CHCS Center for Health Care Strategies, Inc.

Issue Brief

System of Care Approaches in Residential Treatment Facilities Serving Children with Serious Behavioral Health Needs

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Providing an appropriate continuum of mental health services for the estimated one in five children and adolescents in the U.S. who have a mental health disorder is imperative.[1] While it is well established that such services should emphasize community-based care,[2] children and youth with challenging behavioral health problems are often placed instead in residential treatment facilities (RTFs). Those in residential treatment settings can benefit from a system of care approach that facilitates coordination between residential and community-based providers and engages youth and their families as partners in care.

A system of care is a strengths-based approach that recognizes the importance of family, school and community, and addresses the physical, emotional, intellectual, cultural, linguistic and social needs of every child and youth. Through this approach, families and youth work with public and private organizations to design a coordinated network of community-based services and supports — improving functioning at home, in school, and in the community.[3] The federal *Comprehensive Community Mental Health Services Program for Children and Their Families* has funded systems of care for children's mental health in states, tribes and communities across the country, with demonstrated improvements in behavioral and emotional health.[4]

Insufficient home- and community-based options, financial incentives that drive residential placements, and reduced use of inpatient psychiatric care all contribute to increases in the use of RTFs.[5] Accordingly, it is vital to understand how these facilities are delivering mental health services to children and youth to begin to address questions about RTF overuse, lengths of stay, long-term effectiveness, and adoption of evidence-based principles of care.[6]

This paper describes the findings of a national survey of RTFs that serve children and youth with serious behavioral health challenges. The survey sought to identify the extent to which:

- System of care principles are reflected in the policies and practices of RTFs; and
- Residential treatment is providing home- and community-based services and supports in addition to traditional offerings.

Survey findings are particularly relevant to Medicaid and other public purchasers of residential treatment, given the high cost of residential care, its history of overuse, and the potential for home- and community-based services to reduce inappropriate RTF placements and lengths of stay. The findings can also inform child behavioral health policymakers, RTF providers, and child and family advocates seeking promising approaches to better meet the extensive behavioral health needs of children and youth in this country.

The intent is that these findings catalyze discussion among these constituencies to increase incorporation of system of care principles and practices throughout the continuum of care, particularly in RTFs, where they are needed most.

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Survey Partnership

While systems of care emphasize home- and community-based services, their growing use has coincided with increased reliance on RTFs — driving tension between advocates of community-based and residential care. The reasons are many, including limited resources, differing philosophies, and a lack of research demonstrating the effectiveness of residential treatment. Based on mutual concern about these issues, the Child and Family Branch of the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS), the Annie E. Casey Foundation, and the Center for Health Care Strategies (CHCS) engaged Mathematica Policy Research to conduct this survey.

This effort follows CMHS' *Building Bridges Initiative*, launched in 2006 to create partnerships and improve relationships among residential and community service providers, families and youth. The *Building Bridges Initiative* encourages community-based and residential providers to better communicate and coordinate their services within a system of care framework.[7]

Survey Methodology

Development of the Survey of Residential Treatment Facilities ("RTF survey") was guided by an advisory panel of parents, youth, RTF directors, policymakers, advocates, researchers, and other community-based providers, as well as key-informant interviews. Survey items were designed to gather information on RTF: (1) characteristics; (2) values and principles; (3) treatment and assessment practices; (4) workforce needs; (5) cultural and linguistic diversity; (6) relationships with other providers; and (7) financing.

The RTF survey was distributed from April through June 2009 to individuals (primarily RTF directors) who had completed the 2008 SAMHSA National Survey of Mental Health Treatment Facilities (NSMHTF).[*] The NSMHTF included 741 facilities that provide 24-hour residential treatment to children and adolescents age 17 or younger. For those directors responsible for more than one RTF, one facility was selected randomly to avoid overburdening the respondent and/or over-representing any one organization in the findings. This reduced the number of eligible facilities to 611.

