Out of State, Out of Mind:

The Hidden Lives of D.C. Youth in Residential Treatment Centers

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UNIVERSITY LEGAL SERVICES, INC.

Since 1996, University Legal Services, Inc. (ULS), a private, non-profit organization, has been the federally mandated protection and advocacy (P&A) program for individuals with disabilities in the District of Columbia. Congress vested the P&As with the authority and responsibility to investigate allegations of abuse and neglect of individuals with disabilities. Accordingly, ULS provides administrative and legal advocacy to protect the civil rights of District residents with disabilities.

ULS staff directly serves hundreds of individual clients annually, with thousands more benefiting from the results of investigations, institutional reform litigation, outreach and education and group advocacy efforts. ULS staff addresses client issues relating to, among other things, abuse and neglect, community integration, accessible housing, financial exploitation, access to health care services, discharge planning, special education, and the improper use of seclusion, restraint and medication.

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I. Introduction

Ten years ago, in the landmark decision Olmstead v. L.C.,[1] the Supreme Court held that unnecessary institutionalization of individuals with disabilities constitutes a form of discrimination. Despite this, at any given time, the District of Columbia pays for approximately 300 to 550 children who have been diagnosed with a mental illness to attend institutions called Residential Treatment Centers ("RTCs"), congregate institutions that tend to be far from the District, expensive, abusive, and most importantly, generally ineffective. Recently, the District published a report stating that 515 individuals under age 22 were in 96 different RTCs.[2] Approximately 35% of these youth were more than 300 miles from the District of Columbia.[3] The District of Columbia has the second highest percentage of students age 6 to 21 in residential facilities. The only state with a higher percentage of students in RTCs is South Dakota.[4]

There is a professional and legal consensus that youth need and are entitled to treatment in the least restrictive environment appropriate for their needs, and that policies that promote unnecessary institutionalization are both illegal and detrimental to youth. As Justice Ruth Bader Ginsburg explained in Olmstead v. L.C., unnecessary institutionalization is harmful in two ways:

> "First, institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life. . . . Second, confinement in an institution severely diminishes the everyday life activities of

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[1] 527 U.S. 581 (1999).

[2] February 2009 report from City Administrator's Office. On file with author.

[3] June 2008 report from City Administrator's Office. On file with author.

[4] Based on the number of youth served under the Individuals with Disabilities Act in residential treatment centers. U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS), OMB #1820-0517: Part B, Individuals with Disabilities Education Act, Implementation of FAPE Requirements, 2007. Data updated as of July 15, 2008. Available at https://www.ideadata.org/default.asp.

> individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.[5]

In light of this, the trend in most states has been to reduce or eliminate the use of RTCs. However, in the District, the population of youth in these RTCs has stayed relatively steady for years.

On the tenth anniversary of Olmstead, children, youth, and families in the District deserve an open and frank discussion about the District's use of RTCs, their benefits and risks, their efficacy, and their cost. There is little public discourse, however, about who the children in RTCs are, how they ended up in RTCs, what life is like in an RTC, and what they need to return home. This information is not readily available for a number of reasons. First, these children are scattered across the country, out of the public's eye. Second, at least five different District of Columbia agencies have some sort of jurisdiction over these placements, making the regulatory scheme fragmented and the oversight poor. Last, the individuals and agencies that control the placement decisions often have financial, institutional, and personal incentives to promote RTC placements, externalizing the true cost of these placements.

In November 2007 and April 2008, University Legal Services (ULS) requested information, via the District of Columbia Freedom of Information Act (FOIA), from agencies that send youth to RTCs, monitor the well-being and treatment of youth in RTCs, and fund RTC placements. ULS requested copies of censuses, monitoring reports, investigations, and spending related to RTCs from the Department of Youth Rehabilitation Services, the Department of Mental Health, the Department of Health Care Finance (then part of the Department of Health), the District of Columbia Public Schools, and the Child and Family Services Agency. While ULS

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[5] Olmstead v. L.C., 527 U.S. 581, 600 (1999).

sought this information, the District of Columbia Office of the City Administrator began tracking placements in RTCs, and publishing monthly analysis. The FOIA responses, the City Administrator's reports, testimony provided at City Council Oversight hearings, and ULS' experience from years of representing youth in RTCs, form the basis of this report.

