

**Statement of Christopher Bellonci, MD**  
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**Before the U.S. House Committee on Education and Labor**  
**Hearing on**  
**“Child Abuse and Deceptive Marketing by Residential Programs for Teens”**  
**April 24, 2008**

Mr. Chairman and members of the committee, my name is Christopher Bellonci, M.D. and I am pleased to be here in support of your proposed legislation, the “Stop Child Abuse in Residential Programs for Teens Act of 2008”. I am a board-certified child and adolescent psychiatrist and the medical director at Walker, a multi-service agency in Needham, Massachusetts that offers residential treatment as one of a range of programs in our service array. I am a member of the American Academy of Child and Adolescent Psychiatry who paid for my travel to be here today. I co-wrote the Academy’s Practice Parameter on The Prevention and Management of Aggressive Behavior in Child and Adolescent Psychiatric Institutions with Special Reference to Seclusion and Restraint and am a board member of the American Association of Children’s Residential Centers.

First let me start by saying that treatment for a child or adolescent with serious emotional disturbance should be in the least restrictive environment, preferably with their family. However, there are many children that can not effectively be treated and managed in a home or community environment safely and need more acute intensive treatment. I am here today to talk about Walker and the specific needs of children and adolescents being treated in residential centers. We are licensed in Massachusetts through our state’s Early Education and Care (EEC) agency. As an accredited school, we are also approved by our state Department of Education. We are accredited by the Council on Accreditation, a national accrediting body originally affiliated with the Child Welfare League of America.

Our licensing and accrediting agencies all require frequent renewal and on-sight visits by representatives of these various regulatory bodies. We also adhere to reporting requirements that are consistent with those proposed in your legislation. EEC has clear guidelines for adherence to civil rights that would prohibit restriction of access to mail, family visits or phone calls. We do not utilize wilderness programming or boot camp experiences. Our staff undergo a minimum of two weeks of preservice training including instruction in Cornell University’s Therapeutic Crisis Intervention with a focus on de-escalation strategies and techniques that are individualized to the unique strengths and needs of the children we work with. Staff are cleared by the Massachusetts Criminal Records search process before they are allowed unsupervised contact with children. During orientation staff also receive training regarding mandated reporting laws, first aid and CPR. Walker has explicit policies outlining unacceptable forms of discipline consistent with those outlined in your proposed legislation. We also have clear policies regarding notification of adverse outcomes both to parents and guardians, as well as our state child protective service, our licenser, and funding and referral sources.

We strive for transparency in our work and view parents as essential allies in the complex treatment of children. We have an open campus and invite and encourage parents to visit and be an active part of the treatment milieu. Increasingly, we have been serving children and families in their homes, schools and communities. We actively partner with our state's child welfare and mental health departments in advancing best practice principles and provide consultation and program review and development to over 35 school districts in Massachusetts.

We take our commitment to family-driven practice seriously and in the last year have hired our first parent liaison coordinator, a parent of a child formerly in residential care at Walker. For over 5 years we have had a current parent serve as a voting member of our Board of Directors. We also have an active parent council and run parent support groups for all interested families.

I work directly with most of the children served in our residential program providing psychiatric treatment. It is against my ethical and licensing requirements to make a medication change without first discussing the risks and benefits of the proposed treatment and obtaining informed consent. In this regard, I am concerned that your legislation may not go far enough as it calls for notification to parents within 24 hours of a medication change when it is quite clear standards of ethical practice require the informed consent to be obtained prior to any removal or addition of a medication except in emergency situations.

The goal of this legislation is to ensure that children are not abused in these treatment settings, not to limit access to appropriate, regulated and licensed residential care for children who are in need of these services. All of us working in licensed residential centers should support this goal. All residential treatment programs should:

1. provide for all of the child's developmental needs including, mental health care, physical health care and education needs,
2. be licensed within the States where they practice and adhere to national standards,
3. encourage parents to be active parts of the treatment teams for their youth,
4. and employ a well trained, multidisciplinary, culturally competent staff.

The Board of the AACRC is equally concerned about the growing number of unlicensed residential programs. We believe that residential care in licensed and accredited facilities is an important and necessary part of an organized system of care and believe that all residential providers should be licensed within the States where they practice. In fact, all members of the AACRC are licensed and this is a condition of membership. We also strongly encourage residential centers to seek accreditation which hold the standards they must adhere to even higher.

As an organization representing agencies committed to working collaboratively with families and youth, we were disturbed by the concerns raised in this committee's previous hearing about children and youth experiencing harm in residential settings. We support the initiatives of this committee and its proposed legislation and believe that

residential treatment is an appropriate placement for some youngsters and that there are high quality programs being administered by committed and competent staff.

The AACRC's mission is to support the professional development of this committed and competent workforce. The AACRC looks forward to working alongside this committee and state and federal agencies in ensuring that standards are in place for residential centers.