Each RTF director received an email invitation to complete an online survey (a paper version was also available), requiring approximately 30 to 45 minutes to complete. Respondents did not receive compensation or an incentive to complete the survey. Non-respondents received up to four reminder emails and two telephone calls to encourage participation. Sixty-seven individuals (11%) who were invited to complete the survey responded that their facility does not provide residential treatment and/or does not serve children or adolescents. Among those remaining (n=544), 293 (54%) completed the survey. This paper reports on their responses.

NSMHTF data revealed no statistically significant differences between facilities responding and not responding to the RTF survey in terms of the number of children and youth served, type of ownership, religious affiliation, accepted forms of payment, or provision of free treatment. Fifty-six percent of those completing the RTF survey are directors of non-profit facilities, and 44% direct for-profit facilities.

Highlights of Survey Results

Survey results indicate both evidence of and opportunities for improvement in the incorporation of system of care values in RTF policies and practices, and an orientation to community-based care.

[*] RTFs that operate under the auspices of child welfare were only included in the NSMHTF if they offer mental health treatment services.

Most respondents — largely private non-profit or commercial entities — provide a range of residential and non-residential mental health services for children and youth; a few also provide substance abuse services; and many report providing trauma-informed care.[†] The vast majority report mechanisms in place to ensure appropriate residential placement, yet only about half work with referring agencies to determine whether alternative programs might be more appropriate. While nearly all develop individualized treatment plans, the role of youth and families in creating these plans varies greatly, and very few provide family or youth peer support. Staff recruitment and retention is challenging, and only a few respondents believe that their staff has a solid understanding of youth-guided and family-driven principles. RTFs largely report having policies to reduce seclusion and restraint, though most had used the practice in the previous year. About half of RTFs do pre-discharge planning to transition children and youth from their facilities, and a similar proportion assist youth with the transition to adult services. Staff training on the use of culturally competent services and supports is almost universally provided, but application is uneven and some important cultural groups are rarely addressed. Fewer than half of RTFs collect outcomes data, and not for very long following discharge. Additionally, most RTFs surveyed receive Medicaid and child welfare funding, however very few have performance-based contracts.

Detailed Survey Findings[‡]

Description of Facility Types

Survey results reflect the trends of decreasing government ownership of residential beds for children and increasing commercial and non-profit ownership. Eighty percent of reporting RTFs are owned by private partnerships or corporations; only 5% are government-owned.[§] Among non-government owned RTFs, 83% are non-profit or not-for-profit, and 16% are affiliated with a religious organization. Respondents described their primary service area as mental health (68%); substance abuse (4%); a mix of mental health and substance abuse (17%); and other (11%).

Over the past decade, RTFs increasingly have diversified their service offerings,[**] a trend borne out by the survey results. Sixty-six percent of respondents report that they provide both residential and non-residential mental health services. The reporting facilities encompass a range of nine to 100 beds (median=38, mean=48).

Licensing and Accreditation Status

Given the growing federal emphasis on health care quality and accountability, the survey explored facility licensing and accreditation. Most reporting RTFs are licensed by either the state mental health authority (59%) and/or the state department of health (48%), and 79% have some national accreditation. Fifty-three percent are licensed or certified as a psychiatric residential treatment facility according to federal Centers for Medicare and Medicaid Services (CMS) requirements; 13% of respondents do not know whether they are so licensed or certified. Thirty-six percent are accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO); 32% by the Council on Accreditation for Children and Family Services (COA); 10% by the Commission on Accreditation of Rehabilitation Facilities; and less than 1% by the National Committee for Quality Assurance (NCQA).

