

Unlicensed Residential Programs: The Next Challenge in Protecting Youth

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Alliance for the Safe, Therapeutic and Appropriate Use of Residential Treatment

Over the past decade in the United States, the number of private residential facilities for youth has grown exponentially, and many are neither licensed as mental health programs by states, nor accredited by respected national accrediting organizations. The Alliance for the Safe, Therapeutic and Appropriate use of Residential Treatment (A START) is a multi-disciplinary group of mental health professionals and advocates that formed in response to rising concerns about reports from youth, families and journalists describing mistreatment in a number of the unregulated programs. This article summarizes the information gathered by A START regarding unregulated facilities. It provides an overview of common program features, marketing strategies and transportation options. It describes the range of mistreatment and abuse experienced by youth and families, including harsh discipline, inappropriate seclusion and restraint, substandard psychotherapeutic interventions, medical and nutritional neglect, rights violations and death. It reviews the licensing, regulatory and accrediting mechanisms associated with the protection of youth in residential programs, or the lack thereof. Finally, it outlines policy implications and provides recommendations for the protection of youth and families who pursue residential treatment.

Keywords: residential care, institutional abuse, child protection, therapeutic boarding school

In a 1975 review of residential treatment programs in the United States for children with emotional disturbance, Durkin and Durkin pointed out that, “Each night some 150,000 children and adolescents go to bed in approximately 2,500 child care institutions” (Durkin & Durkin, 1975, p. 275). Thirty years later, residential treatment for youth with special needs has changed dramatically and, with this change, three things are very clear. First, there is a glaring lack of information about residential care for children. There has been a dearth of accurate information on just how many children go to sleep every night in a residential treatment program, for example, or on how many children benefit from or are harmed by these programs, or on how many programs actually exist (e.g., Edwards, 1994). Second, although there is a serious lack of adequate information, it is clear from many reports that a significant number of children are being mistreated in such programs and, in some cases, are even dying in them (Kobt, 2005; Montana Department of Public Health and Human Services [Montana DPHHS], 2001; Pinto, Friedman, & Epstein, 2005). Third, there is a glaring absence of independent research on the effectiveness of these programs in helping youth or on the total positive and negative effects of these programs on the residents.

The purpose of this article is to review a residential care phenomenon occurring since the early 1990s that has been linked to reports of mistreatment, abuse, and death (Bryson, 2004; Garifo, 2005; Harrie & Gehrke, 2004; Hechinger & Chaker, 2005; Kobt, 2005; Labi, 2004; Rock, 2005; Weiner, 2003, May 24). Specifi-

cally, this article focuses on issues related to private residential facilities that are neither licensed as mental health programs by states, nor accredited by respected national accrediting organizations.

It should be noted at the outset that residential care in licensed and accredited facilities is generally recognized as an important and necessary part of an organized system of services for children with mental health challenges and their families (Stroul & Friedman, 1986; U.S. Department of Health and Human Services, 1999). Serious risks can exist, however, when vulnerable youth are sent to residential programs with minimal to no safeguards or oversight.

Trends in Residential Care for Youth in the United States

Historically, in this country, we have witnessed a variety of efforts to address the issue of children and adolescents whose behavior is of concern to others. Primarily the response has been to send such children from their homes, whether to almshouses, to rural communities from urban centers so that they might break away from the “negative” influence of cities, to programs for delinquents, or to programs for children with mental health problems (Platt, 1969; Rothman, 1971; Whittaker & Maluccio, 1989). Whittaker and Maluccio point out that the first children’s institution in the United States was established in 1729 by the Ursuline nuns of New Orleans to care for children orphaned by an Indian massacre at Natchez. The House of Refuge in New York became the first institution for delinquents, while the first band of children to be sent from the city to the country was sent in 1855 by the New York Children’s Aid Society (Whittaker & Maluccio, 1989). Particularly after World War II, there was a steady growth in facilities for children with mental health challenges, and many programs that had been established to serve children who were dependent or

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neglected were converted to serve children with identified mental health needs (Pappenfort & Kilpatrick, 1969). It is noteworthy that many of these efforts, in retrospect, have been judged to be ineffective, if not harmful (Platt, 1969).

