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Philadelphia College of Osteopathic Medicine

Department of Psychology

PROGRAM EVALUATION:

THE CLINICAL PROGRAMMING OF AN ADOLESCENT PSYCHIATRIC RESIDENTIAL PROGRAM AND ADHERENCE TO CLINICAL BEST PRACTICE GUIDELINES

By Michael K. Colbert

Submitted in Partial Fulfillment of the Requirements of the Degree of

Doctor of Psychology

June 2009

PHILADELPHIA COLLEGE OF OSTEOPATHIC MEDICINE
DEPARTMENT OF PSYCHOLOGY

Dissertation Approval

This is to certify that the thesis presented to us by Michael K. Colbert

on the 12th day of May, 2009, in partial fulfillment of the

requirements for the degree of Doctor of Psychology, has been examined and is

acceptable in both scholarship and literary quality.

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Dedication/Acknowledgements

I would like to extend my gratitude to my family, friends, and the many people who encouraged, supported, and lifted me in prayer throughout this journey. I am especially thankful for my wife, Holly, and my two daughters, Kaylee and Krista, who were always there for encouragement, unconditional love, and persistent prayer.

I am thankful for my experience at PCOM and would like to acknowledge the faculty and members of my dissertation committee for the hours of instruction and guidance that enabled me to achieve a doctoral degree.

Most of all, I thank God, who continues to bless me in countless ways. He has provided me with the strength, wisdom, and perseverance needed to endure the many challenges faced throughout the course of this doctoral program. As I sit to write this, we are anticipating yet another blessing, the birth of our third child, a son (due any day now).

With thankfulness (and relief) I reflect back upon the years spent working towards this goal. With excitement I look toward the future, trusting that the Lord has great things planned for me and my family and that He will use this degree as a way for me to glorify Him in the field of psychology by serving and helping others.

Abstract

The structure and delivery of clinical services at an adolescent psychiatric community residential program (PCR), located in New Jersey, was evaluated and compared to national clinical guidelines in order to determine the effectiveness of the services being delivered. A multitude of demographic and clinical variables were examined through the review of 70 closed medical records over a 5-year period. An exploration of the history, rationale, and effectiveness of residential treatment services for adolescents is also presented, along with recommendations for the delivery of more effective clinical services.

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Chapter 1

Introduction

The demand for residential care remains high across the wide continuum of services. Residential placement is reserved for youth with the highest levels of need who cannot be maintained at home. Residential treatment centers (RTCs) provide a variety of services to children with emotional, behavioral, and mental health needs. Aside from temporarily relieving exhausted parents, RTCs can provide a consistent, nurturing environment with predictable, consistent expectations that are designed to help shape desirable behaviors and emotional responses (Rosen, 1998a).

Description of the Problem

Accurate statistical information pertaining to the number of youth residing in RTCs is difficult to gather because they are grouped with other forms of out-of-home (OOH) placements. An all-inclusive term is *foster care*, which is defined as '24-hour substitute care for children outside their own homes' (Child Welfare Information Gateway, 2005). Foster care settings include, but are not limited to, nonrelative foster family homes, relative foster homes, group homes, emergency shelters, residential facilities, and preadoptive homes.

According to the Adoption and Foster Care Analysis and Reporting System (AFCARS), there were over a half million (513,000) children in foster care as of September 2006 (U.S. Department of Health and Human Services Administration for Children and Families, 2008). In 2000, there were 131,206 youth ages 15 to19 in foster care in the United States. This figure grew steadily to 137,060 by 2003 (Wertheimer & Atienza, 2006).

From 2003 to 2006, there was a slight decline in the overall number of children entering the foster care system, with a median age of 10.2 and median length of stay (LOS) of 15.5 months (U.S. Department of Health and Human Services Administration for Children and Families, 2008). This is also true for adolescents between the ages of 11 and 17. Between 2003 and 2006, there was a 3.5% decrease in the number of adolescents entering foster care and a 4.4% increase in the number of youth exiting the system. In general, males outnumber females in placement (52% versus 48%, respectively) with a breakdown of ethnicity revealing White/Non-Hispanic having the highest rate of OOH placements at 40%, Black/Non-Hispanic at 32%, and Hispanic at 19%. Despite the downward trend in youth entering OOH placements, it is vital that quality programming is in place for any child requiring this level of service.

Definitions and continuum of out-of-home placements

Various forms of OOH placements are utilized, depending on such factors as severity of problem, program structure, and provision of services. These services can be viewed on a continuum where certain forms of care, such as treatment homes and group homes, are located on the least restrictive end, while RTCs and inpatient psychiatric hospitals are on the more restrictive end. The following definitions and short descriptions have been provided in order to facilitate an understanding of the overall system of care.

Therapeutic/treatment foster homes.

A foster home in which the foster parents have received specialized training to enable them to provide care for a wide variety of children and adolescents, usually those with significant emotional or behavioral problems. Parents in therapeutic foster homes

are more closely supervised and assisted than parents in regular foster homes (Adoption, 2008b).

Group homes.

Group homes serve as an alternative to traditional in-home foster care. In group homes, children are housed in an intimate or home-like setting, and a number of unrelated children live for varying periods of time with a single set of house parents or with a rotating staff of trained caregivers. More specialized therapeutic or treatment group homes have specially trained staff to assist children with emotional and behavioral difficulties. The composition and staffing of the group home can be adapted to meet the unique needs of its residents (Adoption, 2008a).

Psychiatric community residences (PCRs) and residential treatment centers (RTCs).

PCRs and RTCs are OOH, 24-hour facilities that offer mental health treatment using multidisciplinary teams that make therapeutic use of the daily living milieu, but are less restrictive than inpatient psychiatric. Each generally is a nonhospital setting that offers mental health treatment.

A PCR provides supervised, licensed, 24-hour care in conjunction with an intensive treatment program for youth with severe behavioral and emotional disturbances. Treatment in a PCR should include family involvement, where clinically appropriate. The youth being referred has usually received inpatient services or cannot be maintained in his/her current living arrangement with a reasonable degree of safety. Comprehensive services are multidisciplinary, multimodal therapies that fit the needs of the youth. Services include but are not limited to individual, group, and family therapy, psychiatric

treatment services, medication monitoring, psychiatric consultation, behavioral management, crisis intervention, structured recreational activities, and education (Division of Children's Behavioral Health, 2008a).

An RTC is the second most restrictive form of care (after inpatient hospitalization) for children with severe mental disorders. Residential treatment provides 24-hour services in a facility setting for youth who have demonstrated severe and persistent deficits in social, emotional, behavioral, and/or psychiatric functioning. Youth receive therapeutic intervention, education, and specialized programming in a safe, controlled environment with a high degree of supervision and structure. The purpose is to stabilize the youth and prepare him/her for a less restrictive level of care. The goal is to facilitate family or caregiver reintegration or alternative permanency planning, such as preparation for independent living. This level of care is typically provided in freestanding, nonhospital settings with on-site educational facilities. The facility must be capable of providing secure care, typically containing the youth in a staff-secure environment, rather than a physically secure/locked facility (Division of Children's Behavioral Health, 2008b).

The types of treatment vary widely at the RTC level. Some of the major categories include psychoanalytic, psychoeducational, behavioral management, individual/group therapies, medication management, and peer-cultural. Settings range from structured ones, resembling psychiatric hospitals, to those that are more like group homes or halfway houses. RTCs have commonly been utilized for youth requiring long-term treatment (e.g., a year or more). However, recent managed care restrictions have led

to serving more seriously disturbed youth for as briefly as 1 month for intensive evaluation and stabilization (*The Surgeon General's Report on Mental Health*, 2008).

Inpatient hospitalization/inpatient treatment.

Inpatient treatment is the most restrictive type of care in the continuum of mental health services for children and adolescents. Services are delivered in a licensed general, psychiatric hospital or a state-operated psychiatric hospital offering a full range of diagnostic, educational, and therapeutic services with the capability to implement lifesaving medical and psychiatric interventions. Services are provided in a physically secured setting. Patient admission into this level of care is the result of a serious or dangerous condition that requires rapid stabilization of psychiatric symptoms. This service is generally used when 24-hour medical and nursing supervision are required to provide intensive evaluation, medication titration, symptom stabilization, and intensive brief treatment (Riverview Hospital, 2008).

Chapter 2

Research Goals

Many human service programs are not based on any explicit theory of human behavior or any social or behavioral social science theory explaining how particular problems arise or even any particular intervention theory (Royse, Thyer, Padgett, & Logan, 2006). Such “atheoretical” programs may be based on common sense, authority, or tradition. When a program is not successful, the possibility exists that even though the program was implemented as designed, the underlying theory is flawed.

Defining a program as an organized collection of activities designed to reach certain objectives, Royse et al. (2006) consider programs to be interventions or services that are expected to have some kind of impact on the program participants. A clearly defined clinical model and best practice guidelines can greatly impact the overall clinical programming by influencing such aspects as the screening/intake, evaluations, assessments, treatment planning, and psychopharmacological treatment that an individual receives.

This program evaluation examined the quality of clinical programming provided at a PCR located in New Jersey. The goals guiding this evaluation were threefold: First, to provide an overall description of an array of demographic data regarding adolescents who have received residential services at the chosen site. Secondly, to determine whether empirically based practice guidelines were being effectively utilized for disruptive behavior disorders (attention deficit/hyperactive disorder and oppositional defiant disorder), depressive disorders, and posttraumatic disorder. Lastly, a goal was to provide

valuable feedback to the chosen agency and facility in order to enhance the delivery of their clinical programming.

Chapter 3

Hypothesis

The hypothesis for this study was that statistical analysis would indicate that best practices are not being implemented with 90% accuracy for at least 50% of the chosen records. It is important to note that this research paper uses the term *residential treatment center* (RTC) as being synonymous with *psychiatric community residences* (PCR).

Chapter 4

Purpose and Rationale

Despite the importance of program evaluations in the human services field, only 3% of all published social work articles provide interventions that can be replicated (Rosen, Proctor, & Staudt, 1999). As research continues to develop, we learn that there are always alternative, and sometimes better, ways to address problem areas. Because of this, program evaluations can provide important information in order to develop or refine programs/interventions. Therefore, the current study was designed to add to the scarcity of published literature and lead to the development of effective programming within residential facilities.

As Savin and Kiesling (2000) point out, providers must figure out how to gauge consumer and payer interests. Many providers are expected to address more complex and challenging behavior problems such as severe aggression, property destruction, and sexual disorders. These expanded expectations have been compounded due to the lack of clearly defined functional outcomes.

To get a better idea as to how human service organizations across the country delivered services, Savin and Kiesling (2000) sent out an organizational survey. This 10-page survey consisted of 41 questions relating to a number of topics (i.e., quality ansurance, clinical practice, staffing, measurement, and performance improvement) and was coupled with extensive telephone interviews with key figures in the field. Fifty-nine of the surveys from organizations in 21 states and Canada were completed and analyzed.

Despite the importance of clinical records supporting the process of care from the time of admission to postdischarge in a consistent, focused manner and across settings,

Savin and Kiesling (2000) found significant variability in approaches to client records. This is largely due to nearly all (96%) of the responding organizations indicating that they develop their own client record, with only two companies making use of a commercial product. A major limitation among those developing their own records involves the omission of client strengths, functional assessments, discharge criteria, and permanency goals from the record.

There are a vast number of mental health services being delivered to children and adolescents. This research intended to determine whether or not the clinical services at a specific psychiatric community residence (PCR) meet criteria for accountability ranging from admissions to outcomes. The diagnostic criteria established for the best practice evaluation of this study were based largely on the work of Connor, Doerfler, Toscano, Volungis, & Steingard (2004), which specified several critical areas and diagnoses that required special consideration for clinical interventions.

Therefore, the current research project involved an examination of four commonly found diagnoses in residential treatment centers: attention deficit/hyperactive disorder (ADHD), oppositional defiant disorder (ODD), depressive disorders, and posttraumatic stress disorder (PTSD). The evaluation included a comparison to professionally published best practices guidelines.

