

NEW MEXICO SENTENCING COMMISSION

ALEXANDRA TOSCOVA TONIGAN

MAY 2014

Study Highlights

- In most cases, an adolescent is only referred to a Residential Treatment Center (RTC) after one or more unsuccessful attempts for treatment in less restrictive programs.
- Therapeutic Service Standards (TSS) are intended to assure that evidence-based treatment and appropriately credentialed specialists in child and adolescent mental health are integrated into the client's regimen at the RTC.
- Cognitive Behavioral Therapy and Functional Family Therapy are important therapeutic approaches to treatment.
- Numerous RTC's in New Mexico have been shut down, downsized or re-organized – leaving some adolescents without the level of treatment needed.
- Existing RTC's in New Mexico may not have established a set of standardized protocols and procedures.
- Facility oversight may not exist to a satisfactory degree.
- Public RTC facilities for adolescents in New Mexico do not currently serve females.
- There has been an increase in the number of female juvenile offenders, many of which have significant mental health needs.

Adolescent Residential Treatment Centers: Literature Review and Issues in New Mexico

Introduction

Residential Treatment Centers (RTC) are designed to offer medically monitored intensive, comprehensive psychiatric treatment services to adolescents with mental illness, severe emotional disturbance, and/or cognitive delays. The American Academy of Child and Adolescent Psychiatry (AACAP) describes RTC's as, "a facility that provides children and adolescents with a residential multidisciplinary mental health program under medical supervision and leadership. It is often utilized when the child cannot be treated in a community-based setting," (AACAP, 2010). In other words, practitioners emphasize the importance of trying alternatives before turning to inpatient treatment settings. In most cases, an adolescent is only referred to RTC's after one or more unsuccessful attempts for treatment in less restrictive programs (Cigna 2012).

There is no official definition of what it means to be a residential treatment facility. RTC's vary in several ways. While there are some common characteristics, RTC's vary in function, perspective, approaches and philosophies, staff education and qualifications, treatment organization and services offered, family and parental involvement, and post-discharge/ transitional support (OJJDP). One of the few ways in which RTC's can be systematically categorized is through the source of funding—RTC's can be private or public. It is argued by many that private and public RTC's are fundamentally different (Behrens, Satterfield, 2011). Each RTC is unique and so currently, researchers and practitioners are faced with determining what exactly works and for whom.

Over the past ten years, researchers have established a substantial body of literature on the efficacy of RTC's for adolescents. A large portion of this literature has shown that RTC's, when implemented correctly, are an effective treatment model for adolescents. Still, much can be learned about the gaps in adolescent treatment—"there is a lack of research that measures or examines the influence of these factors on the success of treatment, so it remains unclear what program elements are important and beneficial to the treatment process" (OJJDP). Moreover, the majority of existing research and literature focuses on public RTC's. In fact, much less is understood about private RTC's, especially in terms of their outcomes.

A primary purpose of this report is to briefly review existing literature on publically funded adolescent RTC's in relation to New Mexico's Sequoyah Adolescent Treatment Center. Specific areas of interest include gaining a better understanding of the best practices and guidelines for RTC's, as well as a better understanding of the challenges such facilities face.

Background

In 1993, the federal government adopted the term 'serious emotional disturbance' to "indicate a mental health disorder among children and adolescents that involves serious impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities" (Behavioral Health, United States, 2012). Today, mental health disorders are commonly referred to using an array of "umbrella" terms such as serious emotional disturbance, mental illness, and behavioral disorder. There is an extensive range of specific conditions beneath those umbrella

terms, all of which differ in characteristics and treatments. The following disorders have been selected as they relate to specific concerns within the New Mexico adolescent community. This includes their association with aggressive, impulsive and violent characteristics and their prevalence by gender.

Conduct disorder is commonly diagnosed during childhood and adolescence and refers to a group of behavioral and emotional problems. Adolescents with conduct disorder struggle with following rules and behaving in socially acceptable ways. Behaviors may include aggression towards people and animals, destruction of property, truancy or other serious violations of rules.