In contrast to this practice of sending children from their homes to placements often far away, the National Institute of Mental Health instituted its Child and Adolescent Service System Program (CASSP) in 1984 and began to promote the need for community-based systems of care that include intensive and individualized home and community-based alternatives to residential care (Stroul & Friedman, 1986, 1996). CASSP has grown into a large federal grant program to support systems of care (Holden, Friedman, & Santiago, 2001; Manteuffel, Stephens, & Santiago, 2002); there have now been a number of demonstrations that, through intensive and individualized services, often administered through a process known as "wraparound" (Bruns, Burchard, & Yoe, 1995; Burchard, Bruns, & Burchard, 2002), it is possible to reduce the need for out-of-home placements (Kamradt, 2000; Manteuffel et al., 2002; Rotto & Mckelvey, 2002). Recently, the President's New Freedom Commission on Mental Health (2003) issued a strong call for strengthening and increasing community-based services for children and families within a transformed mental health system that is consumer- and family-driven. While intensive, individualized, community-based, family-driven services have become increasingly available in many areas, it is important to note that the pathways into these services are often through publicly funded service sectors, such as the juvenile justice, child welfare, mental health, or education system (Hazen, Hough, Landsverk, & Wood, 2004). As such, services are less accessible to families whose children do not qualify for services in these public systems or families who wish to keep their children out of these systems.

The Recent Increase in Residential "Specialty" Programs

As public policy at a federal level and within virtually every state (Evans & Armstrong, 2003) has called for the development of systems of care and the provision of home and community-based services, there has been a growth of private for-profit residential "specialty" programs that specifically target their services at families who have the resources to pay for such programs and who do not qualify for publicly-supported assistance. This growth is partly reflected in the membership of the National Association of Therapeutic Schools and Programs (NATSAP), a voluntary membership group created in 1999 "to serve as a national resource for programs and professionals assisting young people beleaguered by emotional and behavioral difficulties (<http://www.natsap.org>)."

NATSAP has grown from 43 programs in 1999 to 135 that are listed in their 2005 directory (Hechinger & Chaker, 2005; National Association of Therapeutic Schools and Programs [NATSAP], 2005). This number is likely a gross underestimate of the number of such specialty programs that actually exist. For example, in a 2003 report by the Montana Department of Public Health and Human Services, 29 unlicensed private behavioral healthcare programs were identified, despite the fact that the NATSAP membership only includes 11 programs in Montana, and the report from Montana indicates that the 29 they were able to identify is probably an underestimate (Montana DPHHS, 2003). There are also some programs located in other countries that are run by U.S.

companies (Dibble, 2005; Garifo, 2005; Gehrke, 2005; Weiner, 2003, September 6).

The problem of identifying how many of such programs exist nationally is a reflection of the inconsistency between states in how they define such programs and whether they license them, as well as the absence of any federal efforts to address this issue and overall definitional confusion within the children's mental health field. A report from NIMH in 1983 indicates that "a problem in defining the universe of these facilities has always existed" (Redlick & Witkin, 1983). In its 2005 directory, NATSAP reports that, "Many different types of programs have evolved over the past decade to serve the growing needs and numbers of struggling young people" (NATSAP, 2004, p. 5). NATSAP goes on to identify and define seven different types of programs: emotional growth schools, home-based residential programs, therapeutic boarding schools, outdoor therapeutic programs, residential treatment centers, transitional independent living programs, and wilderness programs.

To date there have been no comprehensive research reports that distinguish between these "specialty" programs in terms of their effectiveness or provide even basic data on the number of children who are served, the services they receive, or the outcome of the service. The report from the Montana DPHHS (2003) says that the 29 unlicensed and unregulated programs that they were able to identify serve about 975 youth, 90% to 95% of whom are from out of state, and Forbes Magazine reports that each year 10,000 children attend such programs (Brown, 2002). However, despite this estimate, there is no set of nationally accepted definitions of such programs or comprehensive national database to provide information on just how many children are in them.

Some states and organizations have made efforts to gather data on certain types of residential programs. For example, the American Association of Children's Residential Treatment Centers (AACRTC) conducted a national survey of residential treatment centers for children in 1999, gathering data from 96 RTCs across 33 states (American Association of Children's Residential Treatment Centers [AACRTC], 1999). This study was limited in scope, in that it included only those facilities that were member programs of AACRTC. As another example, the Colorado Department of Human Services conducted a census of RTCs in Colorado in 2003. This was the state's first comprehensive effort to identify the service capacities and capabilities of RTCs and to study RTCs as part of a system of services and supports (Coen, Libby, Price, & Silverman, 2003). The Colorado Association of Family and Children's Agencies, Inc. then published a white paper on the care of children in residential treatment care in Colorado (2004). While the research sponsored by AACRTC and in Colorado illustrates efforts by organizations and state agencies to more clearly identify and describe residential programs for youth, it does not represent a comprehensive research program that can provide a summary of programs across states and program subtypes.

