47 - 31.18c Residential, Day, and Hospital Treatme

31.18c Residential, Day, and Hospital Treatment

Laugeson EA, Frankel F, Gangman A, Dillon AR, Mogil C. Evidence-based social skills training for adolescents with autism spectrum disorders: The UCLA PEERS Program. J Autism Dev Discord. 2012;42:1025–1036. Laugeson EA, Frankel F. Social Skills for Teenagers with Developmental and Autism Spectrum Disorders: The PEERS Treatment Manual. New York: Routledge; 2010. Liddle HA, Rowe CL, Dakof GA, Ungaro RA, Henderson CE. Early intervention for adolescent substance abuse: Pretreatment to posttreatment outcomes of a randomized clinical trial comparing multidimensional family therapy and peer group treatment. J Psychoactive Drugs. 2004;36:49. Manassis K, Mendlowitz SL, Scapillato D, Avery D, Fiksenbaum L, Freire M, Monga S, Owens M. Group and individual cognitive-behavioral therapy for childhood anxiety disorders: A randomized trial. J Am Acad Child Adolesc Psychiatry. 2002:41:14243. Mishna F, Muskat B. “I’m not the only one!” Group therapy with older children and adolescents who have learning disabilities. Int J Group Psychother. 2004;54:455. Muris P, Meesters C, van Melick M. Treatment of childhood anxiety disorders: A preliminary comparison between cognitive-behavioral group therapy and a psychological placebo intervention. J Behav Ther Exp Psychiatry. 2002;33:143. O’connor MJ, Laugeson EA, Mogil C, Lowe E, Welch-Torres K, Keil V, Paley B. Translation of an evidence-based social skills intervention for children with prenatal alcohol exposure in a community mental health setting. Alcohol Clin Exp Res. 2012;36:141–152. Stallard P, Sayal K, Phillips R, Tahylor JA, Spears M, Anderson R, Araya R, Lewis G, Millings A, Montgomery AA. Classroom based cognitive behavioural therapy in reducing symptoms of depression in high risk adolescents: Pragmatic cluster randomised controlled trial. BMJ. 2012;345:e6058. Thienemann ML. Child psychiatry: Group psychotherapy. In: Sadock BJ, Sadock VA, Ruiz P, eds. Kaplan & Sadock’s Comprehensive Textbook of Psychiatry. 9th ed. Vol. 2. Philadelphia: Lippincott Williams & Wilkins; 2009:3731. Wilens TE, Rosenbaum JF. Transitional aged youth: A new frontier in child and adolescent psychiatry. J Am Acad Child Adolesc Psychiatry. Sep 2013;52(9):887–890. 31.18c Residential, Day, and Hospital Treatment Inpatient, partial hospital, and residential treatment are designed for the management of acute stabilization, stepdown care, and longer-term management of children and adolescents with psychiatric disorders. Given the limited number of psychiatric inpatient units for children and adolescents, however, intensive outpatient programs and partial hospital treatment programs are often used for children with

severe psychiatric disorders. Partial hospital programs are increasingly being offered by managed care companies as alternatives to hospitalization to contain treatment cost. These programs are designed to serve the needs of children and adolescents with severe disorders who require immediate psychosocial and/or pharmacological; interventions but who may not meet the acuity criteria of “medical necessity” for hospitalization. Residential treatment centers are appropriate settings for children and adolescents with psychiatric disorders who require a highly structured and supervised setting for several months or longer. Such settings provide a stable, consistent environment with a high level of psychiatric monitoring that is less intensive than in a hospital. Children and adolescents with serious psychiatric disturbances are sometimes admitted to residential facilities due to

