

# **Characteristics of Residential Treatment** **For Children and Youth with Serious Emotional Disturbances**

**By Abt Associates Inc.**

**For the  
National Association for Children's Behavioral Health (NACBH)  
and  
National Association of Psychiatric Health Systems (NAPHS)**

**Summer 2008**



**Abt Associates Inc.**

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## **Acknowledgements**

NACBH, NAPHS, and Abt Associates wish to acknowledge and thank the key informants who gave their time and shared their perspectives as leaders in children's mental health advocacy, public policy, clinical research, accreditation, regulation, and financing of care.

NACBH and NAPHS would also like to thank their members for participating in a survey illustrating current practices in residential treatment programs. Most importantly, we would like to thank those who participated in the NACBH/NAPHS Work Group on Residential Treatment for their time, talent, and years of commitment to serving children, youth, and their families.

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## **Executive Summary**

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Millions of American children and youth experience serious emotional and substance use disorders (*see chapter on "Prevalence"*). Of these, a critical percentage experience problems so severe, disabling, or complex that they require 24-hour out-of-home placement for treatment.

Many types of residential programs exist. How can the differentiation be made between the 24-hour services that provide *treatment* for children and youth with serious emotional disturbances and substance use disorders and those that only provide care and housing? The question is particularly timely as states, federal policymakers, payers, and others work to identify what services should be funded to meet the needs of youth with the most serious illnesses and how the programs should be defined and regulated.

Abt Associates was asked by the National Association for Children's Behavioral Health (NACBH) and the National Association of Psychiatric Health Systems (NAPHS) to develop this paper to focus on the characteristics and role of a specific type of specialized treatment, residential.

This paper is intended to reintroduce state and federal policymakers and other key stakeholders to residential treatment programs as they are distinguished today from the many other types of residential programs - as a vital resource to attend to the unique needs of children and youth with serious enough and debilitating enough symptoms and diagnoses to require a structured, safe, and therapeutic out-of-home placement.

## **Conclusions**

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An Abt survey of members of the National Association for Children's Behavioral Health (NACBH) and the National Association of Psychiatric Health Systems (NAPHS) indicates that the children and youth served by the NACBH and NAPHS residential treatment programs are clinically complex and functionally impaired, with multiple psychiatric diagnoses and co-occurring substance use, neurological, developmental, learning, medical, and other behavioral disorders.

Residential treatment is a treatment of choice, albeit a difficult one, when a young person is in need of a total 24-hour safe, structured environment to provide an array of appropriate and relevant services to address the severity of social, emotional, and/or behavioral disorders. As important as the admission criteria to assure clinical necessity is the need to assure for the child or youth that there is the therapeutic potential to benefit from treatment.

Residential treatment is an intervention, not a destination. It is a level of care in an array of services that children and youth, with or at risk of emotional or behavioral disorders, need at a particular time given their histories, diagnoses, complexities of impairment, and living and learning situations. It is a critical component of a system of care that some children need in order to have the chance to recover and regain their functioning in daily lives in the community as

productive participants at home and in school, safe and living with hope.

Policymakers and researchers agree that the optimal use of any one service in a comprehensive array of services in a system of care is highly dependent on the availability and capabilities of the other services in the system. When access to any service is limited, the system does not work as effectively as it could.

## Introduction

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Residential programs have a long history of service dating back to the 1700s. Residential treatment has evolved as the mental health service delivery system has grown.

As organizations representing substantial numbers of residential treatment programs, the National Association for Children's Behavioral Health (NACBH) and the National Association of Psychiatric Health Systems (NAPHS) commissioned Abt Associates, Inc., to develop this report – with input and perspectives from multiple stakeholders – to inform discussions within states and communities and at the national policy level about residential treatment for children with serious emotional disturbance (SED) and other behavioral health conditions.

The need for the report was identified through a Residential Treatment Work Group convened in 2007 by NACBH and NAPHS. The Work Group, composed of both clinical and administrative leaders of residential treatment programs that belong to the two associations, identified areas for review and potential gaps in knowledge and information about residential treatment and the population served.

To inform the paper, relevant data were gathered from literature reviews, and key informant interviews were conducted to identify issues, problems, and practices. Abt Associates was asked to evaluate existing information on residential treatment leadership, policy, outcomes and innovation that may influence communities working to develop comprehensive systems of care, as well as recent federal policies assuring that residential treatment is an essential and integrated component of a full array of services. In addition, Abt conducted a survey of NACBH and NAPHS member organizations throughout the United States to gather program policy and practice data that correlate with the issues identified in the literature review and key informant survey.

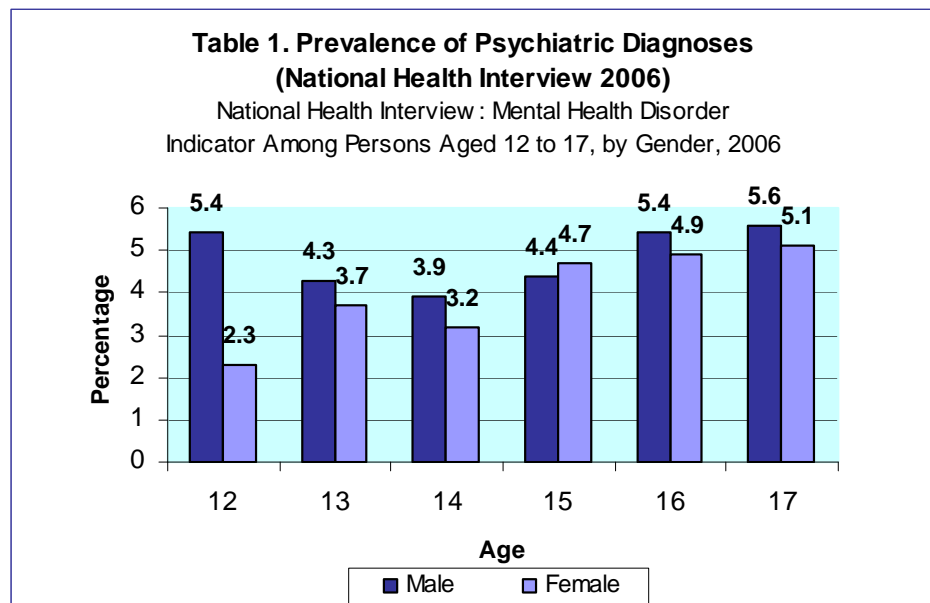


## Prevalence of Emotional and Substance Use Disorders in Children and Youth

According to *Mental Health: a Report of the Surgeon General*, approximately 20% of the nation's children and youth are at risk for or have mental disorders (DHHS, 1999). Emotional disturbance and mental health conditions affecting as many as one in five adolescents require treatment, and about half of those adolescents have significant functional impairment as a result, according to the National Institute of Mental Health (NIMH, 2007).