Alliance for the Safe, Therapeutic and Appropriate Use of Residential Treatment

In the fall of 2004, a multidisciplinary group of mental health and child-serving professionals was formed to study these issues, prompted by rising concerns about reports in the general media and directly from parents describing these unlicensed and unreg-

ulated programs. This group, the Alliance for the Safe, Therapeutic, and Appropriate Use of Residential Treatment (A START), seeks primarily to advocate for the protection and safety of children in such programs, while also striving to make available to families a range of effective service options and information about how to access those services. A START recognizes that residential treatment is an appropriate placement for some youngsters and that there are high quality programs being administered by committed and competent staff. A START therefore does not wish to see residential options eliminated, but believes that there is a great need to understand more specifically about unlicensed and non-accredited programs and their level of effectiveness, to provide for the protection and safety of children in the programs, and to enable families to make truly informed choices about how to support and assist their children.

A START has gathered information from a variety of print and electronic media, interviewed and surveyed state policy-makers, reviewed existing state documents and statutes, talked with parents and children who have been directly involved with the residential facilities, and consulted with former staff members of the programs. A START has been unable to find any published articles about these unlicensed and unregulated programs in the professional literature and is particularly concerned about this "silence" from the professional mental health community in the context of numerous media reports of mistreatment in such programs. The few exceptions that have been identified include: The work of pediatric psychiatric nurse Wanda Mohr to identify youth rights violations in residential facilities (Huffine & Mohr, 2001; Mohr, 1999, 2001); a declaration on the detention of minor children in facilities including "behavior modification boarding schools" by the Association of Child and Adolescent Psychiatric Nursing (1998); an effort by child psychologist Roderick Hall to alert psychologists to the risks associated with these programs ("International Survivors Action Committee," n.d.) and the recent efforts of psychologist Nora Baladerian and attorney Thomas Coleman to increase community awareness about these concerns (<http://www.emancipationproject.org>). There are also several organizations and websites run by people who are not mental health professionals but are concerned about unregulated residential programs and related mistreatment (www.isaccorp.org; www.nospank.org). These organizations and websites are often cited by youth and families as sources of helpful information and support. The purpose of the present article is to review the information obtained by A START and to offer recommendations, based on that information, for better protecting and serving children and families.

The Business of Residential Programming

The programs of concern are typically proprietary, for-profit programs, and some are parts of large chains (Hechinger & Chaker, 2005; Story, 2005). They may be campus-based or wilderness-based; may call themselves schools, camps, programs, or centers; and are spread around the country. The NATSAP directory includes programs from 31 different states. However, there are some states that have a disproportionate number of programs, which has been linked to licensing and regulatory procedures in those states that are either non-existent or lax (Montana DPHHS, 2003; Rubin, 2004). For example, of the 134 programs listed in the

2005 NATSAP directory, 35 are in Utah, 11 are in Montana, and 9 are in Oregon.

As the *Chicago Tribune* reported, "Even in a lackluster economy, business for therapeutic schools is booming" (Rubin, 2004). The cost to parents for programs is variable, but typically ranges between \$30,000 and \$80,000 per year (Hechinger & Chaker, 2005; Rimer, 2001). If families are interested in making a placement, but unable to immediately come up with the necessary money, programs will assist them in immediately securing loans or second mortgages on their homes so that they can afford the programs. In addition, some programs require families to make non-refundable payments for several months in advance. Indeed, the profitability of these programs was recently touted in an article in the business section of the *New York Times*, (Story, 2005) and is one of the main driving forces behind their growth, much as it was for the private for-profit psychiatric hospitals in the 1980s (Mohr, 1997, 1999).

Program Features

It would be desirable to be able to describe the program features based on systematic, comprehensive, and independent data collection. No such data collection has been possible, however. As a consequence, the program descriptions in this section are based on parent and staff reports, media articles, and descriptions prepared by the programs themselves. This makes it impossible to determine precisely how common some of the features are. In selecting features to focus on and as a protection against describing a program characteristic that may be unique to only one program, only those characteristics are included for which there were multiple informants.