Chapter 5

Background

Deinstitutionalization is the name given to the policy of moving severely mentally ill people out of large state institutions and then closing part or all of those institutions. It was based on the principle that severe mental illness should be treated in the least restrictive setting. As further defined by President Jimmy Carter's Commission on Mental Health, this ideology rested on "the objective of maintaining the greatest degree of freedom, self-determination, autonomy, dignity, and integrity of body, mind, and spirit for the individual while he or she participates in treatment or receives services" (Deinstitutionalization, n.d.).

Attention to this issue was first centered on the treatment of the jailed mentally ill. Reverend Louis Dwight established the Prison Discipline Society (PDS) in 1825 for the purpose of improving the public prisons of Boston. As he took Bibles to inmates in jail, he was shocked to see such inhumane and degrading conditions for all inmates, but in particular for the mentally ill prisoners. The PDS was established to publicly advocate for improved conditions at prisons, jails, hospitals in general, but more specifically for the mentally ill prisoners.

Dwight's actions led a Massachusetts legislative committee to recommend that all mentally ill inmates of jails and prisons be transferred to the state's general hospital and that confinement of mentally ill persons in the state's jails should be made illegal. In 1830, the Massachusetts General Court overwhelmingly approved a bill that led to the building of a state lunatic hospital for 120 patients, which opened in 1832 as the

Worcester Insane Asylum (State Hospitals of Massachusetts, n.d.). The PDS established other societies in New York and Pennsylvania.

Dorothea Dix, the most famous and successful psychiatric reformer in American history, added to Dwight's advocacy. In 1843, she argued that the 120-bed facility at Worcester was not sufficient for the large number of insane people she found in poorhouses and jails throughout Massachusetts. This led Worcester State Hospital to expand to accommodate 320 beds (State Hospitals of Massachusetts, n.d.). By 1847, she had taken her crusade to many eastern states and visited 300 county jails, 18 prisons, and 500 almshouses. She was also responsible for the enlargement or establishment of 31 other public hospitals, including the New Jersey State Lunatic Asylum at Trenton NJ in 1848 (Famous New Jersey Women, 2003). The efforts of Reverend Louis Dwight and Dorothea Dix were extremely remarkable in leading the effort to place mentally ill persons in public psychiatric hospitals, rather than in jails and almshouses (charitable houses). By 1880, there were 75 public psychiatric hospitals in the United States for the total population of 50 million people. However, the next 90 years had large numbers of mentally ill reappearing once again in America's jails and prisons (Deinstitutionalization, n.d).

The emergence of deinstitutionalization can be traced back to the 1950s with a major advancement in 1955. Psychopharmacological treatment for mental illness occurred with the widespread introduction of chlorpromazine, commonly known as Thorazine. It became the first effective antipsychotic medication and was a major impetus for the movement of deinstitutionalization. This movement peaked again in the mid-1970s due to protests against the 'warehousing' of children, which is how large

congregate settings were viewed. The civil rights movement also gave birth to an increased consciousness about discriminatory policies, including policies toward the disabled and socially and economically disadvantaged members of society (Coalition for Residential Education, n.d.).

The magnitude of deinstitutionalization of the severely mentally ill qualifies as one of the largest social experiments in American history. In 1955, there were 558,239 severely mentally ill patients in the nation's public psychiatric hospitals. In 1994, this number had been reduced to 71,619. The movement of deinstitutionalization shifted people from inpatient state hospitals to the less restrictive community-based level of care, such as community-based mental health centers, residential facilities, and day hospitals. Furthermore, managed care decreased long-term care and put the severely mentally ill patients in the community in an effort to cut costs and save money. Therefore, the importance of good, sound community based therapeutic programs for all individuals with mental illness is vital.

Establishment of Psychiatric Hospitals

In 1813, the Religious Society of Friends founded Friends Hospital as the nation's first private institution dedicated solely to the care of the mentally ill (Friends Hospital, n.d.). They viewed insanity as a temporary impediment to reaching God within and saw it as their mission to help the mentally ill out of the darkness. These Friends, or Quakers, saw the mentally ill as brethren capable of living a moral, ordered existence if treated with kindness, dignity, and respect in comfortable surroundings. They called their approach to curing insanity 'moral treatment.' Most others viewed the insane as less than human and treated them as such.

On May 15, 1817, 'the Asylum,' as it was called, opened its doors to accommodate 50 patients. It was later renamed Friends Hospital in 1914. In light of the fact that the Asylum accepted many patients who were considered incurable, Friends demonstrated the potential of moral treatment. Of the 66 patients admitted during its first 3 years, Friends Asylum cured or discharged as much improved about 25 of these men and women. Although the Friends established the hospital as a safe haven in which to care for their own, they soon opened the doors to the afflicted of all religious denominations. To make room for more patients in the 1970s and 1980s, the Bonsall and Tuke Buildings were completed, creating the Hospital's current 192-bed capacity. In 1980, Friends Hospital opened the Greystone Program on the grounds of the hospital. The Greystone Program is based on a similar philosophy: to remove long-term patients from a hospital setting to a home. Shortly thereafter, a companion home was built in 1989 and named Hillside House.

History of Children's Residential Services

During the 19th century, the United States recognized the need to provide additional services for special needs children. The rising popularity of Freud's psychoanalysis, along with the development of psychological clinics at American universities, led to the identification of children requiring residential treatment. Here began the development of large residential centers (Rosen, 1998a). In its most general sense, residential treatments of the past were understood to involve orienting the daily life of children in institutions around psychodynamic and other therapeutic principles. Child care staff responsible for overseeing most activities also served as primary therapeutic agents (Leichtman, 2006).

Residential treatment services for children have become increasingly important in recent years, mainly due to the transformation of managed care. Children experiencing severe psychopathology used to have access to intermediate and long-term inpatient care. Today, there are stricter limitations on psychiatric hospitalizations with additional financial concerns. As financial and political support for extended psychiatric hospitalization waned in the early 1990s, demands have been placed on residential facilities to provide similar services for the severely disturbed children formerly treated in hospital settings (Leichtman, 2006). However, residential facilities were expected to do so for significantly less cost and with much shorter lengths of stay than intermediate and long-term hospitals. Consequently, residential programs must now treat adolescents who are more disturbed than ever before in much shorter time periods.

The removal of some youth from their community for a period of time may be necessary. Through much of its history, residential treatment has been considered a long-term modality, whereas current length of stay have shortened. Utilization of residential treatment versus traditional outpatient services relies on a number of factors. Residential services may be the preferred treatment modality, due to the severity of the emotional problems treated and the extent to which living in dysfunctional families was responsible for such problems (Leichtman, 2006). An intensive long-term program like a RTC with a high-level staffing pattern may be of benefit to children needing protection from themselves due to suicide attempts, disruptive behaviors, emotional instability, persistent running away, or severe substance abuse, especially when sufficient supportive services are not available in their communities (Mental Health, 2008).

History of Children's Mental Health Services in New Jersey

Thomas Story Kirkbride, a Philadelphia psychiatrist during the mid-1800s, believed in the philosophy of moral treatment and developed what he called the Kirkbride Plan. This plan involved carefully constructed buildings with "tastefully ornamented" grounds that were meant to serve as a curative effect (Wikipedia, n.d.). The Kirkbride Plan believed that the layout of the asylums, along with their landscapes, served as curative factors. The first Kirkbride Plan building was found at the New Jersey State Lunatic Asylum, but by the 1900s the notion of "building as a cure" was largely discredited and in the following decades, the cost of upkeep for these facilities became too expensive.

Although the Kirkbride Plan did not flourish, the New Jersey State Lunatic Asylum did. However, prior to the opening of psychiatric hospitals in New Jersey, the mentally ill were housed in jails, almshouses, or private homes, where they were frequently confined to attics, cellars, or outbuildings (American Psychiatric Association, 1982). Dorothea Lynde Dix, the renowned pioneer and advocate for humane care and treatment of the mentally ill, founded Trenton Psychiatric Hospital as the first public mental hospital of New Jersey (Famous New Jersey Women, 2003). Services at this hospital began on May 15, 1848, and 86 patients were admitted and treated during its first year of operation.

The various names given to the hospital over the years define its changing role. In 1848, it was the New Jersey State Lunatic Asylum; in 1893, the name was changed to New Jersey State Hospital at Trenton, and then in 1971, it received its current name, Trenton Psychiatric Hospital.

As for children with mental illness, Arthur Brisbane Child Treatment Center (ABCTC) opened in 1947 as New Jersey's only public psychiatric hospital for children under the age of 14 (State of New Jersey, Office of the Child Advocate, 2004). In addition to adult mental health services at Trenton Psychiatric Hospital, an adolescent unit for youth ages 11 to17 was also established. Originally, psychiatric services for youth were provided on the children's units at each of the four state psychiatric hospitals and at Brisbane. The Trenton Psychiatric Hospital Adolescent Unit was designated for adolescents in need of extended inpatient psychiatric care, and Brisbane was designated for the treatment of younger children, averaging a daily population of between 300 and 350 children and adolescents.

As time went on, concerns arose about the quality of care in these psychiatric units, the physical plants, and the programming for the juvenile patients. A new state plan calling for the establishment of children's crisis intervention services (CCIS) units as alternatives to inpatient care was implemented between 1979 and1980. This plan was short lived and by the mid-1980s, the system broke down, and the mental health system for children and adolescents was in crisis again.

Following the death of a patient in the Trenton Psychiatric Hospital Adolescent Unit, the New Jersey Department of the Public Advocate filed a lawsuit, Slocum v. Perselay, on June 27, 1986. Allegations of improperly trained staff, lack of proper supervision of the patients, improper use of physical bonds to restrain children, the overuse of chemical restraints to control behavior, lack of fresh air and exercise, and the failure to identify or develop appropriate and less restrictive placements were addressed,

and ultimately led to the complete closing of the Adolescent Unit by the end of 1988 (State of New Jersey, Office of the Child Advocate, 2004).

As these allegations were being investigated, a new plan emerged in 1987 involving the closing of the Adolescent Unit at Trenton Psychiatric Hospital. As this unit closed, the litigation led to a new plan to regionalize psychiatric programs for adolescents and children (Feldman, 1999b). ABCTC was designated as the Statewide Backup Unit and was transformed from a children's psychiatric institution to one serving adolescents ages 11 to17. Additionally, the Youth Incentives Program was developed, and the children's crisis intervention services (CCIS) units were expanded in order to serve as an alternative to inpatient care. However, the focus of the Slocum v. Perselay litigation moved to Brisbane and was the focus of a long-standing investigation. The first and only patient death at Brisbane occurred in January 1998, when a 17-year-old female died during a physical restraint.

However, this was not an isolated incident, and during the course of a disciplinary procedure, critical and long-standing issues at Brisbane were found. These included an unsafe physical plant, overcrowding, overreliance on physical restraint instead of verbal deescalation techniques, injuries resulting from the pervasive pattern of rough treatment of patients during restraints, lack of proper staffing and supervision in the living units, verbal harassment of patients leading to poor behavior, and the callous, impersonal attitude of some staff members toward patients (Feldman, 1999b).

According to a lawyer from New Jersey Protection and Advocacy, Inc., "New Jersey's mental health care for children and adolescents do not meet the needs of this population for a continuum of care differing intensities based on the child's needs, but

instead are fragmented, rigid, inaccessible and full of gaps…Overall, deficiencies and problems are aggravated by the State's failure to integrate funding streams for juvenile mental health services across departments, divisions and governmental levels" (Feldman, 1999, p.1). It wasn't until spring 2006 that the doors of ABCTC were permanently closed. In light of Brisbane's closing, the state opened Intermediate Units to offer inpatient services to adolescents 11 years of age requiring further stabilization beyond the CCIS units.

