CHAPTER 9
GENERAL DISCUSSION

"Residential child care has been allowed to become a 'cinderella' – overlooked, undervalued and poorly understood, and hence its dynamic potential to change children's lives has been limited. Now is the time to unleash its power by creating a profession to be proud of"
(Lindsay, 2002, p. 86)

9.1 Introduction

The central purpose of the present study was to contribute to the knowledge about factors that are important for successful residential treatment for adolescents with serious behavioral problems. Given the seriousness of the adolescents' problems, the high rates of recidivism, and the lack of knowledge about the (quality of) care that is offered in these settings, we stated in chapter one that it is of public interest to gain a clear understanding of the factors that are associated with positive results. Moreover, since (secure) residential care is an intervention that intensively intervenes in the lives of young people and their families, it is in their interest to identify "good practices" in residential care and to apply these in practice. The negative image of (secure) residential care and the high amount of costs that is associated with both the adolescents' antisocial behavior and this type of care also stress the need for better insight into aspects of (secure) residential care that are important for success.

In the present chapter, we will try to get "the downside up" by pointing out what ingredients are important for improving the outcomes of (secure) residential youth care. Since we focused on 1) characteristics of clients, 2) aspects of the care process, and 3) outcomes of care in association with client and care process characteristics, we will discuss these three topics in separate sections. After discussing the main findings, we will describe the limitations and strengths of the study. We will also describe several recommendations for research and practice on the basis of our findings. The general discussion will be concluded by highlighting the most important findings in a final conclusion.

9.2 Characteristics of adolescents in secure residential care

Since the purpose of secure residential care is to reduce the problem behavior of young people (including delinquency), it should aim at relevant dynamic risk- and promotive factors (Lipsey & Derzon, 1998; Van der Laan et al., 2009; Van Domburgh et al., 2004). Therefore, we examined relevant *dynamic* risk and promotive factors in the sample of adolescents in secure residential youth care in the first study (**chapter two**) by applying a *risk factor approach*. As expected, we found that adolescents with a high number of risk factors were more likely to show more (serious) delinquent behavior than adolescents with relatively few risk factors. This result corresponds with findings that are commonly reported in the literature regarding the association between risk factors and the development and persistence of antisocial behavior (e.g., Loeber & Farrington, 1998; Rutter et al., 1998).

As was also expected in chapter two, many (70%) of the adolescents (N = 164) in secure residential care showed multiple risk factors in both an individual and contextual domain. Moreover, the adolescents were characterized by different

combinations of risk factors, despite similarities in antisocial and oppositional problems that are often prominently present (Boendermaker, 1999; Bullock et al., 1998; Vreugdenhil et al., 2004).

Four *risk groups* resulted from our cluster analysis. These four groups of adolescents mainly differed in terms of the seriousness and type of their problems. Somewhat more than a fifth of the adolescents belonged to a "low risk" group, because they showed relatively few risk factors and several strengths (e.g., no substance abuse, sufficient competence skills and good school performance). The other three groups were more problematic and could be referred to as, in order of seriousness, an "individual risk" group (with mainly a poor treatment motivation and poor competence skills), an "individual and family risks" group (with unstructured daily activities and poor parental control as main risks), and a "high risk" group (with substance abuse and many delinquent friends as most frequent risks).

We have discussed these findings of different risk groups among others in association with Moffitt's theory of "adolescence-limited" and "life course persistent" offenders (Moffitt, 1993, see also chapter one). We hypothesized that the less problematic groups mainly consisted of "adolescence-limited" offenders, while the more problematic groups mainly consisted of "life course persistent" offenders. However, the presence of these two groups should be tested in subsequent research (e.g., Brennan, Breitenbach, & Dieterich, 2008) with (larger samples of) adolescents in secure residential care.

Besides differences in combinations of risk factors, results of the study in chapter two also suggest that *substance abuse* of the adolescents prior to admission, contact with *delinquent friends* and the adolescent's *poor awareness of problems* must be given standard priority within the context of treatment in secure residential youth care, because these factors were among the most prevalent risk factors. In addition, having delinquent friends and substance abuse were both strongly associated with adolescents' delinquent behavior before admission.