Licensing creates a baseline of expectations to which all programs within a state can be held accountable. Effective licensing requirements help promote client rights, staff competence, quality improvement, and consistent practice. They provide the constants, the solid ground from which innovative and transformative practice can be launched. They also provide a degree of safeguard against the potential of harm to children, events of a type that can undermine efforts to create meaningful change. AACRC requires licensure of its members and is concerned about the variability of practice that can occur in unlicensed settings, which can lead to adverse outcomes for children and their families and criticism of the field. AACRC encourages organizations to work with their state authorities to create meaningful and reasonable licensing frameworks for residentially based services.

Accreditation is not an effective replacement for licensing, as the accountability it yields is less stringent than that which typically occurs through licensing and regulation. Nonetheless it is an important accompaniment to licensure. Accreditation standards encompass emerging knowledge and evidence in the field and come together to define clinical and managerial practices that result in high quality and effective care.

Agency-developed standards, policies, and procedures build upon the framework of licensing and accreditation, creating unique, mission-driven structures as the foundation for care and innovation. Establishment and measurement of desired outcomes and performance indicators helps each organization assess the degree to which it is fulfilling its own objectives and creates the possibility of comparison or benchmarking with other similar entities on key aspects of care identified through accreditation and licensing.

Compliance with accreditation standards, particularly in conjunction with adherence to licensing and regulatory requirements and a quality improvement infrastructure, provides the foundation of safety and best practice that can infuse transformational change, elevate practice, and improve outcomes. AACRC supports efforts to establish licensure requirements and encourages agencies to pursue voluntary accreditation, as part of implementing a transformation agenda.

In the last two decades, the thinking about family involvement across the child serving systems has begun to change. The Child and Adolescent Service System Program (1985) envisioned a central role for families in community systems of care for children with mental health problems. Wraparound, family decision making, and parent-professional partnerships have emerged in child welfare, education, medical, and juvenile justice arenas, as well as in mental health. Such service configurations have recently been supported by research and heralded in salient mental health public policy studies,

including the Surgeon General's and the President's New Freedom Commission reports. Research specific to residential care has also consistently identified improved child outcomes when parents and families are more involved. The response from the field to these developments has been slow but not insignificant, as residential centers across the country increasingly design processes and practices for more inclusion of parents and family members in the care of their children. The result has been improved outcomes for children and families.

Parents and families provide important information and feedback. An approach that engages them equally creates a shared responsibility for growth and change. It provides the opportunity for staff to work together with parents and to utilize family members' experience and expertise. This yields an increased ability to understand the child within the context of his/her family, culture and community, and to develop realistic expectations, plans, and supports. The family is affirmed in having their strengths recognized and valued; the staff benefit from having support and assistance and from being relieved of the implicit, at times self-imposed, responsibility to be the ones who will "fix" the child. Family-driven care is a partnership.

Parents are strong and effective voices, advocating in pragmatic and realistic ways for the needs of children on quality improvement, planning, and governance bodies. As political partners with professionals, parents are powerful advocates for the full continuum of care, inclusive of residential, and for efforts to meet the needs of children and families in local communities. The research in residential treatment consistently shows that the processes and outcomes of care improve in correlation with the degree of family involvement.

At the governance level parents are valuable members of Boards of Directors, and offer critical input into strategic planning and resource allocation. At the system level parents can have important voices on advisory committees and interagency collaboratives. Parents understand the importance of a full array of services and, in telling their stories, have a powerful influence on policy makers.

Such multi-level partnerships can help establish and reinforce a culture of family-driven care. They are more readily supported if the organization has made the leadership commitment to become family driven and can dedicate budgetary resources to supporting parent travel, paying stipends, or hiring parents as paid staff. The Board of Directors and CEO can ask themselves a series of key questions in assessing readiness to move in this direction, for example:

- ✓ *Do the staff of the organization act, speak, and interact in ways that truly welcome, support, affirm, and incorporate the perspectives and wishes of parents?*
- ✓ *Do parents have to be "invited" into the organization or is it a baseline assumption of staff that parents are reciprocal partners?*
- ✓ *Is the organization committed to redefining itself as providing an intervention within a community continuum rather than as a placement of last resort?*

- ✓ *Does the organization believe that sharing decision-making, leadership, and power with parents yields better outcomes for children and youth?*
- ✓ *Is the organization willing to implement training and other practices that culturally reinforce the importance of parents and families in day to day actions, discussions, and care planning?*

The responses to these questions can drive strategic planning and practice innovation. Changes in practice, even incremental, can and do lead to positive results.

The American Academy of Child and Adolescent Psychiatry is currently working on a Practice Parameter defining best practice for residential treatment and once available, AACAP would be happy to share it with the committee. Many of my remarks are taken from Position Papers developed over the last 5 years by the AACRC.

Thank you for the opportunity to present these comments to the Committee.