Currently in New Jersey, screening and emergency services are available 7 days a week, 24 hours a day, at emergency room departments of community hospitals. Children and adolescents whose mental health crisis continues to be acute go to one of the nine regional CCIS centers. With 3,500 admissions annually, the CCIS units provide screening, stabilization, assessment, and short-term intensive treatment (Feldman, 1999a). The CCIS centers were originally 28-day facilities. However, in recent years, the length of stay has been decreasing to 10 to 12 days. The change in the length of stay at the CCIS units is attributed to the pressure from managed care organizations to release the patients more quickly, as well as to improvements in medications that make 28-day stays unnecessary.

Long-term psychiatric hospitalizations are no longer an option for adolescents ages 11 to 17 due to the closing of Brisbane. Therefore, patients who need continuing intensive psychiatric treatment after being in a CCIS unit can go to one of three intermediate-care units for placement from 30 to 90 days. Adolescents who need a structured residential setting may be able to obtain placement in one of the limited number of psychiatric community residences (PCR). These facilities serve youths in a

group home setting, with an average length of stay of 6 to 9 months. Other psychiatric community residences serve children between 5 and 10 years of age and older youths who are making the transition from the children's mental health system to the adult system.

New Jersey was among 17 states where the number of youth in foster care changed by 20% or more between 2000 and 2003. During this time, the number of children entering out-of-home (OOH) placements in New Jersey exceeded the number of children exiting OOH placements. In a report prepared on April 17, 2006, by the New Jersey Department of Human Services Office of Children's Services, the OOH trend has finally made a turnaround, as the number of children exiting out-of-home care surpassed the number entering out-of-home placements in 2004 (7,921 versus 7,288), and this continued in 2005 (7,775 versus 6,774).

Meanwhile, the current population in need of residential treatment is younger, more disturbed, more likely to have significant disabilities, more likely to have been sexually abused, and more likely to come from homes with substance abuse problems than in the past. New Jersey continues to experience ups and downs in its efforts to reform its system of care for mentally ill children and adolescents.

Chapter 6

New Jersey's Current Children's Mental Health System of Care

Deinstitutionalization rates vary from state to state. New Jersey had 22,262 patients in public mental hospitals as of December 31, 1955, and 3,405 patients at the end of 1994. The actual deinstitutionalization rate was 84.7%, meaning that for every 100 state residents in public mental hospitals in 1955, about 15 patients were there 39 years later. Although some children continue to be warehoused in detention centers awaiting appropriate residential treatment services (Division of Children's Behavioral Health, 2008c), out-of-state placements for Division of Children's Behavioral Health Services (DCBHS) have dropped steadily over the past 3 years, with a 70% decrease from 327 youth in March 2006 to 98 youth in January 2009.

Currently, New Jersey continues working through its crisis within the children's mental health system of care, since previous attempts are no longer meeting the needs of its youth. On April 22, 1999, Governor Whitman announced the development of a Children's Mental Health System of Care initiative, intended to be a major reform of the state's system for dealing with children with serious emotional disturbance. This new plan has been a slow and arduous process that continues to proceed with mixed results.

Committed to turning around New Jersey's child welfare system with an aggressive and focused reform plan and strong leadership, Governor Jon S. Corzine made one of his first priorities the creation of the state's first cabinet agency devoted exclusively to serving and safeguarding the most vulnerable children and families in the state. On Tuesday, July 11, 2006, Governor Corzine signed legislation, which received

overwhelming support in the legislature, to officially establish the New Jersey Department of Children and Families (DCF).

The New Jersey Department of Human Services (DHS) provides various services for children ages 0 to 18 to ensure their well-being, health, and development. Childrens mental health services are coordinated through both the Department of Human Services and the Department of Children and Families (DCF). Intensive therapeutic placement services for children with severe mental illness may be coordinated through the State Division of Mental Health Services within DHS (New Jersey Department of Children and Families, n.d.).

The following section provides a summary of services within New Jersey's Department of Children and Families.

Department of Children and Families (DCF)

DCF is New Jersey's state child welfare agency that is focused on strengthening families and achieving safety, well-being, and permanency for all New Jersey's children. DCF is staffed by approximately 7,000 employees and encompasses Youth and Family Services, Child Behavioral Health Services, Prevention and Community Partnerships, Specialized Education Services, the Child Welfare Training Academy, and a Centralized Child Abuse/Neglect Hotline (State of New Jersey - Department of Children and Families, n.d.)

Division of Youth and Family Services (DYFS)

DYFS is New Jersey's child protection and welfare agency within DCF. Its mission is to ensure the safety, permanency, and well-being of children and to support families. DYFS is responsible for investigating allegations of child abuse and neglect

and, if necessary, arranging for the child's protection and the family's treatment (State of New Jersey - Department of Children and Families, n.d.).

Division of Child Behavioral Health Services (DCBHS)

DCF's Division of Child Behavioral Health Services (DCBHS) serves children and adolescents with emotional and behavioral health challenges and their families. DCBHS is committed to providing services based on the needs of the child and family in a family-centered, community-based environment (State of New Jersey - Department of Children and Families (n.d.)

DCF is committed to community-based, family-focused care in the home, with placement and hospitalization only as a last resort. There is a broad continuum of care within New Jersey's Child Behavioral Health divisions. A brief description, obtained from the DCF web page (State of New Jersey – Department of Children and Family, n.d.), of each service is provided in the following section.

Mobile response and stabilization services (MRSS).

The goal of MRSS is to maintain children and youth in their home environment and avoid unnecessary hospitalization or out-of-home placement. In order to achieve this, clinical staff is rapidly deployed to the home to respond to a crisis. The families can receive up to 72 hours of in-home crisis and stabilization services, which can be followed by up to 8 weeks of intensive in-community, behavioral assistance or wraparound services.

Community based care management (CMO, YCM, FSO).

Care management organizations *(*CMOs) involve an intensive level of community-based case management designed to coordinate services for youth with

multisystem involvement and high levels of need. The goal of CMOs is to maintain children at home with access to wraparound, community-based services. In the exceptional cases when residential care is necessary, the CMO will facilitate entry, maintain family contact throughout placement and plan and execute step-down.

Youth Case Management Programs (YCMs) are a moderate level of community-based case management designed to coordinate services for youth with multisystem involvement with moderate levels of need. The goal of YCMs is to maintain children at home with access to wraparound community-based services.

Family support organizations (FSOs) are agencies designed to provide support, advocacy, and encouragement to families of children with mental and behavioral health needs. Their goal is to provide individual and group support to parents and family members of children involved with DCBHS. They provide community education and outreach on childhood mental and behavioral health needs and the system of care. They are also responsible for providing youth partnerships for positive peer interactions for youth in their community.

Behavioral assistance and intensive in-community services.

No description was available on the website.

Partial care, outpatient, inpatient hospitalization and inpatient intermediate and acute inpatient treatment.

No description was available on the website.

Residential services.

Residential placement is reserved for youth with the highest levels of need who cannot be maintained at home. The demand for residential care remains high across the

wide continuum of services. DCFs continuing reform of the residential care system presents opportunities to maximize utilization of existing services and develop proven community-based alternatives to high-end residential care, which will eventually allow New Jersey to reduce reliance on out-of-state placements. New Jersey's residential care includes (from least to most restrictive) treatment homes, group homes, psychiatric community residences (PCR) and specialty beds, residential treatment centers (RTC), and intensive residential treatment (IRT).

Chapter 7

Outcome Studies

Within child welfare, residential treatment services represent both an expensive and common intervention for children and adolescents with serious emotional disorders. Residential programs serve an extremely important role for children and adolescents involved in an out-of-home (OOH) placement. In an era of managed care and accountability, residential treatment programs are faced with a daunting task of operationally defining outcome and ways to measure success of such placements. Although a number of residential outcome studies to date have been conducted, the evidence for their effectiveness remains weak (Burns, Hoagwood, & Mrazek, 1999).

This section reports numerous outcome studies relating to RTCs. It is important to note that one of the most salient issues in studying aftereffects of residential treatment relates directly to the way in which outcome is operationally defined. In describing reasons for placement, the American Association of Children's Residential Centers (AACRC) provided data from a national study involving 96 RTCs from 33 states with a combined 7,544-bed capacity. They report the common reasons for placement, in order of frequency, are severe emotional disturbance, aggressive/violent behavior, family/school problems, and abuse (Elson & Murtagh, 1999). Consideration of an OOH residential placement should always seek the least restrictive setting. Despite this noble attempt, the national survey found 6 of every 10 children/youth in RTCs get placed directly from a congregate care living arrangement, and most of these come from settings that are either more restrictive (hospital, juvenile detention) or as restrictive (another RTC) as the

residential treatment setting from which they were placed. Whereas only 26% come directly from home, 18% have most recently been in a foster home (AACRC).

Benefits of Residential Treatment Centers

A consistent finding over the years has revealed positive outcomes being associated with shorter lengths of stay (Hair, 2005; Hoagwood & Cunningham, 1992; Hussey & Guo, 2002; Landsman, Groza, Tyler, & Malone, 2001). In fact, most behavioral and emotional improvements are made within the first 3 to 6 months following admission (Shapiro, Welker, & Pierce, 1999). Outside of this time frame and more generally speaking, reductions in high-risk behaviors, aggression, depression, and psychotic features, but an increase in anxiety and hyperactivity have also been reported (Lyons, Terry, Martinovich, Peterson, & Bouska, 2001). To achieve this, many facilities rely on behavior management programs to help control and modify maladaptive behaviors while teaching prosocial behaviors. Improvements in prosocial behaviors have been in facilities that utilize a behavior modification program that incorporates behavioral techniques such as positive reinforcement, behavioral contracts, modeling, and role-playing (Ansari, Gouthro, Ahmad, & Steele, 1996).

Prior Placements

Despite the existence of policies about placing children into the least restrictive setting possible, data from the National Survey on Child and Adolescent Well-Being (NSCAW) found 25% of youth experienced an intensive or restrictive setting during their first OOH placement. The vast majority (70%) of these first-time placements occurred at group homes and residential treatment facilities (James, Leslie, Hurlburt, Slymen, Landsverk, 2006). Additional information was obtained from the odyssey project, which

was a national, multisite study that involved over 2,600 youth. This project examined the placement histories of youth entering high levels of care in the child welfare system.

Overall findings revealed that youth admitted to RTCs were more likely to be entering from higher levels of care (mental health setting or juvenile justice) and stepping down to the RTC (Baker & Curtis, 2006). On average, these youth lived in over five placements prior to admission, with only 10% of the sample having had only one prior placement. Interestingly, they also found that one third of the RTC admissions had at least one prior admission to an RTC.

Predictors of Success Prior to Discharge

Twenty-four percent of first OOH placements occur with youth in their teenage years (Connor, Doerfler, Toscano, Volungis, & Steingard, 2004). It has been shown that adolescents whose symptoms began prior to age 6, in comparison to those who developed symptoms at a later age, have better results stemming from a residential placement (Ansari et al, 1996). Examining symptomology and number of psychiatric diagnosis at the time of admission into a residential facility, individuals who report greater internalized symptoms and more Axis I psychiatric diagnoses have been found to have greater success (Hooper, Murphy, Devaney, & Hultman, 2000). Apart from the number of diagnoses, youth exhibiting a lesser degree of severity of pathology at the time of admission have led to more positive outcomes (Hussy & Guo, 2002).

As for gender, a major limitation involving the lack of focus on diagnostic improvement is found within the current knowledge regarding the interaction of gender and the effectiveness of residential care. However, there are a few studies that have reported gender differences in regards to success. In a large longitudinal study, over

2,000 adolescents in residential care were examined (Handwerk, Huefner, Smith, Clopton, Hoff, et al., 2006). They found a large number of girls being treated in residential treatment facilities. Despite higher rates of psychopathology among these girls, they were rated as significantly more successful than their male counterparts. A similar study also revealed improvements and greater success in females (Ansari et al, 1996). More specifically, younger females have been reported to have higher success rates than older females and males of any age (Hooper et al., 2000). This is due in part to the finding that many adolescent females present with more anxiety and depressive disorders at the time of admission to an OOH placement, and therefore tend to have greater success (Handwerk et al., 2006; Hooper et al., 2000). Regardless of gender, when evaluating progress made at time of discharge, youth with high internalizing behaviors at admission show significantly less pathology at discharge (Connor, Miller, Cunningham, & Melloni, 2000).