9.3 Relational aspects of the care process

In the studies described in chapter three and four we tried to get an inside view in the "black box" of residential care. We examined a specific aspect of the care process that is expected to be important in achieving positive outcomes with adolescents in secure residential youth care, namely the quality of the *client-staff relationship* and factors that are important for this quality. Since actions of group care workers (Knorth et al., 2010) and teachers (Jackson, 1994) can be considered a most decisive factor in the quality of the care arrangements and education that residential settings provide to young people respectively, we mainly focused on their relationship with young people in residential care.

The results of the review study presented in **chapter three** were mainly consistent with our expectations, because it showed that the development of a positive relationship between young people and care workers during residential care predict positive outcomes. Factors opposing the development of a positive relationship were concerned with a poor motivation for treatment and interpersonal behavior problems of the adolescents, and with the tendency of care workers to rely primarily on their own personal styles and intuition and to apply a controlling approach in their contact with some young people.

Since the findings also indicated that methods applied by care workers in their contact with young people and parents regularly differs from the methodology that should be used in theory (cf. Andersson & Johansson, 2008), effective methods in working with young people and parents might be lacking in practice. This seems to be especially true for young people that show the most serious behavioral problems *during* care, because they are difficult for group care workers to handle and, therefore, tend to be treated in a controlling fashion that is aimed at maintaining control at the residential group. The following description by Moses (2000) strikingly refers to this phenomenon as: "those who are the most emotionally guarded and those who have the most difficulty relating – i.e., those most in need – are likely to receive the least sensitive caregiving" (p. 486).

A focus on maintaining control seems to have a negative influence on the quality of the relationship between staff and young people (see also Polsky & Claster, 1968). These results suggest that is important for residential care workers, but probably also for teachers (cf. Meehan et al., 2003), to be aware of their tendency to act according to their own personal styles and of the limitations in the contact with specific young people so that they are better able to avoid these pitfalls.

The aim of the study described in **chapter four** was to assess the quality of the client-staff relationship for the group of adolescents in secure residential youth care (N = 135), and to identify which factors were associated with a positive relationship. The results showed that adolescents, group care workers and teachers experienced a limited affective bond in their relationship, but that the adolescents tended to use group care workers and teachers as a secure attachment figure in an early stage of care. These results suggest that it is important to pay attention to the relationship early in treatment and that an affective bond is no precondition for the adolescents to experience staff as a secure base.

Since the main predictors of a good quality relationship were the *positive treatment skills* of both group care workers and teachers according to the adolescents, these findings also suggest - in line with the results in chapter three - that there is a need for training and supervision of group care workers as well as teachers to further develop these positive treatment skills so that they are better able to work with these adolescents, and especially with those that show the most serious problems during care (Fulcher & Ainsworth, 2006; Milligan & Stevens, 2006).

Despite the fact that this (therapeutic) relationship is a non-specific or common treatment factor that affects the services offered, regardless of the target group or the type of services (e.g., M. S. Karver et al., 2005), our results and that of other studies show that the client-staff relationship seems to be specifically important for successful outcomes of secure residential care in which adolescents with externalizing and oppositional behavior problems are often placed coercively (cf. Karver et al., 2006; Shirk & Karver, 2003; Van Binsbergen et al., 2004). Therefore, building a good relationship between young people and staff should receive more attention in residential care practice and research (see also section 9.6 and 9.7 of this chapter).

9.4 Client and care process factors contributing to outcomes

The last four studies focused on client and care factors that are associated with outcomes of (secure) residential youth care. There is a lack of knowledge about the (quality of) care that is offered in these settings. As was already mentioned, it is of public interest to gain a clear understanding of these factors in association with successful results of secure residential youth care, because of the often reported persistency of adolescents' antisocial behavior, the impact of this behavior on the community and public safety, and the high costs that are inherent in (secure) residential youth care. The studies in chapter five and six focused on relatively short-term outcomes of residential care since they were focused on changes in young people's behavior *during* care (section 9.3.1), while the studies in chapter seven and eight focused on outcomes *after* the young people had left the residential setting (section 9.3.2).

