



RESIDENTIAL TREATMENT FOR SEVERELY DISRUPTIVE MINORS: TECHNICAL CONTRIBUTIONS TO A SOCIAL AND INSTITUTIONAL DEBATE

Antonio Galán Rodríguez

Family, Childhood and Adolescent Services of Extremadura

Residential treatment for minors with severe conduct problems has been questioned from a social and institutional point of view, but little attention has been paid from academic contexts. Difficulties in definition, implementation and management are analyzed, including problems caused by clinical-based definitions. Management by the Healthcare System is considered the best choice in most cases; nevertheless, Child Protection Services could run these centers for children in foster care. If so, a number of concepts and models different from clinical ones should be used: deficits in self-regulation as the core problem, and psycho-educational intervention as the axis of the treatment. Other controversial topics are analyzed, such as restraint methods, intervention models, or the relationship with the Juvenile Justice System. Finally, some recommendations related to the definition and functioning of these facilities are provided.

Key words: *Conduct disorder, Behavior disorders, Residential care, Self-regulation.*

Los centros para menores con graves conductas transgresoras son recursos muy cuestionados a nivel social e institucional, pero han recibido poca atención desde contextos académicos. Analizamos las dificultades que implica su definición, implementación y gestión, y abordamos especialmente los problemas ligados a una definición basada en criterios clínicos. Se defiende la conveniencia genérica de su adscripción al entorno sanitario, pero también al ámbito de la protección a la infancia cuando se trata de menores desprotegidos; para estos casos se sugiere el uso de conceptos y modelos diferentes a los clínicos: los déficits de autorregulación como problema básico, y la intervención socioeducativa como eje del tratamiento. Analizamos otros aspectos conflictivos como el uso de la contención, los modelos de intervención, o la relación con el Sistema de Justicia Juvenil. Finalmente, planteamos algunas recomendaciones en relación a la definición y funcionamiento de estos centros.

Palabras clave: *Trastorno de conducta, Trastorno del comportamiento, Acogimiento residencial, Autorregulación.*

The current models for child-adolescent Mental Health care and Child Protection, share an emphasis on the search for normalization in their intervention (use of community resources, children remaining within the family, ordinary schooling...). However, some minors require very specific care that does not entirely fit this model. Among them, some adolescents and youth can be found whose personal difficulties entail a pattern of very serious transgressive conduct that makes everyday life very difficult (in their families, or in ordinary children's shelters). Although for most of these minors, community and family interventions are the indicated response, a reduced group persists that require an intensive intervention in a daily living context, that is to say, medium to long-term residential treatment.

There are numerous centers specifically designed to care for them, with a variety of formats and designations. They are questionable facilities on a social and professional

level and they are faced with diverse conceptual, practical and legal problems. The study of these has scarcely been approached in academic contexts, limiting their analysis to institutional spheres or social debates spurred on by the media when unfortunate events occur.

Criticism has frequently been aimed at the System for the Protection of Children and Adolescents (Sistema de Protección a la Infancia y Adolescencia; SPIA hereafter), given that this organization manages most of these facilities. Indeed, and although behavior disorders constitute one of the main causes for requesting care by Mental Health teams, few health care services have opted to undertake this kind of residential care. An illustrative example can be found on revising the Community of Madrid's Mental Health Plan (Department of Health of the Community of Madrid, 2010), which includes no facilities of this type and limits itself to indicating the convenience of "studying the need for a Therapeutic Residential Center offering intense treatment to children and adolescents with serious mental and conduct disorders" (p. 126). On the other hand, the Madrid Institute for Minors and the Family

Correspondence: Antonio Galán Rodríguez. Servicio de Familias, Infancia y Adolescencia. Avda. Reina Sofía, 30. 06800 Mérida. España.
E-mail: antonio.galan.rodriguez@juntaextremadura.es



offered a list of nine facilities under the title of "Specific centers for minors with mental health, behavior and/or consumption of toxic substances disorders".