A heavy emphasis has been placed on the importance of family involvement throughout treatment in order to lead to successful graduation/discharge from residential care (Hair, 2005). In general, postdischarge success has been positively related the degree of ongoing contact with supports in general (Hooper et al., 2000). However, the importance of parental contact is well documented, as evidenced by the findings … greater parental contact leading to positive outcomes (Landsman, Groza, Tyler, & Malone, 2001) and the fact that family support and involvement during a child's residential stay aides in successful discharge (Gorske, Srebalus, & Walls, 2003). Involvement in therapy, specifically family therapy, has been found to be a significant predictor of discharge to a less restrictive setting (Stage, 1999). Additionally, it has been

noted that youth with frequent family visits to the residence were six times more likely to successfully complete treatment (Sunseri, 2001).

Predictors of Unsuccessful Program Completion

The ability to effectively talk with adults is often a foreign task among adolescents in residential treatment centers. It has been shown that youth are four times more likely to not complete a residential program if they exhibit difficulty talking to adults (Sunseri, 2001). In addition to the inability to converse with adults, a history of trauma has also had an adverse impact on treatment progress. It has been found that youth who have endured sexual and physical abuse in their past have been shown to exhibit more psychopathology at discharge (Connor et al, 2000). As previously mentioned, family involvement plays a vital part in an OOH placement. The lack of family involvement can have a profound impact on treatment success. Sunseri (2001) found youth who did not have home visits to be eight times more likely to not complete the residential program.

Residential Factors That Led to Postdischarge Success

According to attachment theory, multiple separations may be expressed as mistrust of and/or lack of ability to develop new therapeutic alliances. Such youth might also demonstrate a heightened and indiscriminate desire for intimacy and contact that could be experienced negatively by child care workers and even therapists. Unless child care workers are provided with ongoing training and supervision to deal with these challenges, these behaviors are likely to interfere with treatment. The limited education and mental health training of many child care workers is considered problematic because of the complex set of relational skills required to interact effectively with such youth.

A lot of emphasis is placed on the therapeutic relationship to serve as a vehicle of change in individuals struggling with emotional and behavioral difficulties. For adults, this relationship, and a therapist who is perceived as gentle and nonjudgmental can serve as agents of change (Nelson, 2005). Similarly, it is believed that children and adolescents who maintain a relationship with caseworkers and other care providers (e.g., therapists), even if only in a peripheral fashion, may hold the key to postdischarge success (Hooper, et al., 2000).

Residential treatment outcome studies involving children have repeatedly stressed the importance of the postdischarge environment to adjustment. Positive outcomes have been found when the community-based services are present (Hoagwood & Cunningham, 1992). Part of this may be due to the importance of ongoing involvement in significant relationships in the postdischarge environment.

Due to residential staff possessing vastly different formalized training and education, dangers lie within the level of understanding and awareness of professional boundaries. These are important in order to safeguard against behaviors that may lead to misconduct or harm to clients. Interestingly, a survey of mental health counselors about their behaviors and attitudes regarding dual-role relationships found approximately one third of counselors had engaged in posttermination friendships (Salisbury & Kinnier 1996). This number has been found to be as high as 57% (Pope, Tabachnick, & Keith-Spiegel, 1987).

Of the many differences between direct care staff (child care counselors) and professional staff (clinical and supervisory professionals, therapists, psychologists, and consulting staff), there seem to be varying beliefs about the ethics of relationships and

posttreatment contact with adolescent clients, particularly with direct care staff. Most professionals are well aware of the dangers of dual relationships: however, it has been found that 20% of direct care workers believe posttreatment friendships are sometimes ethical (Zirkle, Jensen, Collins-Marotte, Murpy, & Maddux, 2002).

Post Discharge

According to AACRC (1999), gains made during the course of treatment are a poor predictor of long-term success, and assessment of treatment requires long-term postdischarge follow-up. Despite this knowledge, only 11% of all RTCs track children for more than 6 months after discharge and a mear 5% track them for more than 1 year (AACRC, 1999). Gains have been demonstrated at the 6-month period postdischarge, with youth reporting less depression and anxiety and improved attention (Larzelere, Dinges, Schmidt, Spellman, et al., 2001).

However, as time goes on, it is less likely the program will continue to exert an impact on the individual's life, and the overall success rate tends to decrease (Bates, English, & Kouidou-Giles, 1997; Frensch & Cameron, 2002; Hooper et al., 2000). Despite this finding, a promising study found 66% of youth in residential treatment reported improved social and personal adjustment 10 years postdischarge (Erker, Searight, Amanat, & White, 1993). However, this study utilized a very small sample that included only 16 youth.

Hair (2005) found six key factors that lead to successful graduation and helped maintain gains postdischarge. These factors involve (a) the extent of family involvement in the treatment process prior to discharge, (b) the stability of discharge placement, (c) the need for aftercare services/support for the child and family, including advocacy for

school and/or gainful employment, (d) shorter lengths of stay, (e) academic success; and (f) successful program completion before discharge. Furthermore, a supportive aftercare plan has been found to lead to positive outcomes (Landsman et al., 2001). As for discharge, AACRC (1999) has found that most children are discharged to a lower level of care, with 34% going home, 3% discharged due to “away without leave” (AWOL) status, and 14% discharged to an equal or higher level of care.

Recidivism

Since the benefits of residential treatment seem to be difficult to maintain as time increases from discharge, several studies have looked at recidivism rates. Connor et al., (2004), found 84% of youth were readmitted to out-of-home placements, and girls were more likely to have more than five prior OOH placements. A large-scale study that tracked more than 800 successfully discharged youth from residential treatment facilities across six states revealed 75% eventually were readmitted to residential treatment (Greenbaum, Dedrick, Friedman, Kutash, Brown, et al., 1996). Even when discharge included reunification with family, 59% of the youth were re-placed in OOH settings, with half returning to residential treatment within 3 years postdischarge (Asarnow, Aoki, & Elson, 1996).

Chapter 8

Development of Adolescent Residential Theoretical Models

A key debate that has plagued children's residential services involves protection versus confinement. Is the overall goal of care to keep the residents out of harm's way or to confine them in order to prevent them from harming the wider society? This question involves concerns about the breakdown of family authority and the decline of community life leading to social instability. Another important issue centers on the goals of social control versus personal growth and development. This debate examines whether residential programs should strive for obedience to authority through punishment or should seek the personal empowerment of residents by using all aspects of the program as a vehicle for therapeutic change (Abramovitz & Bloom, 2003). These long-standing debates have prompted development of theoretical models that have driven clinical services.

Determining the etiology of behaviors that bring children and youth into residential care has been a daunting task, with favored answers continually changing. Some believe flawed social conditions (i.e., "bad" parenting or poverty) contribute more to maladaptive behavior than does individual behavior (Rothman, 1990). Prior to the 1800s religious explanations were given for individual and social problems. Inherently evil individuals contaminated by original sin were a common view in America. This religious understanding gave way to moralistic explanations. This belief attributed behaviors of troubled children to poor child rearing practices by immoral parents who were a bad influence and/or who failed at teaching how to resist corruption.

These ongoing debates often leave practitioners, residential staff, and professionals to reach personal, independent conclusions. Residential programs become of the differing assumptions because they contribute to the problematic absence of a coherent treatment model. Since World War II, most residential centers for youth were guided by psychoanalytic, behavioral, or learning theory. However, two psychoanalytic approaches, intensive individual treatment and milieu therapy, dominated the field and shaped models that followed (Abramovitz & Bloom, 2003). The early residential treatment programs, such as the Devereux School in Pennsylvania, the Orthogenic School in Chicago, and Boys Town in Omaha, all stressed the importance of education and residential treatment. From these beginnings, conceptual treatment models evolved (Rosen, 1998b).

Over the years it has been common practice to operate group homes with a "one size fits all" belief. In doing so, a program may embrace one or several theoretical models to guide the therapeutic milieu. For instance, Munson, Klein, and Delafield (1989) studied a successful adolescent residential facility that utilized components of psychoanalytic, person-centered, and cognitive-behavioral therapy. Although no significant differences were found between the various departments (clinical, school, dormitory) for each of the models, the cognitive-behavioral model of therapeutic intervention was preferred.

Residential settings can vary greatly in their philosophy, treatment model, and environment. A continual need exists to develop a comprehensive and coordinated network of community-based treatment resources to effectively meet the unique needs of adolescents experiencing emotional difficulties (Termini, 1991). The following section

provides a variety of residential models that have demonstrated success in an array of areas.

Milieu

Criticism about the utilization of professional approaches to psychotherapy in a residential program raised concern about the lack of emphasis that was being placed on the social structure. Due to the constant array of services offered through residential treatment, it is difficult to ascertain the exact variables linked to program success. There are many barriers to change that lie outside of the individual. This includes the therapeutic milieu within each of the residential facilities. This is where the program rules and expectations are clear and closely monitored, and acting out behaviors are strictly controlled through the utilization of a behavior management system, where privileges and varying degrees of independence are based on overt behavior.

Within the milieu, a great deal of emphasis is placed on the formation of close relationships with child care workers, who provide structure and enforcement of program rules, assist with negotiations of daily living tasks, and address a variety of emotional and behavioral problems as they arise throughout the course of a day. Other major components of residential care include daily groups that address a variety of topics, clinical/specialized groups led by professional staff, and an array of recreational or therapeutic activities and community outings. Depending on the location and structure of the facility, educational services may be on or off site, but either place contributes to the therapeutic milieu.

A number of distinct features are involved in residential care. First, assuming the entire team (paraprofessional, professional, administrative, and auxiliary staff) is the

primary agent of change, therapy boundaries are often modified in order to encourage an integrated model of treatment. For instance, a therapist can suggest that an adolescent continue discussions with child care workers after a difficult counseling session. The other is also true, where child care staff have the opportunity to refer the resident to his/her assigned therapist at any given time. Rather than treatment being viewed in terms of discrete specialized modalities, emphasis is placed on all members of the team working on issues in repetitive, even redundant ways.

Ecological Models

An ecosystem approach focuses on the interdependence of environmental elements such as the residential program, the school, various social agencies, peer group, culture, and the family in the life of the adolescent. There is an inherent awareness that the changes in one area of the system can have a domino effect and may influence behavior in the other areas. For instance, when a child's problems are dependent upon his or her relationship with the family, the school, and the residential facility, these systems infringe on one another (Termini, 1991).

Ecological interventions consider the significant environmental elements, the relationships among these elements, and the adolescent's interaction with them. An important aspect of this approach focuses on the reintegration of the adolescent from the institution back to the neighborhood school. In addition, it is vital for professionals to address the relationships and linkages between treatment sources.

Although most residential programs are structured with an interdisciplinary team, this has the potential to develop destructive tension among team members by setting the stage for power struggles, differing opinions, and lack of communication. The notion of

an ecological systems approach avoids these issues because the integration involves more than sharing information among interdisciplinary team members (Termini, 1991).

Due to the importance of overlapping communication and reliance on each subsystem, an integrated continuum of care is required. However, Termini's (1991) review of research found that interagency conflict often emerges and can be quite difficult to resolve. Tensions exist over differing basic theoretical orientation, mistrust, fear of lack of resources, placing blame or accepting responsibility, intervening in such ways that impede progress. These tensions run the risk of developing a "we" and "they" mentality, which only serves to complicate the placement and future transition.

Reeducation Model

Hooper, Murphy, Devaney, and Hultman (2000) conducted a study to provide a descriptive follow-up of adolescents admitted to a residential program with an underlying philosophy guided by Hobbs's (1982) reeducation model. This model involves psychoeducational programs for troubled children and adolescents that generally have a highly structured milieu; well-trained front-line staff; group activities designed to address social, academic, and problem-solving impediments; and strong community ties that often even begin before the individual is enrolled in the program. The model is predicated on systems theory, with the treatment components based on a definition of emotional conflict that derives from both interpersonal difficulties and system level defects (e.g., problems with service provision in the mental health system).