9.4.1 Outcomes during care

In **chapter five**, we examined whether residential youth care is an intervention that can contribute to the positive development of youth with serious behavioral and/or emotional disturbances. The main conclusion that could be drawn on the basis of our meta-analysis was that, on average, young people *improved* in their psychosocial functioning during a period of residential care. So, we did not find evidence for the statement that residential youth care (mainly) has negative consequences for individual young people or the society at large. We did found, on the other hand, that residential staff seemed to be more critical in assessing behavioral progress than youth and parents, and that behavior-modification components, family-focused components, and specific training aimed at social-cognitive and social-emotional skills of young people during residential care, can generate a significant strengthening of positive results in terms of change in problem behavior during care.

Our meta-analysis also showed a larger overall effect size for change in externalizing behavior problems than for change in internalizing behavior problems during residential care. This suggests that residential care is better capable of reducing externalizing behavioral problems than internalizing problems. Although externalizing behavior problems are commonly prominent with many young people in (secure) residential care, research has also shown that internalizing behavior problems are quite common (e.g., Boendermaker & Van den Bergh, 2005; Harder et al., 2006) and should receive more attention in both research and practice (Knorth, 2005).

Chapter six specifically focused on the (short term) outcomes of secure residential youth care in association with risk factors that are present with the adolescents (chapter two) and relationship factors that are assumed to be important within the process of care (chapter three and four). We assessed changes in adolescents' functioning during secure residential care and the adolescents' treatment satisfaction. Changes in the adolescents' functioning from admission to departure were measured in terms of motivation for treatment and competence skills, because we assumed that the secure care center would mainly intervene on these variables. The fact is, the primary, underlying methodology of the care and treatment in the secure center was considered to be the social competency model (Durrant, 1993; Harder et al., 2007; Slot & Spanjaard, 1999).

In contrast to our expectations, the results showed that the adolescents did not show significant changes in their competence skills from admission to departure according to group care workers. This result can be explained by the fact that we used a relatively small sample, which might have caused a lack of power to detect differences from admission to departure. A second explanation is that group care workers might have been critical in their assessment of adolescents' behavioral progress during care (cf. Knorth et al., 2008), which resulted in no perceived changes in the adolescents' competence skills.

Another explanation that is in line with the findings of other residential youth care studies, is that methods applied by care workers in their contact with clients differ from the methodology that should be used in theory (see also section 9.2). Such a *lack of program integrity* might have caused the intervention not to intervene on the competence skills of the adolescents. Research that specifically focused on the implementation of new methods in Dutch juvenile justice institutions supports this idea by showing that a good implementation of methods is difficult (Beenker & Bijl, 2003; Hendriksen-Favier et al., 2010). Different factors, such as the safety and security policy in the center and the tension between treatment and punishment, can oppose a good implementation of effective treatment programs in secure residential youth care practice (Bijl, Eenshuistra, & Campbell, 2010).

More consistent with our expectations was the finding that adolescents reported a significant, positive change in their motivation for treatment from admission to

departure: more adolescents were intending to take action in the near future (Prochaska et al., 1993). This result confirms that *motivation for treatment* of adolescent can be developed during secure residential care (Van Binsbergen, 2003). However, the results did not show how and why the adolescents' motivation for treatment was improved. For example, we did found in contrast to our expectations that a positive relationship with staff was not associated with improvements in adolescents' motivation for treatment. Furthermore, while the transtheoretical model of change (Prochaska & DiClemente, 1984) was used as the point of departure for treatment motivation in our study (which assumes that behavioral change occurs in a series of discrete stages), little empirical support for this model of change has been found (Bartelink, 2010; Littell & Girvin, 2002). For example, Littell and Girvin (2002) found that the proposed stages of change are not mutually exclusive and that there is limited evidence of sequential movement through discrete stages.

The study in chapter six also showed that the adolescents' *treatment satisfaction* was, on average, only just sufficient, which indicates that improvements can be made to the secure residential care process. Both a higher motivation for treatment level of adolescents at admission and a positive adolescent-group care worker relationship during care were associated with more treatment satisfaction. Considering specific care aspects, adolescents were the least satisfied about the course of treatment and the goals and results that could be attained. We explained this result by the nature of the care they received, since these adolescents were regularly placed under coercion in the secured environment of the residential setting. This coercive placement might implicate that young people do not perceive a good reason for their placement, which can result in a low level of engagement in treatment (cf. Englebrecht et al., 2008). In addition, almost all the adolescents had received other types of care prior to their admission to the secure care center, which makes that these young people are "experienced" in (residential) care and might have negative expectations about care (cf. Lodewijks, 2007). Since adolescents considered a positive relationship with group care workers as the most important factor associated with satisfaction about goal attainment, this indicates that outcomes in terms of treatment satisfaction can be improved by good relationships with staff.