Research findings indicate that young people experience many different types of problems, as noted in overall prevalence statistics in the Surgeon General's Report:

- mood disorders: 6.2% of children and adolescents aged 9 to 17, with 5% who have major depression and 1% who have bipolar disorder,
- depression: 10% to 15% of youth exhibit symptoms at any given time,
- psychoses: 1% of youth have bipolar disorder or schizophrenia,
- disruptive disorders: 10.3% of children and adolescents aged 9 to 17,
- substance abuse disorders: over 20% of youth with a mental health condition have co-occurring substance use conditions,
- anxiety disorders: 13% of children and adolescents aged 9 to 17,
- eating disorders: approximately 10% of youth, and
- chronic health conditions: an estimated 10% to 15% of children and adolescents have a chronic health conditions, frequently co-occurring with behavioral health conditions.



The prevalence of these mental health conditions varies between male and female youths, as indicated in Table 1. Among those between the ages of 12 and 17, the discrepancy is greatest for 12 year old children, with more than double the incidence reported for boys.

According to the National Institute of Mental Health, while as many as 1 in 5 children and youth require some type of treatment, only about half of these (or 10% of all children), have significant functional impairment (NIMH, 2007). This translates into an approximate total of 4.3 million youth who suffer from a mental health or substance use condition that results in significant impairments at home, at school, with peers and in the community.

As published by the National Center for Children in Poverty (NCCP) in its 2006 Report on Children's Mental Health, about 5% to 9% of children and youth ages 6 to 17 have severe functional impairment in their ability to relate successfully to others within community based environments at home or at school (Dababnah and Cooper, 2006; Masi and Cooper, 2006).

Moreover, researchers identify "barrier behaviors", including extreme aggression, self injury and property destruction that effectively bar some of these children from meaningful integration with family, peers and at school (Isett et al. in McCurdy, 2004).

### **Conditions Can Be Life-Threatening**

The national Youth Risk Behavior Survey (YRBS) conducted through the Centers for Disease Control and Prevention (CDC) estimated suicide attempts for a 12-month period in students in grades 9 through 12. For the year 2005, the YRBS found that:

- 17% of students reported seriously considering suicide,
- 8% reported attempting suicide, and
- 2% reported an injurious suicidal attempt.

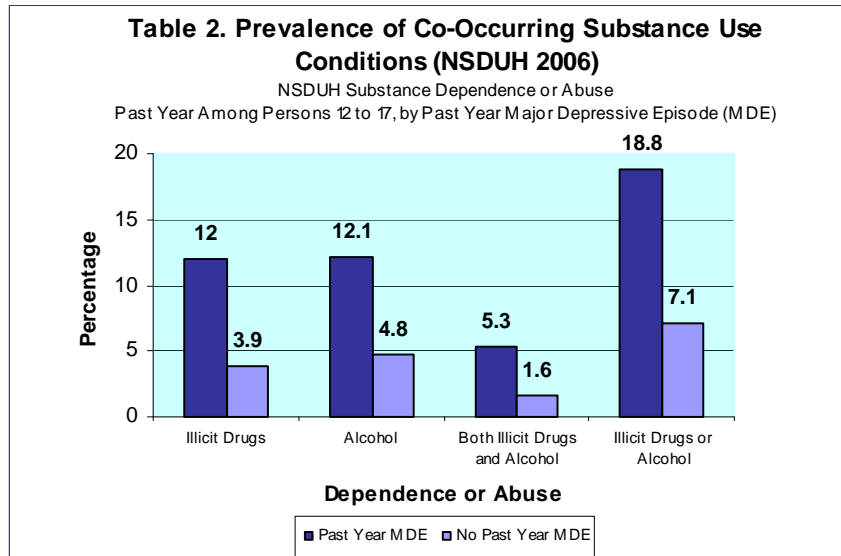
According to data provided by the Nemours Foundation, "Although suicide is relatively rare among children, the rate of suicide attempts and suicide deaths increases tremendously during adolescence." Suicide is the third-leading cause of death for 15- to 24-year-olds, according to the CDC, surpassed only by accidents and homicide.

### **Complexities Add to the Needs of Children and Youth with Serious Emotional Disturbances**

Youth who have mental disorders are at higher risk for substance use. Table 2 below illustrates the results of the National Survey on Drug Use and Health (NSDUH) study revealing the higher rates of co-occurring substance dependence or abuse found among youth with a major depressive episode (MDE in the Table) compared to those without (NSDUH, 2006).

Research literature documents well the high risk of developing serious emotional disturbance, mental disorders, and co-occurring substance use conditions in the presence of multiple risk factors of poverty, violence, childhood abuse, homelessness, trauma of separation from families, exposure to alcohol

and drugs, and/or maltreatment (CDC, 2006). The most prominent research showing the health and social consequences of these risk factors is the Adverse Childhood Experiences (ACE) Study. The study was performed in collaboration between the Centers for Disease Control and Prevention and Kaiser Permanente's Health Appraisal Clinic in San Diego, tracking more than 17,000 Kaiser Permanente members between the ages of 18 and 83, and examining the links between their childhood maltreatment and their later-life health and well being.



“It has also demonstrated that the ACE score has a strong and graded relationship to health-related behaviors and outcomes during childhood and adolescence including early initiation of smoking, sexual activity, and illicit drug use, adolescent pregnancies, and suicide attempts. Finally, as the number of ACE increases the number of co-occurring or ‘co-morbid’ conditions increases” (CDC, 2006).

**Societal Factors**

While mental disorders affect children and youth from all cultural and economic groups, those from families experiencing poverty, illness, and/or crime are at a particular disadvantage. For example, children who have a parent with a mental illness are at a significantly greater risk for multiple psychosocial problems and have rates of diagnoses for behavioral health conditions that range from 30% to 50%, as compared to an estimated rate of 20% (cited above) among the total child population (Beardslee et al., 1996; Oyserman et al., 2000). Children and adolescents without strong family or community supports are at high risk of presenting in public systems other than mental health, including child welfare, juvenile justice, and education systems, which do not treat mental health disorders as their primary mission. An estimated 50% of children and youth in the child welfare system have mental health problems. Some 67% to 70% of youth in the juvenile justice system have a diagnosable mental health problem (Huang et al., 2005).

The stakeholders interviewed by Abt conclude that residential treatment is an essential part of a robust array of services in an organized system of mental health care.

*“Residential treatment remains a needed service for a small but significantly challenging group of children and adolescents.”*

(Stroul, 1996; Stroul & Friedman, 1996)  
(Burns et al., 1999)

## Children and Youth in Residential Treatment

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### Admission Criteria

Criteria recognized and used by clinicians and payers that trigger admission to residential treatment include:

- self injury and other danger to self
- physical aggression, assault and danger to others, and
- disruptive and destructive acts in the community.