Research also suggests that Antisocial, Avoidant, Borderline, Histrionic, Narcissistic, Paranoid, Passive-Aggressive, and Schizotypal Personality Disorders may be associated with violent behavior among adolescents. Such disorders are not commonly diagnosed in childhood, but rather in late adolescence and young adulthood. Lastly, Traumatic Brain Injury (TBI) can result in cognitive impairment, personality changes, and development of one or more mental illness. It is not uncommon for individuals with a TBI to experience rapid mood changes and emotional reactivity, otherwise referred to as affective lability. Other personality changes include (impulsive) aggression and behavioral disinhibition. TBI's have also been associated with the development of Depression, Mania, Over-Compulsive Disorder, Post-Traumatic Stress Disorder (PTSD), and Psychotic Disorders (Psychosis) (NICHCY, 2010).

Behaviors can either be *externalized*, meaning the behavior is directed toward the external environment, or *internalized*, meaning the behavior is directed toward the self. External behaviors include aggression, cursing, and violence. Internalized behaviors include isolation, social withdrawal, self-harm, suicide or suicidal ideation. In the past, externalized behaviors were most often associated with males, while internalized behaviors were most often associated with females. Research has currently shown a strong association between externalizing behaviors and females. In other words, females have higher rates of internalizing behaviors, and equal to or greater rates of externalizing behaviors (Handwerk et al. 2006).

Currently, the discussed mental disorders are just a small sample of the existing and pervasive disorders affecting the adolescent population. TBI's, Personality Disorders, and Conduct Disorder are often seen with co-occurring mental disorders. In such cases, intensive,

multi-dimensional treatment approaches are often necessary. A large body of literature supports RTC's as a successful treatment approach for these specific disorders, particularly in the case of female adolescents. RTC's offer various structured therapy approaches, but most commonly offer some combination of Cognitive Behavioral Therapy, group therapy, and medication. This will be discussed in further detail later in the review.

Best Practices

Protocols

It is essential that residential treatment facilities develop clearly defined policies and procedures. The development of such procedures should include management support, consultation with staff, defined terms of the policies (in writing and discussion), training and regular referral, implementation, evaluations and reviews. Such procedures are designed with the treatment team approach in mind, whereby the roles, responsibilities and leadership duties are clearly defined. Clearly defined procedures and the adherence to those procedures enable staff to make the right decisions when emergency situations arise. In such instances, the staff are able to act immediately to avoid risks to the client, other clients, and staff members. Many mental health care providers emphasize the importance of establishing and implementing scientifically-based guidelines (AACAP, 2010).

Standards

According to AACAP, there are a number of standards for residential treatment facilities, including those issued by state licensing boards. The Licensing and Certification Authority (LCA), which is part of the Children Youth and Families Department (CYFD) for the State of New Mexico, certifies compliance with state and federal regulations such as active treatment, health and safety, personnel requirements, quality of care and other standards. Other regulating agencies include insurance companies, federal government agencies and National Quality Programs (2010). New Mexico requires RTC facilities to complete certain procedures for initial licensure and certification, as well as for annual renewal. Part of the required procedures include on-site inspections, review of documentation of staff qualifications and training, review of a sample of residents' clinical records, and sometimes completing interviews with residents. A national survey conducted by SAMHSA revealed that state facility licensures and certifications are rarely revoked. Annually, less than 1% of the facilities within the U.S have their licenses revoked (SAMHSA, 2006).

While there is variation in laws or regulations between states, there are two general requirements for child and adolescent RTC's. First, RTC's are required to maintain a particular daytime resident-to-staff ratio, and a particular nighttime resident-to-staff ratio. The minimum imposed ratio depends on the size of the facility, although research has shown that in the U.S, 27.3% of RTC's have 2-4 residents per staff, 47.3% have 5-8 residents per staff, and 18.2% have 9-20 residents per staff (SAMHSA, 2006). Second, many RTC's require a minimum education level for facility directors. While the minimum may vary across programs, research has shown that 43.8% of all facilities required a Bachelor's degree or less, 31.3 % required a Master's degree, and 20.8% required a combination of education and experience. In addition to licensing and certification, it is suggested that facilities be regulated and monitored through complaint reviews (by more than one agency to ensure there are no conflict of interests), through critical incident reporting, and through national accreditation.