family situations in which appropriate supervision and parenting are impossible. Dan was a 16-year-old adolescent boy with a long history of depression and multiple suicide attempts. He was admitted to a local adolescent psychiatric inpatient unit after for a life-threatening suicide attempt. At the end of the first week of hospitalization, Dan’s family’s managed care company refused continued coverage, since they determined that he was no longer an acute suicide risk. Dan was remorseful about his recent suicide attempt and was determined not to repeat his self-destructive behavior. However, due to continued serious depressive symptoms and chronic family dysfunction, the inpatient treatment team did not feel that Dan was ready to be discharged to weekly outpatient treatment. Dan was transferred to a partial hospital program affiliated with the inpatient unit. Over the course of Dan’s 8-week treatment, he developed a strong therapeutic alliance with his individual therapist, and the psychoeducation provided to the family resulted in the beginning of meaningful changes. The partial hospital program child psychiatrist met with Dan regularly, managed his medication, and collaborated with his therapist to manage his suicidal ideation. At the end of 8 weeks, Dan’s depressive symptoms were decreased, and he was safely transitioned to outpatient therapy and returned to school successfully. The partial hospital program allowed for a safe transition from full hospitalization with continued consolidation of progress in a highly structured system. (Adapted from case material courtesy of Laurel J. Kiser, Ph.D., M.B.A., Jerry Heston M.D., and David Pruitt, M.D.) Mark was an 8-year-old boy referred to a rural community mental health center for evaluation and treatment. Mark presented with extreme irritability, labile mood, tantrums, and physical violence toward his peers and adults. Even when he was not having a tantrum, he seemed discontent and irritated and had a short fuse. He had received multiple school suspensions and was at risk for expulsion. His family psychiatric history was positive for schizophrenia in his maternal grandmother. Upon finishing his outpatient psychiatric evaluation, the clinician recommended participation in a newly established partial hospital/day treatment program that used a behavioral management program close to Mark’s elementary school. The clinician also recommended a trial of fluoxetine to determine whether Mark’s irritability would be ameliorated, and individual therapy, social skills group, and family therapy. During Mark’s 6-month participation in the day program, his behavioral management program extended into the classroom setting as well as in therapeutic activities. His daily goals included increasing compliance, decreasing anger outbursts, and decreasing physical aggression. He was able to improve peer relations while receiving immediate feedback and direct instruction on social skills in a group setting and also in his individual therapy. Each staff member was able to consistently apply behavior management principles in their domain areas. Mark’s parents actively participated in family therapy sessions and parent conferences. Mark seemed to be benefitting from the fluoxetine and was less irritable. Although he still had occasional

outbursts, they were milder and shorter. Mark was gradually transitioned to half a day in a regular classroom setting, and he remained the other half day in the day program. After 8 more weeks of this transition, he was able to return to his public school. (Adapted from case material courtesy of Laurel J. Kiser, Ph.D., M.B.A., Jerry Heston, M.D., and David Pruitt, M.D.) HOSPITALIZATION Psychiatric hospitalization is necessary when a child or adolescent is contemplating or exhibiting dangerous behaviors directed at him or herself or toward others. The most frequent reasons for psychiatric hospitalization among youth include suicidal thoughts or behavior, and aggressive and assaultive behaviors. Safety, stabilization, and initiation of effective treatment are the main goals of hospitalization. In some cases, psychiatric hospitalization may be a given child's first experience of a stable, safe environment. Hospitals are often the most appropriate places to initiate a new psychopharmacological agent, especially when side effects are prevalent, in order to provide around-the-clock observations of a child's behavior. Children who have been maltreated often show remission of certain symptoms by virtue of being removed from a stressful and abusive environment. Given the frequency of uncontrollable aggression as the trigger for many psychiatric admissions among youth, inpatient units must provide safe and effective ways to defuse and stabilize aggressive and violent acts. Placing a child or adolescent on the verge of a violent act in a contained room away from the rest of the milieu is one method of de-escalating a potentially violent situation. Both restraint and seclusion have been considered therapeutic interventions for youth who cannot control aggressive impulses, but given the rare but reported deaths of patients by asphyxiation during restraint procedures, there have been efforts to reduce this intervention. However, seclusion and restraint cannot be abandoned until another form of intervention is found to be highly effective. In some cases, psychopharmacological interventions, that is, "chemical restraint," has been utilized to defuse acutely dangerous situations on an inpatient unit. Optimally, identifying and recognizing antecedents of aggressive behaviors and intervening before the aggression is enacted is the goal. Inpatient care is a setting for stabilization and the initiation of treatment, with the expectation that when a child or adolescent is discharged to a less restrictive environment, the patient will no longer pose a danger to him or herself or others, and that treatment and support services will be in place for continued care. Partial Hospital In most cases, children and adolescents who attend partial hospital, or day treatment programs, have serious mental disorders and might warrant psychiatric hospitalization without the program's support. Family therapy, group and individual psychotherapy, psychopharmacology, behavioral management programs, and special education are integral parts of these programs. Partial hospital programs are excellent alternatives for