Historically, admission to residential treatment has been based on three factors: 1) community protection, 2) child protection, and 3) benefits for the child, specific to residential treatment (Barker, 1982 in Burns et al., 1999). Though debate continues about the need for out-of-home placement, few clinicians will deny that residential treatment is appropriate for children with complex and intensive clinical needs and safety and protection requirements. These decisions should always be made with the input of families, educators, and other adjunct community systems as appropriate.

### Medication Management

It is not uncommon for children and adolescents who are admitted to residential treatment programs to have been prescribed concurrently multiple psychoactive medications, sometimes more than one in the same class, prior to admission. Residential treatment offers a unique setting to be able to assess a child's medications. Often, inpatient stays are too brief to consider tapering a medication or medications. The outpatient setting is frequently not sufficiently containing to ensure a safe trial with medications. Residential stays provide a safe, structured environment to carefully reassess a child's medication regimen while other interventions are used to teach self-regulatory skills.

### Snapshot of Current Practices

In an August 2007 survey, residential treatment programs throughout the United States provided a snapshot of their practices. The survey was administered electronically to the memberships of both the National Association for Children's Behavioral Health (NACBH) and the National Association of Psychiatric Health Systems (NAPHS). A total of 91% of the associations' residential treatment members responded. The survey participants were licensed residential treatment programs throughout the United States.

The survey was intended to look at the conditions exhibited among children and youth admitted to their residential treatment, and the programs' staffing, service components, and key characteristics.

**Residential Treatment Serves Youth with Serious Disorders**

Children and youth in residential treatment present with multiple and complex needs. Diagnoses of children and youth admitted to NACBH and NAPHS treatment programs are cited in Table 3, below. Of those surveyed, the percentage of organizations that reported the following as “conditions exhibited among children admitted” is as follows:

- mood disorders – 91% of residential treatment facilities reported that they serve youth with mood disorders
- post traumatic stress disorder – 84%
- anxiety disorder – 80%
- alcohol and or substance use disorder – 70%
- psychotic disorders – 63%
- eating disorder – 34%

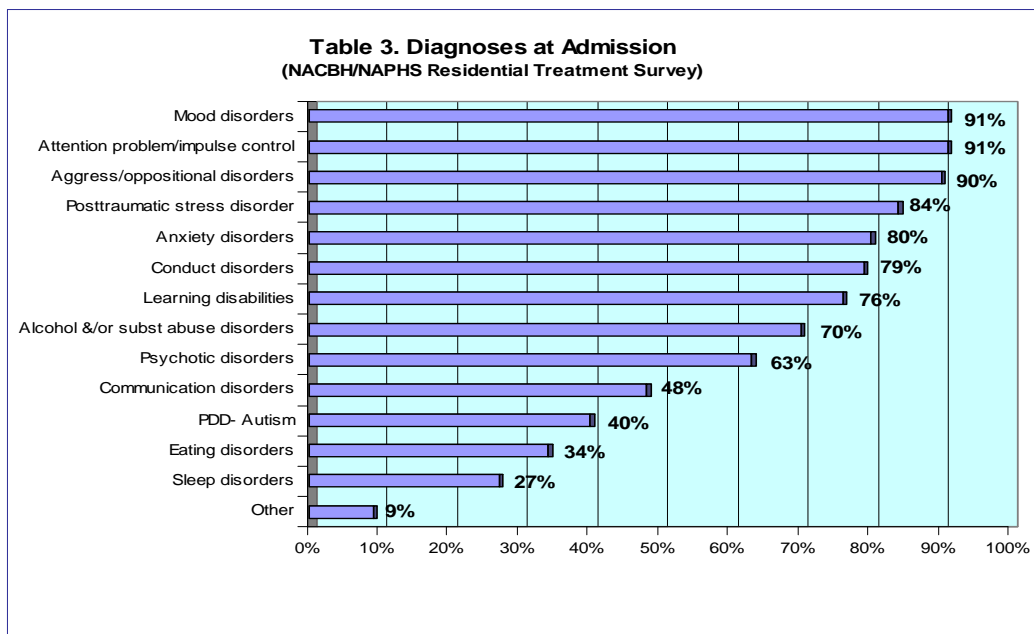
Neurological and other behavioral disorders that organizations reported as being exhibited in this population are:

- attention deficit/hyperactivity disorder/impulse control – 91%
- aggression/oppositional defiant disorder – 90%
- conduct disorder – 79%
- sleep disorder – 27%

Complex and complicating developmental and learning disorders that organizations reported as being exhibited in this population are:

- learning disorders – 79%
- communications disorders – 48%
- pervasive developmental disorder/autism – 40%

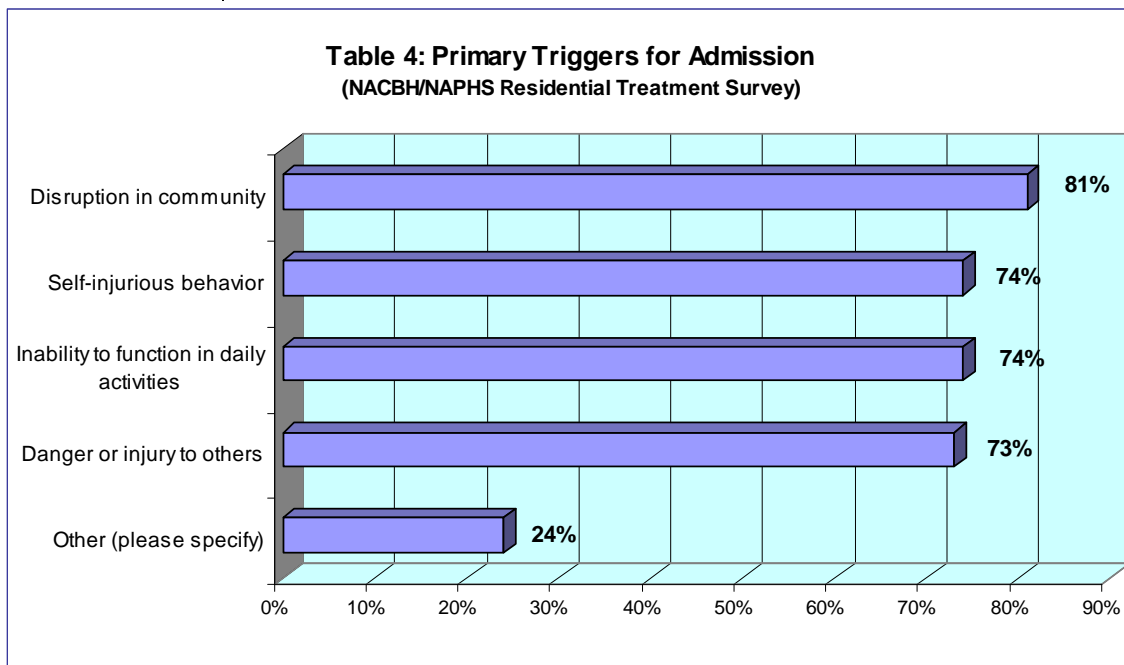
Another significant finding of the survey revealed that 25% of those surveyed reported that children and youth admitted to their programs have medical complications and physical disabilities.



