

# PROTECTING YOUTH PLACED IN UNLICENSED, UNREGULATED RESIDENTIAL “TREATMENT” FACILITIES

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Throughout the country, there is considerable inconsistency in how states regulate residential treatment programs for youth. In states with little oversight, the health and safety of youth are unprotected and they may be subject to substandard treatment, rights violations, and/or abuse. Three initiatives to address this issue are reported: (1) an Internet survey of youth who are former residents, (2) a four-state pilot study of how states regulate and monitor residential programs, and (3) a bridge-building conference between residential treatment providers and mental health leaders. Recommendations address the next steps for lawmakers, lawyers, judges, mental health and education professionals, and parents.

**Keywords:** *residential treatment for youth; licensure/regulation of residential treatment for youth; abuse in residential treatment; state responsibility for residential treatment of youth*

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## INTRODUCTION

*I did not know where I was going when two strangers came to my room at home at 3 in the morning, handcuffed me and dragged me down the stairs into a car. While I was at “name deleted,” the program used forced labor, excessive exercise, sleep deprivation, nutritional deprivation, physical aggression from staff, and threats. We had work sanctions like carrying rocks, digging holes, in both extreme heat and in cold and snow/rain. Staff punched kids when restraining them; restraints were done using duct tape and blankets. Now it is hard to have lasting relationships, and I don’t trust many people. I learned to “play their game” . . . make up things and admit anything to get them off your back.*

*Quotation from a 20-year-old about treatment that occurred  
3 years before*

*I found this program on the Internet and it looked like it was perfect for our son, who argued all the time, skipped school and was disrespectful to me and my wife. We were afraid he would smoke pot and become a juvenile delinquent. They helped us to get a mortgage on our house to pay for the care. They told us to lie to him about where we were taking him, so we did. They told us he would lie to us about what was going on at the school to manipulate us; they told us to ignore his letters. We were not allowed to talk to him on the phone. We never knew what his treatment plan was, but didn’t realize that we had the right to know.*

*When he ran away and was picked up by a shelter program, we were ready to send him back but the woman at the shelter told us she knew from other kids that the stories were true. We found out later that they used outhouses that they dug themselves. They were punished by being forced to eat with the hogs, down on their knees, like animals. There were many punishments that involved isolation or whippings by staff. They had forced marches and had*

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*to carry rocks in their backpacks. Medical problems, like infections, were untreated. We talked to other parents who had kids there and got the same stories. We were horrified about what we did to our son. It has taken years of family therapy to get past this.*

*Quotation from a parent*

A parent's decision to place a child in a residential treatment center is a serious one, usually fraught with anxiety and based on serious concerns about the child's difficulties, emotional stability, and/or behavioral problems. The decision is frequently guided by the recommendations of a mental health professional, school counselor, juvenile probation officer, or judge. In many cases, the decision comes after other, nonresidential treatments have failed. The choice of a residential treatment program is a complicated one, and in the best of circumstances, the decision is made by matching the child's needs to the program's strengths and based on the assumption that the program provides quality treatment, education, medical care, and honors the rights of children and parents.

As seen in the opening quotations, substantial problems can arise when placements are made without verifying that these important elements of residential care are in place. A very basic source of verification of program quality is that the program is licensed by the state in which it is located; a higher source of verification is accreditation by a national organization. Neither is foolproof and questionable programs may exist with one or both of these seals of approval. Alternatively, good programs may exist with neither of these approvals. Thus, the issue of program quality is complex, but extremely important to the well-being and safety of children entering these programs and precedes any consideration of treatment effectiveness. This article addresses the most basic measure of quality—how states handle the issue of licensure; how they review or monitor the programs they license; and how they address problems that arise when the requirements for good child care, good treatment, and good education are deficient.

## UNCOVERING A PROBLEM

One of the strongest reports in the media regarding exploitation, mistreatment, and abuse of minors in unregulated, private residential treatment facilities appeared in July 1999 by Lou Kilzer in the *Denver Rocky Mountain News*. Over the past 4 years, there have been additional important and shocking media reports. Most notable are a series of articles by Tim Weiner, *The New York Times* (May through September 2003); Bonnie Miller Rubin, "The Last Resort: Therapeutic Education Industry Booms as Parents Seek Programs for Troubled Children," *Chicago Tribune* (January 14, 2004); and Maia Szalavitz, "The Trouble with Tough Love," *Washington Post* (January 29, 2006). Szalavitz has further captured the unsavory tactics of some programs in her recent book, *Help at Any Cost* (Szalavitz, 2006). Youth who attended such programs, parents, and former staff have also made powerful public statements about abusive experiences with some of these facilities. These issues have been discussed in publications of the *American Psychological Association: Public Interest Directorate* (Pinto, Friedman, & Epstein, 2005) and the *American Journal of Orthopsychiatry* (Friedman et al., 2006b) and in presentations at meetings of the American Bar Association (American Bar Association, 2006), American Psychological Association (Pinto, Epstein, Lewis, & Whitehead, 2006), and Research and Training Center for Children's Mental Health (Friedman et al., 2006a).

