths reliable and sustainable relations can be a way to compensate for earlier deficits. It has however not yet been proven that attachment relationships do develop between careworker and youth within institutional settings, even if there is some supporting evidence (Schuengel & van Ijzendoorn, 2001). The intention can also be to improve youth's interpersonal and social skills within structured relationships with care workers (Mordock, 2002). 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). A supporting youth-careworker relationship can reduce some of the negative effects following separation from attach-

ment figures and can function as a secure base from which the young person can be helped to cope with different forms of stress associated with residential care.

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

The role of the working alliance between careworker and youth has been studied (Florsheim, Shotorbani, Guest Warnick, Barratt, & Hwang, 2000). The definition of this concept varies, but two core aspects are personal attachments and collaboration or willingness to invest in the therapy process (Horvath & Luborsky, 1993). The working alliance has primarily 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 the working alliance in residential treatment program (Florsheim et al., 2000), this problem was solved by asking each youth to indicate the careworker who 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 the use of different approaches to treatment. The authors found 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 related to a negative psychological change and higher rates of recidivism, however, and was interpreted as a false alliance. Further analyses showed that whether the working alliance improved or declined over time was more important in 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 treatment progress was made, the working alliance was strengthened, and, as working alliance develops, treatment progress occurs. Other findings in 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 seriously delinquent boys (Florsheim et al., 2000).

Careworkers' perceptions of youth have been found to be related to their involvement in them. Staff-client relationships were studied in a residential treatment facility in California by interviewing careworkers about their relationships with the residents (Moses, 2000). Residents who were well liked and easy to work with were given more individual attention and encouragement than hard-to-treat youth. Differences in involvement were also found in a study of staff perceptions

of children in Children's Homes in Scotland (Heron & Chakrabarti, 2003). Careworkers were more involved in trying to understand some of the youths while it was felt that the level of involvement with others was insufficient. The low level of involvement with some of the youths was suggested to be a reflection of the disempowered position of staff (Heron & Chakrabarti, 2003).

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 aspects concerning stable relationships, bullying and abuse have been discussed elsewhere in this thesis (se *Experiences in care*).

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). A residential program that has focused on creating a safe milieu for the residents is the Sanctuary Model (Abramovitz & Bloom, 2003; Bloom, 1997; Rivard, Bloom, McCorkle, & Abramovitz, 2005). The starting point in this program is that most young persons entering residential care have earlier been traumatised through maltreatment and exposure to domestic and community violence. The challenge for the treatment environments is to promote safety and non-violence across physical, psychological, social and moral domains. Preliminary results show that the implementation of the Sanctuary Model can promote physical, social and psychological safety for clients and staff (Rivard et al., 2003; Rivard et al., 2005).

The measures that can be taken to counteract risk factors in residential care are also important for promoting better outcome of the care and treatment delivered in residential settings. This will be discussed in the next section.

Outcome of residential care

Although residential care is a common intervention among children and adolescents there has been a longstanding controversy in opinions about the benefit of separating children and adolescents from their parents and about the considerable costs of 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 as a "last resort" intervention (Frensch & Cameron, 2002).

Frensch & Cameron (2002) and Hair (2005) reviewed studies of outcome of residential treatment. Frensch & Cameron (2002) included studies of residential treatment and group homes in the USA, England and Ireland. Hair (2005) included studies of residential treatment in the USA. These reviews show 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 serious problem is however the difficulties in 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' post treatment environment. This is a challenging task, however, because of 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 nevertheless been shown that an important factor for a positive outcome is that parents or parental substitutes are helped to provide a consistent structure and support for the young person, similar to what he or she experienced in residential care (Chamberlain, 2003). Failure to include parents in the treatment seems to represent the single largest barrier to a generalisation of treatment effects from residential care to living at home (Chamberlain, 2003).