**Psychiatric Disorders Are Complicated by Other Factors**

According to the survey, residential treatment programs responded that “barrier behaviors” exist as factors in admissions. Researchers define barrier behaviors as such problems as extreme aggression, self injury, and property destruction that effectively bar some of these children from meaningful integration with family, peers and at school (Isett et al., 1980; McCurdy). The results shown in Table 4 strongly suggest that multiple barrier behaviors, rather than any single factor, precipitate admission for these children to the majority of responding programs. Primary behaviors that contributed to admission, in rank order, include:

- disruption in the community
- self-injurious behavior
- inability to function in daily activities, and
- danger or injury to others.



## The Challenge of Defining Residential Treatment

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There is a need to differentiate residential treatment providers that operate in a highly regulated health care environment from those operating programs as disparate as boot camps, wilderness programs, boarding schools or homes providing for children's safety and well-being. While all may be labeled *residential*, not all provide residential *treatment*.

States have chosen to use diverse terminology to describe diverse residential facilities, adding to confusion. For example, a recent federal report on "State Regulation of Residential Facilities for Children with Mental Illness" identified 71 types of residential facilities reported by officials in 38 states.

All three national accrediting agencies – The Joint Commission, the Council on Accreditation, and The Commission on Accreditation of Rehabilitation Facilities – recognize the intensity of the type of residential treatment program described in this paper and provide national accreditation for residential treatment facilities.

*"As others have noted (e.g., Fleishman 2004), the lack of standard definitions of key terms such as 'psychiatric residential facility,' 'residential treatment center,' and 'group home' have stymied efforts to develop a national statistical portrait of residential settings for individuals with mental illness. States have adopted widely discrepant terms for essentially similar institutional entities and, conversely, States operate facilities with similar names that provide markedly different sets of services and living environments.\* Important differences may exist between these institutions in terms of their specific target population and services provided, but knowledge of the official name of these facilities offers little insight into the nature of their differences. The diversity of names has impeded the development of standard categories of facilities for which national statistics could be developed."*

(Ireys, 2006)

*\* For example, residential settings with fewer than 16 children are called therapeutic group homes in Maryland and Hawaii, type I residential facilities in Ohio, level 1 residential treatment facilities in West Virginia, residential treatment facilities for youth in Alaska, and supervised independent living programs in South Carolina.*

### **Residential Treatment Definition**

For purposes of this paper, the NACBH/NAPHS Work Group on Residential Treatment (see Appendix B) provided perspective and a definition of residential treatment for children and youth with serious emotional and substance use disorders. It stated:

### Characteristics of Residential Treatment

*Residential treatment is a specific level of care distinguished by the services and setting:*

- *24-hour therapeutically planned behavioral health intervention*
- *highly supervised and structured group living and active learning environment where distinct and individualized therapies and related services are provided*
- *multidisciplinary team of clinically licensed professionals (including psychiatrists, psychologists, social workers, nurses, special education teachers, activity therapists, and others)*
- *diagnostic processes which address psychiatric, social and educational needs*
- *individualized assessment, treatment planning, and aftercare, involving the child and family*

*The purpose is to help each child master the adaptive skills necessary to return to and function successfully in his or her community.*

*(NACBH and NAPHS Residential Work Group, 2007)*

This definition was used by Abt Associates for interviews conducted with key informants to develop this paper.

The Work Group noted that residential treatment programs meeting this definition are governed by a variety of standards and regulations, such as:

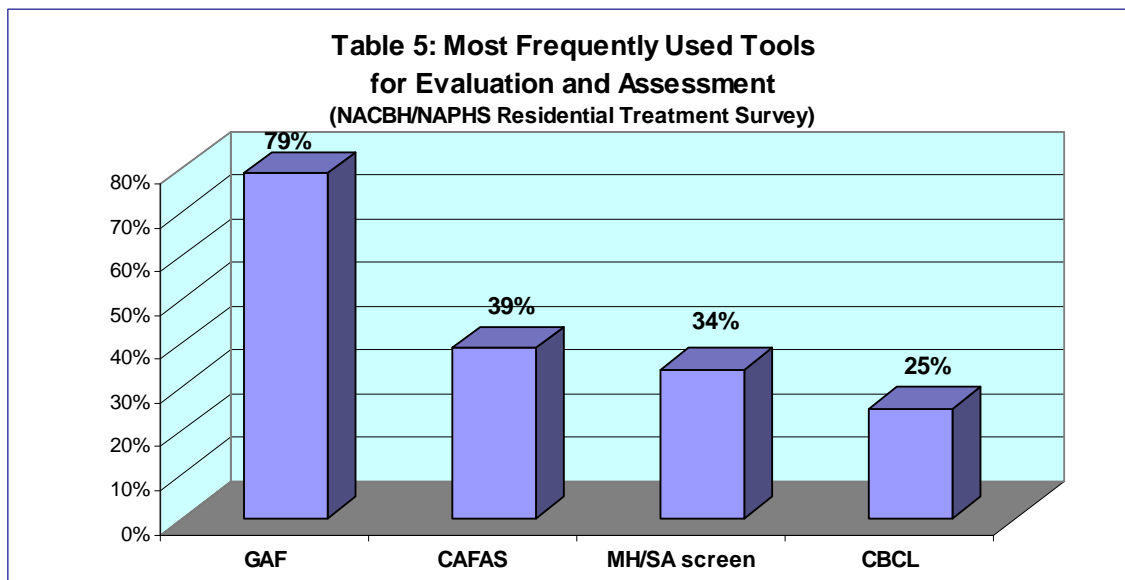
- licensure by appropriate state child-serving and regulatory agencies
- accreditation by nationally recognized accrediting agencies, including The Joint Commission, the Council on Accreditation (COA), and the Commission on Accreditation of Rehabilitation Facilities (CARF).
- certification by state Medicaid authorities.