In view of the lack of adequate responses from other places in the health care network, it is possible that the SPIAs began assuming this specialized residential care due to the need to offer solutions to minors receiving care in their own facilities. In this way, these minors were considered as a new sheltered population profile that needed a specialized care model (Bravo and del Valle, 2009a). As a result, a network of resources has been created and professional past experience has been accumulated, turning the SPIAs into the main reference for this type of residential care. In fact, at present, the rest of the health care network frequently tries to refer cases to them, or the families themselves ask for minors to be admitted, and all this without having duly addressed the appropriateness of this institutional ascription at an institutional and technical level.

We thus find a precarious definition about how this so vulnerable population must be cared for and by whom. Considering the need for a reflective and definitive work in which professionals linked to child care take an active part, this paper has been elaborated as a contribution to the effort to delimit some aspects that should be taken into consideration when addressing this problematic reality.

INSTITUTIONAL CONCERN

Contributions from academic or specifically technical spheres in our country that provide analyses or proposals in relation to these resources are scarce; hence, a great number of current references comes from institutions involved in the defense of childhood. However, the main interest of these has been placed on safeguarding judicial guarantees for minors in residential care; thus, the ongoing references to control facilities when faced with abusive practices (a proposal that judicial authorization be demanded for admission, or that the Basic Regulatory Law on the Autonomy of the Patient be respected when referring to pharmacological prescriptions...) or demands for legislative changes (fundamentally, a state directive with the force of organic law). In this context, the more technical aspects have occupied a secondary place.

For reasons of space, we will limit ourselves to brief references to a reduced number of especially valuable or illustrative documents in order to offer a broad overview.

Many of these initiatives emerged based on a report presented by the Ombudsman in 2009 in relation to centers for "minors with conduct disorders and in a difficult social situation". The report's conclusions caused great social impact, but beyond the media coverage and its excessively naive conception of the problem, it had the beneficial effect of promoting initiatives destined to order and clarify the functioning of these facilities. The report showed the variety of facilities, illustrated by a diversity of designations: centers for conduct disorders, special regime units, centers or homes for socialization or therapeutic care, therapeutic education centers... This variety reflects the difficulty in their definition, and the absence of a state regulation that unifies regional responses. Moreover, this report shows the difficult reality of some families where there are children with serious disruptive behaviors or with certain mental disorders, because they do not receive an adequate response from education and health care providers and finally resort to a public child protection agency to request a specialized center.

It was precisely the complaints about the care provided by these public services (education, health, social) that had already driven a report by the Ombudsman for Children in Andalucía in 2007. This report concluded that if a minor with a behavior disorder presents mild difficulties, these are promptly detected and the family quickly demands an intervention, the facilities in the health, education and social systems being sufficient to address them; but if the disorder is serious, the problem is late in being detected, or they turn to public facilities too late, it is very possible that the family will not find adequate responses. One specific element in this report is that for the Andalusian Ombudsman, the central issue is the clinical category (conduct disorder) and as such primarily requires health care. The study showed that the Health Care System does not offer an adequate response: late detection, referrals and diagnoses, often contributes an exclusively medical response, and does not have specific facilities for the most serious cases (when medium to long-term admission is required); in contrast, the Protection System has created these residential facilities, but as units specifically aimed at its minors.

These social and professional debates reached their maximum institutional level when the Senate dedicated a series of sessions (from 7 March to 20 September, 2011)



of the “Special Commission for the Study of the Problem of National Adoption and Other Related Topics” to analyze the situation in specialized centers for conduct disorders. In the hearings made by different professionals and institutional authorities (session reports can be consulted at www.senado.es), the magnitude of the problem and the uncertainties accompanying it can be appreciated. Proposals aimed at legally regulating some aspects of the functioning of these centers emerged from this Commission, although the end of the legislative term impeded the full enactment of the law.