children and adolescents who require more intensive support, monitoring, and supervision than is available in the community, but who can live successfully at home if they receive the proper level of intervention. The concept of daily comprehensive therapeutic experiences that do not require removing children from their homes or families is derived partly from experiences with a therapeutic nursery school. The main advantages of partial hospital programs are that children remain with their families and the families can be more involved in day treatment than they are in residential or hospital treatment. Partial hospital also is much less expensive than residential treatment. At the same time, the risks of day treatment include a child's relative social isolation and confinement to a narrow band of social contacts in the program's disturbed peer population. Indications. The primary indication for a partial hospital plan is the need for a more structured, intensive, and specialized treatment program than can be provided on an outpatient basis. At the same time, the home in which the child is living should be able to provide an environment that is at

least not destructive to the child’s development. Children who are likely to benefit from day treatment may have a wide range of diagnoses, including autistic disorder, conduct disorder, ADHD, and mental retardation. Exclusion symptoms include behavior that is likely to be destructive to the children themselves or to others under the treatment conditions. Therefore, some children who threaten to run away, set fires, attempt suicide, hurt others, or significantly disrupt the lives of their families while they are at home are not suitable for day treatment. Programs. Ingredients that lead to a successful partial hospital program include clear administrative leadership, team collaboration, open communication, and an understanding of children’s behavior. A major function of child-care staff in partial hospital programs is to provide positive experiences and a structure that enables the children and their families to internalize controls and to function better than in the past. Because the ages, needs, and range of diagnoses of children who may benefit from some form of day treatment vary, many day treatment programs have been developed. Some programs specialize in the special educational and structured environmental needs of mentally retarded children. Others offer therapeutic efforts designed to treat children with autism and schizophrenia. Still other programs provide the total spectrum of treatment usually found in full residential treatment, of which they may be an extension. Children may move from one part of the program to another and may be in residential treatment or partial hospital according to their needs. A school program is always a major component of partial hospital treatment. Attempts have been made to analyze the treatment outcome of partial hospitalization. Many different dimensions exist to analyze the overall benefits of such programs; assessment of level of improvement in clinical status, academic progress, peer relationships, community interactions (legal difficulties), and family relationships are some pertinent areas to measure. In a follow-up 1 year after discharge from a

partial hospital program, comparison of patients at admission and 1-year post-discharge showed statistically significant improvement in clinical symptoms on each subscale of the Child Behavior Checklist, except for sex problems. Improvements were found in mood, somatic complaints, attention problems, thought problems, delinquent behavior, and aggressive behavior. The assessment of long-term effectiveness of day treatment is fraught with difficulties, and may differ when measuring a child’s maintenance of gains, a therapist’s view of psychological gains, or cost-to-benefit ratios. The lessons learned from day treatment programs have encouraged mental health disciplines to have services follow children, rather than have separate programs, which result in discontinuity of care. The experiences of partial hospital programs for psychiatric conditions of children and adolescents have also encouraged pediatric hospitals and departments to adopt models that promote continuity of care for children with chronic physical illness.

RESIDENTIAL TREATMENT Children in residential treatment often have combinations of severe psychiatric disorders and severely troubled families who cannot adequately care for their children. In some cases, a child or adolescent requires a more structured environment than is possible at home. In other cases, a family is unable to oversee a child’s psychiatric treatment due to their own psychiatric illness, substance abuse, or medical debilitation. In cases of child abuse or neglect, a family does not provide a safe and nurturing environment for a child. When families are available and motivated, their participation is strongly encouraged while their children are in residential treatment. The aim is to enable them to reunite with their children and care for them at home in the future. Staff and Setting Staffing patterns include various combinations of child-care workers, teachers, social workers, psychiatrists, pediatricians, nurses, and psychologists; therefore,

residential treatment can be very expensive. The Joint Commission on the Mental Health of Children made the following structural and setting recommendations: In addition to space for therapy programs, there should be facilities for a first-rate school and a rich evening activity program, and there should be ample space for play, both indoors and out. Facilities should be small, seldom exceeding 60 patients in capacity with a limit of 100 patients, and they should make provisions for children to live in small groups. The centers should be located near the families they serve and should be readily accessible by public transportation. They should be located for ready access to special medical and educational services and to various community resources, including consultants. The centers should be open institutions whenever possible; locked buildings, wards, or rooms should be required only rarely. In designing residential programs, the guiding principle should be that children should be removed from their normal life settings the least possible distance in space, in time, and in the psychological texture of the experience. Indications Most children who are referred for residential treatment have had multiple evaluations by professionals, such as school psychologists, outpatient psychotherapists, juvenile court officials, or state welfare agency staff. Attempts at outpatient treatment and foster home placement usually precede residential treatment. Sometimes, the severity of a child's problems or the inability of a family to provide for the child's needs prohibits sending a child home. Many children sent to residential treatment centers have disruptive behavior problems in addition to other problems, including mood disorders and psychotic disorders. In some cases, serious psychosocial problems, such as physical or sexual abuse, neglect, indigence, or homelessness, necessitate out-of-home placement. The age range of the children varies among institutions, but most children are between 5 and 15 years of age. Boys are referred more frequently than girls. An initial review of data enables the intake staff to determine whether a particular child is likely to benefit from the treatment program; often, for every child accepted for