## Components of Residential Treatment

### Assessment

NACBH- and NAPHS-member organizations reported in the August 2007 Residential Treatment Survey (Appendix C) that a number of standardized tools assist with evaluation, assessment, and treatment. The most frequently used tools are:

- the **Global Assessment of Functioning (GAF)**, which is a numeric scale used by clinicians to measure a child's overall level of functioning and carrying out of activities of daily living. The information is useful in planning treatment, measuring its effectiveness and predicting outcome.
- the **Child and Adolescent Functional Assessment Scale (CAFAS)**, which assesses a youth's degree of impairment in day-to-day functioning due to emotional, behavioral, psychological, psychiatric, or substance use problems.
- the **Child Behavioral Checklist (CBCL)**, which is used by parents and others who know the child to rate the degree of problem behaviors and competencies.



The survey also reported the use of other selected measures, for both evaluation and planning treatment:

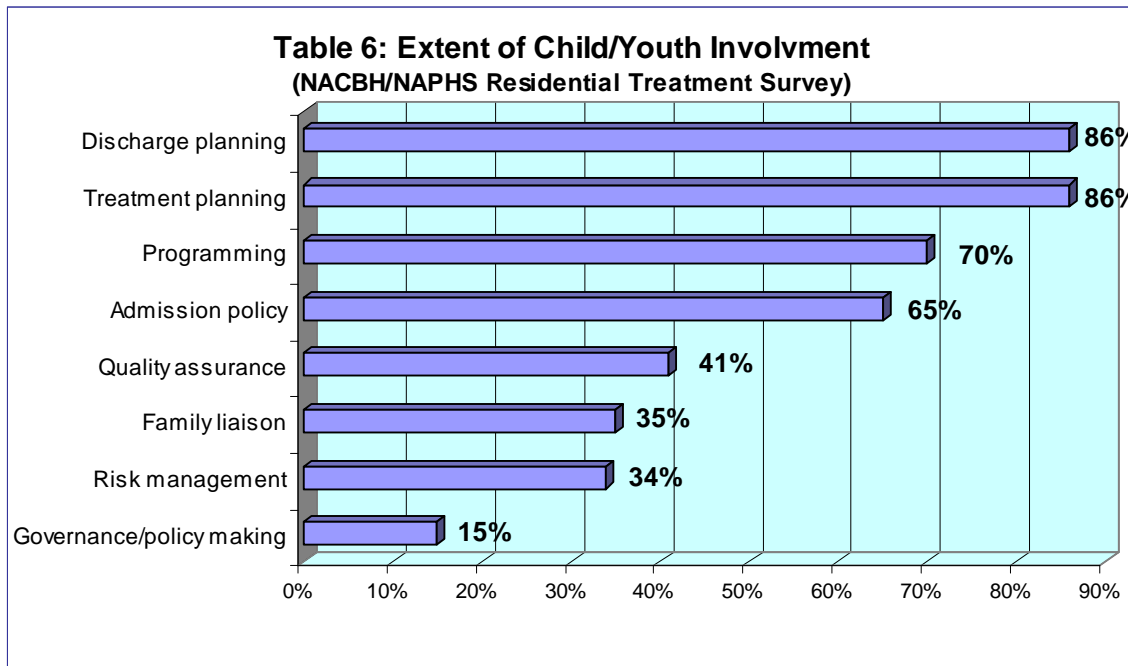
- Child Problem Checklist (CPC)
- Devereux Rating Scales
- Family Problem Checklist (FPC)
- Child and Adolescent Level of Care Utilization System (CALOCUS)
- Restrictiveness of Living Environment Scale (ROLES)
- Family Risk Scales (FRS)

Tools are often used in combination to strengthen the effectiveness of treatment according to written comments from the surveyed residential treatment programs.

### **Children and Families Are Involved**

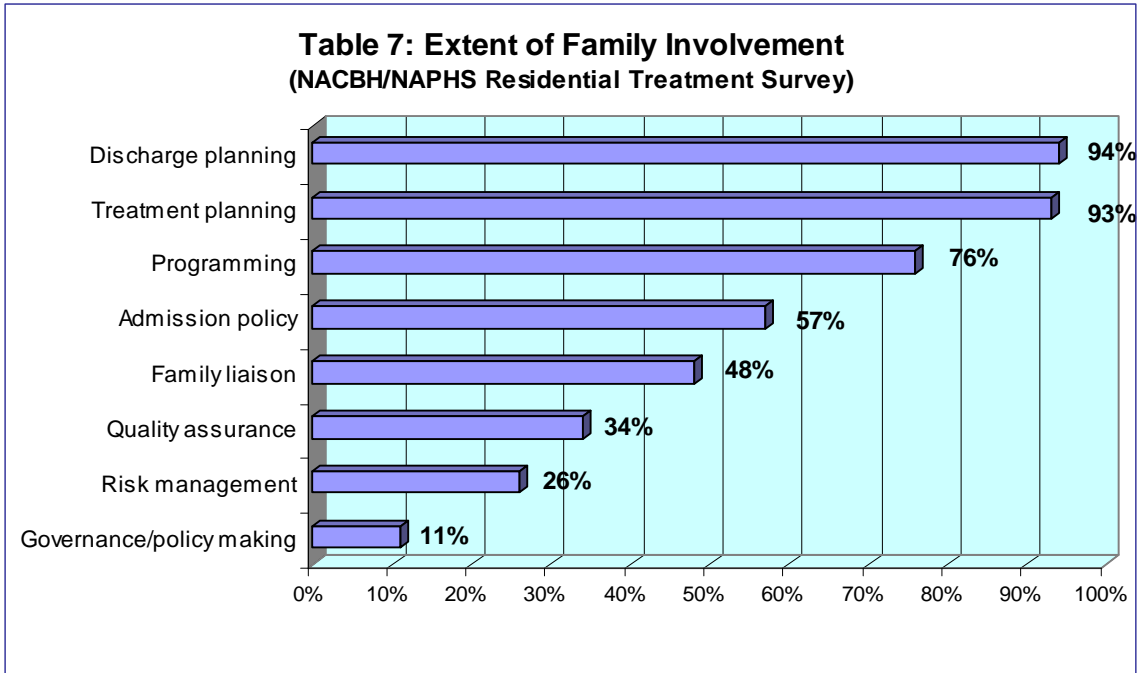
Individualized treatment planning that consistently and actively involves the child, family, and multidisciplinary team is a critical component and hallmark of residential treatment.

The survey found that the vast majority of responding residential treatment programs involve children and youth directly in discharge planning (85%), treatment planning (85%), programming (69%), admission policy (65%), quality assurance (41%), family liaison (35%), risk management (34%), and governance or policy making such as serving on boards or committees (15%).