Another institution involved in this problem is the Juvenile Prosecutor’s Office, given that it supervises the protective interventions of Public Entities and their residential facilities. For this reason, it has created certain regulatory material such as Circular 8/2011 issued by the Office of the Prosecutor-General (FGE) on criteria for the specialized unit for action by the Public Prosecutor’s Office concerning the Protection of Minors. The Office of the Prosecutor-General puts great emphasis on avoiding violating the rights of minors, especially considering the lack of legal definition in which these facilities are found (they are not classified as ordinary centers, but neither can they be typified as special centers according to article 271 of the Civil Code. Finally, the necessary use of constraint measures constitutes another important risk factor in abusive practices. Faced with these dangers, the Prosecutor-General is demanding a government regulation, and while this takes place, is opting for solutions with more guarantees with respect to the rights of minors.

On their part, public entities for child protection made a joint contribution in May of 2010, when the Inter-regional Commission of General Directors of Child Care reached consensus on the “Basic Protocol for Action in Centers and/or Residences with Minors Diagnosed with Conduct Disorders” (General Directorate for Social Policy of Families and Childhood, 2010). In spite of its limitations at a regulatory level, it acquired great relevance on becoming a guide for action with certain institutional support. In fact, it justified the existence of specific facilities to address serious behavior disorders and crisis situations, as these require a very structured context, along with an educational and psychotherapeutical approach that can only be offered in a specific program. It also offered concrete recommendations about diverse aspects of daily functioning.

DIFFICULTIES WITH THE DEFINITION

At present, there is no unequivocal definition of these centers, neither at an administrative level nor at a technical level. Thus, there is no governmental regulation that makes them a specific entity; and at the treatment level, it is difficult to find operational criteria (and that support critical questioning) that allows us to define the population to be treated. From this, there arises disparate proposals on the profile of minors and of the requirements for admission, or the diversity of designations that the facilities receive (residential centers for intensive education, for therapy, for conduct disorders, for socialization...); below this variety underlies, among others, the key question about whether the basic orientation of these facilities should be health or another type (child protection, social-educational...).

One of the most problematic elements in this sense is the role that the concepts “mental disorder” and “conduct disorder” must play in the definition of the facility and in the criteria for admission. Their presence is undeniable, but what at first seems to be a good option (resort to clinical diagnoses), puts us on a slippery slope. The classification of mental disorders offers well-operationalized descriptions of a profile of the minor that fits these facilities well (especially the diagnosis for conduct disorder). Nevertheless, defining the facilities according to these criteria implies a series of problems.

- A. Most of these centers are not catalogued as clinical-health facilities, but as child protection centers; therefore, defining the resident profile according to clinical diagnoses leads to questioning why this particular minor is not being cared for by health care services.
- B. Some professionals (and documents) define these centers as facilities for “conduct disorders”, at the same time as they indicate that they should not treat mental disorders; they make this statement believing that certain mental disorders do not belong (schizophrenia, bipolar disorder, some pervasive developmental disorders, eating disorders), and that they should be treated in other types of facilities. With this, the concept of “mental disorder” becomes confusing and obliges the establishment of a difficult distinction between types of mental disorders. In some respects, it seems as if there is a non-explicit differentiation being made between “authentic mental illness” and “conduct



disorder”, reserving that for clinical symptoms of greater severity (“severe mental disorder” configured as the most traditional baggage of clinical psychiatry). This corresponds to the existence of two differentiated profiles for minors that any professional can perceive but that are not operationalized adequately, perhaps because individual clinical diagnoses are not sufficient, and that a different type of criteria are needed (health care needs, capacities of an environmental support, levels of psychic organization...).

These incoherencies are causing difficulties typical of clinical spheres, which are amplified when transplanting them to this particular context:

1. The weakness of childhood mental disorder classification systems. Thus, the child psychopathology model defended by international mental disorder classifications may be inadequate because it means a transference of the adult model to childhood. The characteristics of childhood psychiatric illnesses (non-specific symptomatology, self-regulation capacity, reversibility and mutability, time-dependent pathology, individual differentiability, comorbidity, psychoplastic effect) (Rodríguez-Sacritán, 1995) give this a specificity that would require a different manner of classification. At the theoretical level, this has been translated into different formulations, such as the developmental psychopathology (Lemos, 2003). And at a more practical everyday level, we find the reluctance of many health care professionals to make diagnoses when caring for children.
2. The weakness of the nosological category “conduct disorder”, as a controversial clinical entity because of its symptomatic heterogeneity, multicausality and high comorbidity (Fernández et al., 2010). In fact, it involves such heterogeneity of situations that it is of little utility for characterizing minors when designing a psychological intervention.
3. In many places, the precariousness of the health care network when serious cases are involved introduces much confusion in relation to the role that it really plays. In spite of its conceptual and institutional resources (theoretic models, intervention instruments, design of care facilities...), the most frequent health care reality when faced with serious cases is that the response is limited:
 - ✓ Psychopharmacology is an important aid in the