Follow-up data was gathered at four 6-month intervals beginning at 6 months postdischarge. Student functioning was rated as satisfactorily or unsatisfactorily in several domains. A rating of satisfactory did not mean that an adolescent was doing well

in a particular domain; it simply indicated that the adolescent was continuing to function on a modestly adaptive level.

Despite the overall success rate decreasing over time, the various elements of the reeducation model are consistent with the key components of successful treatment (i.e., wraparound planning, transition services, and interagency collaboration). This community-based orientation can enhance functioning in a more adaptive fashion upon discharge from a residential placement, help maintain treatment benefits, avert the need for more intense mental health services, and ensure a stronger continuum of care for troubled youth. The reeducation model has potential merit for many troubled adolescents with severe emotional or behavioral impairment.

Psychodynamic and Behavioral Combination Model

The goal for this type of clinical practice is the application of a combination of psychodynamic rebuilding and modification of dysfunctional social behavior. There is also considerable interplay between the sessions themselves and the rest of a patient's life, and all therapists spend an extensive amount of time in the milieu. This approach begins with socialization and highly structured behavioral intervention, but once the adolescent is able to successfully progress through the early resistance, the focus becomes reconstructing one's personality (Miskimins, 1990).

This clinical practice was part of a comprehensive model for the practice of residential treatment developed by the Southern Oregon Adolescent Study and Treatment Center (SOASTC), which provides residential treatment for emotionally disturbed adolescent males. The emphasis is on 40 practice principles, or guiding concepts, which dictate the specific treatment techniques and administrative procedures. These principles

are divided into six clusters, each a critical area of concern for residential treatment: program organization (program system structural variables), physical environment (living space for patients), program personnel (characteristics of staff members), clinical practices (approaches to intervention), therapeutic milieu (description of psychosocial environment), and interpersonal relationships (person-to-person connections).

Cognitive/Cognitive-Behavioral Model

The cognitive-behavioral model focuses on current behavior. The goal is to learn to replace maladaptive behavior with more effective, appropriate patterns. Structuring a therapeutic environment that disconfirms cognitions of hopelessness, powerlessness, defeatism, and failure requires a multitude of inputs and effective linkages. In general, emphasis is placed on the potency of cognitions, in the form of ideas, attitudes, beliefs or other pervasive thoughts, that become automatic over a lifetime and occur specifically in certain critical situations. Such cognitions are assumed to be closely associated with both emotional reactions and behavior. Automatic thoughts may become the basis of a life motif and are accepted unquestioningly by the individual.

In a study with 32 emotionally and behaviorally disturbed adolescents (ages 11to 17), Rosen (1998b) proved cognitive-behavioral therapy (CBT) to be useful within residential treatment. When professional personnel were surveyed, they indicated a preference for the cognitive-behavioral model of therapeutic interventions (Munson, Klein, & Delafield, 1989).

Teaching Family Model (TFM)

One model of residential care for which there is empirical evidence demonstrating positive treatment outcomes is the teaching family model (Handwerk, Huefner, Smith,

Clopton, Hoff, et al., 2006; McNeal, Handwerk, Field, Roberts, Soper, et al., 2006). Youth experience of a normalized lifestyle is promoted by delivering treatment within a typical community environment that includes family-style homes with surrogate therapeutic parenting by a married couple (family-teachers). A core theme of the TFM philosophy includes skill acquisition. Major features include (a) a token economy motivation system, (b) a self-government system managed by the youths, (c) a standardized social skills training program, (d) an ongoing program evaluation system that incorporates youth feedback within administrative performance evaluations (McNeal et al., 2006).

McNeal et al. (2006) found that residents do not experience increases in hopelessness, but rather increases in hopeful thinking, even for those with more serious levels of psychopathology. These changes led to a decrease in antisocial behavior and a greater positive outlook on their life. Furthermore, a large-scale study examining gender differences in adolescents in residential placement that utilized TFM found greater success among female residents (Handwerk et al., 2006). Removing girls from a stressful and perhaps abusive family context and placing them in a more normalized environment with trained, married couples may explain why girls show greater improvement than boys, especially regarding internalized problems.

Benefits/Detriments of a Theoretical Model

The research literature focusing on a specific model when determining the effectiveness of treatment in a residential facility remains scarce. However, implementation of an agreed-upon treatment modality for professional staff (clinical and front-line) not only allows for greater staff cohesion, but may also lead to a more

effective treatment program. On the contrary, the chosen model of therapeutic intervention is often influenced by the educational and professional experiences of their professional staff, and clinical supervisor/consultant. This may have a profound impact on whether or not the model makes proper use of clinical practice guidelines.

Chapter 9

Best Practices: Empirically Based Practice Guidelines

Due to the closing of New Jersey's last children's psychiatric hospital in the beginning of 2007, many providers are expected to address more complex and challenging behavior problems. In addition, managed care has placed high demands and created an array of changes on all levels of organizations, from large multimillion-dollar organizations to group homes operating on a shoestring (Savin & Kiesling, 2000). These expectations have been compounded by the fact that functional outcomes have never been established.

As a national behavioral healthcare provider, Devereux Foundation set out to bridge the gap between expectations and reality in order to give providers operational guidance. Savin and Kiesling (2000) were curious about how providers responded to the demands and changes, so they sent written surveys to the CEOs, executive directors, or other executive officers of 397 organizations. The Organizational Survey consisted of 41 questions relating to 13 areas (Quality improvement (QI) history, current QI initiatives, QI staffing, committee structure, standards for clinical practice, information resources, ethics and client rights, culturally competent practice, medical-psychiatric leadership, professionalization of direct care staff, and measurement and performance enhancement). Fifty-nine of the surveys, from organizations in 21 states and Canada, were completed and returned.

Findings revealed little consistency in organizations' approach to diagnosing and treating patients, which in turn led to varying client outcomes and little accountability among practitioners (Savin & Kiesling, 2000). Devereux's approach followed a four-

pronged action plan, of which two are of particular interest for this research: an adoption of clinical quality standards and identified and implemented empirically based practice guidelines.

There has been tremendous growth in the field of behavioral health regarding its ability to empirically validate various clinical treatments. However, results of Savin and Kiesling's (2000) survey revealed only about half (53%) of surveyed organizations made use of practice guidelines or manualized treatment approaches, which were more commonly used in smaller organizations. Due to the numerous variations in practice, clinical practice guidelines (CPG) were established to limit these variations that might signal problems in the quality of service and help to reduce or eliminate unnecessary costs (Lewis, 1995).

The National Guideline Clearinghouse (NGC) employs the definition of clinical practice guideline developed by the Institute of Medicine (IOM), which states, "Clinical practice guidelines are systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances" (Field & Lohr, 1990,p.8). The American Psychiatric Association (APA) emphasizes the importance of understanding that a practice guideline is not a "standard of care" (American Psychiatric Association, n.d.). These guidelines assist in clinical decision-making and the ultimate judgment regarding a particular clinical procedure. The treating clinician, in light of the clinical information presented by the patient and the diagnostic and treatment options available, must develop a working treatment plan. Individual patients may require decisions and interventions not directly addressed by the available research.

Client Records/Treatment Planning

When it comes to treatment planning for children and adolescents in an RTC, there are a number of valid concerns that continue to be problematic. Savin and Kiesling (2000) found significant variability in approaches to client records, with most agencies developing their own client record. Compounding this problem, Leichtman and Liechtman (2001) report two of the more traditional shortcomings of RTC placements to be the lack of family involvement and decision-making in the treatment process and the failure to provide youths in the RTC with access to the community. Some of the reasons for the lack of involvement by families include the facts that: (a) multiple-placement youth have been removed from their families of origin for a long period, (b) the parents themselves may be incapable of participating in the treatment process, (c) the RTC may be located in a distant community or state, (d) the family has abandoned the child, or (e) the RTC simply makes no effort to involve families (Burns et al., 1999).

A major component of treatment for this population includes discharge planning. With nearly 400 organizations surveyed, only 71% included discharge criteria and permanency goals as part of the treatment plan (Savin & Kiesling, 2000). The goal of discharge planning is to prepare the youth and his/her family for success in a community-based placement and the maintenance and generalization of acquired prosocial skills. As such, this group of interventions should commence at the onset of the RTC placement and carry over to the period of discharge and follow-up, rather than waiting until close to the time at which the child or adolescent is ready to leave the RTC. This involves access to the community for many of their needed services, including participation in community-based recreational activities (e.g., sporting events, swimming, use of the

recreation center). Other opportunities may include volunteering at a humane society, serving meals at a geriatric center, or even offering to clean up and maintain community parks and recreational centers. These arrangements offer youths the naturalistic settings in which to practice newly acquired social and academic skills, thereby facilitating the process of discharge (Leichtman & Leichtman, 2001).

Common to residential treatment is the "one-size fits all" approach. Residential settings often supply identical service packages to all, regardless of the individual's level and type of need (Lyons, 1997). On the other hand, when individually planned programs of mental health treatment are implemented, there is often a lack of systematic means for creating treatment plans for those only known to clinicians for a short period of time (Segal, King, and Naylor, 1995). Vague diagnostic criteria used in residential centers have also contributed to ineffective treatment planning, which often results in a failure to match mental health needs to individuals (Eisikovits & Schwartz, 1991).

In a longitudinal study with nearly 400 adolescents, Connor, Doerfler, Toscano, Volungis, and Steingard (2004) reported the importance of tailoring treatment to the individual needs of each adolescent. In particular, their findings suggest the necessity to develop evidence-based interventions in seven specific areas: These areas include (a) anxiety and affective psychopathology, (b) disruptive behavioral disorders, (c) impulse dyscontrol, (d) reactive aggression and mixed proactive/reactive aggression, (e) trauma-related psychopathology, (f) early onset alcohol and drug problems, and (g) interventions with significantly impaired families.

Chapter 10

Methodology

Setting

A private, nonprofit mental health agency in New Jersey was chosen for this study. This particular agency has been providing services for more than 40 years and today has over 50 programs impacting more than 14,000 individuals throughout nine counties in central and southern New Jersey. Of the five main divisions of the agency (Children & Family, Children's Residential, Specialized Foster Care, Adult Developmental Disabilities, and Adult Community Services), a program from the Children's Residential Services was chosen for this program evaluation.

The selected program is a 10-bed coeducational, residential facility for severely emotionally troubled youth located in the southern region of New Jersey. This residential facility began providing services to adolescents between the ages of 11 and 17 in 1988. Although referrals are statewide, most children have recently been discharged from a psychiatric inpatient unit. This particular PCR is a short-term (6 to 9 months) facility that is staffed 24 hours a day, based on a resident-to-staff ratio of 3:1 during awake hours. Programming involves individual and group therapy on a weekly basis, family therapy as needed, medication monitoring, and recreational outings. Off-site schooling is provided year round through DCF. The main goal for the program is to reunify the adolescents with their family/guardian. When that goal is unattainable, referrals and recommendations are made according to the unique needs of each child.

The current staffing includes a total of 44 professional and nonprofessional staff members. The facility employs a full-time cook and secretary, who are not part of the

daily ratio. Psychiatric and basic medical needs are provided through the employment of a full-time licensed practical nurse (L.P.N.) and a part-time (6 hours per week) psychiatrist (M.D.). A full-time, master's level, licensed professional counselor with over 5 years' experience in the mental health field does the administrative oversight of this program. The residence has two master's level therapists providing the clinical services. One is a nonlicensed social worker employed since 2003, while the other is a licensed professional counselor employed since 2004. Each carries a caseload of five adolescents. There are three residential supervisors and a senior level supervisor who are part of the ratio while directing services being delivered on each of the shifts. Two of the supervisors have earned a high school diploma; one is working toward a bachelor's degree, while the senior supervisor is enrolled in a master's level graduate program. The residential counselors/direct care workers fall into one of three categories: full-time (40 hours), part-time (fewer than 40 hours), and substitutes (as needed). There are 10 full-time, two part-time, and 21 substitute residential counselors who range in education from a high school diploma to a bachelor's degree in the human services field.