The Joint Commission (TJC)—Supplemental Standards:

Therapeutic Services Standards (TSS)

"TSS are intended to assure that evidence-based treatment and appropriately credentialed specialists in child and adolescent mental health are integrated into the patient's daily life at the RTC. To accomplish this goal, TSS describes a clearly delineated treatment philosophy that is multidisciplinary in scope, encompasses all aspects of the child or adolescent's experience, is evidence-based and is appropriate to the population served" (AACAP, 2010). RTC's should have TSS that includes the following components:

1. Licensed professionals with specific expertise in diagnosis specific to the population the RTC is serving.
 2. Trained in evidence-based practices.
 3. The child and adolescent psychiatrist's role should include attendance at multidisciplinary team meetings and treatment planning conferences, clinical supervision of other direct care personnel, involvement in therapeutic program development, and work with the clinical leadership team in monitoring the quality of care and outcomes provided at the RTC.
 4. When medication is used, medication monitoring will be provided by a child and adolescent psychiatrist. If one is not available, a physician or other licensed prescriber with specific training and clinical experience to the population served will provide these services.
5. Engagement of the child or adolescent's family and other community supports in all aspects of treatment.
 6. Treatment goals will build upon the strengths of the child or adolescent and their family, and identify areas to be therapeutically addressed with specific outcomes that document progress toward those goals. This includes an individualized discharge plan with appropriate, realistic and timely follow-up care in place, *and considers the following criteria:*
 - The adolescent can be safely treated at an alternative level of care.
 - The adolescent's documented treatment plan goals and objectives have been substantially met or a safe, continuing care program can be arranged.
 - The adolescent or family member, guardian, or custodian are competent but non-participatory in treatment or in following the program rules and regulation; or consent for treatment is withdrawn, and it is determined that the adolescent, parent or guardian has the capacity to make an informed decision and does not meet the criteria for an inpatient level of care.

The Living Environment

The living environment for children [and adolescents] residing in a residential treatment center is an integral part of the overall treatment experience. The *environment of the RTC should:*

1. Be sensitive to trauma-related issues and their treatment.
2. Provide documentation of a residents' anticipated vulnerabilities and problem behaviors.
3. Be appropriate to the age and developmental needs of the residents.
4. Have areas for privacy as indicated (bedroom, bathroom, etc.).
5. Promote individual dignity.
6. Have a safe and protected space for personal items.

Approaches to Treatment

Treatment approaches for children and adolescents are largely derived from adult treatment modalities. Researchers have been investigating and identifying empirically supported treatments for adolescents for over 60 years. Still, evidence of the effectiveness for such approaches continues to grow, allowing

theoretical perspectives and treatments to be improved. The success of treatment depends on the appropriateness of the type of treatment selected, and how the treatment is administered. Adolescent RTC's must provide the correct type of treatment, and must implement that treatment in an efficient and conducive manner. There are established strategies which RTC's can follow to ensure that correct and consistent treatment is being provided, one of which includes the Six Core Strategies to Prevent Conflict and Violence: Reducing the Use of Seclusion and Restraint (6CS Program) (SAMHSA, 2012). Designed by the National Association of State Mental Health Program Directors (NASMHPD), the 6CS program is a clinical model designed for use by institutions providing mental health treatment to children and adults admitted to inpatient or residential settings. The 6CS program works to change the way care is provided in these settings by focusing on the prevention of conflict and violence, the reduction in use of seclusion and restraint, the implementation of informed care principles, and the inclusion of the client in his or her care (Haimowitz et al., 2006)

The 6CS program is implemented at the institutional level, through the incorporation of the six program strategies: (1) leadership toward organizational change; (2) the use of data to inform practice; (3) workforce development; (4) full inclusion of individuals and families; (5) the use of seclusion and restraint reduction tools, which include the environment of care and use of sensory modulation; and (6) rigorous debriefing after events in which seclusion and restraint might have been used. In addition, items used as alternatives to seclusion and restraint (e.g., rocking chairs, weighted blankets) are placed in the clinical units, and their use is rehearsed. Once implemented, the 6CS program requires changes in organizational culture, such as the way in which staff meetings and debriefings are held; however, once these changes have been made, the program can be implemented by line staff with no special qualifications.

The 6CS program was first implemented in January 2003 at South Florida State Hospital in Pembroke Pines, Florida. Since then, the program has been used by about 1,000 State and private hospitals and agencies across 31 States, the District of Columbia, Australia and Finland, with more than 10,000 individual staff members receiving training (SAMHSA, 2012).

Therapeutic Treatments

The following section will briefly address two particularly effective therapeutic treatments. Cognitive Behavioral Therapy (CBT) and Functional Family Therapy (FFT) have extensive scientific data

demonstrating their use in clinical treatment for adolescent's in RTC's.

