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Pennsylvania Psychiatric Society

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Dear Ms. Erhard:

I am writing as Chair of our Committee on Child and Adolescent Psychiatry to provide our organization's comments on DPW's draft RTF regulations dated October 23, 2010 as published within the *Pennsylvania Bulletin*. We appreciate the opportunity to provide our perspective on the essential elements for providing treatment and care that meet professional standards for the children and adolescents who need this level of care.

Many elements of the draft are highly appropriate. We will limit our comments to those sections where we believe that changes are important, focusing on those that are most critical for an effective program.

§23.14- Maximum Capacity

This section restricts the maximum capacity to 48 beds over four units. As a Society, we appreciate the mandate to reduce the use of Residential Treatment Facilities, and provide care in less restrictive community based settings for children and youth which foster family relationships when possible and promotes community integration. However we have serious concerns as to how this reduction could adversely affect the delivery of services across the Commonwealth. Is there a plan to accommodate the needs of youth if the programs over the 48 bed capacity must reduce their size? It is likely that some RFTs will choose to close. Is there a transition plan or gradual planned reduction in capacity? How does this reduction relate to development and funding of more community based settings such as CRR host homes or treatment foster care? Will there be increased funding to allow for the loss of economies of scale with the planned maximum of capacity?

There are many unanswered questions that need to be addressed, including how capacity will be measured (per each [parent] organization as a whole or per geographical location), how local communities will be impacted financially by closure or consolidation of current RTFs, if there will be additional funding in the community to absorb the additional increase in outpatient treatment, the impact of the increased unemployment of displaced workers, how these consolidations will impact out-of-state placements, and if there will be policies and procedures (or alternate plans) in place to guide the transition from current practice to the reduced bed capacity.

We would implore the department to seriously explore the pros and cons of implementing this section before finalizing this document, and to work through the process of providing less restrictive settings for those consumers that could benefit from them.

§23.20- Consent to Treatment

When reviewing this section, we noticed that there were no references to the Minors Consent to Treatment Act (Act 147 of 2004), wherein consent can be obtained directly from any adolescent over the age of 14. Also omitted is information about obtaining consent for children under 14 years of age for mental health treatment, unless such services are covered under "routine health care..." as written in §23.20 (6)(b)(1). Consent for medication should be cross-referenced with §23.183 (Use of Prescription Medication). We would also recommend separate written consent for each psychotropic medication, and not just overall consent for medications (elaborated further in that section).

§23.53- RTF Director

The credentials necessary to hold the position of RTF director do not include any coursework or administrative experience in fields that are relevant to mental health. We have concerns that that prospective applicant need only a bachelor's or master's degree in administration or human services, with little or no exposure to coursework or relevant experience related to mental health and substance abuse, including psychopharmacology and child and adolescent psychiatry.

§23.54- Medical Director

The role of Medical Director as written is too diffuse and combines direct delivery of clinical care with oversight. The regulations should spell out overall responsibility for clinical leadership, quality of clinical services, including policies and procedures related to clinical care and oversight of quality improvement and safety, credentialing, and other management functions related to the delivery of care. We recommend that the regulations specify a minimum number of hours per week dedicated to oversight responsibilities. Requirements for clinical care time can be enumerated elsewhere as noted below. Although the Medical Director may well be involved in delivering clinical care, this would lessen the blurring between the roles. Also, the document states that the Medical Director could serve as the Clinical Director. We question, without some designation of hours, how the Medical Director's oversight responsibilities would be met, the clinical services delivered and the role of training and supervision which is under the Clinical Director be ensured? Our committee recommends that these important questions be answered prior to the implementation of the final regulation package.

We also would like to seek clarification on the qualifications noted in section (b) of §23.54. Our committee would suggest that the proposed applicant be required to have a board certification in psychiatry. The American Board of Psychiatry and Neurology (ABPN) has eliminated the designation "board eligible," so that language in section (b) should be eliminated. We would also suggest the following replacement language: "board certified in psychiatry, or has completed training in general psychiatry from an ACGME credentialed psychiatry program AND has at least 2 years experience in delivery of services/programs to children and adolescents." The American Academy of Child and Adolescent Psychiatry (AACAP) published the "Principles of Care for Treatment of Children and Adolescents with Mental Illnesses in Residential Treatment Centers" in June of 2010 (attached for your review). This document recommends, for RTF's serving children ages 13 and younger, that the medical director be board certified in child and adolescent psychiatry; if over age 13 years of age, that the medical director be boarded in general psychiatry with extensive experience treating adolescents or be boarded in child and adolescent psychiatry. We support the inclusion of those recommendations into the final regulatory package.