Programs are often reported to maintain a severe and rigid approach to discipline (Aitkenhead, 2003; Kilzer, 1999; Romboy, 2005) and activities of daily living that would be protected as "rights" of youth in licensed inpatient mental health facilities are framed as "privileges" in many of these programs. For example, a number of programs forbid contact with parents both initially (sometimes lasting for months) and when youth are not complying with program rules (Aitkenhead, 2003; Kilzer, 1999). It is not unusual for youth residents to be involved in monitoring and disciplining their peers (Dukes, 2005; Weiner, 2003, June 17), a particularly questionable practice since all youth sent to the program presumably have special challenges themselves. The severe approach to discipline present in some facilities has led to the question of, "When is tough love too tough?" in a recent publication of the National Council of State Legislatures (Herman, 2005).

Therapy within these programs is often provided by staff members who have not received formal clinical training, and there are multiple descriptions of interventions suggestive of gross incompetence (Aitkenhead, 2003; Cole, 2004; Kilzer, 1999; Weiner, 2003, June 17, 2003, September 6). Psychiatrists are not routinely included as treatment team members; dosing errors (Romboy, 2005), as well as over-medication of youth, have been reported (Weiner, 2003, September 6). This substandard treatment is especially of concern because programs are often quite explicitly directing their marketing efforts to families of youth with psychiatric diagnoses and often claim expertise in treating a variety of mental or behavioral health challenges (NATSAP, 2005).

The programs, in describing themselves, use terms like “uncovering true potential,” and teaching youngsters about “accepting personal responsibility” (NATSAP, 2005). They also describe themselves as offering premiere educational programs, although reports suggest that the quality and level of academic programming is very variable (Aitkenhead, 2003; Rowe, 2004). Some programs offer educational opportunities through their local school districts; some offer on-site academic classes through privately employed teachers who may or may not be licensed instructors; and some offer private tutorial-type academic programming, while other focus primarily on non-academic treatment programs. In some cases, unbeknownst to parents, completion of program “class work” may not lead to gathering credits for high school graduation (Garifo, 2005).

Some programs are explicit about refusing to be accountable for delivering the services that they advertise (Kilzer, 1999; Weiner, 2003, September 6). For example, Kilzer reports that in one program parents are required to sign a contract that “holds the program harmless for false advertising or for any medical complication caused by staff mistakes, for ‘bites, sores, infections, slow healing cuts’ and for all illegal or criminal acts committed against their child by staff members ‘outside the scope of their employment’ (Kilzer, 1999, para. 60).

Serious Harm Experienced by Youth

A number of reports have been published in recent years regarding the mistreatment, abuse, and even death of young people in residential programs (Bryson, 2004; Garifo, 2005; Harrie & Gehrke, 2004; Hechinger & Chaker, 2005; Labi, 2004; Rock, 2005; Weiner, 2003, May 24). While all types of harmful treatment are of concern, the death of youngsters in these programs is of course most serious. The Montana report points out that there are no national data maintained on the number of serious injuries that occur in wilderness programs (Montana DPHHS, 2003). The same might be said about other programs as well. In a particularly poignant presentation in July 2005 on Dateline, the story is told of a woman whose son, in need of treatment after suffering a traumatic brain injury, died from improper use of restraints while in a residential facility. The attorney who defended the company that owned the facility against the lawsuit several years later placed his 17-year old son in a program run by the same company. This boy died on his sixth night in the program after a physical struggle with counselors. The attorney, after studying the issue, determined that there had been 16 deaths in Texas alone in these programs since 1988 (Kobt, 2005). Montana reports that there have been five deaths in wilderness run programs in Utah alone from 1990 to 2003 (Montana DPHHS, 2003).

Deaths appear to occur for three reasons: inappropriate use of physical restraints; improper protection against the elements or excessive physical demands in wilderness programs; and suicide. For example, a 13 year-old asthmatic boy in a wilderness camp program in northeastern Georgia recently died after being held in restraint for more than an hour and being denied his inhaler. Six counselors at the camp have been charged with felony murder, child cruelty, and involuntary manslaughter (“National Briefing: South: Georgia,” 2005). At a program in Jamaica run by a U.S. company, a 17-year-old girl died after she jumped off of a 35-foot high balcony (Labi, 2004).

