Practical and Ethical Considerations in Providing Parent-Initiated Residential Treatment to Youth

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Susan A. Stoner, PhD, Research Consultant

Substance use disorders remain a significant concern with regard to the youth of Washington State. Parents seeking substance use disorder services for their children or youth frequently turn to the Division of Behavioral Health (DBHR) and Recovery of the Washington State Department of Health for guidance. As set forth in a 1998 modification of the 1995 "Becca Bill" (Substitute Senate Bill 6208 of the 1998 Washington Legislative Session), "parent initiated" treatment allows a parent to bring a minor child to an outpatient or inpatient treatment provider to have the child assessed for admission, without the child's consent.

Consistent with guidelines of the American Society of Addiction Medicine, multidimensional assessment is used to determine the appropriate level of care. While many youth are recommended for outpatient treatment, some youth who meet criteria according to the severity of their needs are recommended for inpatient/residential treatment. A recommendation of residential treatment potentially poses a dilemma with regard to non-consenting youth, who would be expected to be more likely than consenting youth to attempt to elope or abscond from treatment. Some residential facilities in Washington State provide interior and/or exterior security systems to reduce the potential for youth elopement. It is unknown whether locked facilities differ from unlocked facilities with regard to treatment outcomes, but there is concern that restriction may interfere with the treatment process by placing undue stress on young residents.

We examined the literature on ways in which treatment facilities have balanced the need to keep youth safe (preventing absconding/elopement) with the need to maintain a therapeutic environment (minimizing stress due to restriction). Despite extensive searching, we were unable to find literature that directly addressed these issues in the context of youth substance use disorder or co-occurring disorder treatment. Relevant literature exists in the broader domains of group care for children and adolescents, residential psychiatric treatment for youth, and secure residential treatment in a juvenile justice context. Information from these domains will be considered here.

Guiding Principle #1: First Do No Harm

A 2016 consensus statement by the International Work Group for Therapeutic Residential Care[1] stated that the first principle undergirding therapeutic residential care must be *primum non nocere*, i.e., to first do no harm. This principle acknowledges the potential for harm that may occur by providing treatment in residential settings without proper safeguards. For example, there has been ongoing concern about the potential for negative peer contagion in residential treatment settings in which youth learn dysfunctional behavior from each other and create a culture wherein such behavior is encouraged. Research suggests that the risk of negative peer contagion may be mitigated with careful placement of youths into the most appropriate treatment settings for their needs.[2]

Guiding Principle #2: Provide the Least Restrictive Alternative

For decades, the guiding principle for policies and practices in children's mental health has been the doctrine of Least Restrictive Alternative.[3] While the definition of this principle has been the source of debate over the years, the general idea is that "children with emotional disturbances should receive services within the least restrictive, most

normative environment that is clinically appropriate."[4] Although this principle may seem fairly straightforward on its face, it becomes more complicated with non-consenting minors being presented for parent-initiated treatment. Again, careful placement would be critical to identify the least restrictive environment in which therapy can be provided and the youth's safety can be assured.

Secure Residential Treatment

Secure residential treatment for adolescents is controversial due to the use of restrictions (e.g., close monitoring) and the corresponding loss of freedom. However, many argue that when troubled adolescents refuse or abscond from treatment and continue to engage in high-risk behaviors, physical containment and supervision in a secure treatment setting is strongly indicated to provide for the adolescents' safety and create a stable environment within which therapeutic relationships can have time and opportunities to develop.[5] The effectiveness of secure residential treatment is a topic of ongoing debate. Very little systematic research in this area exists with specific regard to adolescent substance use and co-occurring disorders. While some researchers claim nothing works in secure residential youth care, others show that secure residential youth care can work. Increasingly, researchers are beginning to examine with what youth, using what approaches, and under what other circumstances secure residential treatment is most likely to be effective.[6] Conversely, other researchers are examining what approaches and climates are likely to be harmful.[7]

Repression in secure residential care. A scoping review by de Kalk et al.[7] identified harmful effects of repression in residential treatment settings for youth. The authors note that "repression is a serious trap for staff in residential youth care, because it is hidden in aspects that are an essential part of residential youth care, such as power, structure, and coercion. These aspects become repressive when they are used harmfully, unlawfully, or arbitrarily. This becomes apparent when staff's acting worsens the youth's problems, or when children's rights are violated (for example, when the youth's liberty is restricted without legitimate reason). Arbitrary use of power, structure, and coercion result in youth to see staff's behavior as unpredictable, unfair and unsafe. This may cause reactance and demotivation in youth." (p. 209) The authors make a number of recommendations to reduce the likelihood of repression on organizational and staff levels. Awareness of and vigilance for obvious and subtle ways in which repression may be manifested is considered essential. Organizations are encouraged to promote stronger connections with youth, prevention of escalation, and focus on youth growth and empowerment. Organizations should pay particular attention to staff selection and training regarding harmful consequences of coercion and alternatives to coercive measures.

