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SEEKING TO IMPROVE QUALITY AT A RESIDENTIAL TREATMENT CENTER FOR TROUBLED YOUTH

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ABSTRACT: Improving the quality of service at a residential treatment center for troubled youths in Calgary, Alberta required feedback from (a) the youths themselves, (b) their social workers, (c) the clients' parents or caregivers, (d) the cottage therapists, and (e) child care workers on campus. On a 1 (strongly dissatisfied) to 5 (strongly satisfied) rating scale, four of the five groups (excluding the client group) obtained overall mean scores of 3.56 on behavioral adjustment, 3.51 on general social skills, 3.39 on relationship skills, and 4.14 on program effectiveness. The therapists and child care workers rated the clients' cognitive skills at 3.66 and positive self-esteem at 3.59. Although 46.3% of the youths did not like living in their cottage, 61.1% felt that living there had helped them.

The aim of this study was to identify the strengths and weaknesses of the treatment services offered at a residential treatment center for troubled youths in Calgary, Alberta (pop. 750,000). To do so, five different groups directly associated with the agency were surveyed, including (a) the clients themselves, (b) their social workers, (c) the clients' parents and caregivers, (d) the program therapists, and (e) child care workers on campus. Receiving feedback from all the various groups involved at the treatment center is a necessary step in managing for total quality (TQM). In the business sector, TQM is an extensive process for satisfying consumer needs, generating revenues while reducing costs, and enabling employees to participate more directly in organizational decision-making (Kelada, 1990; Juran Institute, 1993). TQM is also an important management strategy in the successful operation of residential treatment facilities.

The inspiration for this study was derived from the statistical and philosophical developments taking place within the international quality movement for business, in particular, those that have occurred in Japan since the Second World War. Japanese commercial interests chose to rebuild Japan's weakened post-war economy by using the principles of quality developed in the United States beginning in the early twentieth century (Juran, 1989). The adoption and implementation of these principles helped to make Japan economically powerful and contributed to the intense global competition that we have seen in recent years (Byrne, 1987; Imai, 1986; Shepard, 1987; Willis, 1986).

In reviewing these techniques (e.g., Kelada, 1990) in terms of their relevance for child and youth care, it seems that some of the concepts commonly applied in industry (e.g., just-in-time purchasing) do not seem particularly well-suited for the child care field (cf. Hannah, 1987; Schonberger & Ansari, 1984). On the other hand, principles of customer satisfaction can be applied very well in other areas of human services (Sinclair, 1982). In meeting or exceeding customer expectations, organizations must be innovative and receptive to feedback in order to maintain and develop a continuous improvement in the goods and services they offer (Baillie, 1986; Kanter, 1990). The same is true for residential treatment facilities.

METHOD

Subjects

During the course of this study, most of the clients lived in six different cottage programs on the agency's residential campus, whereas others lived in the community but attended the school on-campus during the day. The residential center has typically served about 200 6- to 18-year-old youths and their families annually, while an additional 200 clients have been treated through the agency in a number of community-based programs off-campus (Alberts, 1990). In terms of treatment delivery, the staff consist primarily of youth care practitioners, psychologists, and teachers who provide assessment, rehabilitative, and educational services to the clients and their families.

Prior to admission, the youths typically live in open or closed residential settings, at the homes of parents or other caregivers, or in receiving or group homes. The clients are usually referred to the center by the Alberta Family and Social Services. In terms of their Child Welfare status, the clients have Custody agreements, Permanent or Temporary Guardianship Orders, or are under Apprehension. Some are also involved with the Solicitor General's Department in that they are awaiting trial or are on probation.

Typical reasons for placement include suicide risk, defiance to authority / out of control behavior, running away, aggressive or assaultive behavior, self-harm risk, and so forth. As such, these youths are among the most troubled in Alberta. Their average length of stay ranges from about 1-12 months, depending upon the program in which they are placed.

Procedure

During the late spring and early summer of 1992, the researchers examined the goals of each of the cottage programs. From these specific goals (about 35 in all), six general themes emerged that were used to construct questions pertaining to whether or not the program objectives were being met. These themes were labelled as (a) behavioral adjustment, (b) general social skills, (c) personal relationship skills, (d) program effectiveness, (e) cognitive skills, and (f) positive self-esteem. The two themes dealing with cognitive abilities and self-esteem appeared only in the questionnaires for therapists and child care workers.

The sets of questions that were developed, one for each survey group, were then reviewed by the senior program therapists, several youth care practitioners, and two administrators to ensure that the questions themselves were appropriate for the purposes of the survey. The questionnaire for the clients was retained from an earlier study at the center because it dealt with the main themes and was easy to use with lower-functioning youths.

Data collection began in the summer of 1991 and continued until April, 1992. The survey focused exclusively on those clients who had received treatment services from the center sometime during 1991. To improve the reliability of the responses, a condition of eligibility required that the clients could volunteer for the study only if they had been in one of the residential programs (with a high turnover) for at least seven days and at least three months in any of the other programs.

Clients. The client questionnaire was administered while most of the children were on campus. Clients who had been discharged before the interviews were carried out received their forms by mail in care of their parent(s) or social worker. All of the clients were informed that their participation was on a voluntary basis and that any information they provided would be treated confidentially. In terms of participation, 54 out of 142 clients (38.0%) completed the questionnaire (29 males, 25 females).

Parents/caregivers. Ninety-nine questionnaires were sent to the parents or caregivers of the clients in the fall of 1991. By late February, 1992 only 9 of these forms had been returned. Consequently, in order to increase the response rate for this particular group, an attempt was made in March and April, 1992 to telephone those parents and caregivers who had not returned their questionnaires. Sending reminder notices to individuals over the telephone, or by conducting the survey over the phone itself, resulted in a total of 34 (34.3%) completed questionnaires. A large number of parents for clients could not be reached for their comments.

Social workers. During the the fall of 1991, 124 questionnaires were sent to the social workers of the clients. By April, 1992, 48 completed questionnaires (38.7%) had been returned to the center. Reminder notices were made by mail or telephone to obtain the overall response rate for this group.

Therapists and child care workers. Questionnaires for all 142 clients were delivered to both therapists and child care workers on campus (284 forms in all). Eighty-three forms (58.5%) were returned by the therapists and 55 (38.7%) by the child care workers.

Alpha reliabilities for the five questionnaires were .85 for parents, .89 for social workers, .93 for child care workers, .96 for therapists, and .83 for the children.

Results

For four of the five questionnaires, mean ratings were calculated for each of the questions using a 1 to 5 scale: 1 = strongly dissatisfied, 2 = dissatisfied, 3 = in between or undecided, 4 = satisfied, 5 = strongly satisfied.

The Client Questionnaire used a categorical response format (i.e., yes, no, sometimes, I don't know) from which percentages were calculated. The findings are analyzed according to each group listed below. It should be noted that the n's for the social worker, child care worker, and therapist groups refer to the number of clients represented rather than to the number of individuals who responded; for example, the social workers completed questionnaires pertaining to 48 clients.

Clients

The clients answered 13 questions. For each question the percentage responses are shown in Table 1. Although many of the clients claimed that they did not like living at the center (44.4%) or in their cottage (46.3%), it is interesting to note that a clear majority said that living in the cottage had helped them (61.1%), that the cottage staff cared about them (64.8%), and that the staff listened to them (64.8%). Overall the clients indicated quite strongly that they had been helped to care for themselves, to get along better with other children, with their families, with other adults, and to follow the rules. One area produced a notable negative response: 50% of the clients felt they had not been helped to do better in their school work, even though two-thirds of them indicated that they enjoyed school activities.

Table 1

Client Responses (n = 54)

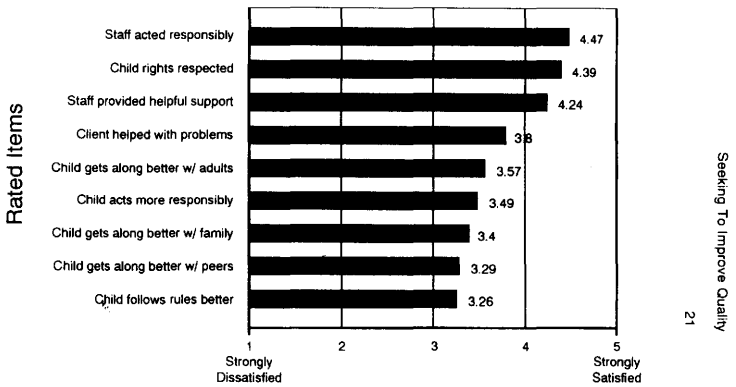
	Categories			
Questions	Yes	No	Sometimes	Don't Know
Do you like living at the Center?	38.9	44.4	5.6	5.6
Do you like living in your cottage?	47.0	46.3	9.3	1.9
Has living in the cottage helped you?	61.1	25.9	3.7	5.6
Do the cottage staff care about you?	64.8	18.5	7.4	5.6
Do the staff listen to you?	64.8	18.5	14.8	1.9
Have you been helped to get along better with other kids?	64.8	33.3	1.9	0.0
Have you been helped to get along better with your family?	48.1	27.8	0.0	5.6
Have you been helped to follow rules?	66.7	27.8	1.9	3.7
Have you been helped to care for yourself?	53.7	44.4	0.0	1.9
Have you been helped to get along better with grown-ups?	63.0	31.5	0.0	5.6
Have you been helped to make friends?	53.7	44.4	0.0	1.9
Have you been helped to do better in your schoolwork?	42.6	50.0	1.9	5.6
Do you like what you do in school?	66.7	27.8	1.9	3.7

Note. Five questions do not include percentages for boys who did not live at the Center or who were no longer in contact with their family.

Parents/Caregivers

Nine items were rated on the 1-5 scale, as shown in Figure 1. Parents were most satisfied (M > 4) with issues pertaining to staff professionalism. They were also reasonably satisfied that their children had been helped with their problems (M = 3.8). They were a little less certain, however, that their children were able to follow the rules and listen to authority better (M = 3.26) or if they were able to get along better with other people.

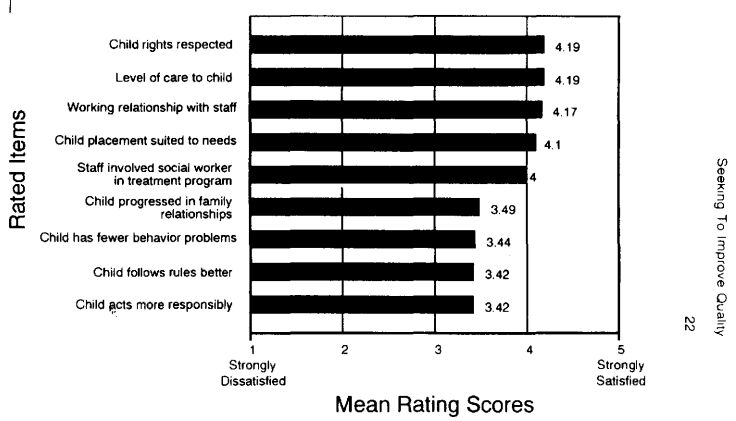
FIGURE 1
Parent Ratings (n = 35)



Social Workers

Figure 2 shows the nine items that were rated by the social workers. They expressed the most satisfaction (M > 4.0) with items pertaining to staff professionalism and the operation of the programs, and that the center was suited to the clients' needs. The social workers, however, were less satisfied that the clients' behavioral problems had been reduced (M = 3.44), that the children had shown an improvement in their family relationships (M = 3.49), and they were not entirely satisfied with the client's sense of personal responsibility or their attitudes toward authority (M = 3.42).

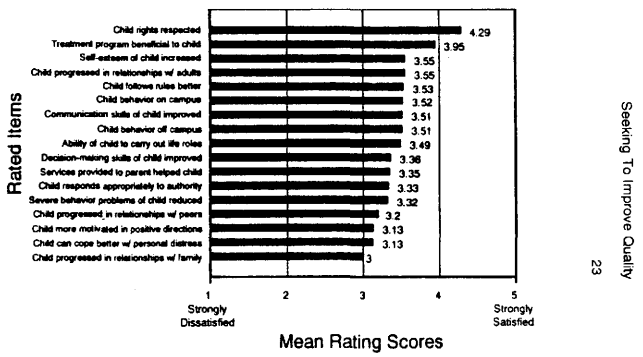
FIGURE 2
Social Worker Ratings (n = 48)



Child Care Workers

Figure 3 shows that none of the 17 items were rated less than 3.0. The child care workers were most satisfied that the clients' rights had been respected (M = 4.29) and that, on the whole, the treatment programs were beneficial to the client (M = 3.95). However, they expressed uncertainty or marginal satisfaction concerning the items pertaining to the clients' amount of improvement in behavioral adjustment, self-esteem, cognitive abilities, and general social skills.

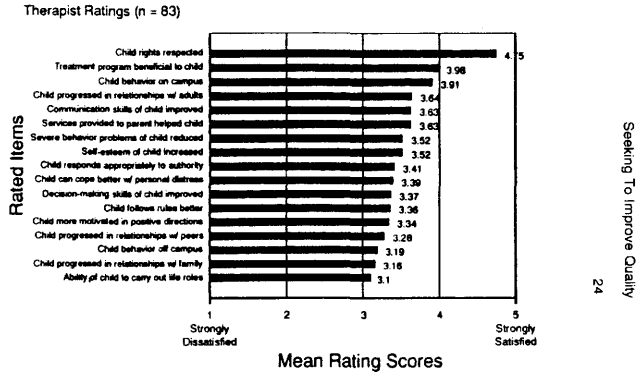
FIGURE 3
Child Care Worker Ratings (n = 55)



Therapists

Figure 4 indicates that the therapists were most satisfied that the clients rights had been respected (M = 4.75) and that the treatment program was effective overall (M = 3.98). In other areas the therapists were undecided or marginally satisfied with the items pertaining to improved cognitive abilities, interpersonal skill-building, positive self-esteem, and behavioral adjustment. Some notably weak areas identified were that the clients had difficulty in adjusting to basic life roles such as being a "student" or "employee" (M = 3.1), and that their peer (M = 3.28) and family relations (M = 3.16) were less than satisfactory. A slight difference occurred between how the therapists felt the clients behaved on and off campus; therapists were more satisfied with the clients' behavior on campus (M = 3.91) than off campus (M = 3.19).

FIGURE 4
Therapist Ratings (n = 83)



Group Differences

Analysis of variance was used to determine if there are statistically significant ($p < .05$) differences in the group ratings of the four themes that were mentioned earlier: i.e., behavioral adjustment, general social skills, personal relationship skills, and program effectiveness. The client group was omitted from this analysis because the client form used a categorical rating scale. Items for each theme were summed to yield composite scores. Using Pillai's criterion, a multivariate analysis of variance (MANOVA) was then performed on the four themes by group. The findings indicated that the four groups did not differ statistically in their ratings of the four identified themes [$F(12,618) = 1.71$, $p < .06$].

An additional MANOVA was carried out to determine if the child care workers and therapists differed significantly ($p < .05$) on their ratings of cognitive skills and positive self-esteem. The findings were nonsignificant [using Pillai's criterion, $F(2, 134) = 0.03$, $p < .97$], which means that for practical purposes we should act as if the two groups have similar ratings.

Discussion

In order for the survey results to be useful in terms of TQM, it seems necessary to establish an arbitrary cut-off score or standard for the questions that are being rated. Once this standard is established (e.g., satisfactory - 3.0), any score below it can identify certain issues that may need to be dealt with to ensure agency-wide quality. More specifically, this means that problems can be identified, along with their possible causes and solutions, to assure conformance to standards in a way that fulfills the needs of the customer. In light of this, defining who is the customer is an important consideration because each consumer group may have different quality requirements (Imai, 1986; Ishikawa, 1985).

In residential youth care, children and their families are the obvious consumers of treatment services. Funders and politicians, however, are also important external customers because they provide the political and financial support that ensures the survival of the organization. TQM dictates that each stage of the production or service process is the "customer" of the previous stage (cf. Imai, 1986). When adapting this notion to residential care, a variety of internal customers begin to appear. For instance, the afternoon shift of child care practitioners expects the morning shift to have met or surpassed specific program standards. In view of this, quality issues need to be identified and addressed at each stage of the treatment process.

With regard to the study's findings, it is noteworthy that none of the groups expressed dissatisfaction (mean < 3.0) with any of the items rated on the 1-5 scale. As such, it may be inferred that the center is accomplishing its goals, as measured by the questionnaires, and is providing useful services to the consumer. On the other hand, improvements in service quality require that treatment practitioners and administrators focus more attention on the many marginal scores pertaining to the treatment outcomes and less attention on the higher ratings that deal with staff professionalism.

Accordingly, several of the groups identified the development of interpersonal skills in clients as a possible area for further consideration. In addition, child-care workers were concerned with the clients' behavioral adjustment and level of self-esteem, while the clients themselves seemed particularly concerned that they had not been helped to improve their schoolwork. A possible factor in the different outcomes is that some variables may be more complex than others, so that they respond more slowly to treatment. Schoolwork, for instance, typically requires a building-blocks approach to learning (e.g., it takes time for the student to catch up before moving forward). With regard to family relationships, they often involve complex circumstances which frequently require more time to sort out satisfactorily. (For instance, in some dysfunctional families it may actually be healthier for the child to disobey particular family rules.) In terms of life-role expectations, younger clients could not be expected to have the same understanding as older ones. As such, an important consideration for future research is to examine the effects of age and the "time in program" on measures of treatment outcome (Josephson, Magee, Alberts, & Selkirk, 1992).

Generally, the findings point to the need for continual training opportunities so that child care practitioners and teachers can constantly upgrade their skills and acquire the specialized knowledge necessary to work more effectively with troubled youths. It is also worth noting that TQM starts with training in that strong efforts are made to instill TQM thinking in all employees, which may include part-time staff and volunteers. In short, everyone becomes involved in the problem-solving process so that constant, gradual improvements are made in all aspects of the service delivery process (Imai, 1986).

Questionnaire ratings and responses to any open-ended questions that may be included in a survey should be discussed in each program (e.g., in staff meetings) so that potential problems can be identified and resolved. In addition, separate meetings could take place with each of the remaining stakeholder groups to discuss their concerns in greater detail. An adjunct or alternative to these meetings could be to establish an agency-wide quality council, consisting of representatives from a variety of programs, to deal with survey results and those problems identified which undermine quality (Harrington, 1987). Some child care workers, for instance, may feel that particular survey questions (and hence program goals) seem irrelevant or they may believe that the operational standard (mean = 3.0) is too low. Through a quality council, important issues may then be discussed that deal with program and agency-wide objectives, including the development of realistic treatment standards within a quality framework, related training needs, agency marketability, political sensitivity, and so forth.

Certain authors have stated that residential treatment services have been disappointingly ineffective (Beker, 1992) or equivocal at best (Fewster & Garfat, 1987). Perhaps this is because not enough attention has been

placed on the intermediate steps that contribute to negative treatment outcomes (Sechrest & Rosenblatt, 1987). Attempts to achieve quality in human services should involve an analysis of these critical intervening processes, which would include the appropriateness of the service itself (Sinclair, 1982). In this context, consumer surveys within an evaluative framework (Love, 1991) can be used to inform the other components of the quality cycle (cf. Kelada, 1990, p. 6) of critical issues so that every step in the treatment program aims to enhance the overall quality of the operation.

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