Population Served

Population data submitted by respondents are consistent with other studies showing that older children and youth are more likely to be served in RTFs than younger children.[8] Eleven percent of respondents serve children under the age of 6 years, 57% serve children ages 6 to 12, 93% serve

[†]Trauma-informed care treats the consumer in the context of the trauma-inducing situations he or she has experienced and uses that information to inform the approach to care.
[‡]Where the response rate for a given question was less than 90% (263 or fewer), the number of respondents is indicated.
[§]The remaining 15% of respondents reported their facility ownership as "other."
[**]Examples include East Ming Quong in Campbell, CA; Youth Villages in Nashville, TN; and Boysville in Converse, TX.

adolescents ages 13 to 18, and 21% serve adolescents and young adults ages 19 to 25. Respondents estimate that 25% of those served were diagnosed with co-occurring mental health and substance abuse disorders. This contrasts with a recent study finding that at admission, 91% of children and youth in residential treatment had mental health diagnoses and 70% had alcohol/substance abuse diagnoses,[9] suggesting a high level of co-occurring disorders.

During the previous 12 months, the total number of children served by reporting facilities ranged from 10 to 290 (median=83, mean=97). The daily census ranged from 0 to 264 (median=34, mean=45).

Efforts to Ensure Appropriate Placement

How RTFs determine appropriateness of placement and continued stay is an issue of great interest in the children's mental health field. Ninety-two percent of 261 facilities responding report that they consult with staff from a referring agency (e.g., the mental health authority, child welfare, or schools) before a youth enters treatment. Those who do not consult with referring agencies indicate that other agencies do not engage in consultation or lack appropriate records, or that RTFs are not reimbursed for such consultation. Only two respondents believe that information from the referring agency is unnecessary. The majority of RTFs help the referring agency determine bed availability and appropriateness of placement — the latter largely through a review of available records and evaluations (100%), discussion with the referring agency (79%), and/or a formal assessment of the youth's functioning (70%). Of those making functional assessments through a formal evaluation, 59% do so with a widely recognized, standardized instrument, such as the Child and Adolescent Functional Assessment Scale (CAFAS).[10] Staff at 46% of RTFs participate in treatment planning meetings at other agencies to discuss treatment needs of youth who have been or will be referred.

Virtually all respondents (99%) report that they conduct periodic reassessments to determine whether continued residential treatment or a transition to community-based services is appropriate. For 77%, this reassessment is triggered by evidence of the youth's improvement, 71% perform reassessment at every treatment team meeting, and 44% do so upon request of the youth or family.

Respondents use a number of practices to monitor ongoing need for placement. Ninety-six percent assess the youth's therapeutic response to residential treatment, 93% gather information about treatment preferences directly from the youth, and 89% gather it from the family. Other common practices are consulting with community providers to determine appropriateness (63%) or availability (68%) of community-based services. Of the 236 responding, 31% conduct in-home evaluations of the family environment after admission.

Relationship with the Courts

Courts often play a key role in placement of children in RTFs, mandating placements as part of the disposition process. Most of the RTFs (63%) are not legally or contractually required to accept some or all youth referred for placement, including those referred by the courts. Of 261 facilities responding, 79% receive referrals from family courts or the juvenile justice department. The vast majority of these (94%) evaluate the referrals to ensure that appropriate treatment can be provided, and more than half (61%) work with community agencies to determine whether home- or community-based services are more appropriate for a child's needs. Slightly more than one-third (36%) do not conduct further evaluations for court-referred youth, either because they must accept these referrals without further evaluation (14%) or because the court has already determined that residential treatment is required (28%).

Transition from Residential to Home- or Community-Based Services

One of the concerns about out-of-home placements is the extent to which youth and their families receive support for a smooth transition back to more natural living and school environments. Of the 261 RTFs responding, 53% begin working on a client's discharge plan upon admission; 26% prior to

admission; 15% during team meetings immediately following admission; and 6% after the youth shows signs of improvement.

Figure 1: Members of Treatment Planning Teams

Members	RTFs Including*
Treatment facility staff	97%
Youth	94%
Family members	92%
Referring agencies	85%
Natural helpers	40%

*Of those using treatment planning teams.

Almost all respondents (98%) offer some service to facilitate the transition from residential to home- or community-based services. The most common activities reported are consulting with educational institutions to plan for education (76%); referring to natural helpers such as family/youth peer support groups (68%); consulting with other agencies/providers to locate appropriate housing (63%); and accompanying youth to outpatient or other community services (58%). Thirty-four percent consult with employers to identify vocational opportunities, and 31% conduct in-home evaluations of the family or living situation.