Lyons et al. (Lyons, Terry, Martinovich, Peterson, & Bouska, 2001) studied the outcome trajectories of 285 adolescents that had received residential treatment in a Western state in the USA. They concluded that there was a reduction of suicidality, depression, self-mutilation and aggression. It appeared however that residential treatment had an adverse effect on anxiety and hyperactivity. These symptoms worsened in many cases. They also concluded that there were considerable differences between different institutions. The adolescents in some institutions had improved more than adolescents in other institutions. At one institution the clients had become statistically significantly worse over the course of residential treatment (Lyons et al., 2001).

Characteristics of the residential settings are related to the outcome of the treatment. In a study of 48 Children's Homes in the UK (Sinclair & Gibbs, 1998) it was found that the outcome among the children and youths was better if the home was small and stable with few changes in the staff and no disturbing reorganisations, the manager had a clear commission and the staff agreed upon how the home should be run. The same study found that the turbulence of the home, defined as "involvement in delinquent activity, a culture marked by the distrust of other residents and a perception that delinquent activity is common, and a lack of commitment to the establishment" (Sinclair & Gibbs, 1999a, p. 58), was related to the outcome. This relation was stable even when the problems of the youths were taken into account (Sinclair & Gibbs, 1999a). Homes with a low degree of turbulence showed a better outcome of the care. These results indicate that the negative influences between youths in residential care can be reduced by the structure and culture of the home. The correlation between factors related to the structure and culture of the homes and outcome has also been shown in other studies of residential care in the UK (Berridge & Brodie, 1998; Brown et al., 1998; Department of Health, 1998)

Results of meta-analyses have changed the view that nothing works in the treatment of institutionalised young offenders. In a meta-analysis of 83 studies of treatment effects of institutionalised young delinquents 10 – 22 years old, Lipsey & Wilson (1998) found that treatment reduced the average rate of recidivism by 10 percent (from 55 % to 45 %) compared to the control group. There was however a large variability around this average value. The variation was related to program characteristics and types of treatment. The best programs reduced recidivism rates by nearly 40 percent while others had no significant effect. The most important program characteristics were the age of the program and whether the treatment was administrated by mental health or juvenile justice personnel. Programs that had been running for at least a couple of years and programs administrated by mental health personnel provided better outcome. Lipsey & Wilson (1998) also found that there were variations in effectiveness among different types of treatment. Social skill training and the Teaching-Family Model were the most effective types of treatment for serious offenders. Programs defined as multiple services and behavioural programs were also effective, although the outcomes were not as consistent as for social skill training and the Teaching-Family Model. Weak or no effects were found in treatments based on milieu therapy and wilderness therapy. Andreassen (2003) compiled several meta-analyses of treatment outcomes in 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 a psychodynamic approach or on other unstructured approaches have not proved to be effective in treating behavioural problems. Approaches defined as unstructured were those that

did not utilise practical training. The results of the meta-analyses described have made a contribution to identifying which treatment approaches are most effective and under what 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).

There are few studies of the results of residential care in Sweden. Levin (1998) studied the situation of 208 youths (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 having left the institution. Only 13 percent left criminality completely. The same was seen for drug abuse. About 70 percent of the youths continued to abuse drugs after they had left the institution. Similar results were found in a study of youths in detention homes in the Stockholm area (Sarnecki, 1996). Two years after discharge, 75 percent of the young persons still had problems such as drug abuse and psychiatric problems and 57 percent were still under treatment (Sarnecki, 1996).

Residential care in Sweden

During the post-war period residential care in Sweden decreased considerably. From 1940 to 1980 the number of institutions for children and youths decreased from almost 400 to less than half that number. The corresponding decrease in the number of beds was from slightly more than 8,500 to barely 2,000 (Sallnäs, 2000). During this time period the number of children and youths placed in foster care also decreased considerably, from about 28,000 in 1950 to about 10,000 in 1990 (Vinnerljung, 1996). Especially during the 1960s and 1970s there was a striving for a more professional care. Therapeutic aspects, with a stress on psychodynamic theories and models, were emphasised and the principal of working with the whole family rather than with the child alone gained importance (Sallnäs, 2000).