Cognitive Behavior Therapy

Cognitive Behavioral Therapy (CBT) is a therapeutic approach that focuses on the relationship between thoughts, feelings and behaviors in maladaptive outcomes. For example, CBT may focus on the idea that dysfunctional thoughts lead to maladaptive behaviors and feelings. This structured approach involves teaching youth about the relationship between thoughts and behaviors and helps them employ more adaptive behaviors in challenging situations. This approach is especially beneficial for youth in the juvenile justice system because it is very structured and focuses on the triggers for disruptive or aggressive behavior (NMHA, as cited by the NCMHJJ, 2002).

Functional Family Therapy

Functional Family Therapy (FFT) is a strength-based model and is considered to be a "well-established" treatment, particularly for Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) (Ollendick, T et al., 2004). FFT is a short-term intervention program with an average of 12 sessions over a 3-4 month period. At its core is a focus and assessment of those risk and protective factors that impact the adolescent and his or her environment, with specific attention paid both intra-familial and extra-familial factors, and how they present within and influence the therapeutic process. The intervention program itself consists of five major components which are completed in three phases:

Phase 1: Engagement in change and Motivation to change

Phase 2: Relational/Interpersonal Assessment and Behavior change

Phase 3: Generalization across behavioral domains and multiple systems.

Ultimately, the therapeutic goals for each RTC patient need to be developed and based on an understanding of the unique needs of each individual child or adolescent. Coinciding with the recent development of Evidence Based Practice (EBP), there has been an emergence in illness specific RTCs and programs that focus on the treatment of one particular illness or disorder. Medical practice indicates that there is some benefit to this approach in so far as expertise and efficiency can both be improved. Residential treatment of illnesses like eating and substance abuse disorders in which the combination of treatment resistance, potential medical complications, and propensity to relapse require a

facility and staff to be well versed in the unique complexities of these disorders. Still, the lack of available treatment centers, the presence of co-morbid psychiatric illness and/or geographic necessity might require that a child or adolescent with these or other psychiatric disorders receive treatment in an RTC that is not specialty focused. In such cases, the clinical and medical directors have the responsibility to determine which disorders their facility can effectively treat using current EBP standards.

Residential Treatment Centers

As suggested by the name, public RTC's are funded with public money and private RTC's are privately funded. Typically, juvenile justice systems, child protection agencies, or other public mental health systems refer clients to public RTC's. Such individuals are "predominately male and disproportionately selected from ethnic minority backgrounds" (Behrens and Satterfield, 2011).

In contrast, private RTC's, which were established between 40 to 50 years after public RTC's, serve more female clients. Typically, private RTC's are associated with costly services, such as adventure activities, challenge courses or equine programs. Research suggests that such clients come from a family of high socio-economic status (Behrens and, Satterfield, 2011). Moreover, Behavioral Health, United States, 2012 found that there are 781 total RTC's in the country that serve adolescents ages 13-18 years old with emotional disturbances. Of these, 26 are public and 755 are private. Of the 26 public facilities, all offer residential services, 6 offer outpatient services; but, none of them offer 24-hour inpatient services. Less than a quarter of these facilities cater to females. Of the 755 private facilities, only 20 offer 24-hour inpatient services, 751 offer residential services and 164 offer outpatient service (Behavioral Health, United States, 2012). The following section will describe a sample of existing treatment centers in New Mexico.

Private Programs in New Mexico

Presbyterian Medical Services (PMS) San Juan County Adolescent RTC

Located in Farmington, New Mexico, PMS San Juan County Adolescent RTC is certified by the CYFD and accredited by the Joint Commission. The RTC has a 16 bed capacity and serves both males and females, ages 13-17 years old. PMS San Juan Adolescent RTC offers a variety of therapeutic 'modalities, approaches, and support' (PMS, 2014).

Desert Hills—Sub-Acute Unit

According to the program's website (www.deserthills-nm.com), in 1990, the private facility known as Desert Hills opened in Albuquerque, New Mexico. The RTC is accredited by the State of New Mexico's Children, Youth and Families Department (CYFD), Licensing and Certification (LAC) Joint Commission and North Central Accreditation. Between 1990 and 1996, the facility expanded its capacity from 54 residents to 131 residents. Today, the RTC offers inpatient and outpatient treatment for both males and females. The facility is organized into units, specifically a dual diagnosis unit, for substance abuse and mental health, a sexually maladaptive behavior unit, a child unit for children between the age of 5 through 11, a MR/DD unit, and a sub-acute unit for children and adolescents ages 11 through 18. Lastly, Desert Hills offers ancillary services such as psychiatric evaluations, outpatient clinic services for medication management, a behavior management services program and a comprehensive community support services program.