The report is divided into five sections:

Section I: Introduction
Section II: Life in an RTC
Section III: The Cost of an RTC
Section IV: The Path to an RTC
Section V: Alternatives and Recommendations
Sections VI: Conclusion

The intent of the report is not to give a complete statistical or fiscal analysis of youth in RTCs. At this point that is not possible, due the paucity of information on certain subjects, and conflicting information regarding others.[6] The hope is that by highlighting what we do and do not know, we can encourage a real dialogue in this city about the District's overreliance on institutions, and offer some recommendations that may help the District start to reform its institutional bias.

II. Life in an RTC

RTCs isolate youth from their families and homes, place youth at risk of abuse, subject youth to dangerous restraint and seclusion practices, and often fail to improve long term outcomes. Because most RTCs the District uses are geographically isolated, unannounced or frequent visits are almost impossible. Youth at RTCs often lack privacy to make telephone calls

[6] This lack of data is not unique to the District. A recent report by the Government Accountability Office (GAO) noted that most states have serious gaps in their oversight of youth in residential programs, making is difficult to report on abuse and neglect accurately: "Youth in some government and private residential facilities have experienced maltreatment including physical abuse, neglect or deprivation of necessities, and sexual abuse that sometimes resulted in death or hospitalization, but data limitations hinder efforts to quantify the problem." GAO, Residential Facilities: Improved Data and Enhanced Oversight Would Help Safeguard the Well-Being of Youth with Behavioral and Emotional Challenges, May 2008, GAO-08-346, at 3.

or write letters, and therefore communication with these children is additionally limited, particularly if the youth is afraid of retaliation. Although gathering information can be challenging, and the 96 different RTCs the District uses vary, some generalizations may be made.

A. Basic Demographics of District Youth at RTCs

The vast majority of youth in RTCs are between the ages of 15 to 18, accounting for 71% of the total RTC population. There are approximately 150 youth in RTCs that are committed to the District's juvenile justice system, the Department of Youth Rehabilitation Services (DYRS).[7] Another 135 or so are in the state's custody through the child welfare system, the Child and Family Services Agency (CFSA). More than 70% are receiving special education services.[8]

The District places youth in a total of 96 different RTCs.[9] Most of these placements are extremely far from home – approximately 35% of these youth are more than 300 miles from the District of Columbia, and more than 50% of the total youth in RTCs are more than 100 miles from D.C.[10] Not only are the RTCs far away, but they tend to be long term placements. At the

[7] According to the June 2008 report by the Office of the City Administrator, there were approximately 160 youth in residential treatment. According to the March 11, 2009 DYRS performance oversight written testimony, as of that date, there were 110 youth in RTCs. Most recently, DYRS provided data that states that as currently there are 153 youth in RTCs. All of these were "point in time" measurements—that is, a count of the number of children in RTCs on a particular day. DYRS data on file with author.

[8] February 2009 report from City Administrator's Office. On file with author.

[9] Id.

[10] See June 2008 Report from City Administrator's Office. On file with author. The City Administrator does not count distance from the District, but rather whether the RTC is in Maryland, Virginia, or D.C. It may be more appropriate to measure distance from D.C., or whether the RTC is accessible through public transit. Many areas of Virginia and Maryland are more than a 100 miles away. For example, the Pines, which had 21 youth from D.C. in February 2009, is located in Virginia, but is almost 200 miles from the District.

beginning of FY 2006, the majority of District youth in RTCs had been in their current RTC for more than eight months. Some had been in RTCs for up to eight years.[11]

B. Residential Treatment Centers are Isolating, Abusive, and Dangerous.

RTCs tend to isolate youth, even when they are in the midst of a city, because their structure inherently separates children from their natural support systems, including parents, extended family, friends, schools, religious institutions, and community-based case workers. The child spends most of his or her day around paid staff and other children with disabilities. School is often part of the RTC. Visiting hours and telephone calls are usually limited. Many times, parents and other caretakers are not included in the child's day-to-day life, making meaningful family involvement during a child's stay all but impossible.

This isolation severely impedes youths' clinical treatment and their quality of life. The isolation that comes from being in an institution cannot be overstated. As the Supreme Court explained, "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."[12]

For obvious reasons, isolation can be counter-productive. For example, if a youth with behavior issues interacts only with other youth with behavior problems, the children will lack positive role models. Isolation can also lead to a lack of "generalization." That is, the skills learned in an RTC often do not transfer to life outside of an RTC because the environments are so different. Isolation also makes children, particularly ones with mental health and other cognitive issues, extremely vulnerable to abuse.