treatment of many minors (Robb, 2010), but it is still a response aimed at the symptom (when referring to anxiety and impulsivity), and thus, it is insufficient.

- ✓ Ambulatory psychotherapy is confronted with a series of limitations: the frequent refusal of minors to participate in an intervention of this type, and the need for session frequency and regularity that many Mental Health resources cannot provide.
- ✓ Home treatment appears to be an important community focused tool in Mental Health Care, but in reality it is scarcely present.
- ✓ A priori, Day Hospitals seem to be an especially interesting facility for this type of minor: spaces with a therapeutic component for shared living are developed, they utilize integrated treatment, and they respect the compulsoriness of schooling. However, these are scarcely implemented, and save very few exceptions (See Bertrán et al, 2011), they are reserved for patients with other clinical profiles (for example, eating disorders) or for those in which the disruptive behavior forms part of a wider range of clinical problems (pervasive development disorders, psychotic symptoms in adolescence...).
- ✓ With respect to long-term residential treatment, the clinical-health sphere has made important contributions at a theoretical level (Jiménez, 2004). However, at present, there are very few facilities of this type implemented by health care administrations and, as occurs with Day Hospitals, they give preference to cases different from the minors to whom we are referring.

We thus see that the bulk of residential care and interventions in informal contexts (home, socialization spaces...) are managed by social services, both generic and specialized, more than by clinical-health services. And even part of the psychotherapeutic response is also contributed by social services (family intervention programs, psychotherapy units concerted by Child Protection Services...). We find ourselves confronted with the paradox in which a problem is defined from the parameters of a health care space foreign to that which will undertake an important part of the intervention. That is, that the clinical healthcare concepts (such as “conduct disorder”) are those which define the intervention in a different professional space. This introduces a notable factor of confusion in the citizenry and in the professionals



with respect to who should take on this responsibility. From a technical point of view, in this psycho-social-educational sphere, we frequently witness an ill-considered transfer of concepts and models coming from other care contexts and the consequent devaluation of the past experience in its own field of belonging. It is for this reason we consider recommendable that if the specialized social services continue to assume this care responsibility, they advance in the elaboration of a model of the understanding of the problem that is coherent with the principles and tools appropriate to this field of work. Our proposal in this sense would be to approach these problems from two basic premises:

- ✓ Self-regulation problems (emotional, behavioral, cognitive) as a key behavior manifestation and a definitive element (instead of being based on clinical diagnoses). It is based on the conceptualization of self-regulation as one of the main organizers in psychological development, just as it is seen from some formulations of the attachment theory (Sroufe, 2005), or in some visions about certain behavioral difficulties (Mas, 2009).
- ✓ The need for a social-educational intervention as the central axis around which complementary actions revolve. As a result, the treatment of minors would be based on important technical and professional experience accumulated in the area of child protection over the past years, and which constitutes one of their signs of identity (Bravo & Del Valle, 2009b).

DIFFICULTIES FOR ITS ASSIGNATION

Based on some questions raised, doubts about the delimitation between child protection and health care institutions can be understood, given that there is a significant overlap sustained not only on theoretical questions but also on institutional negligence.