It is widely understood and accepted that family involvement is central to effective treatment and care. “Families” for many youth in residential treatment may mean caregivers and advocates, such as social workers and court-appointed guardians. In the survey of NACBH and NAPHS member facilities, “family” was broadly defined as “relations and individuals who may include adults and children, parents and guardians, other relatives, and non-related individuals whom the client defines as family and who play a significant role in the client’s life.”

The survey found that family members are directly involved in discharge planning (94%), treatment planning (93%), admission policy (76%), programming (57%), quality assurance (34%), family liaison (48%), risk management (26%), and governance or policy making such as serving on boards or committees (11%).

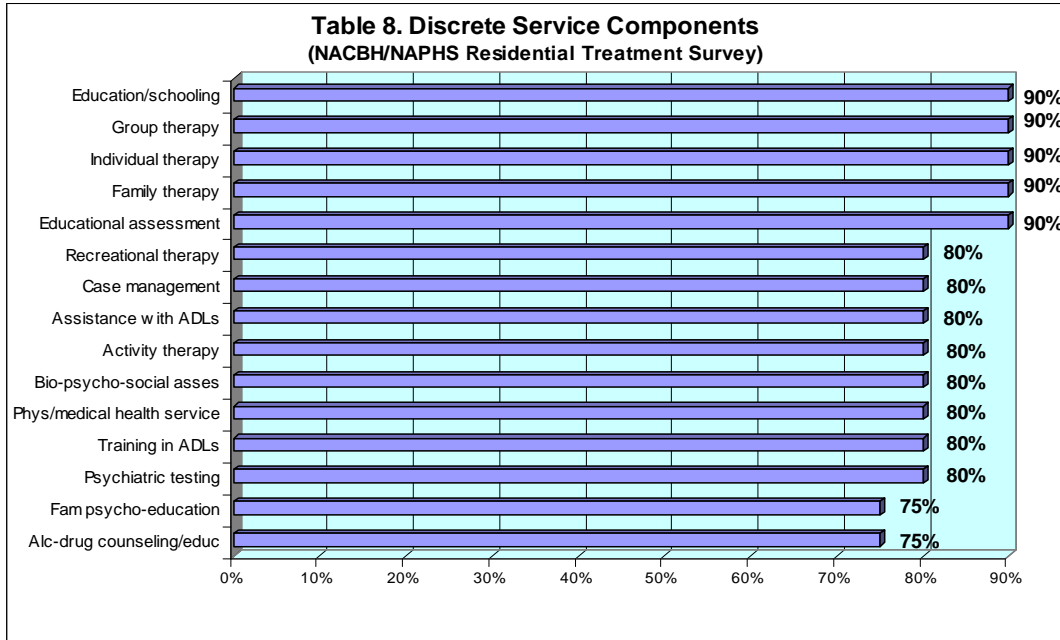


As child mental health services move in the direction of family-centered and child-focused care, residential treatment providers surveyed reported widespread use of family/parent satisfaction studies (used by 67%) and child satisfaction studies (used by 64%) to help inform practice.

**A Comprehensive Array of Therapeutic Services**

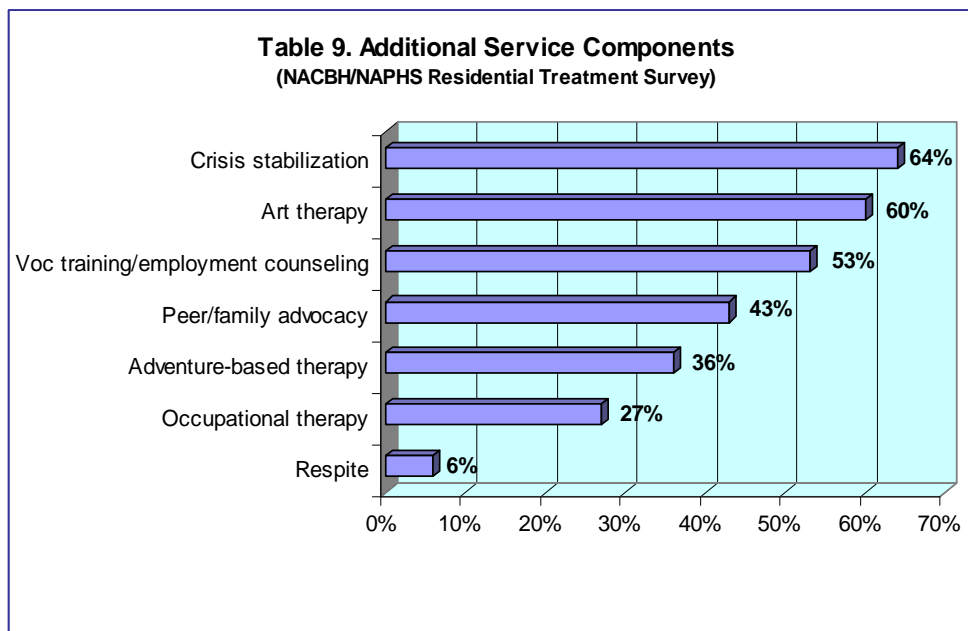
To be effective residential treatment requires the coordination and delivery of a comprehensive array of therapeutic services. Treatment involves individual and group therapies designed to address delays in cognitive, social, and emotional development, and education tailored to a child's grade level, learning style, and individual capabilities. Education is integral to the therapeutic day.

Respondents in the 2007 survey reported that they offer the services shown below within their residential treatment programs (Table 8).



The vast majority (more than 90%) provide education/schooling as well as group, individual, and family therapy. More than 80% provide educational assessment, recreation therapy, case management, assistance as well as training with activities of daily living, activity therapy, biopsychosocial assessment, physical/medical health services. Psychiatric testing, family psycho-educational services, and alcohol/drug counseling and education are also widely available services.

More than half also offered services such as crisis stabilization (64%), art therapy (60%), and vocational training/ employment counseling (53%). Many also offered services such as peer and family advocacy (43%) (Table 9).

