DOI: 10.1111/cfs.12796

ORIGINAL ARTICLE

CHILD & FAMILY SOCIAL WORK WILEY

Quality of experience in residential care programmes: Retrospective perspectives of former youth participants

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Abstract

This exploratory study examined perceptions of care quality within parent-pay youth treatment programmes such as therapeutic boarding schools, residential treatment centres, wilderness therapy programmes, and intensive outpatient programmes. Reflecting on their personal experiences as youths, 214 adults reported on a total of 75 different treatment settings. Two indices developed for this study measured participants' perceptions of quality of experience and the totalistic programme characteristics of their care settings. Regression analyses and ANOVA tests of means indicated a negative relationship between totalistic programme characteristics and quality of experience index scores. Significant relationships were not found between quality of experience and forcible transport, intake decade, or the amount of time in treatment.

KEYWORDS

quality of care, residential care, therapeutic boarding school, totalistic, totality of conditions, wilderness therapy

1 | INTRODUCTION

This exploratory study examined perceptions of care quality within parent-pay youth treatment programmes such as therapeutic boarding schools, residential treatment centres, wilderness therapy programmes, and intensive outpatient programmes. Reflecting on their personal experiences as youths, 214 adults reported on a total of 75 different treatment settings. Two indices developed for this study measured participants' perceptions of quality of experience (QOE) and the totalistic programme characteristics (TPC) of their care settings.

After introducing the context of the study, key concepts and factors for measurement are reviewed to explain the rationale and purpose of the study. A detailed methods section presents five hypotheses, a description of instrumentation, data collection and sampling processes, and a summary of the analysis methods used in hypothesis testing. Demographic and descriptive data are presented in the findings section prior to reporting the testing results. The importance of the study and its limitations are discussed, identifying needed areas of future research.

1.1 | Context of the study

Current data indicate that approximately 137,000 American youths under the age of 18 reside within some type of group home, residential treatment centre, boot camp or correctional facility (US Census, 2018). Deductive calculations indicate that approximately 57,000 of these young people were placed by their parents into some type of 24-h-a-day treatment setting (Sickmund, Sladky, Kang, & Puzzanchera, 2019; US Department of Health and Human Services [USDHHS], 2018). Teich and Ireys (2007) identified 71 different types of residential youth treatment programmes, but according to the Federal Trade Commission (FTC), there are no standard definitions for private-pay programmes such as therapeutic boarding schools, wilderness therapy programmes, behaviour modification facilities, emotional growth academies and teen boot camps (FTC, 2008). Currently, the FTC warns consumers that these "programs are not regulated by the federal government, and many are not subject to state licensing or monitoring as mental health or educational facilities, either" (p. 1).

In 2008, the US Government Accountability Office (GAO) documented widespread cases of institutional abuse in such treatment settings and explained that "the federal government does not have oversight authority for private facilities that serve only youth placed and funded by parents or other private entities" (H.R. Rep. No. GAO-08-346, 2008, p. 1). Licensing and regulation of teen programmes is the responsibility of a widely varying "patchwork" of state and regional agencies (Child Abuse, 2008, pp. 51, 57). The most recent published data indicate that in the 41 states reporting for 2018, 926 youths experienced institutional abuse perpetrated by residential programme staff (USDHHS, 2020). One barrier to the prevention of institutional abuse may be the lack of agreement on the features that characterize problematic programme types (Farmer, Murray, Ballentine, Rauktis, & Burns, 2017).

1.2 | Quality of care

The quality of care young people receive in various treatment settings varies, and better treatment quality is associated with intended treatment outcomes (Huefner, 2018). Therapeutic environments provide for the client-specific psychosocial needs of individuals by enabling high-quality experiences of personal connection, agency and autonomy (James, Thompson, & Ringle, 2017; Ungar, 2011, 2013; van der Helm, Kuiper, & Stams, 2018). However, recipients' actual experiences and assessments of treatment quality are rarely featured in empirical studies (Chama & Ramirez, 2014; Polvere, 2011; Rauktis, 2016). There is a need for research that examines the perspectives of treatment recipients to identify factors that contribute to quality in residential milieus (Lee & McMillen, 2007; Strijbosch, Wissink, van der Helm, & Stams, 2019).