Evidently, we can define the problems of these minors in clinical terms, assign their symptoms to nosological categories, and make use of the conceptual and technical past experience appropriate of the health care realm in order to treat them. If this clinical-health perspective is to be adopted, the Health Care System should have at its disposal the entire corresponding range of care resources, including medium to long term residential stays for serious cases that are intractable at the outpatient level. This model is indisputably the most adequate for a certain profile of minors whose difficulties primarily require concepts, techniques and

health care instruments specific to Psychiatry or Clinical Psychology. Thus, faced with psychotic disorders, certain evolutions in pervasive development disorders, serious affective pathologies...social-educational intervention clearly occupies a secondary place in intervention programs for these minors. Curiously, even centers aimed at these profiles are frequently taken over by specialized social services instead of health care services (see, for example, Decree 355/2003 for Residential Care in Andalusia).

Even excluding these profiles, and save isolated exceptions, the reality of present day health care for a great part of our country is that the healthcare network does not offer an adequate response in serious cases. In this respect, it seems to be in line with a tendency in many world healthcare systems to forgo long-term residential treatment for adolescents and children (Leventhal & Zimmerman, 2004). And thus, in our country there are few facilities of this type and only exceptionally is referral to private centers made; moreover, these admissions tend to be accepted only when the disruptive conduct appears to be linked to a major mental disorder, for which we are referring to a profile of the minor different from the one considered in this article. This is especially visible when some parents apply for residential centers for their children; the negative answer from healthcare institutions leads these parents to resort to SPIAs, in spite of these having been created to provide care for neglected, abandoned, or maltreated children...And, in fact, the inclusion of a minor in this System implies the assumption of a protective measure, which carries with it the legal disqualification of the parents. It thus results in an anomalous situation that is not receiving the public attention it deserves (with a few exceptions, such as that already mentioned in the report made by the Andalusian Ombudsman).

Nevertheless, for those minors already in the protection network and who present serious self-regulation problems, what would an adequate response be? Refer them to the Mental Health sector or continue providing the response from the SPIA itself? We consider both options to be coherent and viable. We have just finished justifying that the Health Care System undertake this care, but it would also be coherent if the SPIA itself would assume that responsibility in the case of unprotected minors.

The main argument brings us back to the needs of a



great part of these minors. Today, adolescents and youth that form part of the Protection System require care that substitutes the family, and a social-educational intervention that favors their personal development; seriously disruptive conduct does not annul this need for attention, and in fact, when confronted by problematic behaviors, intervention makes use of the same concepts and techniques that are applied when providing substitute care that favors growth. That is, a great part of these minors in situation of abandonment with self-regulation problems require an intervention whose two key elements (substitute care and social-educational intervention) comprise the Protection System's own specialty. In fact, in many aspects, this intervention model could be taken as a model by residential resources that wish to care for minors who are not unprotected. Based on this argument, when a minor sheltered in a residential facility requires a specialized center, the minor is demanding a very similar type of attention to that already being received; what is needed is the introduction of some qualitative changes and, above all, an important increase in the intensity of the intervention; and the necessary complementary interventions, many of which could be situated in institutional sectors different from Child Protection, will have to center around this basic objective. In fact, many of these centers have implemented concepts and techniques appropriate to the clinical area (psychotherapeutic techniques, diagnostic categories, medication, etc.), thus, externally, they may seem like health care centers, and in this way increase confusion about their identity.

This approach establishes a continuity between ordinary and specialized resources and is coherent with a residential care conception based on a model of resource diversity (Del Valle & Fuertes, 2000), which supports the existence of specialized facilities covering specific needs that cannot be addressed by generic programs.

Consequently, we see that both assignments (health care resources versus protection services) may be coherent with the principles that sustain both of these areas of care. It would, therefore, be an institutional decision that should opt for the integral development of a health care response for the whole population (including unprotected minors) or the maintenance of two different networks, each one with its specialized care. In some cases, a dual assignment could be made as an ideal option in which both institutions share

responsibility, and in which each one applies its specific experience with such complex problems. We could even widen this assignment to include the Education System. In effect, there are centers that have made use of this multiple administrative dependence (see, for example, Gausachs, 2004). Nevertheless, we should accept that it is always difficult to achieve adequate synergy between institutions whose priorities or resources may not go hand in hand. This is why, and without forgetting that it is an ideal that should be advanced, we must provisionally opt for the more modest solution in seeking joint definitions and of assuring institutional coordination when confronting these cases.