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[11] FOIA'ed documents from CFSA, DMH, DYRS, HSCSN and DCPS, requested April 2007. On file with author.

[12] Olmstead v. L.C., 527 U.S. 581, 601 (1999).

Abuse at RTCs is a serious concern. As the protection and advocacy program for individuals with disabilities for the District of Columbia, ULS has received complaints of beatings and choking, isolation in seclusion rooms for days at a time, excessive and dangerous use of physical and chemical restraints, overmedication with serious psychotropic medications that cause many side-effects, denial of the opportunities to go outdoors for months at a time, unsanitary conditions, insufficient heating and cooling, and denial of access to lawyers and outside advocates. Such abuses are counter-therapeutic and, at worst, lethal: deaths due to restraint have occurred at some of the same facilities where District children either currently reside or have resided in the last five years.[13]

RTCs may also overuse restraint and seclusion. For example, in September 2007, the Pennsylvania Department of Public Welfare sent a letter to CFSA stating its concerns about youth sustaining serious injuries from restraints at an RTC called Kidspeace. CFSA interviewed seven of the eight CFSA youth at the program and found that the records show that for these eight youth, Kidspeace used 214 physical restraints and 37 chemical restraints in one year.

RTCs use restraint and seclusion as a form of punishment or a threat. Youth often complain about this, but may have difficultly proving it because usually the only evidence that restraint or seclusion was misused is the youth's own statement. On one occasion, however,

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[13] Editorial, Unanswered Questions, Baltimore Sun., March 7, 2007 (restraint-related death of 17 year-old at Bowling Brook); Barbara White Stock, In Harm's Way: Use of Physical Force on Troublesome Kids Unchecked." Pittsburgh Post-Gazette, September 20, 2005 (In 1998, "14-year-old Mark Draheim died after being restrained by three workers at KidsPeace, a residential treatment facility. Held down on his stomach, his hands behind his back, the 125-pound boy protested that he couldn't breathe. "); Terry Bitman, Bidding Ending at Bancroft, Philadelphia Inquirer, August 22, 2005 (2002 restraint related death of 14 year old child at NJ facility); Una Marshall and Russell Lieux, individually and as co-personal representatives of the estate of Michael Lieux, deceased v. Florida Institute for Neurologic Rehabilitation, Inc., Fla. Jury Verdict Rep. No. 05:10-23 (October 2005) (describing $5,000,000 jury verdict against Florida Institute for Neurologic Rehabilitation (FINR) for a 1998 homicide through positional asphyxiation. Michael Lieux was restrained eight times in four hours on the day before his death. FINR is an institution where 10 District of Columbia youth in CFSA's custody were placed as of October 2006.).

ULS received a recording of an RTC employee threatening a child with seclusion in order to make him or her behave. The staff person said:

> Let me tell you something, man. After I'm done doing medication [inaudible] ... and you act out, you're going to end up on seclusion, man. . . . Because you testing limits with me, you're not following no directions, you're just running around like you want to. But I'm just letting you do what you want to do so they can see on camera that you not following no rules in here. None. Then I can justify putting you in that seclusion room. [14]

The staff used seclusion as a threat and a form of punishment, instead of de-escalation techniques or interventions to get the child to stop doing what he or she was doing, thereby encouraging the youth to continue acting out so the staff could "justify" seclusion. See Joint Commission, Standards for Behavioral Healthcare PC.12.60 ("The organization does not permit restraint or seclusion for any other purpose, such as coercion, discipline, convenience, or retaliation by staff.").

Furthermore, no matter how well the use of restraint is regulated, and even when all staff are following protocol, restraints still carry inherent risks.[15] While RTCs are permitted to use restraints in certain circumstances, the use of restraints could be eliminated if the District set this as a priority. Public state hospitals, such as the Allentown State Hospital, now operate restraint and seclusion free.[16]

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[14] On Friday, November 3, 2006, at approximately 6:10 p.m., a voicemail recording was left for a ULS staff member where apparently someone left the phone off of the hook on one of the units at Riverside Residential Treatment Center, a District of Columbia RTC that closed around January 2008. Transcription on file with author.