9.4.2 Outcomes after care

Given that adolescents often have problems in their situation after leaving residential care, both chapter seven and eight focused on aftercare or transition services following (secure) residential care since these are believed to improve the longer term outcomes (cf. Ten Brummelaar, Boendermaker, Harder, & Knorth, 2011; Zeller, Köngeter, & Schröer, 2009).

The review study in **chapter seven** concerned the current knowledge on outcomes of *aftercare or follow-up services* for adolescents that have left residential

care. Although studies showed that these services can have positive outcomes, the strength of the evidence is limited because of the weak research designs that were often applied in the studies (cf. Kazdin, 2003). While there seemed to be no specific type of problem that could serve as a criterion for receiving aftercare services, studies did show that youth with more severe problems at discharge from residential care were more likely to receive services after residential care. Furthermore, young people completing aftercare programs tended to show better outcomes than young people leaving aftercare prematurely. Surprisingly, none of the outcome studies that were included in our review focused on both youth and their families in aftercare programs following residential care, despite the fact that young(er) people often return home after residential care (e.g., Trout et al., 2010) and parental involvement in residential treatment can play an important role in improving its outcomes (Geurts et al., 2008, see also section 9.7).

Studies in chapter seven that included residentially admitted youth with delinquent behaviour tended to report poorer outcomes of aftercare services than studies including youth with other problems, such as emotional and behavioral problems. We discussed this finding by the fact that studies focusing on services for delinquent youth regularly applied recidivism as an outcome measure that was often measured one year after departure, which is longer term after departure than is regularly applied for outcomes in the other studies.

Because outcomes of secure residential care are often viewed in terms of delinquent behavior and rarely in terms of other relevant outcomes, in **chapter eight** we additionally assessed outcomes one year after leaving secure residential care in terms of the adolescents' quality of life, living conditions, and the functioning of their social context (i.e., family and friends). Aim of this study was to examine whether and how the transition from secure residential care to the community, including the adolescents' preparation for departure and received follow-up services after residential care, were associated with successful outcomes one year after departure.

Results from admission to one year after departure indicated an overall but non-significant decrease in the adolescents' substance abuse and delinquent behavior, which indicates - in correspondence with findings in other studies - that these behavior problems of adolescents can be reduced, but that the achieved reduction is relatively small and that continued behavior problems are quite common (Garner et al., 2007; Grietens & Hellinckx, 2004; Lipsey & Wilson, 1998).

We also found indications for (small) improvements in the functioning of the adolescents' social context (i.e., family and friends) from admission to one year after departure. Although the adolescents reported few changes in the supervision behavior of their parents, which corresponds to findings of the very few studies that we found on this topic in secure residential youth care (Bullock et al., 1998), adolescents did report to have significantly less delinquent friends at follow-up than before their admission. This change in delinquent friends might partly be explained by the fact that

the adolescents learned positive social skills during and after their stay in the center (Slot & Spanjaard, 1999), making them more resistant to delinquent friends. However, results of the study in chapter six (see also section 9.3.1) indicated that the adolescents did not show changes in their competence skills from admission to departure according to group care workers, which makes that explanation less plausible. Another maybe more plausible explanation is that the adolescents had fewer opportunities to have delinquent friends adolescents one year after departure, because they had more structured daily activities than just before their admission to the secure residential center (see chapter eight).

More than a third (37%) of all the adolescents who had left the secure residential center showed recidivism in the year following their departure. This recidivism number lies within the low range of recidivism rates (30% and 64%) that is found in other studies one year after departure (Bullis & Yovanoff, 2002; Gottfredson & Barton, 1993; Greenwood & Turner, 1993; Van Dam, 2005; Van der Heiden-Attema & Wartna, 2000). The results showed, in contrast to our expectations, no association between care process factors (e.g., the receipt of *aftercare services*) and outcomes one year after departure in terms of officially registered delinquent behavior. Delinquent behavior of the adolescent prior to admission was the main predictor of recidivism, which is consistent with findings in other studies (e.g., Abrams et al., 2008; Cottle et al., 2001).

