

Position Statement 44: Residential Treatment for Children and Adolescents with Serious Mental Health and Substance Use Conditions

Policy Position

Some residential treatment programs, especially community-based non-profit residential programs, provide excellent care and communicate candidly with families. However, the United States Government Accountability Office's 2007-8 studies demonstrated ineffective management practices, lack of staff training, misuse of physical restraints and deceptive marketing practices in eight case studies of abuse and death in residential facilities and called for "enhanced oversight" of facilities that deal with youth with behavioral and emotional challenges.¹

Mental Health America believes that deficiencies in residential facilities for children with mental health conditions are widespread, that the recent growth of non-community-based, for-profit programs is a serious threat, and that urgent action is needed to address issues of quality of care in residential treatment facilities. States should consider amending existing legislation to promote evidence-based practices, monitor outcomes, ban most use of seclusion and restraints,² mandate effective licensure, training, and continuing education, and require background checks of all treatment personnel in child- and youth-serving residential treatment facilities.

State agencies should be vigilant in inspecting and monitoring residential treatment facilities by focusing on outcomes rather than processes and avoiding the kind of "regulatory capture" and "paper compliance" that makes such programs ineffective. And families and caregivers should be provided with honest, understandable, and detailed information about the service options available and the mechanisms by which these services can be funded.

Background

Clifford Beers, the founder of Mental Health America, made his mark in exposing the brutality of the state hospitals for the mentally ill, the residential treatment facilities of his day. As with asylums, mental hospitals and nursing homes, whose scandals fueled the modern mental health movement, assuring quality of care in residential treatment facilities for children and adolescents has proved a difficult task. With some exceptions,³ periodic scandals have not produced effective regulation at the state level, which is the level of government that regulates residential treatment facilities, though the federal government has recently expressed concern.⁴ The number of instances of abuse in out-of-state facilities is a particular cause for federal concern.

Mental Health America believes that the states should act to demand greater accountability from this component of the residential care industry. That role is incumbent on the states because these private facilities have replaced state institutions and now market themselves directly to families without state oversight.

The April, 2008 GAO Report to the House Committee on Education and Labor documented the abuse, neglect and misrepresentation at private “wilderness therapy programs, therapeutic boarding schools, academies, behavioral modification facilities, ranches and boot camps, among other names....” The private children’s and adolescent’s residential treatment industry was indicted by the report, which concluded from the study of eight deaths in treatment that there was: “significant evidence of ineffective management,” “leaders neglecting the needs of program participants and staff,” “hiring of untrained staff,” “lack of adequate nourishment for enrolled children,” and “reckless or negligent operating practices, including a lack of adequate equipment.”⁵ “In the eight closed cases that [the GAO] examined, ineffective management and operating procedures, in addition to untrained staff, contributed to the death and abuse of youth enrolled in selected programs. In the most egregious cases of death and abuse, the cases exposed problems with the entire operation of the program. The practice of physical restraint also figured prominently in three of the cases.”⁶

The other focus of the GAO investigation was deceptive marketing. Posing as concerned parents, the GAO uncovered conflicts of interest and “potential fraud, false statements, and misleading representations related to a range of issues including tax deductions, education, and admissions policies.”⁷ The most egregious case was a “referral” counselor who acted as a feeder for her husband’s boot camp.

The U.S. Department of Health and Human Services, Center for Mental Health Services, issued a report on state regulation of residential mental health facilities for children in 2006, but the report was only a taxonomy and did not test how well the regulation worked.⁸ Significantly, the study did not identify any form of outcome monitoring or monitoring of use of seclusion and restraints beyond critical incident reporting. No follow-up has been done to test the quality of the regulation. But if the GAO is credited, at least the states of California, New York, Texas, Pennsylvania, New Jersey, Mississippi, Utah and Colorado should be concerned. Thus, at a time when community-based mental health treatment has embraced outcome monitoring, residential treatment needs to be subjected to increased scientific scrutiny and regulation.

The great dilemma in intervening to help children at risk of bad outcomes is determining when to abandon the family-centered therapy that we know works best to risk an out-of-home placement in a residential treatment facility. When is the avoidance of harm in the family worth the resultant disruption of family life and community integration? For local, community-based, non-profit facilities, the choice is not as hard and may result in a relatively quick transition back to the community. But it is much harder for parents to compare the risks in deciding whether or not to enroll their child in a private out-of-state facility that may prove unresponsive and even abusive and that may be impervious to community pressures and resistant to transparency and family collaboration. Similarly, when should parents consent to an out-of-state placement by a public agency, knowing that the public agency cannot effectively monitor such a placement? How can we as a society mitigate these legitimate concerns and improve the quality, transparency, collaboration and responsiveness of residential treatment?