Collectively, these reports describe:

- basic human rights violations including (1) youth deaths; (2) inhumane, degrading discipline; (3) inappropriate, often dangerous, use of seclusion and restraint; (4) medical

and nutritional neglect; (5) severe restrictions of communication with parents, lawyers, and advocates;

- substandard psychotherapeutic interventions and education by unqualified staff;
- failure to assess individual needs of residents;
- denial of full access by parents to their children in residence;
- financial opportunism and misrepresentations to parents by program operators; and
- financial incentives to educational consultants who serve as case finders and recruiters of families.

Investigations have been conducted of abuse and neglect at several private unregulated residential programs and lawsuits have been filed as a result; some lawsuits have led to criminal convictions of the programs' officials or expensive civil case settlements (Hechinger & Chaker, 2005; Dukes, 2005; Rock, 2005; Rock, 2004).

Some of the unregulated programs mislead parents to believe that creative programming that rises above regulation and above sound medical and psychological practices is necessary for their difficult children. Attractive advertisements, particularly on the Internet, are aimed at parents who are struggling to find help for their troubled children. Some parents make these placements at their own expense, without first seeking professional evaluations of the youth's problems, and the programs do not require professional assessment prior to placement. Some programs offer to connect the family with an escort service to transport a child whom parents anticipate would not otherwise choose to go to the program, which essentially means that two or more strong adults physically control the youth and force him or her to go along, either by car or by plane, to the treatment facility. In some cases, the parents have not seen the programs, which may be hundreds if not thousands of miles away from home, and they have no independent data, other than promotional material, to attest to the effectiveness of the programs. Many programs severely limit parental contact, by phone and visits, sometimes for as long as a year (Szalavitz, 2006). Last year, the American Bar Association Center on Children and the Law, using data reported by Rubin and Szalavitz, reported an annual estimate of 10 to 15 thousand American youth being placed by their parents in these privately run, unregulated residential facilities, which may also include boot camps or wilderness programs (American Bar Association, 2006).

## **REGULATION OF RESIDENTIAL PROGRAMS**

Policies regarding regulation of both public and private residential facilities are the responsibility of each state. These policies may be implemented by state legislation, regulation, or other administrative action. Although many states do oversee residential programs, in some states private residential treatment facilities for minors are not subject to regulation, or monitoring either as mental health facilities or educational facilities. Yet states regulate other private facilities, such as nursing homes, day care centers, hospitals, and restaurants. Depending on the state, failure to provide state oversight of residential programs for minors may occur because these programs (1) do not accept public funds; (2) are affiliated with religious organizations; or (3) describe themselves (inappropriately) as outdoor programs, boarding schools, or other types of nontreatment programs. In some cases, strong lobbying efforts by interested parties have contributed to creating and maintaining these exclusions. An additional problem in some states is that, although regulations exist, there is ineffective

monitoring of programs for compliance; this may be an issue of insufficient resources being assigned to monitoring, which ultimately is an issue of insufficient priority.

If a residential program advertises that it addresses behavior problems and calls itself a “therapeutic boarding school,” “emotional growth academy,” “behavior modification facility,” “wilderness program,” “boot camp,” or other similar terms, then it most likely should be considered a treatment program because it targets the social, emotional, and/or behavioral functioning of the children. Certainly some unregulated residential programs are reputable and likely could meet licensure requirements. However, other programs do not adequately provide for the safety and well-being of their residents and cannot meet such requirements, and it is these programs that are most concerning.

Another aspect of the problem is which state agency is responsible for the licensing and monitoring of residential programs for youth. In most states these oversight responsibilities are placed in a health and/or human services or education agency, where there is considerable understanding of protection, treatment, and education issues and of the developmental issues of youth. However, in some states, the oversight responsibility rests with law enforcement, where tendencies to accept a more punitive view of corrective programs may prevail.

