# Selecting a Residential Treatment Center for Your Child

## by Peg Nichols

This article has been authored by Peg Nichols, CHADD's director of communications and media relations. Peg is the mother of three sons under the age of 13. Her nine-year-old has multiple disorders and has been enrolled, since 1998, at the Devereux Glenholme School, a residential treatment center in Washington, Connecticut.



Caring at home for a child with a mental disorder is almost always preferable for parents over an out-of-home placement. Yet when a child is so disabled that he or she cannot function at home, is a threat to himself and others, and has repeatedly been failed by inadequate community services, an out-of-home placement may not only be preferable, but critical – even life-saving.

Deciding to send a child to a residential treatment center (RTC) is not only devastating for a family, it's a journey without a road map. Families and caregivers are likely to feel vulnerable and confused about treatment options, and all while under extreme stress from managing their child's chronic

disorder.

Furthermore, increased reports of abuse and neglect in some RTCs add worry – fear that one's own child may not be safe in the very facility designed to care for him or her. Indeed, an RTC placement is a decision mired in emotion, though one requiring sound reason and good judgment.

Families seeking residential services for a young child should raise complex and critical questions before making such a decision. This article considers the most important.

#### (1) What is a Residential Treatment Center?

A residential treatment center is a licensed, although not as a hospital, 24-hour facility that offers mental health treatment. [Which agency grants the license and against what standards is a major current public policy issue. See the licensing box at the end of this article for more information.] Settings range from highly structured – resembling psychiatric hospitals – to group homes, halfway houses, boarding schools or wilderness settings. Treatment methods and philosophies vary, though the most common approaches are psychoeducational, behavioral management, group therapies, medication management, and peer-cultural approaches. [Note: some settings and philosophies – particularly wilderness programs – are under current clinical and public scrutiny due to several recent child and adolescent deaths resulting from the inappropriate use of restraint and seclusion. See page 29 for additional information about restraint and seclusion protection measures recently passed as legislation.]

# (2) How Do I Know If My Child Needs Residential Care?

Chances are you already instinctively know whether an RTC placement is an appropriate next step for your child. If you have exhausted every treatment avenue, your child is being poorly served in either school or community, and the preservation of the family is at stake, a quality residential treatment placement may be a necessary – and ultimately beneficial – intervention for recovery.

Some psychiatric disorders require 24-hour treatment in a highly structured setting. No parents can provide this exhaustive level of sustained care by themselves at home, particularly if there are other children to care for. When making a decision of this magnitude, remember that you know your child, your family's needs, and your own capacity for caregiving better than anyone else. Trust your instinct, though make sure it is a well-informed one.

# (3) Where And How Do I Begin Looking For A Residential Placement?

Which facility you select depends on the level of care needed, cost, functional capacity of the child and severity of the illness. A word-of-mouth recommendation is always best. Speak to other families who have been through the process. They are always your best source of information. Call your local family-oriented advocacy organizations like CHADD, NAMI or the Federation of Families. Ask your child's doctor or other mental health clinicians who know your child for recommendations.

You also can refer to the websites below for comprehensive information about RTCs, but know that a website description is not a substitute for an onsite visit and a thorough investigation of services, staffing and safety standards.

- <u>www.spedschools.com</u>
- <u>www.petersons.com</u>
- www.strugglingteens.com
- www.bpkids.org (provides education and parent testimonials bulletin board)
- www.hometown.aol.com/parforres1/ myhomepage/profile.html

[Note: the websites referenced above are not endorsed by the author of this article or CHADD, they are merely cited as available resources.]

In fact, you should be wary of slick marketing and advertising efforts. Looks can be highly deceiving. Conduct very careful research. Keep a notebook and document your impressions. Learn everything you can – especially from other parents whose children attended the program. Don't be afraid to ask questions. Above all, do not make a hasty placement decision, no matter how dire the need. Emotions can cloud reason when faced with a decision this large. Do not hesitate to ask for guidance from a neutral, though knowledgeable party.

(4) What Criteria Should I Use When Evaluating An RTC?

What Should I Ask When I Call?

What Should I Look For When I Visit?

Residential treatment centers vary in philosophy, treatment-program intensity and structure. Learn what they are, if not before, then certainly during or after your visit. The following is a guide.

# Program philosophy and philosophy concerning families

Look for answers to:

- What are the goals and objectives of the RTC?
- Are you comfortable with the treatment philosophy?
- How is this treatment philosophy delivered?
- Who delivers this treatment and how is it measured?
- Are the treatment modalities well-suited for your child?
- Are parents considered equal partners in the treatment team?
- How often will you receive written or verbal updates about your child?
- Will you receive updated reports if something changes?
- Is the facility amenable to "drop-in" visits?
- Are you given satisfying answers to your questions?