Participants

General information regarding the number of admissions to the chosen residential facility was compiled via their program roster, which included 70 closed charts of adolescent males and females with Medicaid insurance. Due to the inclusion/exclusion criteria, demographic information was compiled using 38 charts. As for the best practice clinical reviews, 13 charts met diagnostic criteria and were reviewed for adherence. All subjects were between the ages of 11 and 17 and admitted to this specific psychiatric community residence (PCR) after January 1, 2003, and discharged by December 31,

2007. Two Children's Crisis Intervention Screening (CCIS) centers in South Jersey served as the primary referral source.

Inclusion and Exclusion Criteria

Male and female adolescents between the ages of 11 and 17, from any racial or religious background, who received residential services between January 1, 2003, and December 31, 2007, were included in this study. The clinical chart review only included residents who possessed a primary Axis I diagnosis of a depressive disorder, ODD, ADD, or PTSD. Additional criteria for eligibility required the placement to be of voluntary status with a minimum length of stay of 6 months.

Furthermore, any individual younger than 11 or older than 17 and any residents with a dual diagnosis (mental health and substance use or mental health and developmental disorder) or a secondary diagnosis of mental retardation, pervasive developmental disorder, or a substance/dependency diagnosis were excluded.

Design of the Study

The study was a program evaluation intended to describe the overall population receiving services and to systematically examine the clinical services of a human service program in order to determine whether best practices are being effectively utilized. This research project utilized a descriptive research design in order to evaluate whether or not the program was meeting the goals. Descriptive data was gathered from nonactive charts from a predefined period.

Materials

A data collection form, shown in Appendix A, was used to record demographic, descriptive, and treatment variable data from chosen residential charts of the facility. This form recorded each resident's date of admission, date of discharge, length of stay, date of birth, age, primary diagnosis, gender, reason(s) for treatment and presenting problem(s). It also included data from the following categories: risk assessment, psychiatric history, treatment history, legal screen, abuse and neglect screen, family history, educational assessment, school/education, culture/ethnicity, spiritual orientation/beliefs, and discharge/transfer information.

Separate forms, titled Best Practice Evaluation Forms were used to ascertain adherence to best practice clinical guidelines for the primary diagnoses of ADHD, depressive disorders, ODD, and PTSD (Appendices A, B, C, and D, respectively). These forms adapted information from either the National Guideline Clearinghouse or the National Collaborating Centre for Mental Health and utilized categories specific to the design of this study, as well as the design of the chosen facility. Information used for the best practice evaluation was grouped in the following categories: screening/intake, confidentiality, assessments and evaluations, comorbidity, treatment (treatment plans, psychotherapies, interventions, drug treatment/medications and therapeutic alliances), ethnic/cultural issues, and follow-up contacts. However, these categories were not consistent across the best practice evaluation forms and each was adapted accordingly.

Procedure

All charts from 2003 to 2007 of residents that met criteria for inclusion in this study were assessed. The principal investigator carefully reviewed each chart and completed the data collection form and Best Practices Evaluation Forms. All data was double checked to ensure accuracy. When indicated, all variables were operationally defined to ensure certain that consistency in the data collection process.

To ensure reliability, a doctoral level clinician collected data on 10% of a random sample of unused charts. Due to the small sample size of the eligible charts for clinical review, one unused chart for each diagnosis was evaluated. In order to establish agreement, the clinician was trained by the principal investigator in the data collection process.

Data Analysis

Descriptive statistics, frequency distributions, and percentages were used to analyze all survey data. The demographic data analysis included variables/categories such as age, length of stay, gender, reason for treatment, presenting problems, risk factors at intake, psychiatric history, treatment history, legal status, abuse and neglect screen, family history, educational grade and classification, culture/ethnicity, spiritual beliefs, summary of treatment provided, and discharge information.

As for the clinical best practice evaluations, numerous categories were evaluated based on best practice guidelines and relevance to the nature of this study. These categories included: screening/intake, confidentiality, assessments and evaluations, comorbidity, treatment (treatment plans, psychotherapies, interventions, drug treatment/medications and therapeutic alliances), ethnic/cultural issues, and follow-up

contacts. Compliance percentages were calculated for each category within the chosen charts, along with an overall compliance percentage score for each file. An overall percentage score was also calculated for each of the specified diagnoses, as was an overall compliance percentage score across all diagnoses.

Informed Consent Process

Informed consent was not required due to the utilization of existing archival records for data collection.

Procedure for Maintaining Confidentiality

All data was collected and reported in a manner in which participants could not be identified, thereby protecting anonymity. Only the principal investigator and a doctoral level clinician were on-site to review the closed records. Permission to survey inactive charts was been granted by the chief operating officer of the specified mental health agency.

Measures

The principal investigator developed all data collection forms. There are no data available on the validity of these forms; however, content validity was established by expert opinion, and interrater reliability was established for each best practices evaluation form.

Chapter 11

Results

The two main goals of the statistical analysis were to provide an overall description of an array of demographic data on adolescents who received residential services at the chosen site and then to determine whether empirically based practice guidelines were being effectively utilized for disruptive behavior disorders (ADHD and ODD), depressive disorders, and PTSD. It was anticipated that statistical analysis would indicate that best practices were not being implemented with 90% accuracy for at least 50% of the chosen clinical charts.

Between January 1, 2003, and December 31, 2007, this particular adolescent facility averaged 14 admissions per year with an average length of stay (LOS) of 7.9 months. Despite having 70 admissions during this time, not all cases met the minimum LOS requirement of 6 months (180 days), and some were discharged after 2007. Therefore, because there were nine active charts at the end of 2007 and 14 charts that did not meet LOS requirements, 47 charts were eligible for demographic overview and best practice consideration.

Of the 47 eligible charts, seven were not scanned into the medical records database and 2 charts contained incomplete/partial scanned data. Although not impacting statistical analysis, two sections within the agency's biopsychosocial form contained numerous omissions (five charts contained omissions for age of onset and 10 charts contained omissions for family history). Demographic information was compiled using the remaining 38 charts.

Upon examining referral sources, a significant number (87%) of overall admissions came from a higher level of care, while admissions by gender revealed a higher intake rate for females (63%). Most adolescents have had multiple inpatient hospitalizations (76%); however, this was the first residential placement for 84% of the youth. The ethnic make-up included Whites (45%), Blacks (42%), and Latinos (13%). The most common age range for onset of symptoms was between 5 and 10 years (49%), with the most typical onset age of 8 years. Many of the adolescents (76%) required additional academic support services due to a classification of special education.

The most common presenting problems at intake were: oppositional defiance (97%), aggression (87%), depressed (82%), mood disorder (82%), noncompliance (74%), attention deficit (71%), feeling anxious (58%), and sleep disorders (45%). The most frequently identified areas in the risk assessment were physical violence (90%), severe depression (84%), suicidality (76%), homicidal ideation (45%), witnessing domestic violence (42%), and child abuse (40%).

Family history indicated 24% having mental health difficulties, 21% struggling with substance use, and 5% had family members in both categories. Although 87% of admissions did not report abuse/neglect and 90% did not report trauma at intake, 42% reported being a past victim of abuse and neglect. A positive coping mechanism for 68% of the youth involved relying on their spiritual beliefs to bring forth comfort.

The program was very consistent in the delivery of treatment services. All residents received a psychiatric evaluation, individual therapy, and group therapy. Other program services included activities of daily living (97%), medication monitoring (95%), and family therapy (90%). Upon discharge, one case indicated the need for further

services that were rejected by the parent/guardian, while all other cases were terminated with a referral (97%).

As for the best practice clinical reviews, 13 charts met diagnostic criteria. The breakdown of the inclusion diagnoses was: depression (7), ADHD (4), ODD (1), and PTSD (1). The remaining 25 charts contained the following diagnoses: bipolar (9), conduct disorder (5), dual diagnosis of mental health and developmental delays (3), dual diagnosis of mental health and substance abuse (2), mood disorder not otherwise specified (2), adjustment disorder (1), impulse control disorder (1), panic disorder (1), and psychosis (1).

Overall, 43% of the eligible charts met clinical guidelines for best practices. In ranking the order of adherence, ADHD scored the highest (48%), followed by Depression (47%), ODD (39%), and PTSD (37%). Each diagnosis had several domains rated for best practice according to the clinical guidelines.

Ratings within the ADHD domains were: comorbidity (75%), screening/intake (67%), periodic assessment (52%), psychosocial (50%), evaluation (42%), and treatment plan (33%).

Depression ratings included: biopsychosocial (88%), psychotherapies (75%), evaluation for presence of self-harm (51%), screening (50%), confidentiality (50%), evaluation (40%), follow-up contacts (38%), treatment (30%), and treatment plan (14%). No compliance was identified for the management of co-morbidity in the treatment plans.

ODD compliance indicated ratings in the following domains: refraining from utilization of ineffective interventions (100%), using medication as an adjunct to treatment (67%), treatment plan (67%), assessment (55%), information gathering (50%),

intensive/ prolonged treatment (50%), and co-morbidity (38%). No compliance was identified for the parameters of therapeutic alliance, ethnic/ cultural considerations, use of questionnaires/rating scales, and parent interventions.

PTSD was evaluated using the following domains, (with percentages): drug treatment (75%), recognition (50%), comorbidity (50%), psychological interventions (50%), practical support/social factors (25%), and treatment planning (13%). No compliance was identified for assessment/coordination of care.

Based on the demographic information obtained, a factitious adolescent who typifies the residents receiving services at this particular facility would be a 13½-year-old White female, diagnosed with bipolar disorder and being referred for step-down services from a higher level of care, with onset of symptoms/difficulties around 8 years of age, resulting in multiple inpatient hospitalizations, but no prior residential placement. Presenting problems include: oppositional/defiance, aggression, depressed, mood disorder, noncompliance, attention deficit, and feeling anxious. This typical adolescent presents at intake with severe depression, suicidality, and physical violence, but reports spiritual beliefs that offer comfort. Academically, the majority of residents have been classified as special education.

Chapter 12

Discussion/ Recommendations

While residential placement continues to be a much-needed level of service, more emphasis needs to be placed on delivering clinical services based on best practice guidelines. The 24-hour, multifaceted structure of residential facilities allows for constant modeling, redirection, support, and encouragement. However, this format lends itself to a complexity of challenges that may actually impede a successful transition to a lower level of care.

The hypothesis of this research was supported due to the fact that best practices were not implemented with 90% accuracy for at least half of the chosen clinical records. In fact, no record received a compliance score over 50%, and no diagnostic category received a score of compliance above 48%. With a 43% overall rating of compliance with best practice guidelines, a focus of attention needs to be on improving clinical services by effectively implementing numerous components of best practices.

One such component involves the use of standardized forms. This would not only enable better tracking of the residents' progress but would ultimately help in many aspects of treatment planning. In addition, making modifications to the existing intake packet may be helpful, due to a variety of inconsistencies found among information gathered at intake compared to written treatment plans. A recommendation would be to modify the existing forms to reflect general information, with indicators leading to review of specific diagnostic criteria, if needed. Although many nonprofits function within very tight budgets, this can be challenging. However, there are a few suggestions to make this happen. The program can create its own internal forms to target specific

needs. Utilizing free online resources or forms contained within purchased material can be other cost-effective methods. Lastly, since many mental health agencies are facing similar budget constraints, it may be beneficial to team up with other programs in order to share resources.