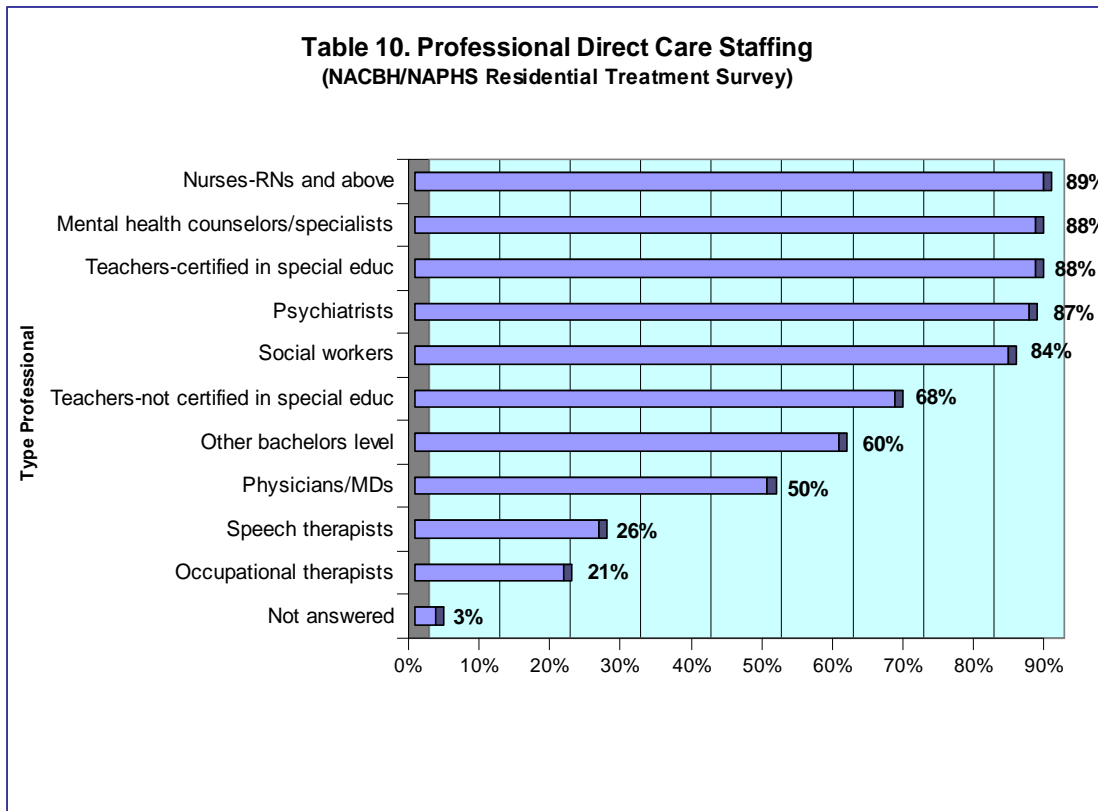


In addition to residential treatment, many reported that they also provide other services such as day schools (offered in 59% of the responding facilities), outpatient services (44%), family support services (44%), day treatment (43%), and inpatient psychiatric services (53%). Some also offer services such as therapeutic foster homes (provided by 18% of respondents), partial hospitalization (18%), in-home services (17%), group homes (16%), individual foster homes (11%), respite care (11%), therapeutic group homes (9%), independent living (8%), and adoption (8%).

**Multidisciplinary Teams**

The residential treatment milieu is defined by having a wide range of professionals who are available under one roof. The mix of professional staffing in residential treatment is based on the specific clinical, developmental and educational needs of the individual child or youth. Treatment also includes medication management, family psychosocial education and treatment, vocational training, speech and language therapies, and a variety of other supports.

Facilities surveyed reported that they are staffed by highly skilled professionals bringing many perspectives to a comprehensive treatment plan. These teams include psychiatrists (in 87% of respondents), registered nurses or nurses with higher training (89%), mental health counselors or specialists (88%), teachers certified in special education (88%), social workers (84%) and other specialists.



## Why Communities Need Residential Treatment

As discussed, there exists a critical percentage of young people whose needs are so complex or disabling that they require intensive 24-hour out-of-home residential treatment.

### Treatment of Choice for Some Children

*“Residential treatment is not about the absence of alternatives, as currently perceived, but is the treatment of choice for some children.”*

(Key Informant, 2007)

Key informants concurred that delayed, insufficient and inappropriate treatments are costly, causing:

- clinical deterioration and dysfunction that are expensive to remediate
- irreparable harm to the children and youth themselves, or to others around them
- increasing involvement with social and juvenile justice systems, and
- educational delay, drop out, or failure.

The cost of limiting access to care – including residential treatment when needed – leads to:

- eventual underemployment or unemployment
- homelessness
- incarceration, and
- family burden and lost productivity.

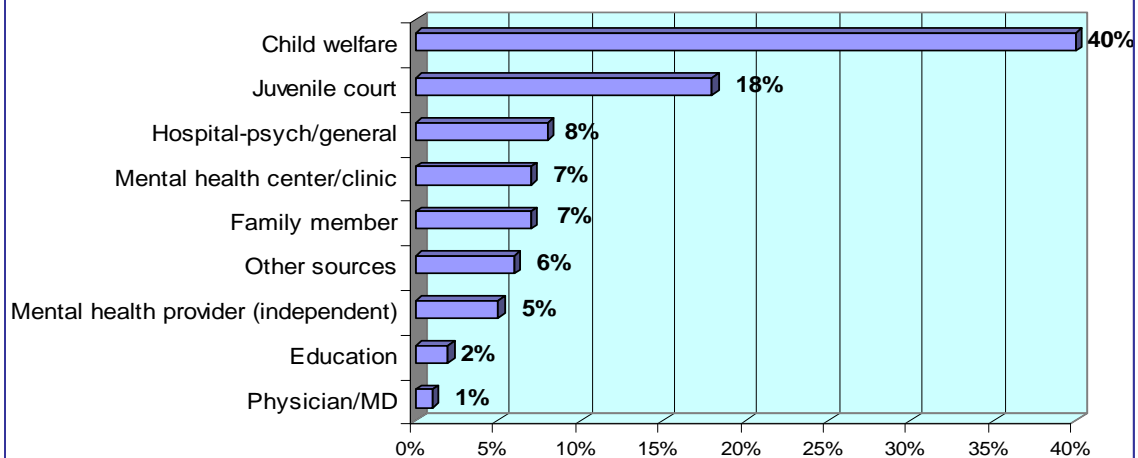
*“Residential treatment often becomes treatment to undo the damage done by lack of adequate early interventions. Children come to residential treatment far later than advisable.”*

(Key Informant, 2007)

### **Children and Youth Enter Residential Treatment From Many Paths**

Referral sources for residential treatment are as diverse as the process is complicated. Depending on the state, county or locale in which they live, children and youth enter residential treatment through schools, primary care providers, hospitals, community mental health centers, welfare agencies, juvenile justice systems, the courts or their families.

**Table 11. First Ranked Referral Sources**  
(NACBH/NAPHS Residential Treatment Survey)



**Families See a Need**

Families and other caregivers of children and youth with serious emotional disturbances and substance use disorders cited several factors that are important to them in making the difficult decision to seek treatment in an out-of-home setting:

- complexity of their child's needs
- challenges in accessing care
- importance of finding clinically competent programs to keep their children safe
- need for a structured, 24-hour milieu to manage their children's needs
- need for medication evaluation and management
- importance of engaging parents in admission, treatment, and discharge decisions, and
- desire for all the components of treatment and care to be aligned in a manageable system.