CONFLICTIVE ASPECTS

There are many more delicate aspects that require a certain analysis, such as that referring to containment. In the context we are referring to, this has acquired negative connotations, connecting it to physical restraint, maltreatment or humiliation; thus, there is an attempt to elude the term. Nevertheless, the unavoidable reality is that the care of minors involves the need to put a limit on destructive behaviors; thus, we must seek conceptualizations and practices that allow us to do so in an efficient and respectful way. A productive way of understanding containment is by including it in a continuum that begins with self-regulation, continues with ordinary regulation, and that upon failure of the former requires an extraordinary procedure. It is then when "containment" is identified with physical restraint, seclusion, or the use of pharmaceuticals that calm the anguish and agitation. Thus constraint:

- ✓ Is situated within the space of the child's needs.
- ✓ Includes two basic dimensions: a) responds to an urgent current demand (prevent affective outbursts, block an aggression, avoid self-harm); and b) has as its final aim, the development of a capacity for self-restraint. Containment is only good when it seeks to offer basic security and at the same time contributes to the construction of that capacity for internal regulation.
- ✓ It includes as a basic idea that the more external a resource used is, the more difficult its internalization will be. This means that the more passive the child is in this process, the greater the difficulties he/she will have in developing his/her own capacity for regulation. For this reason, reflexive dialogue is more productive than physical subjection, and the search for personal strategies to avoid a behavioral outburst (an activity, a



game...) is more constructive than a drug. Thus, strategies that are imposed (pharmacological or mechanical constraint) are very efficient for offering immediate security (this is from where their need arises) but they contribute very little to the development of self-regulation mechanisms. Finding an optimum point between immediate security and the process of personal construction is a decision that must be made by the individual in each case.

Another aspect that generates debate is that referring to the supervision of these resources, especially the risk of abusive practices. Their specificity obliges the maximizing of some aspects of control and vigilance, for example that referring to physical spaces and security. Equally, institutional control should be greater than for ordinary resources, and it should be clearly specified that concrete incidences must be communicated by the centers (unjustified absences, suicide attempts, constraint or isolation measures, etc.) In general, we would proffer a greater exigency in the search for quality that would be reflected in the qualifications and training of the personnel, in the design and implementation of educational programs, or in the development of specific protocols. Likewise, we would commit to the existence of specialized technical teams responsible for admission assessment and case follow-up (Childhood Observatory of Andalusia, 2012).

Another guarantee of good work is making sure that admission is a part of wider Case Planning that includes the minor's care in an integral and longitudinal manner. These centers should not become residual places or spaces outside the System. To avoid this, the incorporation of a minor should be coherent with a general intervention plan. And this is going to imply that said admission is linked to the formulation of concrete goals and the establishment of timeframes; on the other hand, accepting it as a temporary resource will oblige working from the very first moment with the aim of returning the minor to the family home or to the original residential facility. Moreover, we must point out that the current emphasis on community-based models has one of its origins in the verification (both in health care and child protection facilities) that prolonged institutionalization entails diverse pernicious effects (loss of autonomy, personal impoverishment, stigmatization); this is even more prevalent in the need to consider residential facilities

(including long-term) as a transitory stage within a broader intervention

Furthermore, we find a wide variety of designs in intervention programs as described by Zimmerman (2004) classifying them into five types (the psychodynamic milieu approach, "positive peer culture", the behavioral model, the psycho-educational model, and the cognitive-behavioral model) to which we can add some others (such as, medical-psychiatric focus, or the "challenge models"). Studies of the evidence have centered fundamentally on out-patient intervention models (Moreno & Meneres, 2011) or on juvenile detention centers (Le Blanc, 2004), so that the effectiveness of residential treatment for the minors we are referring to here has not yet been duly assessed; to some extent, this may respond to the heterogeneity of the centers and the populations cared for. Evidentially, some models are inadequate because they do not show themselves to be useful or because they are unacceptable for the basic principles of our care system (for example, the popular American "boot camps" whose practices would be considered inappropriate or even illicit in our country). Yet, there are few valid references for other models. This does not mean that strict theoretical foundations for their functioning should not be demanded since an improvised intervention implies a serious risk of failure, or the possibility of the resource becoming a mere containment instrument for defiant behaviors. These models must consider a specific concept of the human being, of the family, of group functioning and of antisocial conduct, which must be explicit and constitute the base on which organization and everyday functioning are established. Obviously, these principles and their application must be the object of control on the part of the entities that supervise these resources.