There are many other reports of physical, emotional, and sexual abuse of youth in these programs (Bryson, 2004; Garifo, 2005; Harrie & Gehrke, 2004; Hechinger & Chaker, 2005; Rock, 2005; Weiner, 2003, May 24). Emotional abuse has been reported in terms of verbal abuse, humiliation, forced personal self-disclosure followed by mockery, forced re-enactments of traumatic events, and extreme fear inducement, often under the pretense of “therapy” despite the lack of empirical data to support these approaches (Aitkenhead, 2003; Hechinger & Chaker, 2005; Kilzer, 1999; Rock, 2004; Weiner, 2003, May 24, 2003, September 6). Reports of excessive discipline include lengthy periods of isolation and restraint through the use of duct tape and pepper spray (Aitkenhead, 2003; Bryson, 2005, April 21; Rowe, 2004; Weiner, 2003, May 9). In one program, for example, youth described lying on their stomachs in an isolation room for 13 hours a day, for weeks at a time (Aitkenhead, 2003; Rowe, 2004; Weiner, 2003, May 9). A youth from one Montana facility reported that he spent six months in isolation (Weiner, 2003, September 6) while signed affidavits from former employees of a program in Utah indicated that youth in that program were restrained face down in manure (Romboy, 2005; Stewart, 2005). Some of these programs are also reported to be neglectful in terms of safety, cleanliness, nutrition, and appropriate medical care (Aitkenhead, 2003; Bryson, 2005, April 21; Kilzer, 1999; Rock, 2005; Romboy, 2005; Weiner, 2003, September 6).

During the time when these incidents are occurring, the residents typically have no access to anybody from outside of the program. They are not allowed to speak to or write to their parents until they have advanced to a certain level in a program, and there is no access to an “abuse hotline” or “patient advocate,” as is required in most psychiatric inpatient facilities. Further, when youth do have contact with their parents, parents are often advised to dismiss their children’s reports of abuse as attempts at manipulation (Aitkenhead, 2003; Kilzer, 1999; Weiner, 2003, May 24).

Any single death or incident of severe abuse is clearly a situation that merits concern. In the instance of these programs, however, the information about the number of deaths and the absence of more complete information, in combination with the reports of excessive use of restraints and other forms of mistreatment, merit extremely serious concern and action. This is particularly the case since the available information is limited, preventing an understanding of the full scope of the problem.

Transportation

An additional concern that has emerged relates to the ways in which youth are transported to residential facilities. Programs sometimes encourage parents to have their children transported by paid “escorts” who are privately hired by the child’s family (Bryson, 2005, February 8; Cole, 2004; Kilzer, 1999; Rimer, 2001; Rowe, 2004). In Legal Affairs, Labi gives a very detailed description of how this operates in the case of one child. Escorts, who are described as large, strong, and physically intimidating, are admitted by the parents into their home after their child is asleep. The escorts then awaken the child, inform him/her of what is to happen, and offer the choice of going willingly or being transported against their will (Labi, 2004). If necessary, handcuffs are used to restrain children (Labi, 2004; Weiner, 2003, June 17). Parents sign a notarized power-of-attorney authorizing the escorts to act on the

parents' behalf while transporting the youth, and promising that the family will not sue the escorts for any injuries caused by reasonable restraint (Labi, 2004). The report from Montana (2003), which indicates that 90% to 95% of the children in these programs in their state are from another state, is just one indication that children are often transported great distances from their home.

These escort services are also unregulated, and the use of such escorts to transport their children hundreds or thousands of miles away from home, sometimes to other countries, is within the rights of parents. In some instances, this practice leads to conflict between the child's parents or relatives (Kilzer, 1999), and when these conflicts occur after the child is already residing in a private program, the power of individuals other than the custodial parent to secure the child's release is limited (Labi, 2004).