9.5 Limitations of the present study

The present study has several limitations. First, the design of the study does not allow for making causal inferences. So, the presented and discussed results comprise associative connections between variables rather than causal connections.

Secondly, we experienced problems with attrition which often resulted in the use of smaller subsamples. The use of small samples may limit the generalizability of the results beyond the sample of the present study (Field, 2009; Kazdin, 2003). Several of our studies indicated in this respect that participating adolescents were somewhat less problematic than non-participating adolescents.

A third limitation is related to the way in which some variables are operationalized in the studies (for example in chapter two and eight). Although we have tried to make the best possible decisions on the basis of the original scoring (i.e., consistently using median scores or the most relevant scores based on the item scales), some of the applied cut-off scores that we used might be under discussion.

A fourth limitation is that some of the instruments that we used might not have been the most suitable for use in the present study. For example, the motivation questionnaire that we used was the only Dutch instrument designed to measure the adolescents' motivation for treatment that we could find before starting our data collection period. Although there are different conceptual definitions of treatment

motivation (Drieschner, Lammers, & Van der Staak, 2004), our instrument only focused on the three stages of behavioral change (i.e., precontemplation, contemplation and preparation) that are distinguished by Prochaska and DiClemente. As we already mentioned, Littel and Girvin (2002) found little support for existence of these separate stages. Therefore, we applied an overall measure of treatment motivation in several studies instead of looking at the separate stages.

9.6 Strengths of the present study

Despite several limitations, to our knowledge our study is one of the first that examines both client and care process factors that can be considered as pivotal within the context of secure residential care for adolescents. By means of a better insight into the characteristics of the young people on the one hand and the care process on the other, a more adequate treatment can be realized by which the risk for future crime can be reduced and the public safety can be improved.

Since our study consists of empirical research in the context of (secure) residential youth care it is highly relevant for residential care practice. By including both international review studies of empirical research and empirical studies that were based on the actual PhD project carried out in secure residential care center *Het Poortje*, we could give insight into (secure) residential youth care from a broad perspective.

Third, the longitudinal design of our study made it possible to gain a clearer understanding of the development of young people during their stay in secure residential care. Therefore, our study indicates whether and in which respects residential youth care is effective (cf. Van Yperen & Veerman, 2008).

A fourth strength of our study is that we used different sources of information. We used information from treatment documents and information from adolescents, group care workers and teachers. By using these different perspectives, a more thorough description of both the client characteristics and the care process is established. Although we did not include information from the parents' perspective, we did include information about the functioning of parents from the adolescents' perspective (chapter two and eight) and the parents' role during care (chapter three, five and seven).

9.7 Recommendations for research

Because we experienced a substantial attrition rate in the PhD project, especially with regard to questionnaires, a first recommendation for researchers in this field is to *use interviews* instead of questionnaires with both the adolescents, parents and staff members that are involved in a study. A positive side effect of using interviews is that

all these participants feel listened to instead of merely doing extra work or effort. Moreover, questionnaires can be included as an instrument during an interview to guarantee reliable information regarding "delicate" topics such as sexual abuse and delinquency (e.g., Van der Laan & Blom, 2006b).

A second recommendation for researchers is to carry out more *in-depth research on the process of change* in (secure) residential youth care, because many studies on residential care lack a specific description of the intervention program (see chapter five). Aspects that should receive more attention in this respect are the building of a good relationship between young people and teachers, between parents and staff, and the specific treatment skills of care workers and teachers that are necessary for building such relationships in the context of (secure) residential youth care (see chapter three and four).