A primary factor shaping the QOE in treatment settings is the degree to which the programme climate is perceived as "open" and effectively providing individuals with psychosocial resources or "closed" and presenting barriers to well-being and development (Strijbosch et al., 2019; van der Helm et al., 2018). Key indicators of quality include administrative professionalism, an abuse-free milieu, positive institutional cultures, least restrictive practices and the provision of developmental resources (Farmer et al., 2017; Huefner, 2018; Lee & McMillen, 2007).

Evidence-based practices, such as the Residential Child Care Project's "Children and Residential Experiences" (CARE) model, provide systematic methods for improving quality through staff education and training in practices such as de-escalation techniques (Holden et al., 2010; Holden, Anglin, Nunno, & Izzo, 2015; Izzo et al., 2016). Therapeutic environments are characterized by experiences of trust in staff members, safety in the milieu, and a sense of fairness in daily procedures (Holden et al., 2010). Evidence-based models of residential therapeutic care should value the subjective perspectives of treatment recipients and work to ensure that the programme structure provides psychosocial resources in a way that is appropriate to the best interests of each individual (Holden et al., 2015). Based on this review of the literature, 15 items were systematically operationalized to measure the subjective experience of care quality from the perspective of former programme participants. This is the first known attempt to operationalize and measure quality of treatment experience across multiple types of programmes.

1.3 | Totalistic teen treatment

The term "totalistic" refers to a continuum of restrictive, intrusive and insular milieu features (Chatfield, 2018b, 2019). These characteristics are associated with treatment programmes that utilize a closed group dynamics approach to affect global personal change (De Leon, 2000; De Leon & Melnick, 1993; Goffman, 1961; Grant & Grant, 1959; Langone, 1993). The concept of the totalistic milieu is well-established in the literature (Gowan & Whetstone, 2012; Hood, 2011; Kaye, 2013; Singer & Ofshe, 1990; Skoll, 1992; Volkman & Cressey, 1963; Weppner, 1983). Numerous authors describe TPC specific to teen treatment programmes (Aziz & Clark, 1996; Behar, Friedman, Pinto, Katz-Leavy, & Jones, 2007; Beyerstein, 1992; Bratter & Sinsheimer, 2008; Chama & Ramirez, 2014; De Leon & Melnick, 1993; Dye, Ducharme, Johnson, Knudsen, & Roman, 2009; Frankel, 1989; Friedman et al., 2006; GAO-08-146T, 2007; GAO-08-713T, 2008; Polvere, 2011; Pope, 2015; Rauktis, Fusco, Cahalane, Bennett, & Reinhart, 2011).

When labelled as a key element of "positive peer pressure," totalistic methods may be promoted as psychotherapeutic tools for those deemed treatment resistant (Bratter & Sinsheimer, 2008, p. 107). Peer encounter sessions meant to heighten "a client's awareness of image, attitudes, and conduct that need modification" have long been a central foundation of "positive youth cultures" (Nielsen & Scarpitti, 1997, p. 280). Some practitioners explain that intensive methods are best applied in highly controlled or remote settings where youth can be isolated from outside influences (Baber & Rainer, 2011; Bolt, 2016; De Leon, 2000). In some programmes, these methods are intended to elicit therapeutic responses through "frequent and uncomfortable experiences" (Bolt, 2016, p. 64) or "institutionalized turning points" manipulated through benevolent frustration (Hitlin & Kramer, 2014, p. 17).

Based on a comprehensive review of the literature, which is summarized in the Appendix A, seven TPCs were identified: (1) a strict system of peer policing, (2) highly controlled communications, (3) a central authority structure governing all aspects of life, (4) required completion of progressive status levels, (5) mandatory confession or confrontation sessions, (6) inflexible rules and punishments, and (7) a philosophy of total personal transformation. The degree to which these programme features are applied simultaneously is the degree to which they should be considered together as an interwoven totality of conditions (Leach, 2016; Montick, 1983). Although these seven features may characterize multiple types of programmes, the current study is the first known attempt to systematically operationalize and measure them from the perspective of programme participants.