The sub-acute unit is structured to provide treatment for children and adolescents with severe emotional disturbance or behavioral problems. While the program is voluntary, the patients are closely supervised and the units are locked. Treatment for each child and adolescent are individualized and self-paced, through the use of Cognitive Behavioral Therapy (CBT). Additionally, children and adolescents attend group therapy three times a week, individual therapy once a week, family sessions once a week, and receive psychiatric care four times a week. Desert Hills provides education through its school or through the charter school for children and adolescents year-round (www.deserthills-nm.com).

Public Programs in New Mexico

New Mexico Behavioral Health Institute-C.A.R.E

The only state owned and operated psychiatric treatment facility resides in Las Vegas, New Mexico, and is known as the New Mexico Behavioral Health Institute (NMBHI). The facility is divided into five separately accredited and substantially different units. The Center for Adolescent Relationship Exploration (C.A.R.E) unit provides treatment services to males ages 13 through 18 years, and has an average capacity of 12-13 clients (NMBHI, 2009).

The treatment plan is a strength-based treatment curriculum designed to last one year. Specifically, treatment focuses on sexual offenders who have co-occurring mental illness and emotional disturbances. Treatment focuses on building healthy relationship and coping skills, and appropriate decision-making and

conflict resolution skills. This is accomplished through several treatment formats, such as individual and family therapy sessions. Other formats include weekly community service, daily group therapy sessions, indoor and outdoor recreation, Therapeutic Engagement, Facing up to the Abuse, and Mapping the Influence of Abuse (NMBHI, 2009).

Sequoyah Adolescent Residential Treatment Center

Sequoyah Adolescent Residential Treatment Center (SARTC) is a public residential treatment facility located in Albuquerque, New Mexico. SARTC has the capacity to provide treatment to 36 males aged thirteen through seventeen. The facility is licensed and certified by New Mexico's Children, Youth, and Families Department (CYFD) and accredited by the Joint Commission (TJC). SARTC requires that the adolescent have a diagnosable mental disorder and is violent or has a history of violence, Residents must be amenable to treatment and have the cognitive capacity to benefit from treatment on a voluntary basis. SARTC utilizes the Building Bridges model with a multidisciplinary team approach. This entails implementing evidence-based treatment approaches that are culturally and linguistically competent, family-driven, youth guided, and strength-based. (NMDOH, September 2013). SARTC emphasizes the importance of individualized treatment and discharge plans. At admission, the entire treatment plan is discussed, including discharge and aftercare services. The treatment plan is then evaluated and monitored every thirty days for any necessary adjustments. Discharge services typically include a thirty day and six month follow-up, as well as case management (NMDOH, 2009).

Generally, individual therapy sessions are provided one to three times a week (or more if needed) and there are several group therapy sessions a week. Group therapies include Life/Social Skills, Anger Management, Drug and Alcohol, Gang Group, Young Fathers, Sexual Abuse/Perpetrator, Community, Art Therapy, Pet Therapy, Recreational Therapy, Speech and Language Therapy, and Cognitive Computer Assisted Brain Injury Therapy (NMDOH, 2009).

SARTC offers a specialized treatment unit, known as the Neuropsychiatric Lodge, for residents who require intensive care within a controlled and secure environment due to more severe cognitive impairments. Special needs typically include receptive and expressive language difficulties, history of traumatic brain injury (TBI), problems with attention and concentration, poor impulse control, difficulty with decision making, limited problem solving skills or

abilities, delays in academic achievement, serious lack of motivation, or a history of pre-natal drug exposure (NMDOH, 2009).

Challenges

This last section will discuss some of the challenges that RTC's have faced. Generally, RTC's receive criticism regarding the necessity of institutionalizing children and adolescents. A large portion of that criticism rests on the separation of children and adolescents from their families (Magellan, 2008). Moreover, it has been argued that RTC's are able to provide treatment for a *broad spectrum of mental illnesses*, but are not structured to provide tailored and individualized treatment plans for the diverse adolescent population requiring mental health services (AACAP, 2010).

According to the Children, Youth, and Families Department (CYFD) Licensing and Certification Authority (LCA), some of the challenges that Sequoyah Adolescent Treatment Center has faced include a lack of adherence to the broad set of procedures within the treatment facility, such as pharmacological treatment problems and the use of seclusion and restraint (CYFD, LCA Certification Report, 2012).

