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W W W . A A C A P . O R G

Principles of Care for Treatment of Children and Adolescents with Mental Illnesses in Residential Treatment Centers

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Introduction

The best place for children and adolescents is at home with their families. A child or adolescent with mental illness should be treated in the safest and least restrictive environment and needed services should be “wrapped-around” to provide more intensive home or community-based services. However, due to the severity of an individual’s psychiatric illness, there are times when a patient’s needs cannot be met in a community-based setting. The Child and Adolescent Service Intensity Instrument (CASII; AACAP, 2007) defines level of service intensity by a combination of variables: clinical services, support services, care environment, crisis stabilization and prevention services. When the treating clinician has considered less restrictive resources and determined that they are either unavailable or not appropriate for the patient’s needs, it might be necessary for a child or adolescent to receive treatment in a psychiatric residential treatment center (RTC). In other cases the patient may have already received services in a less restrictive setting and they have not been successful. Psychiatric residential treatment is part of the medical spectrum of care. The array and intensity of services provided in individual residential treatment centers vary greatly. RTCs are programs designed to offer medically monitored intensive, comprehensive psychiatric treatment services for children and adolescents with mental illness or severe emotional disturbance. The assessment of an individual’s appropriateness for treatment

within a RTC must include a number of factors, foremost being the child or adolescent's safety and the safety of others.

The best intervention for serious mental health issues that cannot be treated in the child's home environment is a facility that has a multidisciplinary treatment team providing safe, evidence-based care that is medically monitored. A mental health professional should lead this team. A psychiatrist with training and experience consistent with the age and problems of the children served should inform and monitor this process. The treatment should be family-driven with both the patient and the family included in all aspects of care. The key components of family-centered residential treatment are consistent with the *Building Bridges* resolution (SAMHSA, 2008) and include the following:¹

- Maximize regular contact between the child and family
- Actively involve and support families with a child in residential treatment, and
- Provide ongoing support and aftercare for the child and family.

This document provides stake holders the best principles for treating children and adolescents in RTCs. There are some residential treatment centers that provide excellent care; however, the U.S. Government Accountability Office (GAO) has reported others have caused harm or death to a child. (GAO report 10/07, www.gao.gov/cgi-bin/getrpt?GAO-08-146T). At times state statute defines "boot camps" or "wilderness therapy programs" as residential treatment centers, but frequently they do not provide the array or intensity of services that would meet the definition of a clinical residential treatment center. Most of the "boot camps" and "wilderness programs" do not utilize a multidisciplinary team that includes psychologists, psychiatrists, pediatricians, and licensed therapists who are consistently involved in the child's care. Also, the Joint Commission nearly universally denies certification for these types of programs that fail to meet the quality of care guidelines for medically supervised care from licensed mental health professionals.

There are a number of standards for residential facilities, including those issued by state licensing boards, National Quality Programs (Joint Commission, URAC, and CARF), insurance companies, and federal governmental agencies (TRICARE/CMS). However, the oversight at the state level varies. There are no federal laws that regulate residential treatment programs, but facilities can voluntarily adopt national standards. The American Academy of Child and Adolescent Psychiatry (AACAP) endorses the adoption of the national Joint Commission standards for certification for residential facilities. However, there are a number of concerns that the Joint Commission does not address in its standards. This guideline is a supplement to the Joint Commission standards.

I. Program Description

An RTC is a facility that provides children and adolescents with a residential multidisciplinary mental health program under medical supervision and leadership. It is often utilized when the child cannot be treated in a community-based setting. Treatments should be implemented by a team of mental health professionals with graduate level training. Psychiatrists and mental health professionals should meet face-to-face on a weekly basis as a treatment team to assess progress and modify the treatment plan when necessary. The psychiatrist should also meet with the patient once a week or more as clinically indicated.

The RTC program should:

- Provide for the child's developmental, emotional, physical and educational needs including intensive mental health care, physical health care, and access to on-going education at the appropriate developmental level
- Offer different modalities of evidence-based treatment specific to the child's psychiatric, educational, developmental and medical disorders
- Follow national guidelines for treatment for specific mental disorders
- Train staff in evidence-based psychosocial interventions
- Train staff in the use of family-centered care
- State what conditions they do and do not treat and the types of treatment they are able to provide
- Have written policies covering significant events like injuries, elopements, restraints, as well as patient and/or family complaints.