1.4 | Key contextual factors

1.4.1 | Forcible transport

Some treatment providers urge parents to hire professional escorts to deliver their child to treatment, especially "when emotional or physical safety is a concern" (Bolt, 2016, p. 69). In some contexts, forcible transport may be conducive to treatment (Tucker et al., 2018; Tucker, Bettmann, Norton, & Comart, 2015). However, the ethical implications and legal questions about such methods are contested (Koocher, 2003; Mercer, 2019; Robbins, 2014). When parents choose to use youth transportation services, they entrust the care of their child to companies with the hope that the child will be transported safely to treatment without any infliction of harm. However, as Robbins (2014) notes, "after suffering the emotional trauma of being taken from their parents, children may suffer physical abuse as well, as the companies often use force in the form of handcuffs and other restraints" (p. 536). Although this practice is typically referred to as "involuntary transport," the phrase "forcible transport" is more accurate because the practice relies on the implicit or explicit use of force and because the voluntary or involuntary nature of such practices may be less salient for young people who have no legal right to refuse treatment.

1.4.2 | Graduate status

One of the basic components for assessing fidelity in the implementation of evidence-based practices is to consider the amount of treatment provided. Programme directors and researchers typically consider treatment amounts as a measure of dosage, gauging how closely the prescribed treatment was actually delivered (Hansen, 2014; Rohrbach, 2014). Providing adequate exposure to a programme regimen is crucial because without a full dose, any intended effects might be compromised. When assessing outcome comparisons between groups, ethical providers and researchers document and distinguish between dosage levels (Gottfredson et al., 2015). The completion of treatment dosage within a residential programme is usually described as a graduation, indicating treatment was successfully delivered and the effects were beneficial. When exploring factors related to perceptions of quality, there is a need to consider how graduate status might affect subjective assessments.

1.4.3 | Intake decade

The extent to which programme quality and TPCs might have changed over time is unclear. Cases of institutional abuse in teen treatment programmes were investigated by the congress in the late 1970s and again in 2007 and 2008 leading to increased scrutiny and a struggle by professionals to legitimate their practices (Abuse and Neglect, 1979; Becker & Hanson, 1982; Cases of Child Neglect, 2007; Child Abuse, 2008; Gil, 1982; Reamer & Siegel, 2008; Stanley, 1999; Whittaker, del Valle, & Holmes, 2015). Some authors explain that a lack of federal oversight has contributed to state-level systemic failures in protecting young people from abuse in institutional settings (Overcamp-Martini & Nutton, 2009). Others describe a contrasting trajectory of improvement explaining that the role of residential care has evolved from "warehousing" to "greenhousing" to "hothousing" as treatment methods were refined and intensified (Barnes, 1991, in Anglin, 2006, p. 11). Little is known about these changes in totalistic settings or the way subjective measures of programme quality may improve across decades.

1.4.4 | Length of time in treatment

For adults, one of the most consistent findings in large-scale outcome studies of the therapeutic community model is a positive relationship between duration of programme retention and treatment success (De Leon, 2015). In similar research on young people, the relationship between retention and outcomes is often confounded by contextual factors or unclear because of questions about the direction of causality (Edelen et al., 2007). Some evidence suggests that there may be a complex relationship between time in treatment and youth outcomes. For example, Strickler, Mihalo, Bundick, and Trunzo (2016) found a positive relationship among young people who were in residential treatment for less than 6 months. However, those in treatment between 6 and 10 months showed no significant improvement, and those in treatment for 10 months or longer showed a decrease in positive outcomes. Little is known about the way treatment duration in totalistic settings affects QOE measures.

1.5 | Statement of purpose

The purpose of this research is to identify and measure factors associated with QOE within totalistic programmes. To explore these concepts, 15 factors associated with care quality are identified in an index variable to measure recipients' retrospective assessments. An additional index variable measures seven TPCs featured in multiple types of treatment settings. Four additional contextual factors are measured to compare their effects on perceptions of care quality. Although these key contextual factors may provide a more objective set of measurements, the index variables presented here allow for a more direct measure of the subjective dimensions of treatment within totalistic programmes. These perspectives are critical to improving the beneficence of teen treatment settings.