Finally, we must point out that many minors susceptible to these resources are involved in criminal conducts and, therefore, the application of Organic Law 5/2000 regarding criminal liability is applicable to them. This means that two institutional systems (Child Protection and Juvenile Justice) are going to coincide in the same case, and it is then possible that discrepancies emerge regarding their respective objectives and procedures. The casuistry shows us that these differences exist, that they have given way to multiple institutional conflicts, and that there is a disparity of criteria between different



administrations. In some of these questions, a clear pronouncement by the distinct institutions involved would be necessary (Office of the General Prosecutor, Juvenile Courts, Child Protection Services), especially in some problematic aspects around which there is a diversity of positions. Think, for example, about whether the resources assigned to child protection services could care for minors who comply with the judicial measure for coexistence in an educational group. A different issue is that relative to which facilities would permit the fulfillment of therapeutic admissions, although their analysis goes beyond the scope of this document.

At a purely technical level, we consider that a judicial measure does not in itself constitute an exclusion criterion. The determinant factor to assess belonging to these resources are the difficulties of the minor that prevent him/her from developing some basic emotional and behavioral regulation mechanisms; committing an offence and the imposition of a judicial measure constitute significant elements in the personal and psychosocial configuration of the minor, but they are not the core element when considering whether this type of specialized center can help him/her. On the other hand, they will influence the way intervention strategies are implemented, whether these are administrative or interpersonal aspects. Thus, the fact of being subject to a judicial measure is going to introduce elements such as the coercive nature of the intervention, the existence of a series of timeframes to be complied with, the presence of certain restrictions on everyday functioning, or the consequences that can be caused by a lack of collaboration in the intervention.

CONCLUSIONS

In our effort to initiate a technical and professional debate about these specialized centers, we will conclude with these final evaluations:

- ✓ There exists a clear necessity in care of having specific residential facilities available for minors with serious emotional and behavioral self-regulation difficulties, and the institutions should assume this ethical commitment to an especially vulnerable population.
- ✓ When these minors are in an unprotected situation, both health care facilities and the Child and Adolescent Protection System network could assume their care. However, there would have to be a definition of profiles and an establishment of communication frame-

works that would allow for the placement of minors in the network that better responds to their needs.

- ✓ Placing part of these resources in the realm of child protection requires the use of concepts and techniques appropriate to this field of care so that design and everyday functioning are coherent with their institutional pertinence. For this reason, the resources must be defined based on criteria different to that of clinical diagnoses.
- ✓ The special characteristics of these minors and of the care that they require obliges putting emphasis on the need for control and supervision of the care received in the facility.
- ✓ The exceptionality of these facilities makes it recommendable to consider a stay in them as a temporary resource, subject to the fulfillment of some goals and timeframes that would be coherent with a broader Case Plan.
- ✓ The nature of the very specialized technical work to be performed with the minors obliges the maintenance of greater quality, which will be reflected in the training of the professionals, the rigorosity of the Educational Projects, and the foundation of Theoretical Models.
- ✓ The complexity of these cases and the variety of care that needs to be provided makes the active collaboration of distinct institutions related to child and adolescent care advisable.