This development can be exemplified with the Children's Village at Skå (Johnson, 1973). The Children's Village started in 1947. During the first decades the work focused on the children who lived together in cottages with a "house father" and a "house mother". The work with the families grew in importance, however, and around 1970 the setting at the Children's Village was changed such that the children came to live with their own families in the cottages together with staff persons (Johnson, 1973). According to Johnson (1973) there was a development from treating the individual child, via working with the whole family, to focus-

ing on factors in society. In 1969 the Hassela Collective started institutions for drug treatment (Hassela kollektivet & Englund, 1984; Westerberg, 2003). This was also a form of residential care in which a group of youths lived together with adults. The difference in setting compared to traditional residential care was that the adults who worked with the youths lived together with them for long periods of time (weeks or months) (Hassela kollektivet & Englund, 1984; Westerberg, 2003). The so called "Hassela pedagogy" has much in common with the psychoeducational model and the positive peer culture model. The focus is not on treatment or therapy but on education and upbringing. One important aim is to clearly mediate values to the young persons and make them aware of political matters (Hassela kollektivet & Englund, 1984; Westerberg, 2003).

A new concept was created in connection with the enactment of a new law in the social services (SFS 1980:620, 1980) in the beginning of the 1980s. All residential care was assembled under the heading of Home for Care or Residence (Hem för Vård eller Boende, HVB). This concept includes all homes that work professionally with children, youth, adults and families. Foster care is not included. Secure treatment of youths is also excluded.

When the legislation was changed, the conditions for residential care also changed. There was now an opportunity for private operators to start HVB. Many former foster homes expanded and changed their business orientation to become HVB (Sallnäs, 2000). The boundaries between foster care and residential care were blurred. In the 1970s, in principal all residential care was run by the public sector. In the two last decades of the 20th century this picture completely changed (Vinnerljung et al., 1999). Privately run institutions became more and more common and today about 80 percent of all institutions are run by the private sector (Riksrevisionsverket, 2002). In spite of the ambition to reduce residential care the tendency has been the reverse. The proportions between foster care and residential care have changed considerably. Between 1983 and 1995 the proportion of placements in foster care of children and youths decreased from 70 to 55 percent (Vinnerljung et al., 1999). The proportion of placements in residential care showed a corresponding increase during the same period. This increase was most obvious in the private sector.

Secure treatment of youths with extensive behavioural problems and need of care and treatment in locked facilities is run by the public sector. During the period 1980-1993 these detention homes were run by municipal social services or county councils. Secure treatment had previously been operated by central governmental authorities. As of 1993 secure treatment is run by the National Board of Institutional Care, a central governmental authority that was founded the same year. Today slightly less than 700 youths are cared for in secure treatment homes.

There is currently no collective picture of residential care in Sweden. There has been criticism that the care is not inspected to a sufficient extent and that knowledge is lacking about the quality of the care (Riksrevisionsverket, 2002). Generally not much is known about the content of the care (Sallnäs, 2000).

The most comprehensive description of Swedish residential care was made by Sallnäs (2000), who summarised the description of residential care for children and youth in the middle of the 1990s as follows:

- Long term care and treatment dominates the field.
- Residential care primarily serves youths.
- The target group is described in general terms.
- Many homes have one or more theories/models for their work but there is a lack of unanimous concepts and a common language, with a terminology that can be used for a systematic description of the care and treatment given.
- There are differences between private and public residential care. Public institutions are to a higher degree aimed at emergency and short term care and serve to a greater extent younger children.
- There are differences between family style homes and institutions, even though the differences not always are clear. Family style homes are generally smaller and have earlier been foster homes.