Additionally, practitioners and community members alike have voiced concern regarding the lack of appropriate treatment facilities, in part due to RTC closures across the state. Another concern is the lack of RTC's that provide treatment for adolescent females.

Lack of Oversight

The use of *pharmacological treatment* and *seclusion and restraint* as a form of restrictive intervention has been a controversial topic. Such methods can be traced back to the 1700's. Since that time until today, "the interpretation and implementation of these interventions has become the basis for debate, public inquiry, governmental regulation, and suggestions for alternative approaches" (AACAP, 2012). In New Mexico, concern has arisen regarding the adherence to restraint and seclusion procedures. Restraint and seclusion are only to be used after all other less restrictive alternatives have failed. Sources indicate that the inability to adhere to such procedures, especially during a patient outburst or crisis, may stem from ambiguous and inconsistent rules and expectations within the facility. Such uncertainties are only further intensified by a lack of communication between staff and administrators (LCA: Investigative Certification Report, August 2012). Furthermore, the License and

Certification Authority (LCA) was contacted numerous times between 2012 and 2013 concerning acute violations of state and federal regulations. Complaints included “non-compliance to regulations related to client discharges, restraints, medication, client supervision, physician-directed care, personnel responsibility, staffing schedules, staff to client ratios, and staff training.”

While it is essential that staff be well-qualified and experienced, it is also imperative that they work together as a team. Staff dysfunction and inconsistency are perceived by patients, and can add to the overwhelming stress they may already be experiencing. Patients respond more quickly when staff implements a consistent and stable treatment approach. In the case of a patient outburst, a skilled staff team can implement specific strategies and techniques designed to prevent and manage patient aggression in a collaborative manner (Masters et al., 2002). Strategies utilized by management and other personnel should be complementary to those implemented therapeutically. This allows the patient to use and practice coping skills directly related to those being addressed in their individualized treatment plan. For example, prompting a patient to ignore peer provocations by using self-directed “time-outs,” reinforces the importance and desirability of self-control skills. Conceptually, “time-outs,” provide the same opportunity to de-escalate as restraint or seclusion. However, “time-outs” are voluntary and provide the patient with a realistic and gratifying solution. In other words, the patient is able to practice skills they will need after they are discharged into the community. AACAP explains that, “it is important that patients practice these strategies, so they are ready to use them in stressful situations” (Masters et al., 2002)

Lack of Facilities

Numerous RTC’s in New Mexico have been shut down, down-sized or re-organized—leaving some adolescents without the level of treatment needed. Professionals confirm that such facilities “seem to have disappeared or quietly slipped into the shadows of available services. The public sector has seen dramatic downsizing or closures of most long- and short-term inpatient psychiatric treatment centers for children and adolescents” (Behrens and Satterfield, 2011). For instance, in the past five to eight years, several child and adolescent treatment centers were forced to shut down in New Mexico, such as:

Casa de Corazon

Casa de Corazon, a comprehensive behavioral health children’s public provider was first established in 1989

in Taos, New Mexico with the initial mission of providing residential care for adolescent females. In 2002, a Casa de Corazon facility opened in Rio Arriba County. The agency was certified by CYFD as a provider for adolescents with co-occurring disorders. In November of 2007, Casa de Corazon was forced to discontinue services due to a lack of funding.

Halvorson House Residential Treatment Center

Located in Farmington, New Mexico, Halvorson House RTC was originally established as a children’s crisis shelter in 1979. Over the years, it grew into a certified RTC for male and female adolescents aged 12-17. Treatment was offered to adolescents who were diagnosed with an emotional, behavioral or neurobiological disorder. The treatment program was forced to close in April of 2012 due to sharp budget cuts. The program was funded through Medicaid and the New Mexico Human Services Department (NMHSD).

Lack of Treatment for Adolescent Females

The remaining public RTC’s do not serve females, and it has been noted that “*Residential providers willing to serve female adolescents, especially those who are also sexual offenders, are almost non-existent,*” (HJM 26, Female Secure Treatment). The OJJDP agrees that girls receive “scant attention,” despite the mandate requiring states to “develop and adopt policies to prohibit gender bias in placement and treatment” (OJJDP, 2010). Research still suggests that mental health treatment for female adolescents is needed, perhaps now more than ever. The Office of Minority Health in the United States Department of Health and Human Services released new minimum data standards for “Race and Ethnicity, Sex, Primary Language and Disability Status,” for which ‘sex’ or gender is identified as a minority with existing disparities. The New Mexico Department of Health declared a desire to move toward “*a status of health equity—the attainment of the highest level of health for all people*” (NMDOH Strategic Plan: 2014-2016). Despite this, many public programs in New Mexico only offer treatment to males. Other RTC’s that do serve girls are privately funded and costly.