REFERENCES

- Bertrán, S., Burgos, F.J., Fernández-Mayoralas, M.C. and Hielga, S. (2011). El Hospital de Día de Adolescentes de Martorell. *Informaciones Psiquiátricas*, 206, 375-383.
- Bravo, A. and Del Valle, J.F. (2009a). Crisis y revisión del acogimiento residencial. Su papel en la protección infantil. *Papeles del Psicólogo*, 30, 42-52.
- Bravo, A. and Del Valle, J.F. (Comps.) (2009b). *Intervención socioeducativa en acogimiento residencial*. Oviedo: Dirección General de Políticas Sociales-Gobierno de Cantabria.
- Consejería de Sanidad de la Comunidad de Madrid (2010). *Plan Estratégico de Salud Mental 2010-2104*. Madrid: Consejería de Sanidad.
- Defensor del Menor de Andalucía (2007). *Menores con trastornos de conducta en Andalucía*. Sevilla: Defensor del Pueblo Andaluz.
- Defensor del Pueblo (2009). *Centros de protección de*



- menores con trastornos de conducta y en situación de dificultad social. Madrid: Defensor del Pueblo.
- Del Valle, J.F. and Fuertes, J. (2000). *El acogimiento residencial en la protección a la infancia*. Madrid: Pirámide.
- Dirección General de Política Social, de las Familias y de la Infancia (2010). *Protocolo básico de actuación en centros y/o residencias con menores diagnosticados de trastornos de conducta*. Madrid: Ministerio de Sanidad y Política Social.
- Fernández, A., González, M.A., Abeijón, J.A., Bravo, B., Fernández de Legaria, J.A., Guadilla, M.L., Gutiérrez, J.R., Hernanz, M., Larrinaga, M.A., Lasa, A., Múgica, M.A., Palomo, J. and Rey, F. (2010). *Abordaje integrado intra y extrahospitalario de los trastornos de conducta en la adolescencia. Investigación comisionada*. Vitoria-gasteiz: Departamento de Sanidad y Consumo-Gobierno Vasco.
- Gausachs, R. (2004). Estructura y organización del centro de menores "Can Rubió": un modelo de abordaje. En Fundación Internacional O'Belen y Fundación MAPHRE Medicina (Comp.), *Trastornos del Comportamiento en Niños y Adolescentes* (pp. 313-320). Madrid: Editorial MAPHRE.
- Jiménez, A.M. (2004). Dispositivos de internamiento terapéutico para patología mental grave de niños y adolescentes. *Revista de la Asociación Española de Neuropsiquiatría*, 89, 167-186.
- Lemos Giráldez, S. (2003). La psicopatología de la infancia y la adolescencia: consideraciones básicas para su estudio. *Papeles del Psicólogo*, 85, 19-28.
- Leventhal, B.L. and Zimmerman, D.P. (2004). Residential treatment. *Child & Adolescent Psychiatric Clinics of North America*, 13(2), 15-17.
- Le Blanc, M. (2004). La readaptación de los jóvenes delincuentes. En Fundación Internacional O'Belen y Fundación MAPHRE Medicina (Comp.), *Trastornos del Comportamiento en Niños y Adolescentes* (pp. 3-52). Madrid: Editorial MAPHRE.
- Mas, C. (2009). El TDAH en la práctica clínica psicológica. *Clínica y Salud*, 20, 249-259.
- Moreno, I. and Meneres, S. (2011). Tratamiento de los trastornos del comportamiento. Revisión de las propuestas actuales. *Apuntes de Psicología*, 29, 183-203.
- Observatorio de la Infancia en Andalucía (2012). *Centros de Protección de Menores en Situación de Desamparo que presentan trastornos de conducta en Andalucía*. Junta de Andalucía-Consejería para la Igualdad y Bienestar Social.
- Robb, A.S. (2010). Pharmacotherapy for aggression in children and adolescents. *Psychiatric Annals*, 40, 231-236.
- Rodríguez-Sacristán, J. (1995). Los rasgos propios del enfermar psíquico en la infancia. En J. Rodríguez-Sacristán (Ed.), *Psicopatología del niño y del adolescente* (pp. 65-77). Sevilla: Universidad.
- Sroufe, L.A. (2005). Attachment and development: a prospective, longitudinal study from birth to adulthood. *Attachment & Human Development*, 7, 349-367.
- Zimmerman, D.P. (2004). Psychotherapy in residential treatment: historical development and critical issues. *Child & Adolescent Psychiatric Clinics of North America*, 13, 347-361.