2 | METHODS

This study focuses on a central research question: among adults who were admitted to a teen treatment programme by their parents, what factors are associated with overall perceived QOE? Study participants were drawn from parent-pay programmes such as therapeutic

boarding schools, residential treatment centres, wilderness therapy programmes and intensive outpatient programmes (see Table 3 below for more detail).

2.1 | Hypotheses

In addition to testing the relationship between measures of TPCs and QOE as index variables, this study tested the effect of four contextual variables: forcible transport, graduate status, intake decade and length of time in treatment. Five hypotheses were proposed to explore the central research question. The dependent or outcome variable for each hypothesis is the participants' index scores reflecting perceived QOE.

H1 *Forcible transport*. QOE index scores will be significantly lower for those who were transported by professional agents when compared with those who were not.

H2 *Graduate status*. QOE scores will be significantly higher for programme graduates than nongraduates.

H3 *Intake decade*. QOE scores will significantly increase when comparing groups arranged by the decade of their intake date.

H4 *Length of time in treatment*. There will be a significant, positive relationship between length of time in treatment and QOE scores.

H5 *TPC*. There will be a significant, negative relationship between scores for TPC and scores for QOE.

2.2 | Instrumentation

To address these hypotheses, two original indices were developed to measure TPC and QOE. These measures help to explore the relationship between degrees of totalism and perceived quality of care. The concept of totalistic teen treatment was operationalized with seven defining features found in the literature (Table 1). These definitional features were developed to measure TPC as an index variable and are original to this study (Chatfield, 2018a). QOE was operationalized with 15 items based on key indicators found in the literature (Table 2).

TABLE 1 Items measuring totalistic programme characteristics (TPC)

	Sample mean	Standard deviation
Residents in the programme were expected to hold each other accountable and/or report on each other for rule infractions.	4.88	0.47
Almost all forms of communication between residents, and with people in the outside world, were controlled or governed by rules.	4.87	0.55
For at least some amount of time in the programme, all aspects of life, such as school, therapy, meals, and recreation, took place in programme or by permission of the programme.	4.86	0.54
Progress through the programme required the completion of prescribed stages, phases, or levels of treatment progress.	4.85	0.51
Everyone was required to participate in group sessions that involved confessions and/or confrontations.	4.83	0.59
The programme had a detailed and strict system of rule enforcement and punishment procedures.	4.82	0.60
The programme philosophy emphasized a need to totally change, to be completely saved, or to be transformed.	4.74	0.56
Sample Mean for Combined TPC Index Variable	4.84	0.40
	Cronbach's alpha = 0.856 (N = 211)	

Note. Items were scored on a 1 to 5 scale; 1 = *strongly disagree* and 5 = *strongly agree*. Mean score range: 1.00 = *least totalistic* and 5.00 = *most totalistic*. Items ranked by the sample's mean.

TABLE 2 Index items measuring quality of experience (QOE)

Programme experience	Sample mean	Standard deviation
How safe or unsafe did you feel in this programme?	2.15	1.1
Overall, how helpful or harmful was this programme for you?	2	1.14
How equally or unequally did the staff members treat the residents?	1.9	1.07
How fair or unfair were the punishments in this programme?	1.59	0.89
How reasonable or unreasonable were the rules of this programme?	1.59	0.93
How easy or difficult was it to adjust to life after this programme?	1.51	0.85
Opinions of experience		
In this programme, my basic physical needs were neglected.[a]	2.61	1.28
I trusted the staff members to act in my best interests.	2.01	1.25
I received an appropriate and adequate education while in this programme.	1.9	1.12
The programme's long-term impact on my life has been positive.	1.85	1.14
Overall, I had a negative experience in this programme.[a]	1.8	1.15
This programme helped me to be a happier person.	1.78	1.16
I experienced negative side effects from treatment while I was in this programme.[a]	1.68	1.03
This programme provided me with high-quality treatment.	1.63	1
I often felt a sense of dread while I was in this programme.[a]	1.44	0.86
Sample mean combined QOE index variable	1.84	0.79
	Cronbach's alpha = 0.938 (N = 214)	

Note. Items were scored on a 5-point scale: Programme experience, 1 = most "negative" and 5 = "most positive." Opinions of experience, 1 = *strongly disagree* and 5 = *strongly agree*.
[a]Reverse scoring. Items ranked by mean score.