II. Leadership Structure and Staffing

Day-to-day clinical leadership of a residential treatment center shall be provided by a professionally trained individual (at a masters or doctorate level) in a relevant mental health discipline, including psychiatry, psychology, social work, nursing, counseling or rehabilitation/activities therapy. This individual should also have at least three years of clinical experience. If the program serves children aged thirteen and under, a child and adolescent psychiatrist with American Board of Psychiatry and Neurology certification should have responsibility for the clinical aspects of the therapeutic program by serving as the facility's medical director. The medical director for programs treating adolescents over age thirteen should be board certified in general psychiatry with extensive experience in the treatment of adolescents or board certified in child and adolescent psychiatry.

A registered nurse with at least one year experience in mental health services or a mental health worker (a person with bachelor's degree in psychology, sociology, social work, counseling, nursing education, rehabilitation counseling and at least one year of experience in mental health services) should provide 24 hour developmentally sensitive child supervision, leisure and supportive care. A person with a high school diploma and five years experience in mental health services may also be a supervisor but on no more than one shift per day. Residential staffing must be consistent with the clinical care needs of the residents, with monitoring of the acuity of the individual so that the milieu and staff resources can respond to patient needs during all shifts. When there are both male and female residents, both male and female staff must be available. Staff, in addition to the supervisors, may be mental health aids with a high school level education and additional training in skills necessary to provide safe and competent care.

Registered nurses who are on-site at least eight hours per day must manage medication and other medical treatment as well as the general health status of each child. An on-site primary care physician or nurse practitioner may provide medical care of physical illness and well-child care. Prearranged and contracted community based services may also deliver that care.

RTC staff/staffing should:

- Be trained in evidence-based/research-based psychosocial and other interventions,
- Be trained on and use family-centered care within the facility,
- Be appropriate for the number of patients,
- Be multidisciplinary and culturally competent,
- Include a child and adolescent psychiatrist or in the case of an adolescent program, an adult psychiatrist with training in treating that age group,
- Ensure that ancillary staff has appropriate training and licensure,
- Include leadership provided by professionals with graduate level training and appropriate license and credentials who demonstrate expertise in the treatment of youth,
- Be appropriate for all acuity levels,
- Be of an appropriate gender for daily hygiene and activities of daily living needs,
- Include on-site nursing care and supervision for one shift a day with on call availability for other shifts,
- Provide medical care (ill and preventive care) by a qualified primary care provider who is available 24 hours a day with hospital resources identified when necessary, and
- Require all staff to be screened with finger printing on a national level, driver's license and criminal record reviews, and a face-to-face interview to minimize the possibility of employing a predator who could endanger a child.

However, in isolated circumstances where workforce issues may mitigate such staffing comparable levels, credential expertise and experience should be documented and required.

III. Admission Process, Treatment Planning and Discharge Planning

As documented in a comprehensive psychiatric evaluation, medical necessity drives admission to an RTC. The primary treatment goal is to return the child or adolescent to the community in order to resume the family, social, and educational functions that contribute to normal development. Discharge planning should begin at the time of admission and shape the treatment process. Along with the items mentioned below, the RTC has the responsibility to collect data on the treatment outcomes and report on that data to assess whether the facility is achieving positive treatment outcomes to the interventions provided.

The admissions process should:

- Include a comprehensive evaluation prior to admission by a licensed graduate-level provider.
- Include a documented current DSM diagnosis and evidence of significant distress/impairment.
- Include a discharge plan.
- Include a medical assessment and a physical examination within the first 24 hours of admission, unless a physician determines that an examination within the week prior to transfer to the facility is sufficient.
- Include a review and approval of the admission by a psychiatrist for appropriateness and safety of the program.
- Identify family resources and family participation in treatment.