[15] See generally Weiss EM, et al. Deadly restraint: A Five Part Series. Hartford Courant 1998; October 11 – 15; Protection and Advocacy Inc., The Lethal Hazards of Prone Restraint: Positional Asphyxiation, April 2002, available at http://www.pai-ca.org/pubs/701801.pdf.

[15] New York State Commission on Quality of Care, In the Matter of Neil Larkin: A Case Study on Restraint, Traumatic Asphyxia and Investigations, available at http://www.cqc.state.ny.us/could_this_happen/caseneillarkin.htm.

[16] http://www.dpw.state.pa.us/PartnersProviders/MentalHealthSubstanceAbuse/StateHospitals/003670147.htm.

C. Residential Treatment Centers are not an Evidence-Based Practice

Research does not support the efficacy of RTCs. According to the Surgeon General, theories justifying admissions to RTCs are often based on faulty presumptions: "In the past, admission to an RTC has been justified on the basis of community protection, child protection, and benefits of residential treatment per se. However, none of these justifications have stood up to research scrutiny."[17] The Surgeon General has noted that "there is only weak evidence for their effectiveness," as much of the evidence regarding outcomes comes from research published in the 1970s and 1980s, and most of these were uncontrolled studies.[18]

III. The Cost of RTCs

RTCs are one of the most costly mental health services provided to District youth. RTCs cost $250 a day per child (not including the cost of the school, which is often paid for separately by DCPS and completely out of local funds). Recently, the District proposed a rule to increase the rate of RTC reimbursement to $300 a day.[19] Because Medicaid funds such placements, the District is responsible for approximately 30% of this cost, and receives federal funding for the remaining costs. For RTCs that are not funded by Medicaid, the cost can be considerably more, and the District is responsible for 100% of this funding.[20]

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[17] United States Department of Health & Human Services, Mental Health: A Report of the Surgeon General, 1999, Chapter 3, available at: www.surgeongeneral.gov/library/mentalhealth/toc.html#chapter3.

[18] In contrast, evidence supports the efficacy of certain community based interventions, such as Multi-systemic therapy. See generally Ashli J. Sheidow, et al., Treatment Costs for Youths Receiving Multisystemic Therapy or Hospitalization After Psychiatric Crisis 55 Psychiatric Services 548 (May 2004).

[19] D.C.R. vol. 55, no. 47 at 012049. November 21, 2008.

[20] Calculating the true financial cost of RTC placements is extremely difficult. According to the City Administrator, the District spends approximately $61 million per year on RTCs in local and federal funds. It is unclear exactly how these costs are divided between local funds and federal funds. Psychiatric Residential Treatment Facilities (PRTFs) are a type of RTC, and they are the only type of RTC that Medicaid will pay for. To further complicate matters, only approximately 60% of the 96 RTCs that the District uses are PRTFs, and so 40% are paid completely with local funds. Finally, many RTCs bill separately for school, which is paid for directly out of DCPS' budget, using local

The District's overreliance on RTC placements also indirectly costs money. For example, at least two class action lawsuits govern RTC placements, and the District's continued noncompliance with the court orders in these cases is costly. While the current administration has publicly stated that it wants to bring both cases to their conclusions, litigation is likely to continue as long as the District's overreliance on institutional placements remains unaddressed.

Pursuant to the LaShawn A. v. Fenty Amended Implementation Plan, a judicially enforceable plan governing the implementation of child welfare reform in the District, "no more than 82 children shall be placed more than 100 miles from the District of Columbia."[21] From the information CFSA provided, it is not possible to determine exactly how many of the 137 children in placements were more than 100 miles from the District, but it is clear that CFSA was at least near the maximum number of children allowed at LaShawn A. More importantly, LaShawn A. guarantees children the right to be placed in the least restrictive, most family-like setting appropriate to his or her needs.[22] The District's continued use of residential treatment centers makes it impossible for the District to meet this mandate, thus prolonging the LaShawn A. litigation and its attendant costs.

Similarly, under the exit criteria in Dixon v. Fenty, the class action lawsuit governing the delivery of mental health services, 85% of children and youth served must be in their own home or a family-like setting.[23] Furthermore, the entire mental health system for children must be

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funding. Therefore, while it is safe to say that a tremendous amount of money is spent on RTCs, at this point there is no existing analysis stating exactly how much local tax dollars are spent on RTCs.