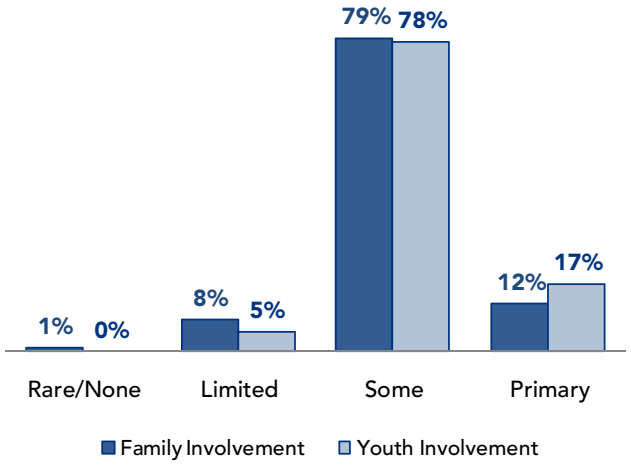
In addition, the majority of respondents (57%) report that there are some services in the community to help youth transition out of residential treatment, but suggest that these are not adequate. About a quarter (24%) indicate that there are very few or no such services, while 19% note that their communities offer a comprehensive range of transition services.

Transition services are especially critical for older youth who are moving into adult service systems, in order to maintain the continuity of care that their conditions require.[11] Of the 258 RTFs responding, 54% provide services to help youth ages 18 to 25 transition to adult services. Eighty-one percent of those provide telephone or written referrals; 79% provide contact information for adult service providers; 75% meet with community-based agencies that help young adults find treatment services, vocational assistance, education, and housing; and 29% provide community-based treatment services.

Individualized Treatment Planning

Individualized treatment plans are a hallmark of systems of care. Virtually all responding RTFs (99%) report that they develop individualized treatment plans for youth. Most incorporate system of care principles including: outcomes reflecting the input of the youth and family; a strengths-based approach to care; an individualized crisis/safety plan; and transition strategies. Sixty-eight percent employ strategies for incorporating natural helpers in the plan of care.

Figure 2: Level of Family and Youth Involvement on Treatment Planning Teams



Ninety-four percent of respondents also indicate that their individualized treatment planning utilizes a team approach incorporating various members (see *Fig. 1*).

While system of care principles stress the importance of family involvement on the treatment planning team,[12] in only 12% of facilities do families play a *primary* role in plan development, and in only 17% do youth (see *Fig. 2*).

Approaches to Behavioral Management

While most facilities (86%) have policies to reduce the use of seclusion and restraint, 83% used these practices within the previous 12 months. Those who did so indicate that they implement standard debriefing and reporting protocols in conjunction with these practices, including staff debriefing (68%), debriefing with the youth and family (72%),

Figure 3: Intervention Strategies for Behavioral Management

Intervention	RTFs Utilizing
Youth-/family-identified supports and interventions	87%
Trauma assessments	73%
Use of other agencies' intervention strategies	67%
Trauma-informed care	64%

recording the incident in the treatment plan (71%), and/or reporting to the youth's physician (65%).

Respondents engage, as well, in other behavior management approaches, including youth-/family-identified supports and interventions, trauma assessments, other agencies' successful intervention strategies, and trauma-informed care (see *Fig. 3*).

Provision of Non-Residential, Community-Based Services

Sixty-two percent of reporting RTFs provide at least one non-residential service (see *Fig. 4*), and 66% are part of organizations that provide both residential and non-residential, community-based services for children and adolescents. However, only half employ staff who provide continuing clinical services to youth in the community.