#### Program credentials/certification

Two very perplexing but fundamental questions are: who licenses and certifies the RTC and how is it done? Unfortunately, there may be no appropriate program standards in the state in which a given RTC is located. For example, until June 2000, the child daycare agency in Florida – using only child daycare standards – granted licenses to RTCs serving children with serious mental illnesses and severe developmental disabilities. As recently as one year ago, a single state employee in North Carolina with absolutely no program criteria could grant RTC licenses by looking at photographs that accompanied written applications. [See page 28 for additional details.]

#### **Campus Tour**

Ask many questions based on these questions:

- Are you given a full tour of the campus? What are your first impressions?
- How is the campus organized and maintained? Does it seem like a good environment for learning and progress? Is it clean? Are the buildings in good condition? Are classrooms furnished with appropriate supplies and equipment?

- Are the living quarters comfortable? Will your child be allowed to bring items from home?
- Where are meals eaten? What kind of food is served?
- What is the demeanor of the staff? Are you given an opportunity to ask them questions?
- Are you comfortable with their responses?
- Do the other children appear comfortable and well cared for? Are you permitted to ask them questions?
- Do you feel welcome on campus? Does your child feel welcome?

#### Clinical/Professional Services

Again, these are the questions:

- Is there an interdisciplinary assessment of your child before he or she is admitted? At admission? Will a psychiatrist be involved in the pre- and at-admission assessment?
- Are children segregated by developmental capacity, by diagnosis, or some other means (note: developmental appropriateness is always best)?
- How are medical decisions determined? Who oversees medication management? Who dispenses medication?
- Are medical staff available 24 hours a day? How are medical emergencies handled and by whom?
- Is there an on-site psychiatrist, or does the facility use a consulting psychiatrist?
- If the psychiatrist is a consultant, how often will he or she see your child? Is this acceptable to you?
- Who will be on your child's treatment team? Psychiatric nurse? Licensed practical nurse? Psychologist? Certified social worker? Special education teacher? Occupational, recreational or physical therapist?
- What is the staff turnover rate?
- How does the facility assure that continuing educations/certifications (e.g., CPR) of staff are current?
- How much contact will clinicians have with your child on a daily, weekly and monthly basis?

# **Behavior Management**

Be sure to ask:

- What behavior management techniques will be used with your child?
- How are staff trained in the use of behavior management?
- Does the RTC use restraint or seclusion? If so, what are the criteria and procedures for their use? [See page 29 for additional information.]
- Will you be notified of behavior management interventions, including restraint and seclusion?
- Are you comfortable with these procedures?

#### Academics/Curriculum

Find out:

- What is taught, how and by whom?
- What is the ratio of teachers to students?
- How often are Individualized Education Plans (IEPs) reviewed

and updated?

- How are differences in learning styles accommodated? What approaches are used to meet these styles?
- What is the length of the school day?
- Is it a year-round school (12 months) or is it shorter?
- Are you comfortable with the educational curriculum?

#### **Residential Life**

Always inquire:

- What is the philosophy toward services and activities taking place outside of school hours? Does this include athletics, the arts, social events and playtime?
- Does the program integrate such activities into the treatment plan?

If so, how? Who supervises the activities?

- Are children involved in the community?
- Do they leave campus for field trips, social events and other occasions?

- What about family religious beliefs and customs? Will your child be permitted to observe important holidays and other family traditions?
- How are friendships fostered and maintained among residents?
- How are telephone calls, mail and ongoing contact with family and friends handled?

#### Average Length of Stay and Transition Policy

You need to know:

- How long does the clinical team think your child will be in residence? (The average length of stay at an RTC is from six months to three years, sometimes longer. However, with the shortage of inpatient psychiatric beds, some RTCs now function as "hospitals" and may provide treatment during stays as short as a month, or until a child has stabilized.)
- Be sure you're told the average length of stay because it will greatly affect your child's short- and long-term treatment plan.
- When your child is ready for a less-restrictive environment, how will the staff ensure a smooth and therapeutic transition? (The primary objective of a "good" RTC is to stabilize the child so he or she can return to and thrive at home; however, a payer's objective may differ.)
- Sustaining gains and transferring them from a residential setting back into the community is a critical component of any treatment plan. Close coordination between family and the treatment team is vital to the child's success.
- Be sure you are comfortable with the transition process described by the clinical staff.

#### Recommendations

Are you given names of parents of past and present residents to speak with about the program? A good facility is willing to offer such information.