Due to the nature of individual therapy being conducted on site, it is easy for the therapist's office to become the place where the overflow of problems from the milieu begin to interfere with aspects of the clinical agenda. For instance, when two roommates are not getting along, it is not uncommon for one of the adolescents to focus on this during the therapy session, which leaves little time to work on the treatment goals. This requires a residential therapist to be able to move beyond the surface issues and creatively tie them into the clinical goals or to sympathize while moving on to the treatment goals. A review of the clinical progress notes written over this 5-year period reflected a lack of cohesion with the formal treatment plan. In fact, one chart's clinical progress notes made no mention of a therapy session involving the primary goal related to the diagnosis, while many others poorly reflected the clinical work being done during individual therapy sessions. Combating this may involve introducing a formalized structure to the clinical progress notes in order to help clinicians focus attention on the goals stated in the treatment plans. This can be easily accomplished by utilizing an existing format (e.g., data assessment plan - DAP or subjective objective assessment plan - SOAP note) or simply developing a format that best suites the program's needs.

Another component worthy of focus involves an apparent disconnect in sharing clinical information within the facility. Completing the intake paperwork may involve a number of individuals and sources or may be limited to a guardian or caseworker. In any

case, it is important that accurate information is obtained and then shared with the rest of the residential team. In many instances, the information reflected in the intake packet did not lead to a corresponding diagnosis. In other instance, a chart contained different diagnoses depending on which form was being reviewed. It is vitally important that a formal system be put into practice allowing for increased communication and better collaboration among the various disciplines, especially between clinical and medical personnel.

Adopting a clinical model or developing an eclectic approach based on aspects of several models may prove to be beneficial. Not only does it allow for a common language to be used throughout the residence, it will also help structure and implement the clinical strategies and interventions specific to the model. Otherwise, a program may be implemented as designed, but have a flawed underlying theory. Based on the results of the domains within the chosen diagnoses regarding best practice adherence, this particular facility may want to consider incorporating cultural programming, along with integrating a parent training module as part of a clinical model.

Some other notable areas of consideration, although not the focus of this research, involve the issues of missing data and a cumbersome data storage system. Due to the finding that 10% of charts either never went to the medical records department or were delivered but not scanned into the database, it is recommended that a system check be developed to ensure that all closed records are scanned into the archives. Prior to closing a record, a system needs to also be in place to capture missing data on other program documents (e.g., biopsychosocial form) because 3% of charts were missing significant

portions of data, 26% were missing information relating to family history, and 13% of charts did not indicate the age of symptom onset within the biopsychosocial assessment.

Although the archival data storage system appears to be able to contain a high volume of records, the retrieval of information was difficult. Navigating the current system requires a trial-and-error method of clicking on various sections of the chart until the correct document is found. Having tabs or labeled sections within the closed record would enhance retrieval of specific information by decreasing time spent searching for specific documents.

Limitations of the Study and Suggestions for Further Research

A major limitation when using archival data is the lack of explanation. One is faced with only the information contained within the record, which cannot be expounded upon. The veracity of the data is dependent upon the person entering the information, as well as the record keeping of each file, which may or may not be an accurate reflection. Additionally, since some of the information entered was based on self-reports, the validity of such data may be questionable.

Due to the absence of clinical best practice evaluative tools specifically designed for residential programs, the data collection forms used in this study were created from expert consensus. As research into clinical best practice guidelines continues, it needs to target other aspects of clinical programming, such as residential services.

More research needs to focus on developing effective means for measuring outcomes in residential facilities. Due to the uniqueness of each residential program, the current literature defines success in a multitude of ways, which then impacts the way the information is studied. Being able to uniformly examine outcomes in OOH placements

would allow for feedback and more effective development/implementation of clinical services.

Conclusions

Key components for a successful residential treatment facility appear to include a sound therapeutic model based on best practices, effective communication across disciplines, an emphasis on relationship building, utilization of assessments and rating scales to track progress, a collaboration system for effective discharge planning, and a formal discharge follow-up protocol. An emphasis on uniform documentation of client information is important in order to decrease the potential for fragmentation. However, the manner in which a program structures the treatment plan will influence the way therapists approach each clinical case. Mayes and Handley (2005) found cookie-cutter type systems created more problems than they solved. They concluded that maintaining focus on each consumer, as an individual, is vitally important.

Additionally, it is noted that achieving and maintaining stability is possible when there is modifiable programming and individualized treatment planning. Allowing best practices to be the driving force behind residential programs not only limits the many variations in practice, but also ultimately helps to better control unnecessary costs (Lewis, 1995).

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Appendix A

Data Collection Form

Admit Date		**Date of Birth**		**Age**	
Discharge Date		**Primary Diagnosis**			
Length of Stay (Days)			**Best Practice Clinical Review**		**Y or N**

VARIABLE	**OPERATIONAL DEFINITION**
Gender	Male or Female
Reason for Treatment	Step Down (from IP/Crisis, RTF, Detention); Step Up (from home, foster home, group home, shelter); Lateral Transition from other PCR
Presenting Problems	Abuse/ Neglect, Addiction, Aggression, Anxiety, Attention Deficit, Alt. Thought Process, Chronic Pain, Cognitive, Compulsions, Crying/ Tearfulness, Depression, Dissociative, Eating Disorders, Factitious, Guilt, Grief, Mania, Mood Disorder, Neg. Self Concept, Neurological, Non-Compliance, Obsessions, Oppositional/ Defiance, Passive-Aggressive, Physical Abuse, Psychotic, Psychological Devel, Sexual Abuse, Sexual/ Gender Identity, Sleep Disturbances, Somatoform, Trauma
Risk Assessment	
Risk Factors at Intake (Present & Past)	Severe Depression, Suicidal Impulse/ Intent/ Plan, Suicide Attempts, Homicidal Impulse/ Intent/ Plan, Command hallucinations, Paranoid Delusions, Severe Anxiety, Severe Panic Attacks, Child Abuse (Victim or Perpetrator), Domestic Violence (Witness), Physically Violent Episodes, Self-Injurious Behaviors, Plan for Self-Harm
Psychiatric History	
Age of Onset	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17
Treatment History	
# of I/P (including o/n crisis)	0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, >10
# of O/P settings	0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, >10
# of Prior Residential Placements	0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, >10
Legal Screen	
Current Legal Status	None, Probation, Parole, Restraining Order, Court Ordered
Abuse & Neglect Screen	
Current or Past victim of abuse/ neglect	Yes or No
Family Hx	
History of Family Treatment	No MH SA Both (MH & SA) Not Indicated/ Unknown
Educational Assessment	
Highest Grade	<5, 5, 6, 7, 8, 9, 10, 11
School/ Education	
Type	Regular, Special Ed., Mainstreamed, Resource Rm, Self-Contained
Culture/ Ethnicity	
Cultural/ Ethnic Background	Caucasian, African American, Latino, Asian, American Indian, Other, Unknown
Spiritual Orientation/ Beliefs	
Spiritual Beliefs that offers comfort	Yes or No
D/C /Transfer Summary	
Summary of Treatment Provided (Check all that apply)	Assessment & Referral, ADL's, Case Mngmnt, Family Tx, Group Tx, Individual Tx, Independent Living Skills, Med Monitoring, Mentoring, Play Tx, Psychiatric Eval, Other:
Discharge Information	
Reason/ Circumstances at D/C	Terminated with referral; Terminated without referral Further services needed but rejected by client &/or parent/ guardian

Appendix B

Adapted From National Guideline Clearinghouse – Best Practices Evaluation Form: Attention Deficit Hyperactive Disorder (ADHD)

Scoring Key: 0 = No	**1 = Partial**	**2 = Full**	**Record #**

Screening/ Intake (Rec. # 1) **RATING**

S1	Includes questions regarding major symptoms of inattention, impulsivity & hyperactivity	
S2	Includes questions about impairment of symptoms	
S3	Makes use of a rating scale or specific questionnaire	

Score: 0/6 = 00%

Evaluation (Rec. #2) **RATING**

E1	Clinical interview with parent/ guardian about the 18 ADHD symptoms (present, duration, severity, frequency, setting)	
E2	Clinical interview with patient about the 18 ADHD symptoms (present, duration, severity, frequency, setting)	
E3	Information obtained about school functioning (i.e. academic intellectual progress, possible symptoms of learning disorders)	
E4	Interviewed parent for other common psychiatric disorders of childhood (co-morbidity)	
E5	Parent/ Guardian completed a standardized behavior rating scale	
E6	Family history and family functioning assessed	

Score: 0/12 = 00%

Co-Morbidity (Rec. #5) **RATING**

C1	Older adolescents should be screened for substance abuse disorders	
C2	Patient evaluated for presence of co-morbid psychiatric disorders	
C3	Develop treatment plan to address each co-morbid disorder in addition to ADHD	

Score: 0/6 = 00%

Comprehensive Treatment Plan Consists of (Rec. # 6) **RATING**

T1	Psychopharmacological intervention	
T2	Behavior therapy	
T3	Parental psychoeducation about ADHD	
T4	Child psychoeducation about ADHD	
T5	Parental psychoeducation about various treatment options (meds & behavior tx)	
T6	Child psychoeducation about various treatment options (meds & behavior tx)	
T7	Addresses School Supports	
T8	Plan reviewed regularly	
T9	Plan updated/ modified accordingly	

Score: 0/18 = 00%

Psychosocial Treatment Along With Medication Treatment (Rec. #11) **RATING**

		RATING
P1	If less than optimal response to medication, **has a co-morbid disorder, or is experiencing stressors in family life** then Psychosocial Treatment (*Beh Mod, ABC's, Parent Training [rules, consistency, predictability], Academic/ School interventions*) along with medication treatment should be employed	

Score: 0/2 = 00%

Periodic Assessment (Rec. # 12 & 13) **RATING**

		RATING
A1	Regular follow-up for medication adjustment (at least several times a year)	
A2	Review behavior	
A3	Review academic functioning	
A4	Periodically assess height, weight, blood pressure, and pulse	
A5	Assess for emergence of medical conditions	
A6	On-going psychoeducation	
A7	Assess the effectiveness of current behavior therapy	

Score: 0/14 = 00%

BEST PRACTICE TOTAL SCORE 00/58 = 00%

Notes:

Appendix C

Adapted From National Guideline Clearinghouse – Best Practices Evaluation Form: Depressive Disorders

Scoring Key: 0 = No	**1 = Partial**	**2 = Full**	**Record #**

Confidentiality (Rec. # 1) **RATING**

C1	Clinician clarified with patient the boundaries of the confidential relationship	
C2	Clinician clarified with the parent the boundaries of the confidential relationship	
C3	Request permission to communicate with medical providers, other mental health professionals involved in care, and appropriate school personnel	
C4	System in place for parents to communicate concerns about deterioration in functioning and high-risk behaviors (i.e. suicide threats or substance abuse)	

Score: 0/8 = 00%

Biopsychosocial (Rec. # 5) **RATING**

B1	Evaluate current stressors (i.e., physical and sexual abuse, on-going intra- and extra-familial conflicts, neglect, living in poor neighborhoods, and exposure to violence) If Abuse is current: Assess the sequelae of the exposure to negative events such as PTSD	
B2	Evaluate past stressors (i.e., physical and sexual abuse, on-going intra- and extra-familial conflicts, neglect, living in poor neighborhoods, and exposure to violence)	
B3	Evaluate presence of family psychopathology	
B4	Assess for discord, lack of attachment and support, and a controlling relationship (affectionless control)	

Score: 0/8 = 00%

Screening (Rec. # 2) **RATING**

S1	Screen for depressive, or sad mood	
S2	Screen for irritability	
S3	Screen for anhedonia (inability to experience pleasure from normally pleasurable life events such as eating, exercise, and social or sexual interaction)	

Score: 0/6 = 00%

Evaluation (Rec. # 3) **RATING**

E1	Evaluate the child's strengths	
E2	Evaluate the family's strengths	
E3	Evaluation should be sensitive to ethnic, cultural, and religious characteristics of the child and his/her family	
E4	Direct interview with the parents/ caregivers	
E5	Direct interview with the adolescent alone	
E6	Whenever appropriate, other informants including teachers, primary care physicians, social services professional, and peers should be interviewed	
E7	Evaluate for subtypes (seasonal, mania/ hypomania, psychosis, subsyndromal, symptoms of depression	
E8	Evaluate for comorbid psychiatric disorders	
E9	Evaluate for medical illness, physical exams, and laboratory tests (other than routine)	
E10	Evaluate for the presence of lifetime manic or hypomanic symptoms	