Absent from these proposed regulations is language related to attending psychiatrist(s). Attending psychiatrist time is not spelled out, but included within the role of the medical director. We have questions as to how the psychiatrist is to be integrated with the treatment team, and how the psychiatrist will be utilized in managing the milieu (which has implications for safety), as well as providing clinical care. In our opinion, the elimination of the role of the attending psychiatrist from evaluation, treatment, team meetings, and milieu will result in poor quality care and serious incidents.

§23.57- Mental Health Worker and Mental Health Aide

The definitions for mental health aides and mental health workers require, respectively, no experience and one year of experience. The qualifications for a mental health worker include an option for a high school diploma or equivalency and

four years experience in children's behavioral health. We would recommend that a mental health worker's educational requirement should be a minimum of a bachelor's degree.

Regardless of the experiential requirement, we believe the educational standards for mental health aides (who have a great deal of direct contact with residents) are so deficient that this staff category should be eliminated from the regulations. The mental health aide is also not counted in the minimum staffing ratios, which needs clarification. Although the ratio spelled in the proposed regulations for mental health workers is 1:4 children while awake and 1:6 when asleep, we have concerns about how the supervision of the mental health aide and worker is provided. We would like to see additional clarification within the regulations in this regard as well.

Our experience is that strong staffing in child and adolescent facilities is required to maximize safety, and that it is a primary means of preventing the need for restraint. Although there are exceptions, as there are with all generalizations, we also find that higher educational levels correlate with a better grasp of the principles of trauma-informed care.

In concluding our comments on §23.57, we have questions as to why being a licensed RN satisfies a requirement for being a mental health worker. What is more significant is that there is not a separate staffing role described for those with a RN license. Since there is no requirement for an onsite registered nurse, who would manage medication and provide other medical treatment as needed? Additional clarification in this regard would be helpful in understand the role of the mental health worker ***and*** that of the nurse. Both roles are significant and necessary in this treatment setting.

§23.60- Family Advocacy

The family advocate staff position is described as a full time equivalent, yet there are provisions within (5) to "ensure availability to families and children as requested." We have a few questions in which we would like to seek clarification:

1) Is there an expectation that the advocate be available 24 hours a day, 7 days a week for families, or are these dedicated staffers to be "on call?"
2) Is there funding for this position?
3) What if a family already had an identified advocate, through another organization- would that individual be permitted to serve as advocate?
4) How does the role of family advocate change if the family was already involved with a High Fidelity wraparound team?

These considerations are in keeping with the importance of promoting a family voice and advocacy, but also recognize pre-existing relationships with advocates and could reduce redundancy and cost. We would like to see this section fleshed out more, as there is no description of background and training of individuals who could serve as family advocates.

§23.62- Staff Training

Language within (b)(5) states that staff must be trained in the "proper, safe use of restraint..." We would recommend that this language be revised to specify that training be in the use of non-prone restraint, and reference the ongoing annual training transcribed within (c)(5)(iv) [DPW's Special Transmittal on Strategies and Practices to Eliminate the Unnecessary Use of Restraint]. Our concern is that new staff may demonstrate that they have 30 hours of training in a number of areas, but it may not be in the safe use of restraint consistent with the DPW policy. In those instances, new staff would not be required to be appropriately trained for a full year, in which adverse outcomes could take place. We encourage the language be made uniform to avoid potential incidents.

§23.96- First Aid Supplies

We would encourage the department to revise this section to include the addition of automated external defibrillators (AEDs), and to train staff on their use. AEDs are now routinely part of first aid supply kits in public areas. RTFs may be at some distance from a hospital and delay in emergency care could result in morbidity and mortality.

§23.141- Child Health and Safety

Language within this section requires that a child health and safety assessment must occur within 24 hours but is signed and dated by medical staff or staff trained by medical personnel as specified in RTF training. It is not clear when a physician would review and sign off on this assessment. As the nursing staff role is not specified, it leaves the oversight of medical staff unclear. We would like to see further clarification in order to ensure patient safety.

§23.143- Children's Health Exam

The requirement of a child health exam within the first 72 hours is too long a time frame for many consumers in need of extensive care. The AACAP document referenced previously in this letter recommends that "medical assessment and physical examination occur within the first 24 hours of admission, unless a physician determines that an examination within the week prior to transfer to the facility is sufficient."

The health examination referenced in (e) should include a "comprehensive biopsychosocial evaluation by a psychiatrist with expertise in child and adolescent treatment, or in adolescents only facility as appropriate to the facility."

§23.183- Use of Prescription Medications

The written consent from the responsible party for the use of medications is detailed in letter (c). In our opinion, the consent process should include an interactive discussion about the purpose, risks, and benefits between the prescriber, the parent/guardian and the youth as detailed within Act 147 of 2004. There should be a mechanism to obtain assent from minors.