### **BEGINNING TO ADDRESS THE PROBLEM**

The Alliance for the Safe, Therapeutic and Appropriate Use of Residential Treatment (A START) was initiated by the Louis de la Parte Florida Mental Health Institute at the University of South Florida to call attention to this problem and seek solutions that will protect children in these programs. A START now includes advisors who are leaders in psychology, psychiatry, nursing, mental health law, policy, and family advocacy, as well as people with direct experience as director, evaluator, parent, or participant in such programs. A START worked with the office of Representative George Miller, now Chair of the House Committee on Education and the Workforce, to host a press conference regarding these programs at the U.S. Capitol Building on October 22, 2005. Major national organizations which endorsed A START’s concerns include the American Psychological Association, American Association of Community Psychiatrists, American Orthopsychiatric Association, Child Welfare League of America, Federation of Families for Children’s Mental Health, National Alliance for the Mentally Ill, and National Mental Health Association. The National Conference of State Legislatures (NCSL) shares the belief that state policy is central to addressing this problem and has distributed information, prepared by A START, to the chairs of relevant state legislative committees to inform them of the issues (Herman, 2005).

In the past year, A START has highlighted the problems of private, unregulated residential treatment facilities through presentations at major conferences of professional and parent organizations (Friedman et al., 2006a; Pinto et al., 2006) and published papers in key professional journals (Pinto et al., 2005; Friedman et al., 2006b). To clarify, the focus has been on facilities that are not licensed and not operated by public or governmental systems but operate private, residential facilities for troubled or difficult children or youth under the age of 18. The focus therefore has not included public or private boarding schools that provide only education, nor has A START addressed concerns related to publicly run psychiatric facilities or private facilities that are licensed and regulated.

The American Bar Association, recognizing the failure of regulation in some states to cover all residential programs in the state, has passed a resolution (by the Association’s House of Delegates at their February 2007 meeting) concerning the use of unregulated residential

treatment facilities. The resolution “urges state, territorial, and tribal legislatures to pass laws that require the licensing, regulation, and monitoring of residential treatment facilities that are not funded by public or government systems, but are otherwise privately operated overnight facilities for troubled and at-risk youth under the age of 18” (see text following this article).

Bringing the problem into focus has been the first step. Efforts currently underway are described below. These include (1) an Internet-based survey of youth who have attended residential treatment programs and a similar survey for parents, (2) a pilot study of four states to gain understanding of the licensure issues and serve as a basis for a national, state-by-state study, and (3) a bridge-building task force of leaders in the child mental health field and directors of residential treatment centers to develop agreement about important elements in residential treatment programs.

### **YOUTH PERSPECTIVES ON RESIDENTIAL PROGRAMS FOR TROUBLED TEENS**

In response to reports of institutionalized abuse, one question that parents, professionals, and residential program operators often ask is, “How do you know that these are not just a few isolated incidents that have been blown way out of proportion?” Sometimes the question asked is, “Yes, but how do you know that these are not just the complaints of disturbed youth who have already tried to manipulate their families and the residential programs and now are trying to manipulate the public?”

As a means of getting better information, an online survey has been developed and posted to gather firsthand reports from young adults who attended residential specialty programs when they were adolescents. The survey is still active, so reports continue to be received. It has provided an opportunity for hundreds of former program participants to share their experiences and express their concerns. It is important that we listen to what they have to say. What follows is only a brief description of the preliminary findings.

#### **SURVEY METHODOLOGY**

Participants were recruited to participate in the survey through e-mail correspondence; links to the survey were posted on various Web sites. E-mail and Web site addresses were identified based upon previous contacts to gain understanding about services provided to youth in unregulated residential facilities for youth (Pinto et al., 2006). Prospective participants were directed to a description of the study on [surveymonkey.com](http://surveymonkey.com), and if they then consented online to participate, they were directed to the survey itself. Participants were informed that their responses would be anonymous and they would not be linked to their e-mail addresses. The survey was programmed such that it would only accept one completed survey from a given e-mail address. It is recognized that this may not be a representative sample of former program participants; however, it was not possible to identify such a representative sample in this type of survey. This sampling procedure did permit A START to gather information directly from many former program participants. Participants who had attended more than one alternative residential program were instructed to choose one program they had attended and to focus their responses on their experiences in this particular program. At the end of the survey, participants were provided with contact information for the National Disability Rights Network as an available resource and were provided with the principal investigator’s contact information in case they wanted to follow up with questions or concerns.