These items reflect generally accepted best practices and measure recipients' assessments of the beneficence of the treatment milieu.

Table 1 includes the seven items measuring how strongly participants agree or disagree with statements about the TPC they experienced. Using a 5-point Likert-type scale, with 1 indicating "strongly disagree" and 5 indicating "strongly agree," each participant's mean per-item score was measured as an index variable created by calculating their mean score for the seven items measuring TPC. The Cronbach's alpha for these seven items was strong (0.856), with each item contributing to increased internal validity.

An additional 5-point Likert-type scale measured each participant's assessment of treatment quality, with 1 indicating lowest quality and 5 indicating highest quality. This score was based on responses to the questions listed in Table 2, with reverse-scored items indicated by an asterisk. Taken together, these 15 items had a very strong Cronbach's alpha (0.938) with each item contributing to an increased internal validity. Each participant's scores in these two domains were combined to create a per-item index score calculated as the mean based on their responses to the items measuring perceived QOE. The QOE score was used to create a dependent or outcome variable measured at the continuous level to allow for more rigorous regression, ANOVA and two-sample *t*-test analyses.

2.3 | Data collection and study participants

This study utilized sampling frame data collected in the first stage of a qualitative research project titled, "Adult Perspectives on Totalistic Teen Treatment: Experiences and Impact" (Chatfield, 2018a). Participants in the study completed an online questionnaire containing 50 items organized into four domains: demographics, contextual factors, QOE and TPC. All questionnaire items were previewed by methodology experts then pilot tested by content experts and revised accordingly. The exact phrasing of all index variable items is shown in Tables 1 and 2.

Invitations to participate in research were shared with six professional organizations, three individual experts and one clinician. These groups and individuals shared the invitation through social media platforms and email. Early data collection indicated an overrepresentation of participants scoring very low on the measure of QOE. In hopes of obtaining a more balanced sample, an earnest attempt was made to share the invitation with additional professional organizations composed of programme owners, staff members, and educational consultants likely to have access to potential participants with more positive perceptions about their programme experiences. Although these attempts extended the data collection period for an additional six weeks, few additional responses scoring high on the measure of QOE were obtained.

A total of 235 participants completed the online questionnaire. In screening, 12 individuals were removed from the sample because they failed the quality assurance question or they were over the age of 17 at intake. Nine were removed because they were placed in

TABLE 3 Mean TPC and QOE scores by programme type

General programme type	TPC	QOE	Number of participants
Therapeutic boarding school	4.88	1.88	120, 122
Residential treatment centre	4.88	1.63	83
Other	4.84	1.59	44
Ranch, wilderness, camp or outdoor programme	4.63	2.19	30, 31
Boot camp	4.91	1.84	13
Intensive outpatient	4.84	1.72	10
Psychiatric hospital	4.54	1.68	5
Training school	4.89	1.70	4

Note. Questionnaire participants were instructed to "check all that apply" when indicating the type of programme they attended.
Abbreviations: QOE, quality of experience; TPC, totalistic programme characteristics.

treatment by a state authority, resulting in a final sample of 214 participants. All of these participants were placed in treatment by their parents or guardians, all were 11 to 17 years old at the time of their intake, and all were 18 or older when they completed the questionnaire.

2.4 | Analysis methods

To test the five hypotheses presented in this study, the following types of analyses were conducted. In testing H1 and H2, a two-tailed independent samples *t* test was used to test for differences in mean QOE scores. In testing H3, a single-factor between-subjects ANOVA tested the significance of differences in QOE scores. In testing H4 and H5, linear regression analyses were used to test the relationships between QOE and time in treatment, and QOE and TPC scores. All statistical analyses were conducted using SPSS Version 25.0.

3 | FINDINGS

3.1 | Descriptive results

In this sample of 214 participants, 86.9% (n = 186) were identified as white and 65.0% (n = 139) as female. Ages at intake ranged from 11 to 17 years, and 55.1% (n = 118) were 15 or 16 years old when they were placed in treatment. A total of 51.9% (n = 111) of participants reported intake dates from 2000 to 2016; the remainder were placed in treatment prior to the year 2000. To describe the type of programme they were placed in, participants were provided a list of options and instructed to check all that apply. The two most selected types were "therapeutic boarding school" (n = 122) and "residential treatment center" (n = 83). Table 3 shows how participants rated each general programme type with TPC and QOE mean scores.