Marketing

Despite the many reports of mistreatment, abuse, and even death and the lack of systematic outcome data to substantiate their claims of effectiveness, these programs continue to prosper. This prosperity likely relates to their intensive marketing efforts. There appear to be three major ways in which these programs are currently marketed: through the Internet, through "educational consultants," and through participating family referrals. In this new electronic era, parents are often quick to consult the Internet for advice and help on dealing with difficult problems. Most programs host their own attractive websites, which are prominently displayed if parents enter such terms as "troubled teens" or "behavior problems" into any Internet search engine. Parents who seek more information get a rapid response, often a strong sales pitch with testimonials from other parents, sometimes an on-line brief "assessment" of problems, and concrete assistance in making arrangements for immediate placement. Parents report that they are often encouraged to act very rapidly before the situation with their child gets more serious and help is too late. Parents have reported that they succumbed to this type of pressure, particularly since it came at a time when they were already feeling desperate for help. This type of marketing through the Internet presents a new challenge to the mental health field, which has traditionally emphasized the importance of a more cautious approach in which a full and comprehensive assessment is conducted before a decision is made or an intervention plan is developed.

In addition, a new field of "educational consultants," with their own national organization, has grown. These consultants assist families with two major tasks: selecting universities for their children or selecting special programs for youth who are presenting special challenges. The qualifications and credentials of these consultants vary (Rubin, 2004), and there do not appear to be any credentialing requirements or regulation. These consultants often market through direct mailing to mental health professionals and assist parents in selecting a program and making the arrangements for a placement. Former staff members of specialty programs have reported that some educational consultant receive "finders fees" from the programs for each student who is placed in the program based upon their recommendation, a fee that is not disclosed to parents. There is no information on how widespread this practice is. Like any other field, this seems to be a field that has a combination of sincere and well-intended individuals; sincere and well-intended, but misinformed individuals; and others who are

motivated more by personal gain than by assisting children and families.

Some programs also encourage families whose youth are attending the program to recruit other families they know and offer fiscal incentives for such referrals (Aitkenhead, 2003). Families have reported sending their children to programs on the recommendation of other parents without ever further investigating the program or services described (Cole, 2004).

Licensing, Monitoring, and Accreditation

There are two primary formal efforts to oversee programs serving vulnerable populations. The first is licensing and subsequent monitoring of such programs, which is traditionally done by states or regional bodies as part of a general governmental responsibility for oversight of quality and protection of vulnerable populations. The second effort is accreditation by independent organizations.

There appears to be great variability in licensing requirements among the states, and, as indicated earlier, this may account for the disproportionate presence of residential programs in some states. For example, Montana currently has no licensing requirement for private behavioral health care programs, although its legislature is beginning to address the issue. In Texas, a residential program is not regulated by the Texas Health and Human Services Commission (which does require licensure of residential treatment centers and therapeutic camps) if the program self-identifies as a private boarding school ("Operations that are exempt," 2002).

Utah, which is believed to have more of these programs than any other state, also has not licensed such programs historically, although concern about them has led to a 2005 law amending the "Licensure and Regulation of Programs and Facilities." This Law now imposes requirements for the licensing of all "human services" programs, including "therapeutic schools," "youth programs," and any "facility or program" that provides "residential treatment" or "residential support" ("Licensure and Regulation," 2005).

In some states, residential programs are required to be licensed unless they are affiliated with a religious institution. This is referred to as a "faith-based exemption," and explains how some programs have existed in Missouri and Florida without state oversight as residential mental or behavioral health facilities (Escobedo, 2004; Franck, 2002).

Unlike Montana, Texas, and Utah, Michigan has only one program listed in the NATSAP Directory, and that program is both licensed and nationally accredited. This likely relates to the fact that in Michigan therapeutic boarding schools must be licensed as "child caring institutions," all public and private residential institutions are equally accountable, and no religious-based exemptions exist. Furthermore, in Michigan, all reports of code violations are publicly available online ("Child care," 1973/2002). Ohio is another state with clear licensing requirements for all residential programs and no religious-based exemptions ("Inspection and licensing," 2001), and this state also has only one program listed in the NATSAP directory, which is nationally accredited as well as licensed. It should be noted that while licensing can provide an important protection, this is only the case if there are thorough and effective monitoring procedures that accompany the licensing requirements.

While licensing is a mandated requirement for programs in those states that have such regulations, accreditation by a national body is voluntary. Accreditation is typically obtained by a self-initiated application and guided self-evaluation, followed by an on-site visit by a voluntary committee associated with the accrediting agency. Accrediting agencies are private, peer-based, member-funded agencies designed to encourage and promote quality client care. Accrediting agencies, however, do not have any governance or jurisdiction over private facilities, although government agencies can choose to make accreditation by an independent national organization a pre-requisite for obtaining a license, operating a program, or receiving government funding, for example.