Summary of the papers

General and specific aims

The general aim of this thesis is to describe and examine different aspects of residential care for young persons (13-18 years of age) in Sweden. Central aspects under study are settings, different approaches to care and treatment and young persons' experiences in care. 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. Papers III, IV and V use data from a research study of 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. Because of missing values in some answers the study group consisted of 150 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 prsent 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 recived 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 recived 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 psychodynamic 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 during 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. Fridas' 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. Bengtzon, P.-A. Rydelius, J. Sarnecki & K. Söderholm Carpelan (Eds.), *Vård av ungdomar med sociala problem – en forskningsöversikt*. Stockholm: Statens institutionsstyrelse, Liber Utbildning.

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.

Anglin, J. P. (2004). Creating "well-functioning" residential care and defining its place in a system of care. *Child and Youth Care Forum, 33*(3), 175-192.

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. (2003). *Abuse of children in residential care*: NSPCC information briefings October 2003

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.

Bloom, S. L. (1997). *Creating sanctury – Toward the evolution of sane societies*. New York: Routledge.

Bronfenbrenner, U. (2000). Ecological systems theory. In A. E. Kazdin (Ed.), *Encyclopedia of psychology* (Vol. 3, pp. 129-133). Washington DC: American Psychological Association.

Bronfenbrenner, U. (2001). Bioecological theory of human development. In N. J. Smelser & P. B. Baltes (Ed.), *International Encyclopedia of the Social & Behavioral Sciences* (pp. 6963-6970). Oxford: Elsevier Science Ltd.

Bronfenbrenner, U., & Evans, G. W. (2000). Developmental science in the 21st century: Emerging questions, theoretical models, research designs and empirical findings. *Social Development, 9*(1), 115-125.

Brown, E., Bullock, R., Hobson, C., & Little, M. (1998). *Making residential care work – Structure and culture in children's homes*. Aldershot: Ashgate.

Bullock, R., Little, M., & Millham, S. (1993). *Residential care for children – A review of the research*. London: HMSO.

Cameron, C. (2004). Social pedagogy and care: Danish and German practice in young people's residential care. *Journal of Social Work, 4*(2), 133-151.

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. (1996). Intensified foster care: Multi-level treatment for adolescents with conduct disorders in out-of-home care. In E. D. Hibbs & P. S. Jensen (Eds.), *Psychosocial Treatments for Child and Adolescent Disorders – Empirically Based Strategies for Clinical Practice* (pp. 475-495). Washington, DC: American Psychological Association.

Chamberlain, P. (2003). *Treating chronic juvenile offenders: Advances made through the Oregon multidimensional 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.

Chapman, M. V., Wall, A., & Barth, R. P. (2004). Children's voices: The perceptions of children in foster care. *American Journal of Orthopsychiatry, 74*(3), 293-304.

Child Welfare League of America. (2004). *Standards of excellence for residential services*. Washington DC: CWLA press.

Children's Bureau of the Administration on Children. (2005). *The national survey of child and adolescent wellbeing (NSCAW)*. Washington DC: Children's Bureau of the Administration on Children, Youth and Families, U.S. Department of Health and Human Services.

Colton, M. (2002). Factors associated with abuse in residential child care institutions. *Children & Society, 16*(1), 33-44.

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.

Curry, J. F. (1995). The current status of research in residential treatment. *Residential Treatment for Children and Youth, 12*(3), 1-17.

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.

Delfabbro, P. H., Barber, J. G., & Bentham, Y. (2002). Children's satisfaction with out-of-home care in South Australia. *Journal of Adolescence, 25*(5), 523-533.

Department of Health. (1998). *Caring for children away from home – Messages from research*. Chichester: John Wiley & Sons.

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., 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.

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.

Epstein, R. A. (2004). *Reconceptualizing residential: Implications for outcomes research.* Paper presented at the Revolutionizing residential: Mapping out new trials. 48th annual meeting of the American Association of Children's Residential Centers, Boston.

Farmer, E., & Pollock, S. (1999). Mix and match: Planning to keep looked after children safe. *Child Abuse Review, 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 outcome in children's homes. *Child and family Social Work, 4,* 1-8.