All participants identified their parents or guardians as the legal authority behind the decision for placement. The questionnaire asked participants to check all that apply when reporting reasons for placement. The three main reasons for placement were identified as "family problems" (n = 167), "behavioral problems other than criminal activity and substance abuse" (n = 131) and "problems at school" (n = 114). The average length of time in treatment was 16.7 months, and the majority (59.8%, n = 128) completed the treatment or formally graduated. A total of 131 participants (61.2%) rated their programme at the maximum possible 5.00 on the 5-point index scale measuring TPC.

3.2 | Multivariate results

3.2.1 | H1: Forcible transport

When comparing those who were transported to the programme by professional agents to those who were delivered by their parents, there was no significant difference in perceived QOE, $t(212) = 0.24$, $p = 0.81$, 95% confidence interval (CI) [–0.20, 0.25]. There were 73 participants who were transported by a professional service, and their QOE scores (M = 1.86, SD = .78) were essentially the same as the 141 participants who were not (M = 1.83, SD = .79).

3.2.2 | H2: Graduate status

When comparing graduates who completed treatment to nongraduates, there was a significant difference in perceived QOE index scores, $t(211.29) = 2.43$, $p = 0.02$, 95% CI [0.05, 0.45]. Graduates reported significantly higher QOE than nongraduates. The 128 graduates' QOE index scores (M = 1.94, SD = 0.87) were relatively low but 0.25 higher than the 86 nongraduates' scores (M = 1.69, SD = 0.62), as measured on a 5-point scale.

3.2.3 | H3: Intake decade

A single-factor between-subjects ANOVA was used to compare QOE index scores between groups arranged by decade of intake. No significant differences were found, $F(4) = 1.15$, $p = 0.33$.

3.2.4 | H4: Length of time in treatment

The Pearson correlation coefficient between number of months in treatment and QOE index scores was not significant, $r(214) = 0.04$, $p = 0.60$. In addition, the linear regression analysis indicated that the number of months spent in a totalistic teen treatment programme was not significantly related to QOE index scores. The average number of months in treatment was 16.70 ($N = 214$, SD = 9.99) and these values were normally distributed.

3.2.5 | H5: Totalistic programme characteristics

There was a significant negative relationship between TPC scores and QOE scores. When outliers were included, linear regression ANOVA indicated a significant linear relationship, $F(1, 210) = 19.08$, $p < 0.001$. The Pearson's correlation coefficient was weak but significant, −0.29, $p < 0.001$. The R^2 value, 0.084, was also weak, but the unstandardized coefficient of the regression slope indicates that when measured on a 5-point scale, for each unit of increase in totalistic features, there was a decrease of 0.57 in scores measuring QOE, $\beta = -0.57$, SE = 0.13, $p < 0.001$.

When the seven outliers were excluded from the model, linear regression ANOVA indicated a weaker, but still significant linear relationship, $F(1, 203) = 11.77$, $p = 0.001$. The Pearson's correlation coefficient was weakened also but remained significant, −0.24, $p = 0.001$. The R^2 value became negligible, 0.055, and the unstandardized coefficient of the regression slope and the standard error of the slope decreased. With outliers removed, when measured on a 5-point scale, for each unit of increase in totalistic features, there was a decrease of 0.39 in scores measuring QOE, $\beta = -0.39$, SE = 0.11, $p = 0.001$.

When participants were grouped according to totalistic programme characteristic score categories, there was an incremental decrease in QOE scores for each incremental increase in TPC score category. A single-factor between-subjects ANOVA was used to compare QOE scores and a significant difference was found, $F(4) = 6.64$, $p < 0.001$. Scheffe's post-hoc test indicates that the two highest categories of TPC score ranges were significantly different from the lowest category. Participants who scored TPC less than 4.00 ($N = 6$) scored QOE significantly higher than two other category groups: those scoring TPC between 4.51 and 4.75, $N = 23$, $p = 0.04$, SE = 0.34, and those scoring 4.76 to 5.00, $N = 168$, $p = .001$, SE = 0.31 (Table 4).