Consequences of Withholding Treatment

Conduct Disorder, which is sometimes referred to as an Emotional and/or Disruptive Behavioral Disorder, and Personality Disorders have been found to be increasing

in prevalence in the female adolescent population. Researchers have found a correlation between female adolescents with Emotional and Disruptive Behavioral Disorders (i.e. Conduct Disorder) and a later development of Personality Disorders in early adulthood (Johnson et. al, 2000). The data suggests that untreated female adolescents are much more likely to develop a Personality Disorder later in life than treated females and males. Such disorders are associated with aggression, violence and criminal behavior (Helgeland et. al, 2005). Many studies have found gender-specific risk factors, such that females were found to be at a greater risk for delinquent behaviors related to and influenced by their specific mental health problems (NCMHJJ, 2009). The concern lies in the perpetuation of mental illness due to incorrect treatment, or lack of treatment. Yazzie (2011) describes this perpetuation as one of the many 'revolving door (s),' stating "youth offenders' mental health symptoms may go untreated and create long term difficulties for youth as they return to the community. The implication is that if adolescents do not receive the necessary treatment to function within the community this lack of treatment could potentially lead to further criminal activity and re-entry into the juvenile justice system. These findings are supported by an observable increase in the number of female juvenile offenders, many of which have significant mental health treatment needs. Previous research has already recognized that there is a high prevalence of mental illness in youth involved in the juvenile justice system (70% of these youth have at least one diagnosable mental illness, and 27% require immediate and critical treatment due to its severity). Data supports that the high prevalence is not a coincidence, and that the presence of one or more mental health disorders serves as a risk factor for juvenile offending. According to the National Alliance for the Mentally Ill (NAMI), the prevalence of females in need of mental health services outnumbers that of males by over 20%. Additionally, females requiring urgent mental health treatment are more than twice that of males (7% males, 15% females) (Behavioral Health, United States, 2012).

Research has also revealed that co-occurring mental health conditions that go untreated during adolescence can trigger a later onset of an alcohol or drug use disorder during adulthood. The work of Myszkka et al (2013) further explains the importance of identifying and treating mental health conditions early on, by stating, "It is important to consider that early interventions with children and youth who have an identified mental disorder could prevent or change the course and development of a substance use disorder." Failure to treat adolescent females also has financial

consequences. Typically, untreated individuals are forced to seek emergency treatment for episodic flare-ups. Such utilization can be costly to the individual and the community. In 2012, females aged 0-17 years old accounted for 59.3% of the emergency psychiatric inpatient treatment use, staying a mean length of 6 days. Of these individuals, 42% were uninsured, costing a mean total charge of \$10,206.00 (Behavioral Health, United States, 2012).

Benefits of Providing Treatment

Most residential programs, such as Sequoyah, emphasize that their clients must "be amenable to treatment and have the cognitive capacity to benefit from such treatment." In other words, before being admitted into RTC's, professionals must establish the necessity and benefits for potential clients.

Interestingly, research suggests that at admission, female youth are often more troubled than male youth (Handwerk, 2006). Despite this, at departure, "girls were rated as being more successful than boys by clinical staff" (Handwerk, 2006). Before jumping to the conclusion that this suggests girls are possibly more resilient or are more capable of recovering from mental illness (perhaps even on their own), consider the most simple explanation. Girls, regardless of the severity of their troubles, typically respond very well to residential treatment centers (Handwerk, 2006).

A study by Pine, Amanda Guyer, Ph.D., Eric Nelson, Ph.D., and colleagues utilized functional magnetic resonance imaging (fMRI) to measure brain activity in adolescent females. They found that girls experience a heightened sensitivity to interpersonal stress and peer's perceptions. The brain imaging revealed that girls show more brain activity in a social emotion circuit located near the amygdala during adolescence. The amygdala plays a key role in the processing of emotions, specifically those related to approaching or avoiding, also known as "fight or flight." Additionally, this area of the brain is associated with mood and anxiety disorders, which girls are at an increased risk for during this developmental stage. Emotional processing is complex, however, it can be thought of as driven by our most basic human motivations or instincts.