Views of adolescents and their parents regarding successful secure residential care. Harder et al.[8] noted that while adolescents often improve in their functioning during secure residential care, the fact that they still regularly show problem behaviors after their departure could be explained by the severity and complexity of their problems or by limitations of the treatment approach, insofar as it is coercive instead of therapeutic. Thus, these researchers conducted in-depth interviews with eight adolescents and their parents concerning the adolescents' secure residential care experiences and their views regarding what constitutes successful care. The adolescents themselves considered their own motivation for change to be a key element of the change process in secure residential treatment, and the authors recommended Self Determination Theory[9] as a relevant theoretical model. The environment was also thought be important to behavior change, particularly the group care workers were felt to be pivotal. Adolescents identified several characteristics of a good group care worker. The most salient were providing a good balance between rules and freedom and being empathic and available for help and support. Parents' responses were comparable to those of adolescents' in referring to power dynamics and empathy. Parents indicated that group care workers should be straightforward and firm in setting boundaries with adolescents but not be overly authoritarian. Parents also felt a good group care worker should be able to anticipate the feelings of adolescents, empathize with them, and have an understanding of their problems.

Enhancing adolescents' motivation to participate in parent-initiated treatment. When substance use or co-occuring disorders treatment is initiated by parents and youth are non-consenting, youth motivation to engage in treatment would be expected to be low. Brauers et al.[10] reviewed the literature on enhancing adolescents' motivation to participate in compulsory residential treatment and found the scientific evidence to be quite limited. Certain therapeutic techniques were identified as promising. Stein et al.[11] found that a Motivational Interviewing intervention decreased negative engagement in substance abuse treatment in incarcerated adolescents. Collier et al.[12] found that when a technique called node-link mapping was used with adjudicated adolescents in an eight-month residential chemical dependency program, youths rated themselves as more motivated to get along with staff and more motivated to engage in the treatment process. In terms of treatment milieu, a study by van der Helm et al.[13] found that an open group climate wherein group workers sought to promote meaningful interpersonal contact that fostered mutual respect and trust, autonomy, equality, responsibility, and feelings of safety, enhanced adolescent offenders' treatment motivation and internal locus of control in a juvenile justice context.

Keeping adolescents' perspectives in mind. Being taken to residential treatment essentially serves as a "time out" from adolescents' usual lives. Although not specifically about residential treatment for substance use or co-occurring disorders, a qualitative study by Haynes et al.[14] of adolescents' experiences of psychiatric hospitalization provides an interesting glimpse of their perspectives. Ten youths who were admitted for a range of psychiatric problems (e.g., anxiety, depression, PTSD, anorexia) were interviewed. A common theme was a sense of living in an alternate reality while being in the hospital, which was exacerbated by unusual rules and routines. Participants were expected to navigate new and complex relationships with staff and peers, in the unfamiliar context of the hospital, which added to sense of alternate reality. Participants described feeling restricted with a loss of freedom and privacy as they were closely monitored. Regaining freedom and autonomy was considered a positive step toward recovery, which increased self-esteem. All participants described feeling disconnected from family or friends during their time in the hospital, with some experiencing misunderstanding or stigma from their peers. Some reported feeling disconnected from their goals. The researchers made a number of recommendations based on the results of their interviews. The most relevant to residential treatment for substance use and co-occurring disorder treatment settings are as follows:
- It is important to provide comprehensive and accurate information to adolescents prior to admission and according to how much they want to know so they have some understanding of the rules and restrictions and the reasons why they are upheld.
- Maintaining connections with family and friends (as appropriate and desired by the individual) may be particularly important. Similarly everyday activities could be incorporated into the daily schedule to protect against feelings of disconnection from everyday life.
- Adolescents should be encouraged to maintain connections with their ongoing goals and ambitions wherever possible.
- Adolescents should be given the chance to share and explore feelings of disconnection and restriction with other residents, and staff should aim to enhance individual coping strategies where appropriate.
- Assigning roles to individual residents and nurturing autonomy wherever possible may help to protect against decreased self-esteem and help residents move through the recovery process. Offering follow-up after discharge may give adolescents the chance to fully process their residential treatment experience.

Taking a closer look at absconding/elopement. In parent-initiated treatment where youth are non-consenting, it would be expected that the risk of absconding or treatment elopement is high. There is some literature on predictors of elopement from adolescent residential or inpatient treatment. This literature may provide some guidance on youth who may be at highest risk to run away from treatment. A study by Kashubek et al.[15] compared a sample of young patients who eloped from residential treatment to those who did not elope. They found that runners were more likely than non-runners to have a prior history of elopement, a suspected history of sexual abuse, a diagnosis of mood disorder, and parents whose parental rights had terminated. Bowden and Lambie[16] conducted a comprehensive review of the literature on absconding from out-of-home care and found a number of

factors predicting increased risk of youth absconding: female gender, minority ethnicity, older age, presence of mental health difficulties, substance use, antisocial behavior, history of absconding, history of instability, family "pull" factors, residential treatment setting "push" factors (e.g., friction with peers), earlier in length of stay, boredom, decreased supervision, and adjustment difficulties.

Summary and Conclusions

In summary, in the context of harmful substance use and co-occurring disorders, there are no clear answers when it comes to balancing the need to keep youth safe with promoting their autonomy when they do not consent to treatment. No research exists that directly addresses this topic. For some ideas or guidance, it does seem useful to look to the juvenile justice literature though there are important differences between parent-initiated treatment for substance use and co-occurring disorders in their children and court-mandated treatment for juvenile offenders, probably the most glaring of which is relevance of punishment to the latter but not the former. Similarly, the literature on adolescent psychiatric hospitalization and child welfare is informative in some regards. A body of literature that was not consulted here that may be relevant is the literature on involuntary treatment for substance use disorders in adults. As with adults, there is unfortunately no guarantee that treatment of adolescents will be efficacious. As with involuntary treatment, it is hoped that in non-consenting treatment, the adolescent can be engaged early and become consenting to promote the best possible outcome.

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