admission, three are rejected. The next step usually is interviews with the child and the parents by various staff members, such as a therapist, a group-living worker, and a teacher. Psychological testing and neurological examinations are given, when indicated, if they have not already been performed. The child and parents should be prepared for these interviews. Milieu Most of a child's time in a residential treatment setting is spent in the milieu. The staff consists of clinicians and care workers who offer a structured environment that forms a therapeutic milieu; the environment places boundaries and limitations on the children. Tasks are defined within the limits of children's abilities; incentives, such as additional privileges, encourage them to progress rather than regress. In milieu therapy, the environment is structured, limits are set, and a therapeutic atmosphere is maintained. The children often select one or more staff members with whom to form a relationship; through this relationship, they express, consciously and unconsciously, many of their feelings about their parents. The child-care staff should be trained to recognize such transference reactions and to respond to them in a way that differs from the children's expectations, which are based on their previous or even current relationships with their parents. This requires an awareness of countertransference in staff members. To maintain consistency and balance, the group-living staff members must communicate freely and regularly with each other and with the other professional and administrative staff members of the residential setting, particularly the children's teachers and therapists. Behavior modification principles are typically embedded into the daily program for children in residential settings. A recent study examined the association between use of antipsychotic medication and seclusion/restraint (S/R) frequency in the management of acute aggressive behavior in adolescents in residential facilities. Adolescents who were in the moderate

and high groups for having S/R were significantly more likely to have changes in antipsychotic medication and receive higher doses of medication. However, even with high doses, their rates of S/R continued to be frequent. These findings bring into question the efficacy of antipsychotic agents for managing acute aggression in residential settings. Education Children in residential treatment frequently have severe learning disorders, disruptive behavior, and ADHD. Usually, the children cannot function in a regular community school and consequently need a special on-grounds school. A major goal of the ongrounds school is to motivate children to learn. The educational process in residential treatment is complex; Table 31.18c-1 shows its components. Table 31.18c-1 Education Process in Residential Treatment

Therapy Most residential facilities use a basic behavior modification program to set guidelines and to give the residents a concrete sense of how to earn privileges. These behavioral programs range in detail and intensity. Some programs operate with level systems that are associated with privileges and responsibilities. Some programs use a token economy system in which residents earn points for appropriate behavior and for meeting specific goals. Most programs include basic tasks of living as well as specific therapeutic goals for the residents. Psychotherapy offered in these programs generally is supportive and oriented toward reunion with the family when possible. Insight-oriented psychotherapy is included when it can be used by a resident. Parents Concomitant work with parents is essential. Children usually have a strong tie to at least one parent, no matter how disturbed the parent may be. Sometimes, a child idealizes the parent, who repeatedly fails the child. Other times, the parent has an ambivalent or unrealistic expectation that the child will return home. In some instances, the parent must be helped to enable the child to live in another setting when it is in the child’s best interest. Most residential treatment centers offer individual or group therapy for parents, couples, or marital therapy, and in some cases, conjoint family therapy.

DAY TREATMENT The concept of daily comprehensive therapeutic experiences that do not require removing children from their homes or families is derived partly from experiences with a therapeutic nursery school. Day hospital programs for children were then developed, and the number of programs continues to grow. The main advantages of day treatment are that children remain with their families and the families can be more involved in day treatment than they are in residential or hospital treatment. Day treatment also is much less expensive than residential treatment. At the same time, the risks of day treatment are a child’s social isolation and confinement to a narrow band of social contacts in the program’s disturbed peer population. Indications The primary indication for day treatment is the need for a more structured, intensive, and specialized treatment program than can be provided on an outpatient basis. At the same time, the home in which the child is living should be able to provide an environment that is at least not destructive to the child’s development. Children who are likely to benefit from day treatment may have a wide range of diagnoses, including autistic disorder, conduct disorder, ADHD, and mental retardation. Exclusion symptoms include behavior that is likely to be destructive to the children themselves or to others under the treatment conditions. Therefore, some children who threaten to run away, set fires, attempt suicide, hurt others, or significantly disrupt the lives of their families while they are at home may not be suitable for day treatment. Programs The same ingredients that lead to a successful residential treatment program apply to day treatment. These ingredients include clear administrative leadership, team collaboration, open communication, and an understanding of children’s behavior. Indeed, having a single agency offer both residential and day treatment has advantages. A major function of child-care staff in day treatment for psychiatrically