There are three main accrediting groups nationally that are pertinent to this type of program: the Council of Accreditation (COA), which was formed in 1977 by the Child Welfare League of America and Family Service America and operates primarily from a social service model (<http://www.coanet.org>); the Council of Accreditation of Rehabilitation Facilities (CARF), which was formed in 1966 and operates primarily from a rehabilitation model and has separate behavioral healthcare standards (<http://www.carf.org>); and the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), which was established in 1951 and uses a primarily medical model and also has separate standards in behavioral healthcare (<http://www.jcaho.org>). The 2005 NATSAP Directory indicates that three of the 134 programs have COA accreditation, five have CARF accreditation, and 23 have JCAHO accreditation. Altogether, slightly less than one-quarter of the programs have accreditation from any of these organizations. This is not to suggest that NATSAP member agencies are any lower in accreditation rates than non-NATSAP agencies. In fact, the opposite may very well be the case in comparison to similar programs that do not belong to NATSAP. The data for NATSAP member agencies is presented here primarily because it is the only such data available. These data do suggest that the accrediting bodies that have developed and refined clear standards to safeguard youth are being underutilized as a means of ensuring appropriate standards in residential facilities.

The Association for Experiential Education (AEE) is a new nonprofit professional membership association that accredits adventure education programs: "The accreditation process determines if the program has an educational mission; has clearly defined and appropriate objectives; maintains conditions under which those objectives may be achieved; and appears to be achieving them" (Association for Experiential Education [AEE], n.d.). This is a relatively recent process, in operation for less than ten years, and there are no data to indicate how effectively this accreditation process is promoting high quality and safe care.

The State of Washington has addressed the issue of protecting the well being of youth by legislating that individuals as young as 13 years of age have the right to refuse care for mental health and substance abuse problems ("Minor voluntarily admitted," 1998). The age at which youth have this right is lower in Washington State than any other state in the U.S. The fact that youth have the right to walk away from care that they feel is irrelevant or harmful may in part explain why unregulated residential programs have not proliferated in this state.

There are two other potential licensing, regulatory, or accrediting mechanisms that may provide protection for children. One of these is the Interstate Compact on the Placement of Children

[ICPC], which is designed to protect children who are sent from one state to another for purposes of placement in foster care. However, the Compact specifically does not include placements in medical, educational or mental health facilities (Article II (d)). In addition, Article VIII (a) specifically excludes from coverage under the Compact the placement of a child made by a family member or non-agency guardian (Association of Administrators of the ICPC, 2002).

A second potential protection is accreditation by an educational organization. Many programs seek such accreditation because they include on-site education or because they prefer to consider themselves as a school rather than a treatment program, even if the primary reason that children are sent to them is because of concern about their behavior. However, the scope of protection provided by educational accreditation is limited. As the report from the State of Montana indicates concerning the Northwest Association of Schools and Colleges and Universities, an educational accrediting organization "only reviews the educational component, it does not review the behavioral component or overnight care that the youth may receive while they are at the program" (Montana DPHSS, 2003, p. 9). Similarly, a response to a question about this issue addressed to the Southern Association of Colleges and Schools also indicates that, "there are no direct standards or indicators referencing the types of discipline/control measures utilized at these schools" (Flatt, personal communication, October 11, 2004).

It is also important to note that academic requirements vary across states, with some states mandating number of days in attendance and specific curriculum in order to meet graduation requirements. Because many youth are sent to residential programs outside of their home state's educational jurisdiction, they may experience problems with transfer of credits after they return to their home state.

Government Responsibility

The current situation regarding residential services for youth raises a number of issues. First and foremost is the responsibility of government and of professionals to ensure the safety and well being of children. Governmental oversight to ensure such safety is an honored practice in this country and is not limited to the licensing of programs and facilities formally designated as mental or behavioral health programs. It is reflected in everything from regulation of special programs that serve children or vulnerable populations, like day care programs, nursing homes, and programs for individuals with disabilities, to licensing of professionals to practice in a particular field and to protecting against fraudulent and misleading advertisements. Within health care, concerns about safety and quality have also led to the development of monitoring and accreditation procedures, and these have grown in scope in recent years.

Laws and procedures regarding the report of child abuse and neglect and the transport of children across state laws are primary mechanisms to keep children safe. Yet, despite the growing number of reports regarding mistreatment, abuse, and death of youth in unlicensed programs, the response by states has been very uneven.