Ultimately, activation of the social emotion circuit motivates girls to respond to their peers and seek out interpersonal emotional ties—it reflects resilience. Such findings can be used to better understand the success girls experience when treated in residential centers. Residential treatment centers may offer the right amount of peer and general social interaction. This balance lays somewhere between still having a connection to the outside world while maintaining interaction with a much smaller set of peers within the center.

Conclusion

In conclusion, four issues merit further attention.

First, it is important to recognize that existing RTC's in New Mexico may not have established a set of standardized protocols and procedures.

Second, facility oversight may not exist to a satisfactory degree.

Third, it is important that community members' voices be heard, and that policy makers recognize the lack of adolescent RTC facilities around the state.

Fourth, RTC facilities for adolescents in New Mexico do not currently serve females.

With some changes, RTC's, like Sequoyah, have the potential to provide the best treatment for adolescents in New Mexico. The most important change, however, should be the easiest—extend treatment to females.

References

Lambie, Ian, Randell, Isabel (2013). The Impact of Incarceration on Juvenile Offenders. *Clinical Psychology Review*, Volume 33, Issue 3, Pages 448-459. (<http://www.sciencedirect.com/science/article/pii/S027273581300010X>)

Caldwell, F. Michael., Van Rybroek, Gregory (2013). Effective Treatment Programs for Violent Adolescents: Programmatic Challenges and Promising Features. *Aggression and Violent Behavior: A Review Journal*. Elsevier Ltd.

Office of Juvenile Justice and Delinquency Prevention

Behavioral Health, United States, 2012. U.S. Department of Health and Human Services; Substance Abuse and Mental Health Services Administration (SAMHSA).

The American Association of Children's Residential Centers, accessed on November 11, 2013 at: http://www.aacrc-dc.org/public_policy

Ireys, Henry, Achman, Lori, Takyi, Ama. State Regulation of Residential Facilities for Children with Mental Illness (2006). US Department of Health and Human Services (SAMHSA)

Behrens, Ellen and Satterfield, Kristin. A Multi-Center Study of Private Residential Treatment Outcomes. (2011)

Handwerk, M. Huefner, J., Smith, G., Clopton, K., Hoff, K., Lucas, C. Gender Differences in Adolescents in Residential Treatment. *American Journal of Orthopsychiatry* 2006, Vol. 76, No. 3, 312-324)

Yazzie, R. Availability of Treatment to Youth Offenders: Comparison of Public versus Private Programs from a National Census, 2011. *Children and Youth Services Review* 33, 804-809

Helgeland, M., Kjelsberg, E., Torgersen, S. Continuities Between Emotional and Disruptive Behavior Disorders in Adolescence and Personality Disorders in Adulthood. 2005. *AM J Psychiatry*; 162:1941-1947.

Cigna Behavioral Health, Inc. 2012. Medical Necessity Criteria for Treatment of Behavioral Health and Substance Use Disorders.

Myszka, M., Muise-Hill, J., Harden, Vickie., Benningfield, M., Burley, H., Perry, T., Rose, R., Horvath, K. 2013. TDMHSAS Best Practice Guidelines. Co-Occurring Disorders: An Integrated Approach.

Emotional Disturbance, National Dissemination Center for Children with Disabilities (NICHCY) Disability Fact Sheet #5. June 2010.

Collection of Evidence-based Practices for Children and Adolescents with Mental Health Treatment Needs, 5th Edition, 2013. Commission on Youth Membership. Ollendick, T., King, N. 2004. Empirically Supported Treatments for Children and Adolescents: Advances toward Evidence-Based Practice. *Handbook of Interventions that Work with Children and Adolescents: Prevention and Treatment*.

Principles of Care for Treatment of Children and Adolescents with Mental Illnesses in Residential Treatment Centers, June 2010. American Academy of Child & Adolescent Psychiatry (AACAP).

The New Mexico Sentencing Commission

The New Mexico Sentencing Commission (NMSC) serves as a criminal and juvenile justice policy resource to the three branches of state government and interested citizens. Its mission is to provide impartial information, analysis, recommendations, and assistance from a coordinated cross-agency perspective with an emphasis on maintaining public safety and making the best use of our criminal and juvenile justice resources. The Commission is made up of members of the criminal justice system, including members of the Executive and Judicial branches, representatives of lawmakers, law enforcement officials, criminal defense attorneys, and citizens.

This and other NMSC reports can be found at: <http://nmsc.unm.edu/reports/index.html>