#### Watch for the Following Red Lights

Be wary of programs that:

- Have a "no contact" policy with the family for a designated number of weeks.
- Limit visits with family to supervised sessions with a therapist.
- Have a firm rule against communicating with peers outside of the facility.
- Are excessively clean and orderly and with a décor designed for adults, not kids.
- Are too quiet with little or no signs of youthful energy.
- Have children that are unusually well behaved.

• Feature advertisements (publication or websites) that are overly stylized and reflective of significant budgetary expenses.

#### Also Remember

Effective treatment programs respect peer relationships and offer privacy to the residents, particularly adolescents. In addition to the child's own feelings of comfort when visiting the campus, older siblings should be encouraged to get a "peer level feel" for the community. Kids can immediately sense what is real and what is phony. Sibling input should not be underestimated, though clearly the placement decision lies in the hands of the parents, caregivers, or payers.

# (5) We Know We Need to Send Our Child to an RTC, but How Can We Afford It? What is the Cost for One Year of Treatment? How is Treatment Financed?

Residential treatment programs are very expensive: costs range from \$50,000 to \$150,000 for a year of treatment, depending on the state and the program. A small number of families pay out-of-pocket for residential care, but most cannot afford it.

Private health insurance rarely covers residential treatment services, and when it does, it seldom covers enough of the cost to make it affordable. Private insurance may pay for RTC treatment if it is medically necessary and if no appropriate alternative community service is available, as determined by the insurance company. At the same time, many private insurance companies view RTCs as a less costly alternative to hospitals.

Special education may pay for RTC treatment if no other geographically accessible education program can meet the special education needs of the child, as determined by the school district. Some school districts insist that a child must go to the closest RTC; many states require placement in an RTC within that state; and some states send kids out-of-state.

Children with healthcare coverage through Medicaid are entitled to a range of medical services and treatments, including residential care; however, families too often must relinquish custody to the state to secure the services. [Refer to page 12 for more information on the pending Family Opportunity Act.] Some families obtain funding for residential care through the Individuals with Disabilities Education Act (IDEA), which guarantees a free and appropriate education, including services that help make the child "available" for learning. Other families work with attorneys or educational consultants to be sure that their child's eligibility for these services is recognized and supported by the local educational agency. (Some attorneys or educational consultants are reimbursed by the local school system or provide services pro bono, but many require payment that ranges from \$1500 to \$3000 or more.)

## (6) How Can We Guarantee that Our Child Will be Placed in the RTC of Our Choice?

Unfortunately, it is the payers who often have the greatest say in placement decisions, not families or consulting professionals. A family's influence depends on the funding source's protections and appeals procedures. Special education, child welfare, mental health, Medicaid and other agencies frequently finance RTC placements.

There are no national standards for placement procedures or appeals processes. Each state agency has its own policies and procedures. The greatest opportunity to impose uniformity on RTC placement decisions rests with special education because of federal special-education laws. But even here there are many local and state variations. At least when decisions fall under special education, placements are governed by the requirement for an appropriate education provided in the least restrictive setting. But ultimately, payers carry the decision-making weight. Work closely with an attorney or other knowledgeable source to understand your child's placement rights and RTC services in your state or elsewhere.

# (7) Reported Abuses in RTCs Have Made Headlines Over the Past Several Years. How Can We Be Sure Our Child Will Be Safe?

Although many RTCs offer outstanding treatment, too many provide questionable services or permit dangerous practices. There are several ways to tell a good program from a bad one. The most important tip is to find out everything you can about the facility before visiting (or deciding not to).

#### Make a checklist:

- Have formal complaints been made against the RTC? By whom?
- Has an agency investigated these complaints? Are there documented instances of abuse? When did they occur?
- What corrective action was taken? How did the RTC respond?
- Are background checks done on all prospective staff members?
- How much training does staff receive in order to minimize risks for restraint or seclusion?
- Does the program have a parent advisory council or other mechanism for parents to meet regularly to communicate concerns?

You can also contact the Protection and Advocacy program in the state where the RTC is located for information. For the phone number, call the National Association of Protection and Advocacy Systems at 202-408-9514 or see www.protectionandadvocacy.com. You can also contact the National Information Center for Children and Youth with Disabilities at 800-695-0285 or www.nichcy.org.

# (8) Our Child has Been Accepted by An RTC. How Can We Prepare Our Child, Ourselves, Our Other Children, Family Members, and Friends for What's to Come?

Selecting an out-of-home placement is a highly emotional and intensely personal decision. When you have made a final choice, it is important that you temper your own expected anxieties, grief, fear and sadness when discussing the placement with your child and extended family members.