The survey comprised 194 questions regarding direct experience in residential mental health treatment programs. Questions were organized into sections focused on: (1) basic demographics and program identifying information, (2) the process leading up to program entry, (3) program participation, and (4) program effects. Questions were designed to gather information regarding the various aspects of residential care that have been highlighted as problematic in public media accounts, but efforts were made to ensure that questions were not framed in ways that would bias responses. The survey included a combination of forced choice and free-response questions.

## **SURVEY FINDINGS**

The survey was posted online in July 2006. The findings reported are for the first 3-month period and include responses of 500 individuals. For the purposes of the current analyses, individuals were included if they provided the name of the program they attended ( $N = 376$ ), and the program named was an unregulated therapeutic boarding school, emotional growth academy, or residential treatment program ( $N = 298$ ), rather than a licensed residential treatment center or a program of unidentifiable type. Of these individuals, only 5 reported that they had received the phone number of an advocacy organization to contact if they had any questions or concerns while participating in the program and 63 individuals provided no response to the question about access to an advocate. Responses from these individuals were removed as well, so that the sample for the current analyses included 230 individuals who attended a residential specialty program and who reported no or unknown access to an advocate while attending the program. This group of participants represents a group of especially vulnerable youth, as they were attending the types of programs that are likely to have no state oversight, and the youth were not formally advised about seeking help if they perceived themselves to be in danger while attending the program.

### **WHO ARE THESE YOUTH?**

The majority of the 230 respondents are White (87% Caucasian, 6% biracial/bicultural, 3% Latino/Hispanic, 3% Asian or other cultural identities) and the majority are female (68.6%). Half reported that their family income was \$100,000 or greater. Half reported that they had received a psychiatric diagnosis prior to admission to the program (50.4%). Almost a third reported that they had also been prescribed psychotropic medications prior to attending the program (31.3%). Slightly over half (57.6%) reported that they had tried services and supports in their home community before attending the residential specialty program. At the time when they were sent away, youth were most commonly living in the states of California (26.9%), Florida (7.3%), New York (6.9%), Texas (5.2%), Michigan (4.3%), or Washington (4.3%). Almost half reported that they were transported to the program by an escort service (47.6%) that involved strong adults who forced the youth to leave home and then, using force or the threat of force, accompanied the youth to the residential program.

### **WHAT ABOUT THE PROGRAMS?**

Respondents identified 58 programs in 21 states. Survey participants most frequently reported that they had attended a program in Utah (15.7%), Montana (13%), New York (10.8%), California (7%), or Georgia (5.7%). There were also a number of individuals who reported

that they attended a program outside the United States in Jamaica (12.2%) or Mexico (7%), and 4% reported attending programs in the Dominican Republic, Western Samoa, or Costa Rica. Lengths of stay in both the U.S.-based and foreign-based programs were extended; slightly over two-thirds (69.1%) reported that they attended the program for a year or longer.

## CONCERNS THAT EMERGED IN THE REPORTS FROM YOUNG ADULTS

### VIOLATIONS OF PATIENT'S RIGHTS

Many participants reported that they experienced patient rights violations. In addition to having no access to advocacy contact information, the majority reported that their mail was monitored (93%) and their calls were monitored (96%). Furthermore, the majority also reported that their letters or conversations were filtered, restricted, or interrupted (86%). As one participant explained, "They isolated you from your family back home. You had no way to freely contact anyone. They also enacted arbitrary bans to isolate you from friends/peers." Another reported, "I never spoke to my mom, or even touched a phone once during the 6 month stay in [*program name deleted*]. On Christmas you got to speak with your parents for 5 minutes and I did not get to talk to my mother because she was never informed of the call." And another: "As for the e-mails and letters, they read them as they came in, and before you sent them out. I wrote 7 letters to my mom before they would send one. It ended up being one big lie, because I could not tell her I was upset or that I hated it there. At the time, that was all I was feeling."

### MISUSE OF SECLUSION AND RESTRAINT

Many reported firsthand experience in seclusion (57%) or restraints (34%), and a number of participants witnessed their peers being placed in seclusion (45%) or restrained (60%). While the most commonly reported trigger for seclusion or restraint was aggressive behavior, especially aggression toward staff (87%), a number of behaviors that would never warrant seclusion or restraint in a licensed or accredited residential treatment center were endorsed as well, including breaking a program rule (67%), saying something disrespectful (52%), cursing (48%), or making a face (30%).

Many responses were similar to these:

They had a room with tile flooring where the kids went at 6:00 am until 10:00 pm, where each hour you would rotate positions. One hour would be lying on your stomach with your chin on the ground, the next position was standing on your knees for an hour and the next one was standing for an hour with your nose to the wall.

When participants were being "restrained", they were in fact being tortured. They would be forced face down on the hard tile floor by 3-6 staff members. One staff would "hold" your legs down, which usually meant they spent their time grinding your ankles into the floor. One or two other staff held your arms out at your sides, "held" in the same way the ankles were. The last staff would keep his knee in your back as he pulled up one or both arms behind your back to the point where you could literally touch your ear with the opposite hand from behind your back.

They would duct tape your hands behind your back then your legs together then wrap you up in a blanket like a burrito and duct tape that tighter so you couldn't move or get out. Sometimes it would be so tight kids would be screaming that they couldn't breathe and really start panicking. They made the students do this to other students.

Isolation is where you didn't see the sun or other people for weeks at a time, were given even more unrealistic exercise expectations, were more easily restrained, given less time to shower, and you were forced to lay on your face all day unless exercising, for 16 hours each day.

Note that none of these treatments or punishments are acceptable at any level in regulated programs.

## REPORTS OF INHUMANE TREATMENT

Beyond seclusion and restraint, there were multiple reports of various forms of inhumane treatment and abuse. Many participants reported that they had been required to participate in forced labor (71%), restricted access to the bathroom (68%), scare tactics (63%), and exposure to harsh elements like extreme heat, snow, or rain (60%). In addition, participants described experiences of excessive exercise (58%), food/nutritional deprivation (43%), sleep deprivation (41%), and physical punishment (31%). When asked whether they were ever emotionally, physically, or sexually abused by staff, a number of individuals reported that was often or sometimes true (45%). It should be noted that, although each of these practices violates current U.S. standards regarding the treatment of adults who are prisoners of war and detainees, they are occurring in youth residential facilities across the country, without oversight or accountability.

Here is one description that typifies the experiences reported by participants:

We would be forced to do pushups until some boys got hernias. We would be put into an 'iso' box exposed to extreme heat. We would be deprived of meals as a punishment. They used stress positions. They beat people with sticks and their fists and feet. They made kids carry trash and building supplies up and down the hill above the program. They made kids move piles of rocks for no reason. They would keep you up as a way to 'break' you.

## THE DISTRESS AND SUFFERING

Youth were clearly distressed and suffering. When participants were asked to rate how much they experienced a variety of feelings while attending the program (where responses included "not at all," "a little bit," "some," "a lot," and "don't know"), the majority endorsed "a lot" of feeling sad, stressed, angry, confused, hopeless, and scared; most participants reported feeling happy, loved, hopeful, and proud only "a little bit" or "not at all." In response to the question, "Would you recommend the program to others?," participants' responses included: "I still have bad dreams about it. I wake up shaking and nervous that I am there again. It has scarred me emotionally and I don't know if I will ever get over it;" "The program helped me realize what a sick sad world we live in;" "It was terrible. I was and still am horrified by the whole experience;" "It was a terrible place. Mentally scarring. I would hope NO ONE would ever have to go to a place like that. It's worse than jail;" "They abused me. That's what they do. They abuse people;" "I don't ever want another child to be so abjectly hopeless or so horribly abused. I don't ever want another family to be torn up when there is the possibility of being reunited and healed;" "There are better ways to deal with a troubled teen than send them to a school that abuses kids."

## WHAT CAN WE CONCLUDE?

Recognizing that the reports provided are retrospective and fully acknowledging that these accounts are not necessarily a representative sample of all youth who have attended



residential specialty programs, these findings nonetheless provide compelling evidence that widespread mistreatment is occurring and that youth are suffering in programs across the country. As for the question that parents, professionals, and program operators ask, here is a direct answer from one program participant:

Okay . . . I have a good idea of what you may or may not be thinking at this point. 'This guy's just some defiant little bastard who hates the world, and sees everyone and everything negatively!' Understandable, but whether you'll believe it or not, I'm not making this stuff up. I'm not just some pissed off kid who wants to whine. I'm a highly intelligent, well-educated, and responsible citizen, and as such a person, I know very well that my rights were totally and completely denied.

## **A STUDY OF FOUR STATES**

A study of four states was undertaken as a pilot effort for a larger, national state-by-state study through a partnership of four organizations: A START, based at the Florida Mental Health Institute; the American Bar Association Center on Children and the Law; the National Disability Rights Network; and the Federation of Families for Children's Mental Health. The 2-year study will involve (1) an in-depth review of state laws, policies, and practices regarding regulation and oversight of residential programs; (2) education of and technical assistance to state lawmakers and leaders to bring about needed policy reform; and (3) guidance for parents about placing children in residential centers. The preliminary findings from the pilot study are presented because, even with such a small number, it is clear that there are problems of state policy that contribute to the problem of mistreatment of children and their families.

## **STUDY METHODOLOGY**

While we acknowledge that there are several approaches to remedying the problems that are described above, we believe the wisest course of action is to first systematically gather information about how states handle the issue of licensure and regulation of residential treatment programs for minors, as well as information on monitoring and quality assurance requirements. In order to begin this process, we developed a brief protocol designed to elicit the desired information from state administrators responsible for licensure of these programs and for ensuring quality of care, state child mental health administrators, and other key stakeholders such as the protection and advocacy administrators. The protocol was designed as a telephone interview and was expected to take between 45 minutes and 1 hour to complete.

The study was conducted in Connecticut, Missouri, Utah, and California. These states were selected in order to achieve geographic diversity as well as diversity in size and history/experience in regulating residential programs for minors. Respondents were from the Protection and Advocacy agency, child welfare, education, juvenile justice, and mental health. We intended to assess: (1) the degree to which respondents were knowledgeable of the regulations and the monitoring process and the degree to which they agreed with each other and (2) the extent to which there were laws, regulations, and policies in place to address this issue. As the intent was to get an overview of what problems might exist regarding regulation, rather than to determine which states did this well or badly, the findings are not reported by specific state.

## STUDY FINDINGS

Most respondents deferred to the individual who was in charge of licensing for the state. In some states, representatives from other agencies did not seem to have a working knowledge of how programs were regulated. The person with this responsibility was variously located in child welfare, social services, or human services. In general, the child mental health administrators were less familiar with the state regulations governing licensure and monitoring and did not see this as part of their domain. Representatives from the Protection and Advocacy agency saw this as an important issue, but had not become directly involved.

All four states had legislation requiring the executive branch to issue rules/regulations regarding the operation of residential treatment facilities for minors. However, there was variance as to which kinds of programs the regulations applied. In one state, the rules applied only to facilities in which a governmental agency placed youngsters. In some states, there was an attempt to define levels of residential care, with more stringent treatment standards applying to the most restrictive group homes and community treatment facilities.

All four states reported that there are several pathways to residential placements for minors. Placement could occur through social services/mental health (into therapeutic foster care, group homes, community treatment facilities, or hospitalization); juvenile justice (into boot camps); special education; and private placement. Respondents also stated that licensing and monitoring of juvenile justice, mental health, and special education residential programs were the purview of their respective agencies. None of the states were able to report how many children were placed privately by their parents or how many children were placed out of state by local agencies or by parents, nor was there any attempt to monitor the effectiveness of those placements.

Programs were able to opt out of the licensing requirements established for the purpose of providing mental health treatment in facilities for minors in several ways. In some states, if the programs were considered to be religious institutions, they were exempt. Also, in some states, if a program accepted only private placements, it did not require licensure. In some states, if a program defined itself as a boarding school or educational facility, it could be exempt from regulation, even though the services provided were described as “emotionally corrective” or “therapeutic.”

Despite the plan to describe the states with anonymity, it is important to mention Utah, a state that has had substantial problems with questionable programs existing and being exempt from regulation. In 2005, the state legislature amended the licensure law to ensure that all programs, except legitimate private residential schools, be subject to state regulation and monitoring (Utah Legislation, 2005). The rule-making process took over a year, which is not unusual given the importance of public review and comment. Commendably, Utah is now implementing its new, more stringent regulations that address how programs will be included in licensure requirements and will be monitored for compliance with those requirements. Although it is too early to understand the impact of new regulations in Utah, this state certainly bears watching.

All four states reported that they have in place regulations establishing standards for treatment services, educational services, and child care/supervision; however, as noted above, these requirements do not apply to all programs in the state. The basic requirements included such elements as (1) each child must have an individualized treatment plan and (2) the provider must be able to meet the needs identified in the plan. Monitoring includes assessing (1) the individualized treatment plans, (2) the individualized educational plans, and (3) requirements to assess quality of services. In some of the states, there were

requirements related to child care and supervision but these treatment aspects were not specified except for the higher end, more restrictive programs.

For programs to which the rules and regulations apply, all four states reported that specific rules regarding children's rights, parental rights, punishment, and use of seclusion and restraints are in place. All four also stated that there are procedures in place for reporting abuse. These included reporting abuse to a child welfare hotline and requiring that abuse laws be posted in every facility. Children must have access to a phone and employees of residential programs must be trained about the different kinds of employee behaviors that are not permitted.

While all four states have established licensure requirements and standards for at least some types of residential treatment facilities providing services to minors, their ability to monitor compliance was of concern. Some states monitor compliance with requirements which govern such things as staff qualifications, staffing patterns, and number of hours of psychotherapeutic service per week per child.

In some states, following application for licensure, there is an on-site review of requirements and interviews with staff and management. There may be unannounced licensing monitoring visits, as frequently as quarterly. There may also be a requirement for an annual inspection, which comes with the renewal process. On-site visits may also be made if a complaint is made, either from staff, clients, family, or citizens. However, respondents reported that monitoring is compromised by the number of staff who do the job. In one state, the monitoring agency is staffed to visit a 10% random sample of licensed facilities, and this is not as frequent as once per year. States vary in whether they provide licensing and monitoring at no cost to the program or whether they charge to cover these services.

## **STUDY CONCLUSIONS**

While we recognize that four states are too small a number upon which to draw conclusions, it was apparent that there is an absence of data about how effective current laws are. Most agency respondents deferred to the person who was in charge of licensing and did not see licensing or in some cases even the monitoring of quality of care delivered as part of their responsibility. There appeared to be an assumption that providers will obey the laws, but there were no safeguards in place to protect children who are placed privately by their parents. Staff from the responsible state agencies is already stretched in its ability to monitor the safety and the effectiveness of the quality of care delivered for the children already in their custody.

## **BUILDING BRIDGES WITH RESIDENTIAL TREATMENT CENTERS**

The concerns about state policies regarding residential treatment have been supported by a related development. The Child, Adolescent, and Family Branch of the U.S. Center for Mental Health Services convened a meeting in Omaha, Nebraska in June 2006 to address the historic split between providers of residential care for children with mental health challenges and advocates for home and community-based care within systems of care. The meeting brought together representatives from the federal, state, and local level, youth and family advocates, system of care council members, tribal representatives, providers of service, and representatives of national associations related to children's mental health and to residential care. Although residential programs which lack oversight were not represented, the agreements that emerged should serve to inform parents, professionals who provide

referrals to residential treatment programs, and the operators of residential programs—good and otherwise—of the expectations that constitute good care and treatment.

The purposes of the summit were to identify areas of agreement in values and philosophies between the different groups, to identify emerging best practices in linking and integrating residential services with home and community-based services, and to set the stage for strengthening relationships and services partly by developing a joint statement about the importance of creating a comprehensive and integrated service array and partly by creating action steps for the future.

The sponsoring organizations involved with residential care were largely representative of well-established not-for-profit licensed residential programs rather than the unlicensed and unregulated, for-profit programs that have been the primary concern of A START (Friedman et al., 2006a; Friedman et al., 2006b). However, the summit was of direct relevance to the concern of A START about protecting children in residential settings and enhancing the availability of a wide range of supports and services for children and families.

The summit did result in the beginnings of a “joint resolution to advance a statement of shared core principles” which was then distributed to participants and modified over a period of several months. This resulted in a final product, which was distributed by Dr. Gary Blau, Chief of the Child, Adolescent, and Family Branch of the Center for Mental Health Services, on September 14, 2006, with a request for individual, agency, and/or organizational endorsement. This process of securing endorsements is still ongoing.

As indicated in the preamble to the resolution, the call is for “a comprehensive, flexible, family-driven and youth-guided array of culturally competent and community-based services and supports, organized in an integrated and coordinated system of care in which families, youth, providers, advocates, and policymakers share responsibility for decision making and accountability for the care, treatment outcomes and well-being of children and youth with mental health needs and their families” (Child, Adolescent, and Family Branch, 2006, p. 1). The joint resolution acknowledges the need for 24-hour out-of-home treatment settings but indicates that within such settings children and youth should have a developmentally appropriate role in their care and in creating rules and that family members should be viewed as partners and have open access to the setting.

In the section on “Clinical Excellence and Quality Standards,” the joint resolution calls for ensuring “that all treatment services are licensed and regulated by appropriate agencies, and that monitoring is performed by well-trained individuals (including families and professionals) whose values are consistent with the principles articulated in this resolution” (Child, Adolescent, and Family Branch, 2006, p. 5). It also indicates in this section that programs should strive to eliminate coercive interventions such as seclusion, restraint, and aversive practices and that visits between families and children should not be restricted for punitive purposes.

The document offers a set of values, principles, practices, and standards that, if implemented, would go a long way to addressing the concerns about the protection of children with mental health challenges and the pattern of sending children hundreds if not thousands of miles from home to unlicensed programs which reduce their contact with their families. The document provides important guidelines for policy makers and advocates who are seeking to develop a comprehensive, integrated system and also for policy makers who are seeking to develop or strengthen licensing and monitoring procedures to ensure that children are treated safely, that they and their families have an appropriate voice in their treatment, and that the use of coercive and aversive practices is eliminated. Over the next several years, if the values and principles of this joint resolution are not only endorsed but,

more importantly, put into practice, they will go a long way toward ameliorating the risk that children and families are now encountering because of unlicensed and unregulated programs that are highly coercive and aversive in their practices.

### THE IMPORTANCE OF ACTION: NEXT STEPS

The abusive and deceitful practices described in this article are unconscionable and cry out for remedial action. The following actions are recommended for questionable practices, to eliminate programs and protect against further harm to vulnerable children and families:

- Identify programs that engage in the practices described above. Monitoring the Internet is one way of identifying them; this effort could be undertaken as a project of an organization involved in the protection of youth and advocacy for them. An additional way to identify programs is by locating children and families who have had negative experiences. Several Internet sites, used by youth, provide for information exchange with a focus on experiences in residential programs. The information collected should be organized to allow for systematic review. Similarly, the analysis of data from the current, ongoing Internet-based survey of youths' experiences in residential programs (Pinto et al., 2006) should continue to include a focus on identifying programs that do not meet quality standards for care.
- Identify states that do not license or regulate the operation of residential programs for youth or that otherwise tolerate the existence of programs with questionable practices. The proposed national, state-by-state study described above should provide good information to help states address needed policy changes. Individual state legislators, state legislative committees, and ultimately each affected state's legislature must be aware of how their laws and policies govern the existence of these programs and take necessary actions regarding licensure, regulation, and monitoring to assure appropriate care and safety for the youth they purport to serve.
- Advocate with the National Conference of State Legislatures to address these practices nationally and offer guidance to the states to strengthen oversight of residential programs.
- Work with Congress to address the existence of these programs, including those that operate outside the country, and determine whether federal action is appropriate to assure that vulnerable children are not harmed and that parents are not paying exorbitant prices for programs that are ineffective at best.
- Promote the 2006 "Recommendation from the ABA Youth at Risk Initiative Planning Conference" with all legislative bodies to "[p]rohibit operation of unlicensed, unregulated residential treatment facilities that operate programs whose efficacy has not been proven empirically, such as boot camps, tough love, and 'scared straight' programs, and require the closing of such facilities. The law should provide for such facilities to be replaced with: better access to preventative services, with a focus on family involvement and community-based resources, wherever possible; and carefully regulated 'residential treatment facilities' that are reserved for youth whose dangerous behavior cannot be controlled except in a secure setting."
- Urge vigilance by juvenile probation officers and other court officials, including lawyers and judges, as well as mental health, education, substance abuse, and other professionals who encounter troubled young people, in identifying youth who are at

risk of being placed in one of these treatment facilities; encourage them to engage the youth and parents in a discussion regarding better options; impress upon them the necessity of parental involvement in the youth's treatment; and identify to them the safety risks and the costs associated with programs that promise a quick fix or an unorthodox fix.

- Create a coalition of national advocacy and legal organizations, mental health organizations, and professional organizations that promote the well-being of children to demand state and national action regarding the degrading and demeaning practices to which children in these unregulated programs are subjected.
- Inform civil rights and tort attorneys of the practices in which these programs engage and encourage them to take legal action against them.
- Also inform attorneys who represent youth in juvenile court proceedings of the risks these programs pose to their young clients and of more appropriate, evidence-based alternatives. Ensure that attorneys have ready access to the National Council of Juvenile and Family Court Judges' "Delinquency Guidelines."
- Ensure that schools are cognizant of the risks that face youth who are placed in these programs and that they disseminate information to parents about child and adolescent behavior and the best available treatment programs for youth whose behaviors require intervention. School psychologists, social workers, and counselors must likewise be well informed about alternatives, ideally evidence-based programs.
- Disseminate widely best practices that address diagnostic and treatment issues and placement issues with the collaboration of state mental health, child welfare, education, and juvenile justice agencies and by the U.S. Departments of Health and Human Services and Justice to those involved in the care, treatment, and education of youth. This information should also be disseminated by parent organizations and other sources of information for parents.

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