TABLE 4 ANOVA between totalistic score categories and quality of experience

Categories based on TPC scores	Group mean score for quality of experience	Number of participants ($N = 211$)
5.00 to 4.76	1.72***	168
4.75 to 4.51	2.05*	23
4.50 to 4.26	2.14	9
4.25 to 4.00	2.19	5
Less than 4.00	3.12***	6

Note. Those scoring less than 4.00 have significantly different mean scores compared with the two highest scoring groups.
Abbreviation: TPC, totalistic programme characteristics.
*$p < 0.05$.
***$p < 0.001$.

3.2.6 | Controlling for TPC on graduate status

When controlling for TPC score, graduate status remained a significant factor for those who rated their programme at 4.75 or below for totalistic features, but for those who rated their programme as extremely totalistic (4.76 to 5.00 on a 5-point scale), programme completion was not significantly related to QOE scores. Among those who reported extremely totalistic settings no significant difference in QOE means between graduates and nongraduates was found, $t(166) = 1.09$, $p = 0.28$, 95% CI [−0.09, 0.32].

4 | DISCUSSION

In this exploratory study, the most salient factor affecting QOE scores was the degree to which the treatment milieu was characterized as totalistic. Bivariate linear regression and additional two-tailed independent-samples ANOVA tests of means revealed a negative relationship, and for each level of increase in totalism, there was a decrease in QOE. The positive relationship between QOE and graduate status is less salient because for those who rated their programme as extremely totalistic ($n = 168$), measured by a mean score of 4.76 to 5.00 on a 5-point scale, no significant difference was found between graduate and nongraduate QOE index scores. In hypothesis testing, forcible transport by contracted agents, intake decade, and the length of time spent in treatment were not related significantly to QOE measures.

The negative relationship between QOE and totalistic characteristics suggests that we should revisit such approaches in the context of improving programme delivery for young people in residential treatment settings. In their review of the literature, Huefner et al. (2018) identified several domains of quality that are relevant to this discussion of residential treatment, including safety and freedom from abuse; positive group culture; family culture and connections; and establishing the least restrictive environment possible. Research also emphasizes the importance of the personal relationships between staff and residents in treatment settings (Moore, McArthur, Death, Tilbury, & Roche, 2018), concluding that "the characteristics of these trusting relationships included workers who showed they cared; were tenacious and persisted when things were tough, recognized the risks for young people in residential care and were available – they made time to hang out with young people in a relaxed way" (p. 73). To support these relationships, it is important to create institutions and settings that facilitate such positive interactions.

This research is also noteworthy in emphasizing the importance of listening to young people who typically do not have a powerful voice in shaping their own treatment options. Youth perceptions of programme quality and positive programme outcomes are an essential part of the dialogue related to children's rights and humane treatment in residential settings. In their review of research related to youth decision making in residential care settings, ten Brummelaar, Knorth, Post, Harder, and Kalverboer (2018) identify both possible obstacles to youth decision making as well as apparent benefits. Further, the broader concept of youth voice and the importance of listening to youth perspectives about their experiences and well-being is an expanding field of study (Anyon, Bender, Kennedy, & Dechants, 2018; Gomez & Ryan, 2016; Jolivette, Boden, Sprague, Parks Ennis, & Kimball, 2015).

When measuring programme quality, it is important to consider first-hand retrospective accounts and assessments by recipients. The range of negative experiences reported by participants in this study highlight the importance of understanding youth perspectives on restrictive, intrusive and insular programme design features. As evidence-based methods are implemented in more types of treatment programmes, it will be important to consider the relationship between positive outcomes and TPC.

4.1 | Strengths and limitations

A retrospective study allows researchers to ask questions that young people might be hesitant to answer while they are in treatment. In settings where complaints are equated with a failure to respond to treatment or where complaints might be punished as evidence of disloyalty, ingratitude, or resistance to treatment, critical questions about programme quality might be unwelcome, and responses to them may be of questionable accuracy. However, the effects of time and the variations in adult development that affect the accuracy of subjective responses in any retrospective study must be considered as well.