[21] Available at http://dmh.dc.gov/dmh/frames.asp?doc=/dmh/lib/dmh/pdf/Dixon_Criteria_4/Dixon_2008_Report.pdf.

[22] Id.

[23] According to the Dixon Court Monitor's January 2009 report, approximately 94% of the children and youth served are served in their own home or a surrogate's home, but the penetration rate is only 1.74%. The penetration

found to be at an 80% acceptability rating for youth reviewed through the Community Service Review process. In last year's report, the District earned only a 36% acceptability rating. This general failure of the local children's mental health system is a driving force behind RTC placements. As the 2008 Community Service Review report noted, areas that stakeholders found were "in critical need of addressing" included delays in being able to timely access community-based services such as Multi-systemic Treatment, and that CFSA reported that "they frequently cannot get the right services for their kids when they need the services and with the quality that is necessary to be effective." Until the District fixes these problems, RTCs will continue to be used as a stop-gap solution in a system where youth cannot obtain high quality services in a timely manner.

IV. The Path to an RTC Placement

Given that RTCs are expensive and difficult to regulate, and there is relatively little evidence that they are effective, why does the District continue to rely on them so heavily? Unfortunately, there is not one simple answer. Almost all youth at RTCs are deeply involved with one or more public agency. Most children pass through one of four cabinet-level departments: the Department of Youth Services, the Child and Family Services Agency, the District of Columbia Public Schools, and the Department of Health Care Finance, which in turn subcontracts to Managed Care organizations. The ways in which each of these agencies fund and facilitate RTC placements is discussed below.

A. Department of Youth Rehabilitation Services

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rate for youth with serious emotional disturbance must be at 2.5% before this obligation is met. Available at http://dmh.dc.gov/dmh/frames.asp?doc=/dmh/lib/dmh/pdf/dixon_court_monitor_report_1-09.pdf.

Of the 720 youth committed to DYRS' custody,[24] DYRS sends approximately 150 at any time to RTCs.[25] That is, approximately 20% of DYRS-committed youth are sent to RTCs, or two to three times the population of youth committed to New Beginnings (the District's new secure facility for youth committed to DYRS custody). While advocates, courts, and the media have rightly focused on conditions at Oak Hill (the predecessor of New Beginnings) for more than 20 years,[26] youth who are committed to DYRS are more likely to be sent to an RTC than they are to go to New Beginnings.

Youth committed to DYRS are placed in RTCs at DYRS' discretion. A judge commits youth to the care of DYRS, and in turn, the agency determines the most appropriate placement. Judges exert indirect pressure on placement. For example, DYRS must submit a proposed plan of care describing what will happen to a youth if committed, and a judge can stretch out the commitment process if he or she does not agree with the plan. Furthermore, even though the majority of youth involved with DYRS are not a danger to the public, when small numbers of youth commit serious, violent crimes – or worse yet, are hurt or killed – public, politicians, and the Attorney General's office often exert intense pressure for more secure settings for all youth.[27]

Additionally, once a decision has been made to send a youth to a secure setting, DYRS has a financial incentive to use RTCs instead of their own juvenile correctional facilities. A placement at an RTC costs about the same as a placement at a long-term juvenile correctional facility, but Medicaid generally pays 70% of the placement at a RTC. Therefore, during times of

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[24] As of March 2009, written responses provided by DYRS to FY 2009 Performance oversight hearing, March 11, 2009. On file with author.

[25] As of February 2009, supra, n. 6.

[26] See generally District of Columbia v. Jerry M., 571 A.2d 178 (D.C. Feb 12, 1990), describing history of case.

[27] Colby King, Hidden Details in a Teen's Death, Washington Post, May 9, 2009 at A15.

financial constraint, trans-institutionalization becomes a real danger, as it becomes increasingly tempting to divert youth who may have been the type of youth sent to a correctional facility in the past, and place those youth in RTCs.

B. Child and Family Services Agency

The District's Child and Family Services Agency (CFSA) sends almost as many youth to RTCs as DYRS. Youth in CFSA's care have been taken away from their families and are in the District's custody. Their parent's rights may or may not have been terminated, and the family may be working towards reunification or the child may be awaiting adoption. As of April 2007, CFSA had 137 children in RTCs. This comports with the data from the City Administrator's Office, reporting that as of February 2009, approximately 135 youth in CFSA's custody were in RTCs.