Use of Family-Driven Practices

A central tenet of a system of care approach is the engagement of families as partners in care, which includes facilitating family visitation and children's visits home. All but one responding RTF allow family visitation. Of these, 59% permit family visits at any time, while 22% do so only after a specified period of time following admission. Eighty-four percent allow home visitation. Seventy-three percent of those permitting visitation do not allow that right to be taken away as a consequence of unacceptable behavior by the child or youth.

Families of children and youth in behavioral health treatment may need support to be effective partners in care. Support provided by respondents (see *Fig. 5*) includes conference calls (the most common), off-site visits, social events for youth and family, reimbursement for meals during visits, reimbursement for transportation to and from the facility, and family-to-family peer support (provided by less than one-quarter). Of those that offer family peer support, more than half do so for all families, about a third based on staff judgment of usefulness, and the remainder to families upon request. Family mentors typically are unpaid.

Figure 4: Non-Residential Services Available to Youth

Service	RTFs Offering
Supported housing	62%
Outpatient mental health counseling*	52%
Integrated co-occurring treatment	48%
Intensive in-home treatment	38%
Crisis intervention	37%
Family preservation and reunification	35%
Multi-Systemic Therapy	38%
Therapeutic foster care	23%
Supported employment	15%
Vocational training	12%
Educational tutoring	10%
Electroconvulsive therapy	1%

*Of those providing outpatient mental health counseling, services include group therapy (95%), cognitive/behavioral therapy (94%), interpersonal psychotherapy (86%), and Functional Family Therapy (44%).[13]

Systems of care also call for family and youth involvement with RTF policy and operations. However, the survey found family involvement with RTF governance and facility operations to be minimal. Only 12% of RTFs involve families in programmatic oversight, most often as peer mentors, board members, or liaisons between other families and staff. Fewer than 25% of RTF directors surveyed believe licensing and accreditation standards should require that family members have a governance role.

Use of Youth-Guided Practices

Engagement of youth as partners and consumer-driven care are key system of care principles. Less than one-third (30%) of respondents offer youth-to-youth peer support; of these, half offer it to all youth, while half do so based on staff judgment of usefulness. Only 12% of RTFs involve youth who have stayed in an RTF in programmatic oversight or operations, most in unpaid

roles. Similarly, few involve youth as legislative advocates, in marketing, to assist in staff training, or as quality reviewers.

Forty-three percent of RTFs have an advisory board or "student council" of youth currently in residential care. Only about one-quarter (26%) of RTF directors believe that licensing or accreditation standards should require youth involvement in governance.

Figure 5: Types of Family Support Offered

Activity	RTFs Offering
Conference calls	94%
Off-site visits	72%
Social events for youth and families	70%
Reimbursement for transportation for visits	56%
Reimbursement for meals during visits	54%
Family-to-family peer support	22%

Culturally and Linguistically Competent Services and Supports

Systems of care stress the importance of a culturally and linguistically competent approach to care — a critical principle for RTFs, as racially and ethnically diverse children tend to be overrepresented in residential care.[14] Of 261 RTFs responding, 86% indicated that they require training on cultural diversity and/or cultural competency for all treatment staff, and 85% have provided such training on a variety of topics in the previous 12 months (see *Fig.* 6).

Only 34% of 258 responding RTFs have procedures for monitoring the cultural competency of services, most commonly through management review with staff (55%), management discussion of needed improvements (51%); a standing committee or team (46%); and/or management meeting with family members or youth (18%).

Of 237 RTFs responding, all have written policies related to the religious practices or faith of residents. The most common of these are provision of time for religious practice (83%); escorting youth to a place of worship in the community (77%); and ensuring that someone is available to talk to youth about their faith and beliefs (59%). A smaller percentage (22%) has dedicated space for religious observance.

Just over half of respondents believe that their staff can meet non-English communication needs of children, youth and families involved in behavioral health treatment, either directly or through a translator.

Staff Training in Family-Driven and Youth-Guided Care Principles

Sixty-five percent of 260 responding RTFs have provided treatment staff with training on how to apply principles of family-driven or youth-guided care, and 71% of 258 RTFs have provided training on its importance. Despite this, only 12% of respondents believe that most of their staff understand and apply principles of family-driven care, and only 19% believe this to be true for youth-guided care (see *Fig.* 7).