Additional limitations should be addressed in future research. The two indices developed for this study may have failed to capture the full range of participant experiences. By extending the range of instrument items to capture more negative and more positive extremes, fewer participants would "bottom out" at 1.00 or "hit the ceiling" at 5.00. In this study, if the instruments had been able to capture nuances beyond these limits, the index scores may have been more normally distributed, making regression analyses more robust. The relatively weak correlations between TPC and QOE scores are likely due to the low variation in the distributions as well as the limited scope of QOE index items. Future studies would benefit from extensive psychometric research in expanding the indices introduced here. The generalizability of future studies might expand with the ability to recruit a larger, wider ranging sample. It is expected that future projects will explore how QOE in totalistic programmes may relate to gender, sexual orientation, race, socioeconomic factors, reasons for placement, number of placements and public versus private pay systems.

5 | CONCLUSION

The number of teen treatment programmes operating in the United States and the percentage that might be rated as highly totalistic are not known. Participants in this study reported on 75 different programmes and rated 72 of these as highly totalistic with a TPC index score of 4.00 or greater. These programmes operated or continue to operate within 25 different states across the United States.

This exploratory study provides empirical evidence characterizing totalistic teen treatment programmes and presents two original indices for measuring the relationship between TPC and QOE. The findings in this study are based on data provided by adults who were placed in a programme by their parents. For this sample, the data analysed indicate that the strongest predictor of low-quality treatment experience is the totalistic nature of the milieu. Research that investigates these restrictive, intrusive and insular programme features together could inform theory-based efforts to prevent harm and promote healthy development.

ETHICAL APPROVAL

This study is approved by the Institutional Review Board Office at the University of Florida (approval number UF-IRB201701655).

CONFLICT OF INTEREST

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

Research data are not shared.

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How to cite this article: Chatfield MM, Diehl DC, Johns TL, Smith S, Galindo-Gonzalez S. Quality of experience in residential care programmes: Retrospective perspectives of former youth participants. *Child & Family Social Work*. 2020; 1–12. https://doi.org/10.1111/cfs.12796

APPENDIX A.

TPC items analysis summary table

	1	2	3	4	5	6	7
De Leon, 2000	x	x	x	x	x	x	x
De Leon & Melnick, 1993	x	x	x	x	x	x	x
Goffman, 1961		x	x	x	x	x	x
Grant & Grant, 1959	x	x	x	x	x	x	x
Langone, 1993	x	x	x		x	x	x
Gowan & Whetstone, 2012	x	x	x	x	x	x	x
Hood, 2011	x	x	x	x	x	x	x
Kaye, 2013	x	x	x	x	x	x	x
Singer & Ofshe, 1990	x	x	x	x	x	x	x
Skoll, 1992	x	x	x	x	x	x	x
Volkman & Cressey, 1963	x	x	x	x	x	x	x
Weppner, 1983	x	x	x	x	x	x	x
Aziz & Clark, 1996	x		x	x	x	x	x
Behar et al., 2007		x	x		x	x	
Beyerstein, 1992	x	x	x	x	x	x	x
Bratter & Sinsheimer, 2008	x		x		x		x
Chama & Ramirez, 2014			x		x	x	x
Dye et al., 2009	x	x	x	x	x	x	x
Frankel, 1989	x	x	x	x	x	x	x
Friedman et al., 2006	x	x	x	x	x	x	x
GAO-08-146T, 2007		x	x		x	x	
GAO-08-713T, 2008	x	x	x	x	x	x	
Polvere, 2011		x	x	x		x	
Pope, 2015	x		x		x	x	
Rauktis et al., 2011		x	x	x		x	
Nielsen & Scarpitti, 1997	x	x	x	x	x	x	x
Baber & Rainer, 2011	x	x	x	x	x		
Bolt, 2016	x	x	x		x	x	x

Note: Totalistic programme characteristics (TPC) index variable items: (1) a strict system of peer policing, (2) highly controlled communications, (3) a central authority structure governing all aspects of life, (4) required completion of progressive status levels, (5) mandatory confession or confrontation sessions, (6) inflexible rules and punishments and (7) a philosophy of total personal transformation.