Children in foster care enter RTCs three ways. CFSA may decide to place them directly, through the Office of Clinical Practice. Until approximately five years ago, all CFSA youth entered RTCs this way. Once the Department of Mental Health became a cabinet-level department, however, the system changed. Now, if the RTC is a Medicaid-funded facility, youth generally enter through a "system of care" meeting that is held in conjunction with DMH. Ideally, this is a meeting where the youth and his or her relatives, service providers, and agency employees meet and decide whether the youth should go to an RTC or whether other interventions should be tried. Last, at times the judge involved in the youth abuse and neglect proceeding will order a residential placement, either on his or her own initiative or based on the urging of a party.

C. District of Columbia Public Schools

Youth that end up in an RTC through the school system generally do so through the special education system. Either a team of individuals that is responsible for determining what environment is least restrictive[28] determines that a residential placement is necessary in order for that child to make adequate educational progress, or a hearing officer decides that an RTC is necessary in order to provide the child with a Free and Appropriate Public Education (or to compensate for a previous failure to provide a Free and Appropriate Public Education). Under either scenario, these placements are voluntary, to the extent that the child stays in the family's custody, and the parents maintain the authority to withdraw the child from the RTC.

It is often assumed that Hearing Officer orders fuel RTC placements, and therefore placement decisions are not in DCPS' discretion. In fact, it appears that a rather small percent are ordered to RTCs by hearing officers. In June 2008, the City Administrator found that approximately 70 youth (or 14% of the total RTC population) were sent to RTCs through DCPS, without the involvement of any other agency. Strikingly, only approximately 5% of the total RTC population was ordered there from a Hearing Officer decision.

This does not mean that advocates and attorneys are not the driving force behind RTC placements, but if the data the City Administrator based his report on is correct, this suggests that the school system, through the special education process, is consenting to a majority of the placements. One of the District's basic requirements under the Individuals with Disabilities Act requirement is to ensure "to the maximum extent appropriate, children with disabilities, including children in public or private institutions or other care facilities, are educated with

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[28] 20 U.S.C. § 1412(a)(5) (Individuals with Disabilities Education Act).

children who are not disabled."[29] The District cannot meet this requirement while consenting to such large numbers of RTC placements.

D. Medicaid Managed Care

In the District, youth remaining out of state custody tend to be enrolled in a Medicaid managed care program (in contrast to fee-for-service Medicaid, which is most often used for youth in CFSA or DYRS custody). Managed care can be roughly divided into two categories: regular managed care and health services for children with special needs. As many have already discussed, the organization of the District's Medicaid managed care system has created serious fragmentation and impeded quality service delivery.[30] Similarly, this fragmentation makes it particularly difficult to track and assess the status of youth in RTCs.

1. Regular Managed Care

Information regarding how many District youth were sent to RTCs through a managed care organization (MCO) is not available. MCOs are required to pay for one full month (up to 60 days) of RTC treatment. After that, MCOs may switch residents to fee-for-service Medicaid. This means that the MCO is no longer responsible for funding the placement, and bills are processed directly through the Department of Health Care Finance (DHCF) (the District's Medicaid Agency). Prior to January 2009, no single government agency tracked the admission or discharge of these youth to RTCs. Starting January 2009, the Department of Mental Health

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[29] Id.

[30] See generally Towards a True System of Care by District of Columbia Behavioral Health Association Part 1 of 2 February 2009, on file with author; Human Systems and Outcomes, Inc., 2008 Report on Children and Youth Serviced by the District of Columbia Department of Mental Health, May 2008, available at http://dmh.dc.gov/dmh/frames.asp?doc=/dmh/lib/dmh/pdf/Dixon_Criteria_4/Dixon_2008_Report.pdf

(DMH) and DHCF agreed to require MCOs to produce information about RTC placements, and DMH agreed to begin tracking and monitoring these placements.[31]

2. Health Services for Children with Special Needs (HSCSN)

HSCSN is a Medicaid-funded managed care organization for D.C. residents under age 24 who are receiving Supplemental Security Income (SSI) disability benefits or have an SSI-related disability as defined by the D.C. Department of Health Care Finance. This means that HSCSN tends to serve the youth with the greatest medical needs in the District. To compensate for this, instead of receiving a capitated rate for services, HSCSN is able to bill directly for what youth use.