Figure 6: Cultural Diversity and Competency Training Offered

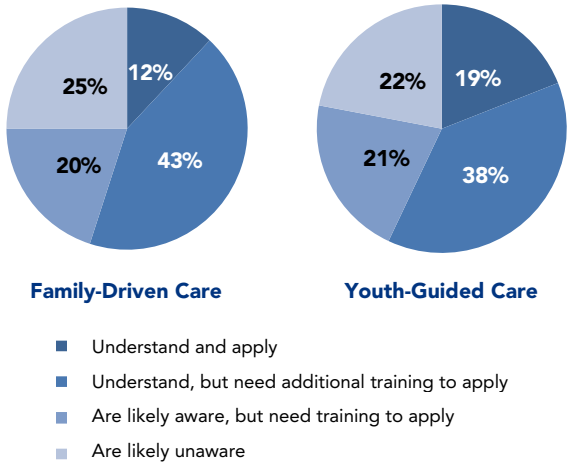
Topic	RTFs Offering
Racial /ethnic views of mental health treatment	79%
Religious diversity and practices	64%
Youth lifestyles	61%
Mental health needs of GLBT* youth	47%
Community resources for GLBT youth	19%
New languages	3%

*Gay, lesbian, bisexual, and transgender

Staff Recruitment and Retention

Sixty-four percent of RTFs report difficulty hiring staff, particularly child care workers and registered nurses, citing a shortage of applicants and the inability to offer competitive salaries. In addition, salary levels hamper staff retention at 56% of facilities. Inadequate staff training may further impede recruitment and retention at these facilities.

Figure 7: Staff Understanding and Use of Family-Driven and Youth-Guided Care Principles



Utilization of Quality Assurance Practices

Federal health care agencies have begun to put greater emphasis on the provision of high-quality care for children.[15] Accordingly, RTFs report having a number of quality assurance practices in place (see *Fig.* 8).

Given the system of care emphasis on using data to improve the quality of care, RTF directors were asked about efforts to monitor outcomes following discharge. Of several categories of information, only satisfaction with residential treatment services is collected by more than half (69%)of RTFs. Less than half monitor contact with the legal system, use of other community-based mental health services, housing stability, employment, use of hospital or residential treatment, clinical and functional status, and/or educational attainment. Among those collecting post-discharge data, most do so for no more than six months, and only about one-third share this data with youth and families at admission.

Description of RTF Financing

Survey data reveal Medicaid's significant role in RTF financing. As reported by 260 respondents, in the past 12 months, RTFs received Medicaid reimbursement for a mean of 69% of youth, and Title IV-E (child welfare) payments for room and board for a mean of 29%. Notably, 19% of respondents did not have knowledge of the extent to which Medicaid is a financing source, and 42% could not report on their facilities' reliance on Title IV-E funding.

Bundled rates are an alternative and typically more flexible financing mechanism for services provided to children and youth with serious behavioral health needs. By removing service constraints that often arise from a single funding source, bundled rates enable a provider to tailor services to a child's needs. Among 250 respondents, 60% receive bundled rates for some or all of their youth; of those, 42% say the mechanism allows sufficient flexibility to meet care needs.

While the health care field has shown an increasing interest in performance-based contracting, this is not reflected in the survey results.[16] Only 21% of 256 reporting RTFs receive financial incentives to reduce lengths of stay. Of these, 72% undergo periodic review of plans of care by state or county officials; in 50%, contracts with the state or county cover specific in-home or community services to help youth transition out of residential treatment; and in another 20%, reimbursement is reduced after a youth has been in residential treatment for a certain period of time.