Recommendations

Based on our understanding of the issues and concerns that have emerged regarding residential programs for youth, we propose the following response:

1. There is a need for all states to have laws and policies that promote licensing and monitoring of all residential programs, whatever they may be called, to ensure that quality services are provided, to decrease the likelihood of abusive or harmful behavior, and to ensure that incidents of abuse are reported. The Montana Department of Public Health and Human Services (2003) has laid out 13 possible policy options in response to this problem, with the last one being to do nothing. For Montana and for all other states, the last option is clearly unacceptable. Although licensing and monitoring or accreditation does not by itself ensure that tragic incidents will not happen, it is one critical part of a multifaceted response to this problem and all states should examine their current licensing and monitoring procedures to make sure that they are adequate to protect children from abuse and families from exploitation. Federal Bill HR, 1738, the End Institutionalized Child Abuse Bill, was introduced in Congress in April, 2005; this bill proposed to provide funding to states to support the licensing and monitoring of the full range of residential treatment programs, and as such would facilitate the protection of youth and families.
2. Further, the Interstate Compact should be re-examined so that before children can be transported across state lines for purposes of receiving special help, at a minimum, parents are provided with information about prior deaths and complaints of abuse or neglect at the facilities. Before children are sent across state lines to a foster care or relative placement by the child welfare system, a home study is done to ensure that the home to which they will be going is safe and appropriate. Surely a similar requirement is in order for this vulnerable population that is being sent across state lines for purposes of treatment.
3. A part of this overall child protection effort should be a systematic and comprehensive examination of such programs, under the auspices of the federal government. It is unacceptable to have so little information about such basic issues as the number of children served, the characteristics of the children, the services they receive, the overall outcomes, and particularly the number of deaths and serious injuries. Such an information collection effort should not be just a one-time activity, but should lead to ongoing data collection about the status of these programs and the well being of the youth served within them. Resources should also be made available at the federal and state levels to support independent evaluation of the effectiveness of these programs.
4. The growing use of these unregulated programs, despite the lack of evidence of effectiveness and the increasing evidence of mistreatment and abuse, is a reflection of the great need that children and families have for access to

effective care. If such care were available in one's own community, then parents would be less likely to select a high-risk program far from their home community out of a sense of urgency. Significant progress has been made in developing individualized, culturally competent, and intensive home- and community-based interventions, in which parents and professionals work together as partners (Huang et al., 2005; Kamradt et al., 2005). The challenge now is to increase the availability of these services so that they are accessible to all families. An important lesson to be learned from the use of these programs is that within all social classes of families and within all racial and ethnic groups, children and families are in need of help and there needs to be a concerted effort to provide that help.

5. The mental health field needs to actively respond to the growing evidence of mistreatment and abuse of youth in unregulated programs. The almost total neglect of focus on these programs in the professional literature and the silence about it from within the mental health community are causes for alarm. Somehow, mental health professionals should be the loudest voices complaining about abusive and exploitive practices that are inconsistent with sound mental health practice and yet are being done in the name of treatment. It is encouraging that as this issue has been brought directly to the attention of organizations such as the American Psychological Association, the American Orthopsychiatric Association, the American Association of Community Psychiatrists, and the Child Welfare League of America, they have become important allies in the effort to address the problem. In the future, however, these organizations and many others have an important watch-dog and oversight responsibility specifically for actions taken in the name of providing treatment for mental health problems and should set up structures to ensure that this watch-dog function is carried out.

As noted earlier, within the United States, there is a long history of sending children who are not conforming to expected standards of behavior to institutions, often far from their home, despite the lack of evidence that this is effective. The current trend to escort and transport children in the middle of the night to unlicensed and non-accredited programs often thousands of miles away from home, and sometimes in other countries, programs about which very little is known but which are notorious for harsh discipline if not actual abuse, is a particularly pernicious continuation of this practice of removing of children from their homes and communities. The challenge now is to gather complete and accurate information about these facilities, to develop a comprehensive child protection strategy including better use of licensing, monitoring, and accreditation procedures, and ultimately to develop the supports and services that will allow children and families to address their needs within their own home and community. A powerful and effective response to this latest trend in residential care is now needed if we are truly committed to safeguarding and promoting the well being of youth and families.

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