Children and youth enrolled in HSCSN enter RTCs differently than any other children in the District. HSCSN, like other managed care organizations, makes the initial determination of whether or not it will fund the RTC. Unlike the other MCOs, HSCSN retains responsibility for funding the placement throughout the youth's stay at the RTC; entering an RTC does not cause a child to switch to fee-for-service Medicaid. Compared to other funding and/or sending agencies, HSCSN only accounts for a small number of youth in RTCs at any one time. According to information from the FOIA requests, HSCSN funded only approximately 10 youth in RTCs in April 2007.

E. Multiple Agency Involved Youth

Last, youth may have funding from multiple agencies. For example, the school system may be responsible for sending the child, but if the child is eligible for Medicaid, the school system may only pay for the educational portion and room and board for the child, and Medicaid

[31] Memorandum of Understanding Between the undersigned District of Columbia Agencies: The Department of Health Care Finance (DHCF) and the Department of Mental Health (DMH) For Implementation of DHCF's Solicitation Number DCHC-2007-R-5050. On file with author.

may pay for treatment. This creates a system rife with miscommunication and confusion. As the D.C. Behavioral Health Association recently commented: "The District's current model of delivering behavioral health services to children adds up to a fragmented system, with duplication of services and efforts. It is a model that is simultaneously costly and difficult to access."[32] Fragmented funding leads to a lack of coordination among agencies, delays in discharge, gaps in monitoring, and a general lack of accountability. "There is currently no interagency system in place for the communication of patient records and evolving needs to case managers."[33]

V. Alternatives and Recommendations

There is little evidence that RTCs work. Furthermore, unnecessary use of RTCs constitutes a form of segregation. RTCs isolate youth from their families and place them at risk of abuse. Despite this, the District still has approximately 500 youth in RTCs across the nation, and the number does not appear to be decreasing. In light of this, ULS offers the following suggestions to help the District fulfill the mandate and promise of Olmstead:

A. Reinvest in Community-Based Services

To erase the institutional bias youth face when seeking mental health services are, the District must commit to investing in quality local services on more than a pilot or trial basis. Some have suggested solving the problem of distant RTC placements by building a local RTC in the District. A local RTC would not, however, remedy the problem. A local RTC would have many of the same issues as a distant one: it would still be a model of treatment that is not

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[32] Towards a True System of Care by District of Columbia Behavioral Health Association Part 1 of 2 February 2009, pg. 13.

[33] Id. at 12.

evidence based, it would still subject youth to seclusion and restraint and put them at risk for abuse, and it would still be costly. Investing in evidence-based community services is a long-term solution.

1. Provide Therapeutic Foster Care

Therapeutic foster care is an intensive intervention designed to let a foster parent be the primary agent for interventions with the child, but also gives the foster parent intensive, 24-hour support, training and guidance. It is usually paired with an array of therapeutic services from traditional mental health providers, and is marked by frequent contact with the therapeutic foster care provider. A therapeutic foster parent is paid more than a regular foster parent, and in turn a greater time commitment and skill level is expected.

The District of Columbia lacks true therapeutic foster care. The District has a Medicaid billing code called "therapeutic foster care," which allows the District to reimburse therapeutic foster parents a per diem rate (approximately $60 per day) in addition to what they are paid by the child welfare system. However, families do not receive the extensive pre-service training and in-service supervision and support that are a hallmark of successful therapeutic foster care programs.[34] Many families acting as therapeutic foster parents quickly find themselves overwhelmed when they need to provide support to a child with significant needs. Furthermore, this service is only available to youth in the foster care system and the juvenile justice system, while it is a service that any child experiencing a disruption in his or her home could benefit from. This creates a perverse incentive for youth to be placed in state custody in order to receive

[34] For a description of characteristics of therapeutic foster care, see generally Surgeon General report, available at http://mentalhealth.samhsa.gov/features/SurgeonGeneralReport/chapter3/sec7_1.asp

services. Parents may be faced with the choice of sending their child to a distant RTC that District Medicaid is willing to fund, or relinquishing their child to CFSA so that he or she can get funding to go to a local therapeutic foster home placement. Such choices are unconscionable, but are the real and direct result of the District's failure to fund sufficient high-quality community-based services.