Figure 8: Use of Quality Assurance Practices

Practice	RTFs Utilizing
Regular case reviews with supervisor	99%
Periodic client/patient satisfaction surveys	97%
Monitored continuing education for staff	94%
Periodic utilization review	91%
Regular case reviews by quality review committee	75%
Client/patient outcome follow-up after discharge	68%

Policy Implications

To varying degrees, the RTFs responding to this survey have adopted some policies and practices informed by system of care principles, and to a lesser extent, have evolved toward greater provision of home- and community-based services. While there are some promising findings herein, there remains room for improvement in these areas.

Reflection of System of Care Principles

Family-Driven and Youth-Guided Care

Overall RTF adoption of family-driven and youth-guided care is limited, and additional staff training in this area appears needed. Nationwide, communities

implementing systems of care are demonstrating effective partnerships with families and youth at direct service, program operations, and governance levels. In addition, many states and communities have strong family- and youth-run organizations that have grown as systems of care have spread – offering valuable lessons. System of care initiatives such as those funded by SAMHSA can reach out to RTFs to help them integrate family-driven and youth-guided principles in their policies and practices. State purchasers such as Medicaid and mental health authorities can include these principles in performance measures, provider capacity-building efforts, and pay-for-performance initiatives.

Cultural and Linguistic Competency

While virtually all facilities recognize the importance of cultural and linguistic competence and have provided some training in these areas, few facilities monitor cultural competency and/or explore related satisfaction levels of diverse youth and families. Federally funded, national technical assistance centers that support systems of care can help RTFs in building their competency in this area. State purchasers that are concerned about health care disparities can address high rates of RTF placement among racially and culturally diverse youth by working with referring agencies to examine racial biases and expand culturally competent home and community alternatives.

Survey results also point to an unmet need to provide culturally competent care beyond language services alone. For example, despite research suggesting that gay, lesbian, bisexual, and transgender (GLBT) youth are at high risk for behavioral health problems, out-of-home placements, and homelessness, low rates of staff training on GLBT issues and community resources were found.[17]

In facilities where staff racial and ethnic backgrounds largely do not reflect the individuals they serve, it is particularly important to provide opportunities for community feedback to the cultural competency of specific services. Given the many varied dimensions of culture — including race, ethnicity, age, gender, religion, and sexual orientation — this is a particular challenge; but if done appropriately, can reduce and/or eliminate barriers to engaging youth and families as partners in care.

Youth with Co-Occurring Mental Health and Substance Abuse Disorders

Despite the high rate of co-occurring substance abuse in children and youth receiving mental health services, only 17% of RTFs reported that their services focus equally on mental health and substance abuse. This is not surprising given that state purchasers of mental health and substance abuse services often operate independently with different licensing, contracting and financing processes. State purchasers can change purchasing and financing approaches to encourage integrated co-occurring treatment, which is critical and more effective than non-integrated treatment for this population.[18]

Home- and Community-Based Services and Supports

Although most facilities discuss appropriateness of placements with referring agencies, it was notable that only about half explore home- and community-based alternatives with these agencies. Furthermore, over one-third of the facilities that accept court-referred youth do so with little discussion of appropriateness. Adoption of strengths-based screening tools and individualized service planning approaches by RTFs, referring agencies and the courts could help to ensure that home and community alternatives are appropriately considered.

Most facilities either provide or are part of larger organizations that provide non-residential, community-based services. While there were promising reports of capacity to provide intensive in-home services, family preservation, crisis services, and evidence-based practices such as Multi-Systemic Therapy and Functional Family Therapy, a minority of reporting facilities provide these services, vocational training or supported employment. State purchasers can address this by including RTFs in efforts to encourage provider adoption of evidence-based and effective practices.

To enhance their provision of system of care informed services and supports, RTFs should consider incorporating related principles into their missions and visions. Frequent staff training that is designed to increase both the understanding and practice of youth-guided and family-driven care is essential given the high turnover rates among RTF staff. Additionally, enabling youth and families to be full partners in treatment planning and goal setting garners their commitment to the plan, and promotes use of informal and natural supports.