Moreover, specific aspects of residential care need more attention in research, such as the skills of group care workers that are necessary to attain and preserve a positive group climate (cf. Kamphof-Evink & Harder, 2011; Van Dam et al., 2010; Van der Helm, Klapwijk, Stams, & Van der Laan, 2009), the type and number of adolescents that is the most optimal for a residential group to be effective (cf. Chipenda-Dansokho & The Centre for Social Policy, 2003; Harder & Knorth, 2007), and good quality education within the secure residential care context (cf. Houchins et al., 2009). Only by paying attention to these aspects within the process of residential care, explanations for why programs work can be generated and used to make improvements. To further increase the knowledge about effective care processes within the "black box" of residential care, more research into what actually happens "on the ground" is needed.

In the present study, we paid attention to a specific care aspect of residential care that is expected to improve the relatively poor outcomes that are often reported for adolescents after they have left residential care: aftercare or follow-up services. As we already mentioned in section 9.3.2, the strength of the evidence that these services have positive outcomes is limited because of the weak research designs that are applied in studies. Because many studies do not mention the content or quality of the offered follow-up services (see also Daniel et al., 2004), little is known about the specific aftercare factors that are important for positive outcomes.

Therefore, a third recommendation that is in line with the previous is that *more good quality research of aftercare or follow-up services* should be carried out to make clear which adolescents are the most likely candidates for follow-up services and which services are successful for whom after leaving residential care. There is a need for research studies to compare groups of adolescents that do and do not receive services following residential youth care, while controlling for adolescents' problem characteristics at the moment of departure from residential care. Moreover, when (it is expected that) young people (will) return home to their parents after residential care, studies should include parents or families of the young people as respondents to gain an insight into their perspectives. If researchers are looking at follow-up services,

they should also pay attention to the living conditions of the young people after leaving care, because studies consistently show that young people leaving out-of-home care and transitioning into adulthood are at high risk for poor outcomes, especially in terms of education, health and well-being (cf. Harder, Köngeter, Zeller, Knorth, & Knot-Dickscheit, 2011; Munro & Stein, 2008; Ten Brummelaar et al., 2011).

Since we found that adolescents in secure residential care are characterized by different combinations of problems (chapter two), our fourth recommendation is that more *research of specific interventions* applied in secure residential care is desirable. These interventions should be aimed at adolescents' individual problems (see also section 9.1). Although research suggest that the non-specific factors (e.g., the client's motivation for treatment and the relationship between clients and therapists) have a relatively strong effect in comparison to specific treatment factors, the role of specific methods have not been sufficiently addressed in youth care studies until now (Van Yperen et al., 2010). Our meta-analysis in chapter five showed that behavior-modification and family-focused components of interventions seem to achieve positive results, as well as specific training, aimed at social-cognitive and social-emotional skills of youths, which seemed to generate a significant strengthening of treatment effects. Moreover, a review of Genovés and colleagues (Genovés et al., 2006) showed that cognitive-behavioral treatment methods are the most effective in decreasing recidivism of juvenile offenders in secure correctional institutions. And more recently, a meta-analysis of Lipsey (2009) pointed out that interventions for juvenile offenders with "therapeutic" philosophies, such as counseing and skills training, are more effective than interventions based on strategies of control or coercion (i.e., surveillance, deterrence, and discipline). These promising results all point to the need for more research of (outcomes of) specific methods within the context of secure residential youth care.

9.8 Recommendations for practice

A first recommendation for practice, which corresponds with the previously mentioned fourth recommendation for research, is that the basic therapeutic milieu (Scholte & Van der Ploeg, 2000) in secure residential should be completed with *specific treatment* that is aimed at the specific needs of every individual child (cf. Boendermaker et al., 2010; Harder et al., 2006; Thomson, McArthur, Long, & Camilleri, 2005). Our findings concerning different risk groups indicate that this specific treatment should be mainly focused on the individual needs (i.e., motivation for treatment, behavior problems) for some adolescents, while a majority of adolescents need intensive, multimodal treatment focusing on both risks in the individual, family (i.e., parental functioning) and peer domain (i.e., antisocial peers).

Given that adolescents in secure residential care are often unaware or under aware of their problems and not intending to take action in the foreseeable future (see also chapters two and six), it is an explicit task for secure residential care centers to get insight into the adolescents' motivation for treatment level and to *motivate adolescents* during the process of care (Klomp et al., 2004; Orlando et al., 2003). Previous care experience, which was applicable to almost all the adolescents in our sample, makes that these young people might have negative expectations about care (cf. Lodewijks, 2007). Therefore, there should be explicit attention for adolescents' *previous care experiences* in the assessment of adolescents' treatment motivation. In addition, goal-oriented working and creating a perspective for these adolescents should be explicit aspects of care, because these are factors that can motivate young people for treatment (Klomp et al., 2004; Van Binsbergen, 2003).