Score: 0/20 = 00%

Evaluation for Presence Of Harm To Self Or Others (Rec. # 4) **RATING**

H1	Evaluate suicidal thoughts and behaviors at intake and during subsequent assessments by utilizing low burden tools to track S/I and behavior (i.e. Columbia Suicidal Severity Rating Scale)	
H2	Evaluate risk (e.g., age, sex, stressors, comorbid conditions, hopelessness, impulsivity)	
H3	Evaluate the protective services (e.g., religious beliefs, concern not to hurt family) that might influence the desire to attempt suicide	
H4	Assess current severity of suicidality	
H5	Assess the most severe point of suicidality in episode	
H6	Assess the most severe point of suicidality in lifetime	
H7	Ascertain presence of guns at home (If so, recommend parents secure or remove them	
H8	Differentiate suicidal behavior from other types of self-harm behaviors (i.e. self-cutting), the goal of which is to relieve negative affect, rather than end one's life	
H9	Assessment for homicidal thoughts should be similar to that of suicide with regard to what factors are influencing, either positively or negatively, the degree of likelihood that one will carry out a homicidal act. Important to restrict access to any lethal agents	

Score: 0/18 = 00%

Management Of Comorbid Conditions (Rec. # 13) **RATING**

CM1	Clinician must determine which condition is causing the greatest distress and functional impairment, and begin with that disorder (Reflected in treatment plan)	

Score: 0/2 = 00%

Psychotherapies (Rec. # 9) **RATING**

P1	Multimodal approach such as CBT, IPT interventions, individual psychodynamic psychotherapy, family therapy, school/learning interventions, and/or community consultation	
P2	More severe depressive episodes will generally require antidepressants, either alone or combined with psychotherapy.	

Score: 0/4 = 00%

Treatment Plan (Rec. # 6) **RATING**

TP1	Acute phase: goal is to achieve Response (No symptoms or a significant reduction in depressive symptoms for at least 2 weeks) and ultimately full symptomatic remission (Period of 2 weeks & less than 2 months with no or very few depressive symptoms	

Score: 0/2 = 00%

Treatment (Rec. # 7) **RATING**

T1	Family Psychoeducation about causes, symptoms, course, and different treatments of depression and the risks associated with those treatments as well as no treatment at all. o Depression is presented as an illness, not a weakness, which is no one's fault but has genetic and environmental contributions o Prepare the family for what is likely to be a recurrent and often chronic illness that may have prolonged periods of recovery o Provide education to parents about when to be strict and when to be lax o Provide written material and/or reliable web sites about depression and tx	
T2	Patient Psychoeducation about causes, symptoms, course, and different treatments of depression and the risks associated with those treatments as well as no treatment at all. o Depression is presented as an illness, not a weakness, which is no one's fault but has genetic and environmental contributions o Prepare the patient for what is likely to be a recurrent and often chronic illness that may have prolonged periods of recovery o Provide written material and/or reliable web sites about depression & tx's	
T3	Supportive Management o Include active listening and reflection, restoration of hope, problem-solving, coping skills, and strategies for maintaining participation in tx	
T4	Family Involvement o Treatment contract must involve parents in order to ascertain vital information about the child's behavior/ functioning, increase motivation in treatment, monitor progress, and serve as a safety net	
T5	School Involvement o Psychoeducation for school personnel to help them understand the disease model of depression o Discuss issues regarding confidentiality o Clinician, along with family, should advocate for some accommodations (e.g., schedule, work load) o If after recovery the child continues to have academic difficulties, then assess for subsyndromal depression, comorbid conditions, or environmental factors that might explain the persistent difficulties.	

Score: 0/10 = 00%

Follow-Up Contacts (Rec. # 14) **RATING**

F1	Interview child, parents, and if appropriate, other informants (e.g., teachers) to review symptoms of depression; S/I; H/I; mania or hypomania; development of new comorbid disorders; psychosocial and academic functioning; and environmental conditions	
F2	Satisfactory Response = BDI $\leq$ 9; Children's Depression Rating Scale $\leq$28, together with persistent improvement in functioning for at least 2 weeks	
F3	Overall improvement – 1 or 2 (very much or much improvement) in the Clinical Global Impression Scale, Improvement subscale	
F4	If treated with medication, then evaluate adherence, presence of side-effects, and youth and parent beliefs about the medication benefits and its side effects that may contribute to poor adherence or premature discontinuation of treatment	

Score: 0/8 = 00%

BEST PRACTICE TOTAL SCORE 00/86 = 00%

Notes:

Appendix D

Adapted From National Guideline Clearinghouse – Best Practices Evaluation Form: Oppositional Defiant Disorder (ODD)

Scoring Key: 0 = No	1 = Partial	2 = Full	Record #

Relationship/Therapeutic Alliances (Rec. 1) **RATING**

R1	Treatment Plan and/ or Clinical Progress Notes reflect the clinician's empathy with the patient's anger and frustration	
R2	Treatment Plan and/ or Clinical Progress Notes reflect the clinician's empathy with the parent's frustration	
R3	Treatment Plan and/ or Clinical Progress Notes reflect therapist's attempt to compile an exhaustive list of parental strategies currently being used	
R4	Clinician discusses effectiveness of parental strategies in terms of short and long-term outcomes	

Score: 0/8 = 00%

Ethnic/ Cultural Issues (Rec. 2) **RATING**

E1	Clinician addresses standards of obedience and parenting within the specified ethnic background of parent(s)	
E2	If mismatch in patient-clinician ethnic backgrounds, clinician should be educated in patients ethnicity	

Score: 0/4 = 00%

Assessment (Rec. 3) **RATING**

A1	Information obtained includes core symptoms of ODD	
A2	Information obtained includes age at onset	
A3	Information obtained includes duration of symptoms (Min duration 6 mos. – DSM)	
A4	Information obtained includes degree of functional impairment	
A5	Delineation of ODD from normative oppositional behavior, transient antisocial acts, and CD	
A6	Explore possibility that the child's oppositionality is triggered or even caused by incidents of abuse or neglect in the family or extended social orbit	
A7	Indicates settings in which oppositional-defiant behaviors occur	
A8	Functional Analysis includes identification of the antecedents and consequences for the child's behavior	
A9	Functional Analysis includes parent and others' behavior that may reinforce the problem behaviors	
A10	Access to weapons and supervision of such	
A11	Child's involvement in bullying either as a victim and/ or perpetrator	

Score: 0/22 = 00%

Comorbid Psychiatric Conditions (Rec. 4) **RATING**

C1	Delineate ODD from a simple adjustment reaction	
C2	Determination of whether it is still ODD or already progressed to CD	
C3	Treatment plan addresses comorbid conditions	
C4	Most recent pediatric examination available for review upon initial assessment due to common increases of disruptive behaviors due to chronic pediatric illness	

Score: 0/8 = 00%

Information Gathering (Rec. 5) **RATING**

I1	Information obtained from multiple informants, such as day care providers, teachers, and other school professionals	

Score: 0/2= 00%

Questionnaires And Rating Scales (Rec. 6) **RATING**

Q1	Make use of structured or semi-structured interviews that include a special module for the assessment of disruptive behavior disorders	
Q2	Make use of scales to help establish the diagnosis but also track progress and response to interventions	

Score: 0/4 = 00%

Individualized Treatment Plans (Rec. 7) **RATING**

T1	Interventions should target dysfunctional domains identified in the biopsychosocial	
T2	Plan should be multitarget, multimodal, and extensive	
T3	Plan should a combination of individual & family psychotherapy, pharmacoltherapy, and ecological interventions	
T4	Individual psychotherapy should include problem-solving skills training	
T5	Plan includes family interventions in the form of parent management training	
T6	Plan incorporates psychopharmacological interventions	

Score: 0/12 = 00%

Parent Interventions (Rec. 8) **RATING**

P1	Parent management training that incorporates the principle of reducing positive reinforcement of disruptive behavior	
P2	Parent management training that incorporates the principle of increasing reinforcement of prosocial and compliant behavior	
P3	Parent management training that incorporates the principle of using punishments in the form of time-out, loss of tokens, and/ or loss of privileges	
P4	Parent management training that incorporates the principle of applying consequences and/ or punishment for disruptive behavior	
P5	Parent management training that incorporates the principle of making parental responses predictable, contingent, and immediate	

Score: 0/10 = 00%

Medications As Adjuncts To Treatment (Rec. 9) **RATING**

M1	Baseline of symptoms or behaviors obtained prior to the start of medication	
M2	Medication should not be the sole intervention	
M3	After starting medications, adherence, compliance, and possible diversion are monitored carefully	

Score: 0/6 = 00%

Intensive And Prolonged Treatment (10) **RATING**

P1	Due to some associated risks of residential placement, rapid return to community and family should be the basic goal when out-of-home placement occurs	

Score: 0/2 = 00%

Refrain From Ineffective Interventions (11) **RATING**

II1	No evidence of inoculation approaches (dramatic, one-time, time-limited, or short-term intervention) such as boot camps, shock incarceration, exposure to frightening scenarios or situations	

Score: 0/2 = 00%

BEST PRACTICE TOTAL SCORE 00/80 = 00%

Notes:

Appendix E

Adapted From National Collaborating Centre for Mental Health – Best Practices Evaluation Form:Post Traumatic Stress Disorder (PTSD)

Scoring Key: 0 = No	**1 = Partial**	**2 = Full**	**Record #**

Recognition Issues for Children **RATING**

R1	Directly question the child about the presence of PTSD symptoms	
R2	Directly question the parents/ guardians about the presence of PTSD symptoms	

Score: 0/4 = 00%

Assessment and Coordination of Care **RATING**

A1	Completion of a Risk Assessment that addresses physical, psychological, & social needs	
A2	Information given to PTSD sufferers about effective treatments (TF-CBT or EMDR); Apart from trauma-focused treatments there is NO convincing clinical evidence for supportive therapy/ non-directive therapy, hypnotherapy, psychodynamic therapy or systemic psychotherapy – Nor good evidence for play therapy, art therapy, or family therapy alone)	

Score: 0/4 = 00%

Practical Support and Social Factors **RATING**

S1	Identify the need for social support & advocate the meeting of this need	
S2	Discuss/ offer advice on how to alleviate or remove continuing threats related to the traumatic event	

Score: 0/4 = 00%

Treatment Planning **RATING**

T1	Psychoeducation about common reactions to traumatic events, symptoms, course, & treatment	
T2	Address common issues of heightened anxiety regarding treatment that can often interfere with engagement in therapy	
T3	Establish a trusting therapeutic relationship and emotional stabilization before addressing the traumatic event	
T4	Trauma-Focused psychological treatment (TF-CBT or EMDR)	

Score: 0/8 = 00%

Comorbidity **RATING**

C1	Concentration on management of high risk suicidality or harm to others should be addressed first (if present)	
C2	Comorbid personality disorder – consider extending the duration of treatment	

Score: 0/4 = 00%

Psychological Interventions **RATING**

		RATING
P1	Trauma-focused psychological treatment (Trauma-focused CBT or EMDR)	
P2	Sessions addressing the trauma should be longer in duration	
P3	Treatment should be regular and continuous (at least 1x/ week)	
P4	Treatment should be delivered by the same person	
P5	Non-Trauma focused interventions (relaxation or non-directive therapy) which do not address traumatic memories, should not be routinely offered with chronic PTSD	

Score: 0/10 = 00%

Drug Treatment **RATING**

		RATING
D1	Medication education regarding potential side-effects and discontinuation/ withdrawal symptoms	
D2	Drug treatment should NOT be routinely prescribed	

Score: 0/4 = 00%

BEST PRACTICE TOTAL SCORE 00/38 = 00%

Notes: