OUTCOMES IN CHILDREN’S RESIDENTIAL TREATMENT CENTERS:

A NATIONAL SURVEY

AMERICAN ASSOCIATION OF CHILDREN’S RESIDENTIAL TREATMENT CENTERS
Allendale Association
Archdeacon Gilfilian Center
Buckeye Ranch
Casa Pacifica
Children’s Center, Inc
Children’s Home & Aid Society of IL
Eastern Oregon Adol Multi-Treatment Center
Eau Claire Academy
Five Acres
Forest Heights Lodge
Graham-Windom Services to Families & Children
Graydon Manor
Green Chimney’s Children’s Services
Harmony Hill School
Jewish Child Care Association
Julia Dyckman Andrus Memorial
KidsPeace
Klingberg Family Center
Lawrence Hall Youth Services
Leroy Haynes Center for Children & Family Services
Linden Hill RTF
Lutheran Child and Family Services
Mercy Home for Boys and Girls
Methodist Youth Services
Midwest Center for Youth & Families
Orchard Place
Provo Canyon School
Secret Harbor School
Southern Oregon Adol Study & Treatment Center
St. Joseph’s Home for Children
St. Joseph’s Villa of Rochester
St. Vincent Center
Tamarack Center
The Children’s Center
The Children’s Home
The Christie School
The House of the Good Shepherd
The Spurwink School
The Sycamores
Three Springs, Inc.
Villa Maria
Vista Del Mar Child and Family Services
Woodbourne Center
Yellowstone Treatment Centers

Thanks to these AACRC member agencies who provided support for this project.
In response to the increasing pressure to track children’s services outcomes, a national survey of residential treatment centers (RTCs) for children was commissioned by the American Association of Children’s Residential Centers (AACRC). In the spring and summer of 1999, ninety-six RTCs from 33 states with a combined 7,544 bed capacity responded to a detailed survey on outcomes.

The findings illuminate how residential treatment providers are responding to the demand for increased accountability. This “snap shot” shows the level of effort spent on data collection and analysis, what kinds of data are tracked, how the data is used, and to what extent it is helpful.

*We found that*—

- Residential treatment centers do capture data about their programs.
- Data collection does change programs and services for the better.
- Meeting accreditation requirements and improving services propels data collection.
- RTCs are investing in staff and technology for program evaluation purposes.
- More resources must be dedicated to outcome research for children and youth.
Benefits of treatment for children and youth in residential settings are under increased scrutiny as a result of powerful market forces that require shortened lengths of stay, reduced out-of-home placements, and performance-based contracting. Measurement approaches are shifting from symptom reduction to longer-term life changes that keep children at home, in school, and out of trouble.

This AACRC survey addresses the areas outlined by the Outcomes Roundtable for Children and Adolescents (SAMHSA 1996,1998). We have organized the presentation of results around what we learned.

- The kinds of data RTCs collect.
- What drives data collection efforts.
- The benefits of these efforts.
- The resources RTCs devote to data collection and analysis.
- RTC demographics — size, population served, services offered, accreditation status, and referral/payer sources.

We found that RTCs face numerous obstacles to collecting and analyzing data. Barriers include lack of time, resources, priority setting, commitment, and technical support. We also learned that despite these obstacles, more and more RTCs are tracking key indicators of performance.
It is our hope - and that of the American Association of Children’s Residential Centers - that the information provided here will stimulate additional discussion about outcomes in children’s services and will motivate RTCs to assess the effectiveness of what they do and share what they learn with others. For example, the significant finding that 80% of children/youth receiving residential services graduate to lower levels of care should be shared with policy makers and payors.

In this era of managed care and accountability, the very survival of residential treatment as a viable service option may depend upon the field’s willingness to track results and to make themselves accountable to all stakeholders in the children’s services system.

Steven E. Elson, Ph.D.,
Research and Education Committee Chair, AACRC
Executive Director,
Casa Pacifica
Camarillo, California

Leslie A. Murtagh, MS,RN,CS,CPHQ
Consultant
Director of Clinical Services
Wyoming Behavioral Institute
Casper, Wyoming
Residential treatment centers (RTCs) use multiple indicators to monitor their performance.

Of seventy-one performance indicators/evaluation tools identified, we asked RTCs to tell us how many they used. All RTCs participating in this survey use a number of different measures to monitor performance. On average RTCs track 24 measures of performance and/or outcomes.

- 25% up to 55
- 50% up to 25
- 75% up to 17
- 100% up to 16
Data is collected and analyzed for quality assurance/improvement rather than to track client outcomes.

Residential treatment centers have focused their primary attention on quality improvement and program performance. Preferred indicators track client safety, client satisfaction, and quality improvement rather than the results or outcomes of treatment.

We asked RTCs to identify the outcome measures/performance indicators they use.

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical incident trending</td>
<td>82%</td>
</tr>
<tr>
<td>Client/family satisfaction</td>
<td>80%</td>
</tr>
<tr>
<td>High risk behaviors</td>
<td>75%</td>
</tr>
<tr>
<td>Compliance with medication</td>
<td>74%</td>
</tr>
<tr>
<td>Length of stay</td>
<td>72%</td>
</tr>
<tr>
<td>Use of physical containments</td>
<td>71%</td>
</tr>
<tr>
<td>Client/family complaints</td>
<td>71%</td>
</tr>
<tr>
<td>School attendance</td>
<td>71%</td>
</tr>
<tr>
<td>Elopement (AWOL)</td>
<td>70%</td>
</tr>
<tr>
<td>Q.I. projects</td>
<td>60%</td>
</tr>
</tbody>
</table>
However, RTCs do measure client progress during treatment.

We asked RTCs what data they gather to help assess a client’s progress. Measures tend to cluster around symptom reduction, behavior change, and improvement in social functioning. Although employed less frequently than individual performance indicators, RTCs identified thirty-three standardized evaluation tools. The most frequently used instrument was the Child Behavior Checklist (55%) followed by the Child and Adolescent Functional Assessment Scale (52%).

Only individual child data sources collected more than once during treatment are included in the list below. Typically, these are administered/collection upon admission, at intervals during the course of treatment, and when services are terminated.
But, only about one third routinely collect post-discharge follow-up data.

Because gains made during the course of treatment is a poor predictor of long term success, assessment of treatment requires long-term post-discharge follow-up.

However, only 11% of all RTCs track children for more than six months after discharge.
RTCs collect data to improve services and to comply with external agency requirements.

When asked what motivates data collection and analysis, ratings are heavily skewed toward improving services. However, “accreditation body requirement” is the single most important reason for tracking performance indicators and using standardized instruments. As the pie chart below indicates, nine of ten agencies participating in this study are either accredited by a national accrediting body or are pursuing accreditation.

We asked: “Why do you collect data and what do you do with it?” with 1 being “of no importance” and 5 — “very important.”
They overwhelmingly believe that data collection efforts are worthwhile.

Four of five RTCs indicate that data collection and analysis helps them to:
- improve their programs,
- garner staff and Board “buy-in,” and
- market their services.

However, even while indicating that efforts are worthwhile, 18% stated it is too early to tell if they would benefit from data collection efforts.

A surprising 15% told us that data collection efforts had a negative impact on their agencies. The theme that seemed to pervade this response is that increased paperwork takes time away from clients. Ironically, these same RTCs felt that data helps them improve treatment efforts.

We asked: “Did/does the data change your programs and services for the better?”

![Bar Chart]

- YES 88%
- NO 12%
However, outcome evaluation efforts are not where RTCs want them to be...

Most RTCs are not satisfied with their current data collection and analysis efforts. They are frustrated by the lack of resources, which they define as money and technical support.

Only one in five is satisfied with evaluation efforts. This level of satisfaction corresponds with those who believe they have sufficient resources to support data collection and analysis and/or who have effective quality improvement/assurance programs. We hypothesize that this satisfaction level does not extend to follow-up efforts, though we did not ask that question.

Based on their experience with data collection and analysis RTCs advise others to:

- keep it simple,
- involve stakeholders in the design,
- listen to the needs of consumers of the data,
- make what data is collected relevant, and
- provide timely feedback.
...but, RTCs are beginning to invest seriously in data collection and analysis efforts.

On average, 1.0 full time equivalent position is dedicated to data collection and analysis including scoring and data entry. In about three-quarters of RTCs the person who has oversight of this function is assigned primary responsibility for other, unrelated activities.

Yet despite limited person power, agencies are beginning to invest in computer hardware and software. Two-thirds of all RTCs have computerized management information systems and about half of these are clinical charting programs through which data (performance indicators) can be aggregated and analyzed. Thirty-five percent state that they use their electronic systems to track outcomes.

Generally, about 1% of a RTCs annual budget supports outcome evaluation. We asked: “Does your RTC have sufficient resources to support comprehensive data collection and analysis?”

![Bar Chart]

NO 61%
YES 39%
Most RTCS participating in this survey are single sites with long histories.

Two-thirds of RTCs operate a single, campus-based program with an average of 57 beds. About a third are multi-site programs with an average of 118 beds. One in seven - whether a single campus or multi-site - operates residential services in the community (group homes) to complement the campus program.

The average time of operation is 48 years though with significant variation - the median “age” is 32 years with a standard deviation of 39 years. Though we did not ask the question, it appears that, in many cases, orphanages transitioned into treatment centers to keep pace with the changing needs of children and society.
Almost two-thirds serve both boys and girls.

The total number of residential treatment beds represented in this survey is 7,544. About two-thirds of the beds are devoted to boys (68%) and one-third to girls (32%).

Most RTCs (61%) serve both boys and girls. About one third treat only boys and they are divided evenly between those serving latency age boys (4-12 years old) and those serving adolescents (13-17). Only three percent are exclusively girl's programs and all are for adolescent girls.
A disproportionate share of clients are minorities.

Although slightly over half of children and youth in residential treatment are white non-Hispanic, minorities are over-represented. African-Americans make up almost one third of the total population while one out of every ten children is Hispanic. Those indicating “other” listed biracial and Russian youth.
Common reasons for placement are severe emotional disturbance, aggressive/violent behavior, and family/school problems.

We asked: “Give the three most common reasons for placement.”

Reasons in order of frequency tend to cluster around clinically diagnosable conditions, aggression, and problems with family and/or in school or the community.

- **SEVERE EMOTIONAL DISTURBANCE** – clinical depression, post traumatic stress disorder, mood disorders, anxiety disorders, attachment disorder, and self-destructive behaviors.
- **AGGRESSIVE/VIOLENT BEHAVIORS** – oppositional & defiant behaviors, conduct disorder, assault, and other forms of physical aggression including self-injurious behavior.
- **FAMILY/SCHOOL/COMMUNITY PROBLEMS** – inability to function at home, in school, or in the community; family dysfunction, placement failures, needing an alternative to juvenile justice and drug use/abuse.
- **ABUSE** – physical, sexual, or emotional abuse.
Prior to placement most children/youth were in “congregate care” settings...

Six of every ten children/youth in RTCs are placed directly from a “congregate care” living arrangement and most of these come from settings that are either more restrictive (hospital, juvenile detention center) or as restrictive (another RTC) as the residential treatment setting into which they are placed. Only 26% come directly from home while 18% have most recently been in a foster home.

Boys tend to stay about a month longer in residential care (13.6 months) than girls (12.3 months), though both average over a year in placement. However, the length of stay includes a wide range from slightly over a month (shelter-focused program) to nine years.

Children/youth come from one of the following settings immediately prior to placement.

- Home - 25.6%
- Foster home - 18.5%
- Group home - 8.6%
- Another RTC - 13.5%
- Hospital - 18.3%
- Juvenile hall or emergency shelter - 15.4%
...but they are discharged to lower levels of care, most go “home”.

Eight of ten children/youth are discharged from RTCs to a lower level of care with most going home, to a foster home, relative home, or adoptive home. Indeed, the most likely living situation after discharge is home with biological parents.
RTCs employ staff from a wide range of professional disciplines...

In terms of licensed/certified professionals most RTCs procure the services of psychiatrists, social workers, nurses, and teachers. However, the most widely used discipline is “child care worker.” Those who do not use childcare workers indicated that they employ psychiatric technicians.

We asked: “Check the professional disciplines of staff working in your RTC.”
...and provide a broad mix of assessments, therapies, specific training, and academic instruction.

Clearly there is a strong belief in that assessment is a critical component of treatment. More than any other single activity, RTCs assess their clients on a variety of dimensions – education, level of functioning, psychiatric needs including the need for medication, and family functioning.

A set of simultaneous therapeutic activities forms the core of the RTCs treatment program. Direct training/education on a variety of life management topics are also offered by most RTCs. In addition, special education and academic achievement is a strong focus in residential programs.

We asked: “Check all of the services you provide for youth and their families.”

- medication assessment – 96%
- individual psychotherapy – 96%
- psychiatric evaluation – 95%
- family assessment – 92%
- special education/classroom instruction – 91%
- academic testing – 89%
- group psychotherapy – 88%
- recreational therapy – 86%
- family psychotherapy – 85%
- milieu therapy – 83%
- psychological testing – 81%
- extended school year – 80%
- sex education/STD/HIV instruction – 74%
- drug & alcohol education – 69%
Services RTCs tend not to offer include detoxification, respite care and job placement.

Not a single RTC offers detoxification and only one in four offers respite care. The lack of job placement services may suggest that RTCs tend to serve younger or more seriously emotionally disturbed children who are not prepared to take advantage of such services.

Services provided by the least number of RTCs are:
The most frequently identified program orientation is cognitive behavioral/behavioral.

The second most common program orientation is eclectic – those who (a) describe themselves as eclectic or (b) who report that their program is based on a number of different theoretical approaches. Virtually all eclectic programs have a psychodynamic component.

Regardless of theoretical orientation, half of the programs indicate strong family involvement/participation.

We asked: “Briefly describe the program orientation for residential treatment.”

- Cognitive behavioral: 31%
- Behavioral: 9%
- Eclectic: 30%
- Psychodynamic: 7%
- Psycho-educational: 6%
- Family systems: 3%
- Attachment theory: 3%
- None indicated: 4%
The main referer and payor is The Department of Social Services/Child and Family Services.

We asked RTCs to tell us their referral patterns over the last two years. Slightly over half of all referrals come from State Departments of Social Services/Child and Family Services while one in five come through Departments of Mental Health or schools. Other referrals include Departments of Probation and private insurance.

Departments of Social Services fund over two-thirds of RTC costs. Mental Health and public schools together provide about one out of every six dollars. Other payors are defined as “courts, adoptions, drug and alcohol” funds. Private contributions provide about 3% of costs while other public agencies fund the balance of the costs.
Most RTCs provide some aftercare services though funding is problematic.

Two of three residential treatment centers stated they provide aftercare services defined as case management, family support, and outpatient services.

The survey did not ask whether aftercare is offered on a voluntary basis or provided to all graduates. Funding for aftercare services suggests that services are provided only to those willing to take advantage of it.

We asked: “How are your aftercare services funded?”

- 44% separate contract with placing agency
- 23% grant/private funds
- 19% third party reimbursement
- 8% other funding
- 6% not funded
Methodology

The findings are based on 96 survey respondents located in 33 different states and Canada. Total bed capacity represented in this survey is over 7,500. We mailed 400 surveys to members of several national associations: the American Association of Children’s Residential Treatment Centers, the Child Welfare League of America, the National Association of Psychiatric Services for Children, and the National Association of Homes for Children. In a cover letter we asked agencies to respond only if they operated a residential treatment center as defined below. Using descriptive data from the national associations we assume that only two-thirds of those receiving the survey operated an RTC. Consequently, we estimate the response rate to be 36%.

The survey instrument was a specially developed questionnaire divided into seven sections with more than 200 data elements. The survey asked:

- Who are you?
- Whom do you serve?
- What services do you provide?
- What kinds of data do you collect?
- How is your data collection effort organized?
- Is the data collection effort useful?
- Why do you collect data and what do you do with it?

**RESIDENTIAL TREATMENT CENTER:** An organization whose primary purpose is the provision of individually planned programs of mental health treatment, other than acute inpatient care, in conjunction with residential care for seriously emotionally disturbed children and youth, ages 17 and younger. It has a clinical program within the organization that is directed by a psychiatrist, psychologist, social worker or psychiatric nurse who has a master’s degree or doctorate. The primary reason for the admission of more than half the clients is serious emotional disturbance/behavior disorder that can be classified by the DSM-IV, other than moderate to severe mental retardation or developmental delay.

— Adapted from the Center for Mental Health Services, SAMHSA
The American Association of Children’s Residential Centers (AACRC), is a non-profit membership organization founded in 1957. AACRC is dedicated to promoting high quality research and innovation in the practice of residential treatment for emotionally disturbed children.