Furthermore, we recommend that motivating the adolescents for change is also aimed at improving the awareness of their problems regarding substance use. While research suggests that substance problems are associated with higher treatment costs (Hussey et al., 2008), an intervention such as "Motivational Interviewing" seems to be very relevant and important for adolescents in secure residential care (Bartelink, 2010; Feldstein & Ginsburg, 2006; Schippers & Jonge, 2010; Underwood et al., 2004). A variant of this intervention in the Netherlands is called "Brains 4 Use". This Dutch intervention is acknowledged by the so-called "Acknowledgement Committee Behavioral Interventions Justice" (*Erkenningscommissie Gedragsinterventies Justitie* in Dutch), which judges whether behavioral interventions can lead to prevention or reduction of recidivism.

Besides specific treatment that is aimed at adolescents' individual problems, such as poor treatment motivation and substance abuse, for some adolescents there is an explicit need to *involve parents* during the care process. This seems to be especially important for those who (are expected to) return home with their parents after (secure) residential care. Since almost half of the adolescents in our sample were living with their parents (one year) after their departure from secure residential care (see chapter eight), parents or family seems to be an important social support network for the young people (cf. Courtney & Dworsky, 2006).

Although parental involvement in residential treatment can play an important role in improving the outcomes of (secure) residential care (Geurts, 2010; Noot & Van de Poll, 2008; Wever, 2010), several researchers also point to the need for caution when returning young people to their families (e.g., Biehal, 2007; Clough et al., 2006), as we already described in chapter one. In this respect, Bullock et al. (1998) mention with regard to the situation of young people after their departure from secure residential care that: "those that manage to get on with relatives and maintain some reasonable contact with them are usually the most successful at establishing an independent way of life" (p. 65).

Specific intervention programs that explicitly focus on families of youth with serious emotional and behavioral problems, such as Multi Systemic Therapy (MST, Henggeler, 2009) and Functional Family Therapy (FFT, Sexton & Alexander, 2002), can be a appropriate supplement to the course of treatment in secure residential care (cf. Van Aggelen et al., 2009). Both MST and FFT are also acknowledged by the Dutch "Acknowledgement Committee Behavioral Interventions Justice". However, our study in chapter eight showed no clear indications that MST and FFT after secure residential care could reduce recidivism of the adolescents after departure.

To be able to *distinguish adolescents' needs*, our third recommendation is the standard use of an *intake interview protocol* with the adolescents shortly after their admission that includes questions concerning dynamic risk and promotive factors. In this respect, we consider (an adapted version of) the Scientific Research and Documentation Centre (SRDC) interview (Van der Laan & Blom, 2006b), which was used as an interview with adolescents in the present study, as a potentially suitable instrument. Such an interview should be used besides existing risk assessment instruments (Gammelgård et al., 2008; Lodewijks et al., 2010), since those are often based on information from treatment documents. An interview protocol can serve as an important guideline for treatment and forces staff to pay attention to the *adolescents' perspective* so that for example the adolescents' motivation for treatment level becomes instantly clear. Additionally, risk factor assessment can be used to prioritize, in consultation with adolescents and parents, which problems needs to be addressed first during treatment given that adolescents in secure residential care often show multiple problems (cf. Harder et al., 2006; Van Yperen & Van der Steege, 2006).

A fourth implication that derives from our study is the need for *support of residential staff* in their contact with clients. This support should be especially focused on group care workers and teachers, since they make a relatively large contribution to the process of residential care as they provide day-to-day guidance to the young people. The support may consist of training, coaching, supervision and working with treatment protocols (cf. Van Yperen et al., 2010) and needs to be focused on specific situations, such as interactions with "difficult" young people that show oppositional behavior or do not react to attempts by staff to establish contact during care (see chapters three and four). A specialization in residential youth care would also be a desirable addition to the vocational training program of care workers and teachers, so that they will be better prepared for working in this specific type of care.

Our findings suggest that support of residential staff should include a focus on the development and persistence of social skills to provide a basic therapeutic climate of firm, but not harsh, control in combination with consistent, but non-obtrusive, emotional support for the young people (Scholte & Van der Ploeg, 2000; Van der Helm et al., 2009). This balance between control and support corresponds with the authoritative parenting style (Maccoby & Martin, 1983), which can be considered the

most appropriate parenting style for positive development of children (e.g., Lamborn, Mounts, Steinberg, & Dornbusch, 1991). Appropriate interaction skills enable group care workers and teachers to build positive relationships with adolescents by applying a good balance between empathy and emotional support on the one hand and collaboration with regard to the tasks and goals of treatment on the other.

We expect that better (methodological) support of staff in (secure) residential care will lead to *better program integrity* of interventions. Results from the present study indicate that there might be a lack of program integrity concerning interventions in (secure) residential youth care (see chapters three, six and seven). Other Dutch studies in secure residential settings support this idea by showing that a good implementation of methods is difficult (Beenker & Bijl, 2003; Hendriksen-Favier et al., 2010). Because poor program integrity seems to be a common problem in (residential) youth care and interventions implemented with a high quality (i.e., with good program integrity) are more effective than poor implemented programs (Lipsey, 2009; Stals, Van Yperen, Reith, & Stams, 2008), it is desirable that (secure) residential care practice pays more attention to this phenomenon (cf. Bijl et al., 2010).

Residential youth care settings should be organized in such way that care workers, individual therapists, and teachers experience sufficient support in their work so that they are able to maintain good program integrity. Aspects or preconditions promoting program integrity that might be especially important within the context of secure residential care are for example a positive organizational climate (Glisson & Hemmelgarn, 1998; Glisson, 2002), a clear vision of leaders or the management on how changes should be achieved with the young people (Berridge & Brodie, 1998; Sinclair & Gibbs, 1998) and involvement of staff in decisions about changes in the care process (Stals et al., 2008). In this respect, the quality of the primary care process in secure residential youth care can be improved by making improvements on all levels within the organization.

9.9 The downside up?

Given the seriousness of the adolescents' problems in secure residential care, the high risk for relapse into delinquent behavior, the threat of public safety that is often associated with this behavior and the high amount of costs associated with both the adolescents' antisocial behavior and this type of care, a clear understanding of how improvements can be made in this care context is essential and of public interest. Moreover, the considerable impact of secure residential placement for young people and their families warrants the need for conscientious placement and good quality care. Although placements in secure residential care are often coercively in nature, the legal context implies that care should be offered client-focused and needs-led, or put in another way, be in "the best interest of the child" (see also the United Nation Convention on the Rights of the Child, United Nations, 1989). So, an important intention of secure residential care centers is to meet the needs of the young people and to improve their functioning.

Regarding both the individual clients' and public interests that are associated with secure residential youth care, the central question of the study was: Which factors are associated with a successful course of treatment for adolescents who are placed in secure residential care due to delinquent behavior and/or serious behavior problems? Based on our findings, we can conclude that both client and care process factors are important starting points for improving the outcomes that can be achieved with secure residential youth care. More adequate treatment can be realized by paying more explicit attention to the characteristics and perspectives of young people and their parents on the one hand and treatment skills and support of staff *during* secure residential care on the other.

Since placements in secure residential care are often coercively in nature, young people and their parents should be explicitly involved in the care process to make the placement comprehensible and efficient. In this respect, research from both our study and other studies (e.g., Lipsey, 2009; Parhar, Wormith, Derkzen, & Beauregard, 2008) suggest that interventions which are focused on treatment, such as skills training and counseling, are associated with better outcomes than interventions that are mainly based on control and coercion, such as discipline and punishment.

By carrying out the present study, we have made an attempt to gain more insight into *how* results are achieved instead of merely investigating the results that are achieved. Although we experienced difficulties in achieving this insight, subsequent studies should persistently focus on care practice. Since secure residential care is the "instrument" that we can use to make a change in the lives of adolescents and their families, it is of pivotal interest to know how this instrument should be used and for whom to achieve the best results in a most efficient way.