2. Create Flexible Funding for Wrap Initiatives

Jurisdictions that have successfully transitioned youth from RTCs to the community have done so by creating funding mechanisms for mental health care that allow youth to access mental health care in their community. Jurisdictions must plan creatively and carefully for this because there is no simple federal mechanism to divert money that would be spent in RTCs back into the community. For example, federal Medicaid law does not include RTCs as one of the types of institutions that a state can create a 1915(c) (home and community based) waiver for. That is, under Medicaid law, no mechanism would allow the District to create a program exactly like the programs we have for adults with developmental disabilities, or for adults who have a nursing home level of care.[35] However, the District could make changes that would increase flexibility in funding and provide more services to youth in the community.

The District could designate a flexible funding pool, much like the District currently does through the D.C. City Wide Wrap Pilot, a program that currently has an enrollment of approximately 15 youth deemed to be at risk of RTC placement. With this program, each agency

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[35] As part of the Deficit Reduction Act of 2005, the federal government created a demonstration grant program for Community-based Alternatives to Psychiatric Residential Treatment Facilities, allowing 10 states to divert money that would have been spent in RTCs to the community. However, the District did not apply for this grant. For more information, see generally National Evaluation of Medicaid Demonstration: Home- and Community-Based Alternatives to Psychiatric Residential Treatment Facilities: Implementation Status Report as of October 1, 2008. Available at http://www.cms.hhs.gov/DeficitReductionAct/20_PRTF.asp.

dedicates a certain lump sum per child, and those funds are blended together to make a pool of local dollars to support the youth in the program. The project is designed to utilize Medicaid funds first, but also empowers frontline employees to use flexible local funding, when necessary, to purchase services or items that the child needs but are not covered by Medicaid. For example, if a child is very motivated by taking boxing lessons, and this helps him or her concentrate in school and reduces the traditional therapeutic interventions he or she needs, the fund could pay for that. This allows the individuals who know the child best to control the purse strings, and allows for non-traditional services to be purchased, in much the same way that a waiver might, without delay.

B. Vest Control and Oversight Responsibility for RTCs with a Single Agency

Too many government agencies currently fund and monitor RTC placements. Admission standards are haphazard and oversight is fragmented. Four different agencies control placement decisions. Each agency responds to its own financial and political incentives and pressures when making placement decisions. However, RTCs are extremely restrictive mental health placements. They should never be used unless absolutely medically necessary. They should not be used because a child needs a place to live, because an agency wants to draw down federal Medicaid dollars, because a social worker is overworked and poorly supported, or because the District has failed to invest in alternative services that would be more appropriate.

The Department of Mental Health should be the only department that has the authority to authorize residential treatment, should be the single entity responsible for monitoring youth in RTCs, and should be responsible for ensuring appropriate discharge. [36] Under District law, the

[36] DMH is already doing some of this, and there is currently a proposal to the Subcommittee on Residential Placements of the Mayor's Interagency Collaboration and Services Integration Commission (ICSIC) to have DMH

Department of Mental Health has the authority to "[a]rrange for all authorized, publicly funded mental health services and mental health supports for the residents of the District, whether operated directly by, or through contract with, the Department except that DYRS shall be responsible for the provision of mental health services for youth in custody in DYRS secure facilities."[37] The only two DYRS secure facilities are New Beginnings and Youth Services Center. Outside of this, all arrangements for mental health services should go through DMH and be provided by a DMH contractor or directly by DMH.

Vesting control of RTC placements and RTC oversight with DMH would comply with District law, would streamline guidelines to ensure that all placements are medically necessary, and help guard against unnecessary placements. It would also add accountability to the system, especially for youth placed in RTCs through the school system or by their parents, and would help prevent unreasonably long lengths of stay.

VI. Conclusion

On this tenth anniversary of Olmstead, the District should reflect on its unfulfilled promises and obligations to its youth, and take a moment to assess the cost of this failure, both in dollars and in children's and families' lives. The District can no longer afford to invest in non-evidence based, isolated, and costly institutions. More importantly, the residents of this city deserve better—they deserve a community where youth have access to services near their homes so that their children are not sent away to distant institutions. They deserve a frank discussion about the type of mental health programs that the District is investing in, whether those programs

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review all PRTF placements and to implement standardized admission criteria. However, as the publication of the report, this remains a proposal and standardized admission criteria have not been implemented.

[37] D.C. Code § 7-1131.04

are what youth actually need and what families want, and the alternatives they are entitled to under the law.