In addition to the elements listed within this section (including rationale, side effects, and expected effects of withholding medication), the following elements are recommended:

- under (g), the rationale should include the condition or targeted symptoms;
- if the selected medication is off label, the nature of the off label use and reasons for choosing a non FDA approved medication;
- if the medication has a black box warning, the physician should discuss the nature of the warning, the regulatory requirements and monitoring schedules set forth by the FDA, proposed strategy for tapering and or discontinuing the prescribed medication; and
- under (j), it is recommended to give examples of psycho-educational materials and medication information sheets.

In addition, there should be a section on monitoring of medication, with the expectation that evidence-based strategies would be used to screen and monitor adverse effects. Providers should have a policy outlining how psychotropic meds are monitored and at what time intervals.

Specific monitoring and management of metabolic syndrome should be outlined. There are a several evidence based documents to be referenced, including a myriad of material from the Consensus Development Conference on Antipsychotic Drugs and Obesity and Diabetes (*Diabetes Care*, Volume 27, Number 2, February 2004). We can provide this and other materials upon request.

§23.190- Medication Performance Monitoring

Language within this section requires a six month reporting on the number and percentage of youth receiving three or more psychotropic medications and those receiving one or more antipsychotic medications. We would recommend requiring RTFs to create policies regarding:

- screening and treatment of metabolic syndrome
- on the FDA labeling and off-label use of psychotropic medications in children and adolescents
- the elements of informed consent; and
- planning for monitoring adverse events.

§ 23.223- Development of the ISP

The standard of care in the community is that children and adolescents who need an RTF-level of care require the services of a psychiatrist trained and experienced to treat persons in those age ranges. Each treatment team in the RTF should include "a psychiatrist with expertise in child and adolescent treatment, or in adolescents, as appropriate to the facility," instead of just a "board-eligible or board certified psychiatrist" as stated within (d)(2).

As always, we appreciate the opportunity to provide the perspective of our organization, and particularly that of our Committee on Child and Adolescent Psychiatry. Together, they represent a great depth and variety of experience and knowledge pertinent to RTF's and other settings for children and adolescents with serious mental and behavioral disorders. We hope our comments will be helpful to the Department.

Sincerely yours,

Gail A. Edelsohn, MD, MSPH
Chair, Committee on Child and Adolescent Psychiatry

Enclosure

cc: Mr. Stan Mrozowski, Director, Children's Bureau
Ms. Amy Bolze, Executive Director, Senate Public Health and Welfare Committee
Ms. Neeka Jones, Executive Director, Senate Public Health and Welfare Committee
Ms. Karen Shaffer, Executive Director, House Health and Human Services Committee
Ms. Melanie Brown, Executive Director, House Health and Human Services Committee
Mary E. Diamond, DO, Medical Director, OMHSAS
Mr. James Smith, Analyst, IRRC

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

June 2010

These guidelines were developed by the Work Group on Healthcare Access and Economics: Michael Houston, M.D., co-chair, Harsh Trivedi, M.D., co-chair, Alan Axelson, M.D., Sherry Barron-Seabrook, M.D., David Berland, M.D., Martin Glasser, M.D., Sherry Goldman, M.D., Anthony Jackson, M.D., Lisa Ponfick, M.D., Barry Sarvet, M.D., Robert Schreter, M.D., Benjamin Shain, M.D., Ph.D., and AAP liaison Lynn Wegner. The Inpatient, Residential, and Partial Hospitalization Committee also reviewed these guidelines. This committee includes Erin Malloy, M.D., chair, Basil Bernstein, M.D., Shashi Bhatia, M.D., Shiraz Butt, M.D., Jane Gaffrey, M.D., Gary J. Gosselin, M.D., Bruce M. Hassuk, M.D., Charles R. Joy, M.D., Kim J. Masters, M.D., Sricharan Moturi, M.D., M.P.H., Kambiz Pahlavan, M.D., and Michael T. Sorter, M.D. AACAP Staff: Kristin Kroeger Ptakowski. Disclosures of potential conflicts of interest for individuals who developed and reviewed this document are provided at the end of the principles of care.*

This document was approved by AACAP Council in June 2010.
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Introduction

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

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

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

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

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

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

I. Program Description

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

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The RTC program should:

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

II. Leadership Structure and Staffing

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

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

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

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RTC staff/staffing should:

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

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

III. Admission Process, Treatment Planning and Discharge Planning

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

The admissions process should:

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

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

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

Discharge planning should:

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

IV. Prevention of Aggressive/Dangerous Behavior

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

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To ensure RTC safety, all RTCs should:

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

V. Therapeutic Services Standards

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

RTCs should have TSS that includes the following components:

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

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

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

VI. Special Populations and Programs

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

Specialized populations include children and youth with

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

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

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VII. Educational Services

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

All RTCs should:

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

VIII. Therapeutic Environment

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

The environment of the RTC should:

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

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APPENDIX: Special Populations and Programs

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

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

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

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

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

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

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

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

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

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

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

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