Mental Health America believes that in spite of the imperative to avoid it whenever possible, residential treatment programs for children and adolescents with mental health and substance use conditions are necessary components of a continuum of care, to be used especially when the

capabilities of the family are seriously impaired or the safety or the behavior of the child or adolescent requires out-of-home placement, despite support from community mental health and substance abuse programs. Children and youth may require residential treatment when community-based alternatives have been explored and have not successfully addressed the person's needs, when the complexity of his/her needs confounds community-based care and requires a 24-hour environment to accurately understand those needs and respond, and when the severity of the behavioral problems requires a 24-hour environment in order to keep the person safe and prepare him/her to be more responsive to community based care.

MHA believes that community-based, non-profit residential programs are usually better run and more subject to community scrutiny. Most importantly, when a child enters residential treatment anywhere, it is imperative that the service agencies in that child's community redouble their efforts to be actively involved in treatment and discharge planning and post-discharge preparation, ensuring that the treatment facility has comprehensive information about the child's history and the impact of previous treatment efforts, participating in the development and implementation of the care plan, working with the family to increase their ability to manage the child's behavior after returning home, and ensuring that a meaningful care plan is developed to support the child's return to the community after the goals of residential treatment have been met.

Call to Action

Mental Health America urges that its affiliates support model state legislation in their states to improve state oversight of residential treatment facilities in general. As stated in the policy, states should consider legislation to promote evidence-based practices, monitor outcomes, ban most use of seclusion and restraints,⁹ mandate licensure, training, and continuing education, and require background checks of all treatment personnel. State agencies should be vigilant in inspecting and monitoring residential treatment facilities by focusing on outcomes rather than processes and avoiding the kind of “regulatory capture” and “paper compliance” that makes such programs ineffective. And families and caregivers should be provided with honest, understandable, and detailed information about the service options available and the mechanisms by which these services can be funded. A state-funded complaint line should be available to families and other witnesses to alert states to the need for increased vigilance and proactive enforcement as needed.

Service providers should cooperate and:

- fully disclose the nature and extent of services they offer, for whom the services are intended and whom have been shown to benefit, areas of specialization supported by credentials, and staffing patterns.
- Fully involve the family in placement, treatment and discharge planning
- Update the family on any concerns detected through monitoring the child
- furnish statistical information regarding the outcomes for children and adolescents who have been served.
- acknowledge when a particular program or service might be inappropriate to meet a child's needs.

Effective Period

The Mental Health America Board of Directors approved this policy on January 1, 2010. It is reviewed as required by the Mental Health America Public Policy Committee

Expiration: December 31, 2015

1. GAO, “Residential Treatment Programs: Concerns Regarding Abuse and Death in Certain Programs for Troubled Youth,” GAO-08-146T (October, 2007), GAO, “Residential Programs: Selected Cases of Death, Abuse, and Deceptive Marketing,” GAO-08-713T (April, 2008), and GAO, “Residential Facilities: Improved Data and Enhanced Oversight Would Help Safeguard the Well-Being of Youth with Behavioral and Emotional Challenges,” GAO-08-346 (May, 2008).
2. See Mental Health America Position Statement No. 24 “Use of Restraining Techniques and Seclusion,” suggesting that these techniques be banned.
3. The Utah statute is the most comprehensive, designed to capture every type of facility. See Utah Code, [Title 62A](#) Human Services Code, [Chapter 2](#) Licensure of Programs and Facilities, **Section 106** Office responsibilities. Section 31.26 of the New York Mental Hygiene Law, cited as Laws of New York MHY§31.26, is considered exemplary. It forbids for-profit residential treatment facilities and establishes uniform admissions and cost-accounting procedures, but leaves the rest to regulations and cooperative agreements. Outcomes monitoring is still not mandated.
4. The 2007 and 2008 GAO reports cited in footnote 1 were a direct critique of state regulation of the industry.
5. April, 2008 GAO Report, “Residential Programs: Selected Cases of Death, Abuse, and Deceptive Marketing,” GAO-08-713T, at p. 1.
6. *Id.*, at p. 3.
7. *Id.*, at p. 5.
8. Ireys, HT, Achman, L, Takyi, A. “State Regulation of Residential Facilities for Children with Mental Illness,” DHHS Pub. No. (SMA) 06-4167. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2006.
9. Federal regulations last amended in 2008, while assuring the least restrictive alternative, specifically allow use of restraints or seclusion to protect the individual or staff. 42 C.F.R. §482.13(e).