### Family Vignette

*“As a physician whose child has serious emotional disturbance with co-occurring conditions, I was stunned at how difficult it was to find accurate information from public sources as well as from respected behavioral health colleagues on the existence or availability of intensive treatment programs to meet my child’s escalating needs. The time wasted and risks posed by barriers to the right treatment at the right time, to ‘trials’ in inappropriate services, were disheartening and dangerous. We finally hired a private consultant to search on our behalf. What happens to families with fewer means?”*

(Family Member, 2008)

## About the Organizations

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**Abt Associates, Inc.**, founded in 1965, has conducted social policy research for 40 years. The firm has both a substantial portfolio of work related to Medicare, Medicaid, and commercial insurance and a large behavioral health practice. Principal authors of this report are Danna Mauch, PhD, Gail Robinson, PhD, and Ariane Krumholz, MSPH.

**Danna Mauch, PhD**, a Principal Scientist/Associate at Abt Associates, is based in Cambridge, MA and has more than 30 years of experience in designing, implementing and managing research, clinical and administrative services in the behavioral health arena. Her original experience, gained throughout the 1970s, was in residential treatment developed in the context of emerging community based care systems. She held positions as counselor, psychologist, program director and executive director for a variety of programs serving children and adults with behavioral disorders in residential treatment programs funded by state departments of mental health, mental retardation and juvenile justice. The focus of her work as a state mental health director, managed care executive and consultant has been on integration of systems of care, financing, and management information.

**Ariane Krumholz, MSPH**, is a Senior Associate at Abt Associates Inc., Cambridge, MA. Her work is focused on consulting to state and federal agencies on redesign and unification of care systems. Prior to joining Abt, she held planning executive positions for behavioral health in vertically integrated health care systems and was executive director of a community health center and plan.

**Gail Robinson, PhD**, is a leading expert in mental health policy and a Vice President in the Washington, D.C. office of Abt Associates. She has more than 25 years' experience in health and behavioral health issues at the national and State levels, particularly in the area of service delivery and financing. She applies her technical expertise in evaluation and health services research to solving policy and implementation problems.

**The National Association for Children's Behavioral Health (NACBH)** works to promote the availability and delivery of appropriate and relevant services to children and youth with, or at risk of, serious emotional or behavioral disturbances and their families. NACBH members are multi-service providers of mental health and substance abuse treatment, family and child services and supports, educational and juvenile justice programs. With roots in mental health, child welfare, education, or juvenile justice arenas, all are committed to creating responsive systems of care for children and families dealing with emotional and behavioral disturbances.

**The National Association of Psychiatric Health Systems (NAPHS)** advocates for behavioral health and represents provider systems that are committed to the delivery of responsive, accountable, and clinically effective

prevention, treatment, and care for children, adolescents, adults, and older adults with mental and substance use disorders. Its members are behavioral healthcare provider organizations that own or manage more than 600 specialty psychiatric hospitals, general hospital psychiatric and addiction treatment units and behavioral healthcare divisions, residential treatment facilities, youth services organizations, and extensive outpatient networks. The association was founded in 1933. Through its Youth Services Committee, NAPHS works to promote the need for behavioral health treatment, education, and rehabilitation services for troubled youth; to get more visibility for youth services; and to raise youth services on the national agenda.

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## Appendix A

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### Key Informants

Key informants interviewed by Abt Associates for this paper included researchers, clinical experts, national accrediting body executives, policy experts, state healthcare leaders, federal agency leaders, academicians, association executives, and family/consumer leaders.

Individuals were selected for their professional and/or personal experiences with residential treatment, national and state perspectives on system-wide issues impacting the delivery of behavioral healthcare services for youth.

Interviews were conducted by Abt Associates throughout 2007.

**Chris Bellonci**, MD, The Walker School

**Gary Blau**, PhD, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration

**Barbara Burns**, PhD, Duke University

**Mary Cesare Murphy**, PhD, The Joint Commission

**Janice Cooper**, PhD, National Center for Children in Poverty

**Henry Ireys**, PhD, Mathematica Policy Research

**Chris Koyanagi**, MA, Bazelon Center for Mental Health Law

**Stephen Mayberg**, PhD, California Department of Mental Health

**Sandra Spencer**, National Federation of Families for Children's Mental Health

**Beth Stroul**, PhD, Management & Training Innovations

## Appendix B

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### Work Group on Residential Treatment – 2007

April 11, 2007

NACBH / NAPHS Joint Meeting with Abt Associates, Inc.

(and other NACBH/NAPHS project advisors)

**Pat Connell, RN, MBA, CHE, CBHE, CIP**  
Director  
Girls & Boys Town Behavioral Health Division  
Omaha, NE

**John Damon, PhD**  
NACBH Board  
Chief Operating Officer  
Mississippi Children's Home Services  
Jackson, MS

**Leonard F. Dziubla, ACSW, CHE**  
(NAPHS Youth Services Committee)  
CEO  
Phoenix Care Systems, Inc.  
Milwaukee, WI

**Vickie Lewis**  
Chief Executive Officer  
La Amistad Residential Treatment Center  
Maitland, FL

**Ray Luccasen**  
(NAPHS Youth Services Committee)  
Vice President & Chief Clinical Officer  
Youth & Family Centered Services  
Birmingham, AL

**Denis McCarville**  
NACBH Treasurer and Past President; President  
Uta Halee Girls Village and Cooper Village  
Omaha, NE

**Diana Ramsay**  
(NAPHS Youth Services Committee)  
Executive Vice President & COO  
Sheppard Pratt Health System  
Baltimore, MD

**Beverly Richard**  
Sr. V-P for Program Development  
Three Springs, Inc.  
Huntsville, AL

**Elliot Sainer**  
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CRC Health Group  
S. Pasadena, CA

**Robert P. Sheehan**  
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President and CEO  
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**Fran E. Wilson, PhD**  
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**Sharon Worsham**  
CEO  
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**Kathleen McCann, RN, PhD**  
Director of Clinical and Regulatory Affairs

**Carole Speak**  
Director of Operations & Communications

**Nancy Trenti, JD**  
Director of Congressional Affairs

## Appendix C

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### **About the Survey of Residential Treatment Programs**

Using a collaborative approach with the Residential Treatment Work Group consisting of members of NACBH and NAPHS, Abt Associates, Inc. designed a nine-question on-line survey on residential treatment for children and youth. The goal of this survey was to gather information on key characteristics of the NACBH and NAPHS residential treatment programs, including: demographics, referral patterns, admission criteria, staffing, quality and outcomes measurements, and program components.

The survey participants were licensed programs from throughout the United States.

The survey was administered electronically to the memberships of both NACBH and NAPHS. A total of 91% of the associations' residential treatment members responded.





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