Outcomes, Quality, and Financing

Attention to quality of care, the monitoring and reporting of outcomes, and accountability in general are areas warranting more focus by RTFs. Few track outcomes such as clinical and functional measures, recidivism, school or employment status, or housing stability, and with short tracking periods. It is not surprising, then, that few share outcomes data with families and youth at the time of admission.

Despite Medicaid's emphasis on quality and performance measurement, and its role as a major funding source for RTF services, most RTFs reportedly are not bound by performance- or incentive-based contracts tied to desired outcomes (such as reduced lengths of stay) promoted in a system of care. As a result, RTFs do not have strong financial incentives to pursue interventions — such as evidence-informed home and community alternatives — that focus on these outcomes. State purchasers could require RTFs to track and monitor key system-, child- and family-level outcomes as part of their quality improvement initiatives.

The majority of facilities have national accreditation, and nearly all are licensed by their respective states. Those that have national accreditation are most likely to be accredited by JCAHO, which employs a model that is more medically than socially oriented, and/or by COA, which has standards more closely reflecting system of care values. State purchasers could increase the rates of national accreditation — particularly from COA — through contract requirements, purchasing specifications and pay-for-performance measures with RTFs.

Areas for Future Inquiry

There are a number of questions that ideally would have been included in the survey, but were omitted to prevent an undue burden on respondents. For example, given widespread interest among child behavioral health advocates, youth and families, and policymakers in the average length of stay (ALOS) for children and youth in RTFs, it would have been of interest to determine whether greater adherence to system of care principles corresponds to shorter ALOS. Other areas of interest include the primary sources of referrals to RTFs and how those differ by state or region, and the use of evidence-informed practices such as wraparound in RTFs. The current findings and remaining questions suggest that further study is warranted to better understand the approach of RTFs to services and supports for children and youth with serious behavioral health challenges.

Conclusion

While study findings reveal some uptake of system of care principles and practices among RTFs nationally, a greater emphasis on home- and community-based care, youth-guided and family-driven care, and cultural and linguistic competency is warranted.

Federal and state programs addressing the mental health needs of children and youth increasingly are requiring provider attention to these issues — supporting technical assistance and providing grant funding to make them the hallmarks of care. This leadership should guide RTFs seeking an evidence-based approach to sustaining and enhancing their mental health programs for children and youth.

Advancement of systems of care for this population requires that federal, state and local agencies engage RTF providers more effectively. RTFs, in turn, should reach out to entities that are engaged in system of care reform efforts in their states and communities to align and leverage their efforts. Continued dialogue is needed to build a common values base and practice model across the entire service continuum — supporting the best possible outcomes for children and youth with serious behavioral health challenges and their families.

About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. CHCS works with state and federal agencies, health plans, and providers to develop innovative programs that better serve Medicaid beneficiaries with complex and high-cost health care needs. For more information, visit **www.chcs.org**.

Related CHCS Resources

Through its *Children in Managed Care* program, the Center for Health Care Strategies (CHCS) works with state child-serving agencies, health plans, and family- and youth-run organizations to improve the delivery of behavioral and physical health services and supports, with a focus on children served by multiple public systems. Visit **www.chcs.org** to for more information on the following resources and initiatives:

Improving Medicaid Managed Care for Youth with Serious Behavioral Health Needs: A Quality Improvement Toolkit - This toolkit details the experiences of a workgroup of nine Medicaid MCOs that collaborated to identify ways to improve care for youth with serious behavioral health needs.

Medicaid Managed Care for Children in Child Welfare - This issue brief examines the complex physical and behavioral health care needs and associated costs for children in child welfare and outlines critical opportunities and challenges within Medicaid to better manage care for this high-risk, high-cost population.

The Use of Psychotropic Medications for Children Involved in Child Welfare - This CHCS webinar presented evidence-based and promising practices related to the use of psychotropic medication among children involved in child welfare and the critical role of families as partners in care. A resource paper presenting these findings will be published this year.

Improving Outcomes for Children Involved in Child Welfare - This national collaborative is working with nine managed care organizations and their child welfare partners to improve the delivery of physical and mental health care to children in child welfare.

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