An initial comprehensive treatment plan must be completed within 7 days. Treatment planning should:

- Be developed jointly with the family and youth.
- Include multidisciplinary assessments.
- Establish measurable goals and objectives.
- Be reviewed every 4 weeks.
- Include appropriate monitoring of medications.
- Include treatment modalities that are appropriate to the clinical needs of the child.
- Include the family in at least weekly therapy or, if the family lives greater than 3 hours from the facility, weekly telephone contact for family therapy must be conducted with monthly face-to-face family therapy sessions.
- Include supportive services such as religious services when requested.
- Be an extension of treatment plans formulated in previous clinical settings.

Discharge planning should:

- Begin at admission.
- Include coordination of follow-up and ongoing involvement with family and/or guardians.
- Take advantage of all community services.
- Reflect specific discharge criteria.
- Ensure that the child has a place to go at the time of discharge and that person or agency actively participated in the treatment. If a biological parent or extended family member is not available or appropriate, the designated foster parent must actively participate in the child's treatment.
- Provide families with the strategies to help their child adopt to "family life" when they return home.
- Involve coordination with community-based services to ensure a continuum of care.

IV. Prevention of Aggressive/Dangerous Behavior

An RTC must provide a safe treatment and physical environment for children and adolescents, as well as for staff and visitors, without compromise. All policies for its implementation and enforcement must be reviewed and updated on a regular and timely basis. Prevention of aggressive and dangerous behavior is essential. For a detailed guideline on prevention of aggressive behavior, please see the *Practice Parameter for the Prevention and Management of Aggressive Behavior in Child and Adolescent Psychiatric Institutions, With Special Reference to Seclusion* (JAACAP, 2002).

To ensure RTC safety, all RTCs should:

- Have a policy that strives for a restraint-free milieu consistent with national standards and regulations.
- Review these policies with staff at least annually.
- Train all staff on effective de-escalation techniques and anger management techniques to eliminate the need for seclusion or restraint.
- Study causes of aggressive incidents and implement evidence-based techniques to prevent recurrence.
- Evaluate the patient by a medical professional or nursing staff within a timely manner after a seclusion or restraint or complaint of physical injury occurs, consistent with Joint Commission and CMS requirements.
- Train all staff in a protocol that includes the method to hold or contain a child who is a threat to themselves or others. The protocol must be nationally accepted and shown to be safe and not harmful to the child or staff. There is no clear indication or evidence to support use of “holding therapies.” Interventions that restrict the physical movement of the child or adolescent are a form of restraint and should only be used to ensure the safety of the child and others and should not be used for punitive measures. Aversive therapies should not be used.
- Track all incidents of physical hold or restriction of movement by the facility and be reviewed periodically by the clinical and administrative staff. Treatment plans should be altered as needed.
- Have a written protocol for transfer of a patient to an inpatient psychiatric facility if a child is deemed to be unsafe to self, peers, or staff.
- Refer all crimes committed by staff to local law enforcement.
- Behavior that could constitute a basis for criminal charges should be evaluated from a clinical and legal perspective. After such a review, staff should consider the appropriateness of bringing criminal charges.

V. Therapeutic Services Standards

Therapeutic Services Standards (TSS) are intended to assure that evidence-based treatment and expertise of appropriately credentialed specialists in child and adolescent mental health (including child and adolescent psychiatrists) are integrated into the patient’s daily life at the RTC. To accomplish this goal, TSS describe a clearly delineated treatment philosophy that is multidisciplinary in scope, encompasses all aspects of the child or adolescent’s experience, is evidence-based and is appropriate to the population served.

RTCs should have TSS that includes the following components:

- Licensed professionals with specific expertise in diagnoses specific to the population the RTC is serving.
- Trained in evidence-based practices.
- The child and adolescent psychiatrist’s role should include attendance at multidisciplinary team meetings and treatment planning conferences, clinical supervision of other direct care personnel, involvement in therapeutic program development, and work with the clinical leadership team in monitoring the quality of care and outcomes

provided at the RTC. The child and adolescent psychiatrist's role should include participation in multidisciplinary treatment planning and quality assurance activities and should not be limited to the role of medication management and patient direct services. Additional meetings, including IEPs, family conferences, and other planning meetings may be attended as appropriate.