disturbed children is to provide positive experiences and a structure that enables the children and their families to internalize controls and to function better than in the past regarding themselves and the outside world. Again, the methods used are essentially similar to those in full residential treatment programs. Because the ages, needs, and range of diagnoses of children who may benefit from some form of day treatment vary, many day treatment programs have been developed. Some programs specialize in special educational and structured environmental needs of mentally retarded children. Others offer special therapeutic efforts required to treat children with autism and schizophrenia. Still other programs provide the total spectrum of treatment usually found in full residential treatment, of which they may be a part. Children may move from one part of the program to another and may be in residential treatment or day treatment according to their needs. The school program always is a

major component of day treatment, and psychiatric treatment varies according to a child's needs and diagnosis. Results Recently, attempts have been made to analyze the treatment outcome of day treatment and partial hospitalization. Many different dimensions exist to analyzing overall benefits of such programs. Assessment of level of improvement in clinical status, academic progress, peer relationships, community interactions (legal difficulties), and family relationships are some pertinent areas to measure. In a recent follow-up 1 year after discharge from a partial hospital program, comparison of patients at admission and 1-year post-discharge showed statistically significant improvement in clinical symptoms on each subscale of the Child Behavior Checklist, except for sex problems. These improvements were in mood symptoms, somatic complaints, attention problems, thought problems, delinquent behavior, and aggressive behavior. The assessment of long-term effectiveness of day treatment is fraught with difficulties, from the point of view of a child's maintenance of gains, a therapist's view of psychological gains, or costto-benefit ratios. At the same time, the advantage of day treatment has encouraged further development of programs. Moreover, the lessons learned from day treatment programs have moved mental health disciplines toward having services follow children, rather than perpetuating discontinuities of care. The experiences of day treatment for psychiatric conditions of children and adolescents have also encouraged pediatric hospitals and departments to adopt a model that promotes continuity of care for the medical treatment of children with chronic physical illnesses. REFERENCES Aarons GA, James S, Monn AR, Raghavan R, Wells RS, Leslie LK. Behavioral problems and placement change in a national child welfare sample: A prospective study. J Am Acad Child Adolesc Psychiatry. 2010;49:70–80. Baeza I, Correll CU, Saito E, Aranbekova D, Kapoor S, Chekuri R, De Hert M, Carbon M. Frequency, characteristics and management of adolescent inpatient aggression. J Child Adolesc Psychopharmacol. 2013;23:271–281. Damnjanovic M, Lakic A, Stevanovic ED, Jovanovic A. Effects of mental health on quality of life in children and adolescents living in residential and foster care: a cross-sectional study. Epidemiol Psychiatr Sci. 2011;20:257–262. Epstein RA Jr. Inpatient and residential treatment effects for children and adolescents: A review and critique. Child Adolesc Psychiatr Clin N Am. 2004;13:411. Geller JL, Biebel K. The premature demise of public child and adolescent inpatient beds: Part I: Overview and current conditions. Psychiatric Q. 2006;77:251. Geller JL, Biebel K. The premature demise of public child and adolescent inpatient beds: Part II: Challenges and implications. Psychiatr Q. 2006;77(4):273–291. Kober D, Martin A. Inpatient psychiatric, partial hospital and residential treatment for children and adolescents. In: Sadock BJ, Sadock VA, Ruiz P, eds. Kaplan & Sadock's Comprehensive Textbook of Psychiatry. 9th ed. Philadelphia: Lippincott Williams & Wilkins; 2009:3766. Miller L, Riddle MA, Pruitt D, Zachik A, DosReis S. Antipsychotic treatment patterns and aggressive behavior among

Revision #1
Created 2026-01-04 19:52:24 UTC by Omar Ayman
Updated 2026-01-04 19:52:24 UTC by Omar Ayman