Gibbs, I., & Sinclair, I. (2000). Bullying, sexual harassment and happiness in residential children's homes. *Child Abuse Review, 9*(4), 247-256.

Giorgi, A., & Giorgi, B. (2003). Phenomenology. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 25-50). Thousand Oaks, CA: Sage Publications, Inc.

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.

Hansson, K., Olsson, M., Balldin, T., Kristoffersson, R., & Schüller, P. (2001). Multidimensional Treatment Foster Care – Ett nytt sätt att arbeta med fosterhem. *Socionomen, 2001*(2), 40-45.

Hassela kollektivet, & Englund, G. (1984). *Fostran för framtiden*. Stockholm: Tidens förlag.

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.

International Development Cooperation. (2001). *Children in institutions*. Stockholm: Ministry for Foreign Affairs.

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.

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. (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.

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 & violent juvenile offenders: Risk factors and successful interventions.* (pp. 313-345). Thousand Oaks, CA: Sage Publications, Inc.

Lique Naitove, P. D. (2002). *A comprehensive review of adolescent residential treatment outcome studies.* Antioch University, Antioch New England Graduate School, US, Keene, New Hampshire.

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., & 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 and Adolescent Psychiatry, 45*(2), 247-251.

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.

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.

NOU. (2004). *Barnehjem og specialskoler under lupen* (No. 2004:23). Oslo: Barne- og familiedepartementet.

Odgers, 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.

Riksrevisionsverket. (2002). *Tillsyn av behandlingshem för barn och ungdomar*. Stockholm: Riksrevisionsverket, Effektivitetsrevisionen.

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.

Rivard, J. C., Bloom, S. L., McCorkle, D., & Abramovitz, R. (2005). Preliminary results of a study examining the implementation and effects of a trauma recovery framework for youths in residential treatment. *Therapeutic Communities: International Journal for Therapeutic and Supportive Organizations, 26*(1), 79-92.

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 of Child Psychology and Psychiatry, 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.

Schein, E. (1990). *Organization culture and leadership: A dynamic view*. San Francisco: Jossey-Bass.

Schiff, M., Nebe, S., & Gilman, R. (2006) Life satisfaction among Israeli youth in residential treatment care. *British Journal of Social Work, 36*(8), 1325-1343.

Scholte, E. M., & van der Ploeg, J. (2000). Exploring factors governing successful residential treatment of youngsters with serious behavioral difficulties – Findings from a longitudinal study in Holland. *Childhood, 7*(2), 129-153.

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, 3*(3), 304-323.

Sellick, C. (1998). The use of institutional care for children across Europe. *European Journal of Social Work, 1*(3), 301-310.

SFS 1980:620. (1980). *Socialtjänstlag*.

Sinclair, I., & Gibbs, I. (1998). *Children's homes – A study in diversity*. Chichester: John Wiley & Sons.

Sinclair, I., & Gibbs, I. (1999a). Measuring the turbulence of English children's homes. *Children and Youth Services Review, 21*(1), 57-74.

Sinclair, I., & Gibbs, I. (1999b). Staff qualifications and ratios in children's homes: Are they the key to the outcomes of care? *Policy & Politics, 27*(2), 187-197.

Socialstyrelsen. (2006). *Förekom övergrepp och kränkningar vid institutioner inom den sociala barnavården1950-1980?* 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.

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.

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.

Wilson, L., & Conroy, J. (1999). Satisfaction of children in out-of-home care. *Child Welfare, 78*(1), 34-79.

Vinnerljung, B. (1996). *Fosterbarn som vuxna*. Lund: Arkiv.

Vinnerljung, B., Sallnäs, M., & Kyhle Westermark, 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, Research supplement, 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.

Vorria, P., Rutter, M., Pickles, A., Wolkind, S., & Hobsbaum, A. (1998). A comparative study of Greek children in long-term residential group care and in two-parent families: I. social, emotional, and behavioural differences. *Journal of Child Psychology and Psychiatry, 39*(2), 225-236.

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.