- When medication is used, medication monitoring will be provided by a child and adolescent psychiatrist. If a child and adolescent psychiatrist is not available to the program, a physician or other licensed prescriber with specific training and clinical experience to the population served will provide these services.
- Engagement of the child's or adolescent's family and other community supports (such as referring physicians, therapist agencies, and school systems) in all aspects of treatment.
- Treatment goals will build upon the strengths of the child or adolescent and their family, and identify areas to be therapeutically addressed with specific outcomes that document progress toward those goals.

VI. Special Populations and Programs

Some specific populations and diagnostic groups require specialized RTCs that admit individuals with these disorders. They must have in place an appropriate therapeutic milieu and treatment programs. Due to both therapeutic needs and safety concerns, it is frequently necessary for individuals within these diagnostic groups to receive treatment with specialty-specific RTCs, or within contained programs as part of a larger RTC. The RTC should be able to provide evidence that all clinical staff is familiar with the specific treatment needs and therapeutic goals for these groups. It is ultimately the responsibility of the clinical and medical directors to determine which disorders their facility can effectively and safely treat using current standards of evidence based medicine.

Specialized populations include children and youth with

- Autism/pervasive developmental disorders
- Eating disorders
- Reactive attachment disorders
- Substance abuse disorders
- Oppositional, defiant and conduct disorders
- Sexual perpetrators.

RTC's should have programs to meet the needs of unique populations, including specialized trained staff and ensure that children and/or adolescents with potentially dangerous behaviors and conditions are not residing or being treated with vulnerable individuals.

VII. Educational Services

Educational services should be appropriate to the individual patient's needs, and consistent with the academic pace that was maintained previously. Other special services may be needed.

All RTCs should:

- Ensure that a formal educational plan is in place for each child within 30 days of admission.
- Coordinate with the student's home school. If an individualized education plan (IEP) is in place, it should be followed. Every child should have a 504 plan or IEP.
- Provide for staffing of teachers who are appropriately specially trained to teach youth with mental illness and learning disabilities, or to contract with the local school district special education program to obtain these services.
- Include formal testing for vision, speech and language, academics, (and when appropriate, psycho-educational testing) if not previously done.
- For placements longer than the state board of education designated absentee limits, the child should receive accredited educational services.

VIII. Therapeutic Environment

The living environment for children residing in a residential treatment center is an integral part of the overall treatment experience. The space arrangement, size, appearance and maintenance of the facility should communicate messages of caring, comfort and safety. Children making the transition from home often form their initial impressions of the facility from its physical presentation. The physical layout of sleeping rooms and living areas impact the effectiveness of staff supervision of resident interaction. Adequate, well-maintained space and furnishings contribute to the exercise of self control in the residents. Failure to promptly repair any damage contributes to dangerous situations.

The environment of the RTC should:

- Be sensitive to trauma-related issues and their treatment.
- Provide documentation of a residents' anticipated vulnerabilities and problem behaviors
- Be appropriate to the age and developmental needs of the residents.
- Have areas for privacy as indicated (bedroom, bathroom, family visits and therapy).
- Promote individual dignity.
- Include basic rights to food, shelter, medical care, religious freedom, and education.
- Have a safe and protected space for personal items.
- Allow for face-to-face contact with family or others unless the treatment team finds specific individuals detrimental to treatment goals and documents that in the resident's record.
- Allow for telephone communication with family or guardians or to speak with the court/state's representative if the state has custody.
- Follow grievance procedures that should be posted in plain view of residents.

APPENDIX: Special Populations and Programs

The therapeutic goals for each RTC patient need to be developed and based on an understanding of the unique needs of each individual child or adolescent. Alongside the recent development of Evidence Based Practice (EBP), there has been an emergence in illness specific RTCs and programs that focus on the treatment of one particular illness or disorder. Medical practice indicates that there is some benefit to this approach in so far as expertise and efficiency can both be improved. Residential treatment of illnesses like eating and substance abuse disorders in which the combination of treatment resistance, potential medical complications, and propensity to relapse require a facility and staff to be well versed in the unique complexities of these disorders. Still, the lack of available treatment centers, the presence of co morbid psychiatric illness and/or geographic necessity might require that a child or adolescent with these or other psychiatric disorders receive treatment in an RTC that is not specialty focused. In such cases, the clinical and medical directors have the responsibility to determine which disorders their facility can effectively treat using current EBP standards.