They need to feel confident about your decision to place the child in a program where he or she will get better. Make it clear that you and the RTC will work together to ensure the child's success. In other words, set the stage in a loving, respectful, productive manner.

Although your child may not feel it initially, in time he or she will understand that everyone's intent is to help. A

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# Licensing RTCs: A Major Public Policy Issue

## Scope of the Problem

The issue of program credentials and standards has long been a national disgrace, which the national government recently corrected. Although many RTCs claim they are licensed by multiple agencies, this is not actual licensing, but an approval to receive payment by a state agency. Most payers require simply that the RTC "be licensed" to receive payment. But in terms of meeting standard qualities of care, the license may be practically meaningless.

# Background

When Congress established the Medicaid program in 1965, it prohibited funding of 24-hour specialty facilities serving persons with mental illness (known as institutions for mental diseases-IMDs). In 1972, Congress liberalized this payment restriction by allowing Medicaid payment for RTCs.

On January 19, 2001, the federal administering agency, HCFA (Health Care Financing Administration) issued interim final regulations governing Medicaid payment to RTCs and regulating restraint and seclusion. The rules

may be found on the U.S. Federal Register website at <a href="http://www.access.gpo.gov/su\_docs/fedreg/a010119c.html">http://www.access.gpo.gov/su\_docs/fedreg/a010119c.html</a>.

#### What Families Need to Know

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) will tell you if a facility is accredited, if it has been through an accreditation review, and what the accreditation status is. The Commission on Accreditation of Rehabilitation Facilities (CARF) and the Council on Accreditation of Services for Families and Children (COA) also provide this information. These are currently the best, most uniform, nationwide standards. However, advocacy groups question the comprehensiveness and rigor of both the standards and their application. Information is available from JCAHO at 1-800-994-6610 or <a href="https://www.jcaho.org">www.jcaho.org</a>; CARF at 520-325-1044 or <a href="www.carf.org">www.carf.org</a>; and COA at 212-797-3000 or <a href="connet@aol.com">connet@aol.com</a>.

## Restraint & Seclusion: What You Need to Know

Children and adolescents are especially vulnerable to the tragic consequences that can result from the inappropriate use of restraints and seclusion (R/S). It is critical that you understand what restraints and seclusion are and how – if at all – they are used in the facility you are considering.

## Legislative Efforts Designed to Protect Children

On October 17, 2000, former President Clinton signed P.L. 106-301, the "Children's Health Act of 2000." Sections 3207 and 3208, in the 36 detailed legislative titles, establish a federal government standard for the use of restraint and seclusion. Under a special set of provisions that includes RTCs, restraint and involuntary seclusion may be used only in emergency circumstances and only to ensure the immediate physical safety of the child and/or those around him or her. Mechanical restraints are prohibited. Seclusions are allowed only if a staff member is continually present and monitoring the child in a face-to-face capacity. Physical escorts are not considered restraint and time out is not considered a seclusion.

#### What This Means to Your Child

The legislation lists a comprehensive set of skills and competencies which both the interim supervisory and senior staff, as well as the individual trained and certified by the state, must possess. These include prevention and use of R/S, needs and behaviors of the population served, relationship building, alternatives to R/S, de-escalation methods, avoiding power struggles, thresholds for R/S, physiological and psychological impact of R/S, monitoring physical signs of distress and obtaining medical assistance, legal issues, position asphyxia, escape and evasion techniques, time limits, the process for continuing R/S, documentation, investigation of injuries and complaints, and other related skills and competencies. Within six months of enactment, states which license such facilities must develop licensing rules and monitoring requirements and HHS will begin to develop national guidelines and standards on quality, quantity, orientation and training of staff.

#### **Definition of Terms**

- Chemical Restraint The term 'chemical restraint' means a behavioral management technique involving the use or overuse of a medication for purposes of sedation.
- Mechanical Restraint The term 'mechanical restraint' means a behavior management technique involving the use of devices as a means of restricting a resident's freedom of movement.
- Physical Restraint The term 'physical restraint' means a behavior management technique involving the use of physical holding as a means of restricting a resident's freedom of movement.
- Physical Escort The term 'physical escort' means a behavior management

technique involving the temporary touching or holding of the hand, wrist, arm, shoulder or back for the purpose of inducing an

acting-out resident to walk to a safe location. A physical escort is not a physical restraint.

- Seclusion The term 'seclusion' means a behavior management technique involving locked isolation.
- Time Out The term 'time out' means a behavior management technique involving the separation of the resident from the group, in a non-locked setting, for the purpose of calming. Time out is not seclusion.

Public laws may be accessed from the website of the U.S. Congress at <a href="http://www.thomas.loc.gov">http://www.thomas.loc.gov</a>.