The following subsection is a list of specific psychiatric disorders that by nature of their complexity generally require treatment programs that are highly specialized. Also included is a short summary of specific program requirements that an RTC would need to have in place in order accept and effectively treat a child or adolescent with that disorder. This list of disorders and their individual program requirements is not intended to be exhaustive. For additional information regarding the accepted treatments and ancillary services needed to address the needs of these populations, please refer to the Practice Parameters of the American Academy of Child & Adolescent Psychiatry and to the Practice Guidelines for the American Psychiatric Association.

The treatment of each of the following disorders require at an absolute minimum that the RTC have on-site a integrated, multidisciplinary treatment team consisting of a medical director, educational specialist, nurse, behavioral psychologist, and social worker who are all familiar with the treatment and developmental needs of children and adolescents.

1. Autism and Pervasive Developmental Disorders
 - a. A structured educational setting staffed with graduate level professionals familiar with the special educational needs of developmentally delayed children and adolescents.
 - b. A licensed speech and language therapist, physical therapist and occupational therapist must be included in the multi-disciplinary treatment team.
 - c. Evidence exists for the efficacy of Applied Behavioral Analysis and other therapies utilizing the non-punitive, non-coercive reinforcement of pro-social behavior in a highly structured setting for the treatment of behavioral problems in children with autistic spectrum disorders. A licensed doctoral level professional should supervise these programs. That person is also responsible for overseeing the development of an individualized behavioral plan based on the unique needs of each child and adolescent.

2. Eating Disorders

- a. Residential care should be considered for those children and adolescents who present with prolonged and chronic symptoms that have not responded to acute, short-term hospitalization.
- b. This multi-disciplinary treatment team should include a child and adolescent psychiatrist, pediatrician, dietitian, graduate level psychologist, social worker, nurse, physical or occupational therapist as well as counselors and mental health technicians. Each team member must be familiar with the special needs of children and adolescents with eating disorders.
- c. The RTC must have access to emergency medical services 24 hours a day.
- d. Please see the American Psychiatric Association Eating Disorder Guideline for more detail.

3. Foster Care Children and Reactive Attachment Disorder

- a. Given the frequency of developmental delays that occur in children with Reactive Attachment Disorder and children in foster care, the following professionals should be included in the multidisciplinary treatment team: a child and adolescent psychiatrist, a graduate level psychologist or social worker, nurse, a licensed speech and language therapist, a physical therapist, and an occupational therapist.
- b. Placement and reintegration into the community should be active and ongoing. The child and the parent or legal representative should be involved throughout the treatment process.
- c. Social work and family based services must be included from the beginning of treatment to insure a successful transition upon discharge to the patient's family or foster family.

4. Substance Abuse Disorders

- a. Residential treatment might be indicated to treat adolescents with substance abuse disorders when the chronic nature of their problems has failed to respond to intensive outpatient or partial hospitalization programs.
- b. The RTC treatment team should include a child and adolescent psychiatrist in addition to licensed mental health professionals who are familiar with the needs of patients with co occurring substance abuse and psychiatric disorders. Mental health services should be fully integrated with the individual's substance abuse treatment program.
- c. In all programs, including those lasting sixty days or less, an educational assessment should be included with a plan to address the adolescent's ongoing educational needs.

5. Conduct Disorders

- a. Residential treatment programs should provide multi-modal treatment, including a therapeutic community with a level system, behavioral modification and other techniques.
- b. The family or guardian should be involved in treatment, including parent training and family therapy with or without the patient present. The younger the patient,

the more critical is the family's or other caretakers' involvement. If family treatment is not provided, the reasoning for its omission should be documented.

- c. Individual and group therapies should be included. An appropriate school program, including special education and vocational training should be part of treatment.
- d. An individualized treatment plan should address specific treatment for comorbid disorders. Psychosocial programs should be included if indicated.
- e. Treatment coordination with school, social services, and juvenile justice personnel should be ongoing, to assure timely and appropriate discharge to step-down facilities and return to the community.

ⁱ*Family-centered Residential Treatment: Knowledge, Research, and Values Converge.* Walter, Uta M.; Petr, Christopher G. Residential Treatment for Children. Vol. 25(1), 2008, 1-16.

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