U.S. Senate Finance Committee

"Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions"
June 12, 2024

Submitted by the Child Welfare League of America
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Chairman Wyden, Ranking Member Crapo, and Members of the Senate Committee on Finance, thank you for the opportunity to submit this statement for the record.

The Child Welfare League of America (CWLA) is a coalition of hundreds of private and public agencies that, since 1920, has worked to serve children and families who are vulnerable. Our expertise, leadership and innovation on policies, programs, and practices help improve the lives of millions of children across the country. Our impact is felt worldwide.

We thank the Committee and Members for the hearing held on Wednesday, June 12, 2024, and the accompanying report, "Warehouses of Neglect: How Taxpayers are Funding Systemic Abuse in Youth Residential Treatment Facilities." We are grateful for the Committee's investigative efforts and the comprehensive documentation and reporting of the abuses found. The safety of children is paramount and is a fundamental requirement for successful treatment of mental and behavioral health concerns. Our hope is that this report, the hearing, and the subsequent testimony submitted will lead to increased safety for all children and youth, and particularly for the children and youth in residential treatment programs.

As the nation's oldest and largest child welfare membership organization, CWLA has developed 13 volumes of Standards of Excellence in Child Welfare, covering a range of services and programs in the child welfare field. For 70 years, CWLA's Standards have played a unique national role in shaping quality child welfare practice. They have been a foundational tool for improving the national child welfare system, guiding policymakers, practitioners, advocates, and the broader public. The Standards are widely accepted as the foundation for sound U.S. child welfare practice. The CWLA Standards of Excellence in Residential Services encompass all aspects of residential care, from service delivery to staffing to improved services both before and after residential care.

In addition to the Standards of Excellence, CWLA published the National Blueprint for Excellence in Child Welfare in 2013. The National Blueprint "presents a vision for the future of child welfare that all children will grow up safely in loving families and supportive communities."[1] This Blueprint is intended to drive change and to spur communities and agencies to pursue improvement and reform. It also forms the foundation for current and future updates to the Standards.

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[1] CWLA National Blueprint for Excellence in Child Welfare. Child Welfare League of America. Washington, D.C. 2013. p. 1.

The Role of Residential Treatment Services

The Blueprint states that children have the right to health care.

> "***Children should have access to quality health care***. *Each child should be provided with health care based on practical, scientifically sound, methods, and technology. Health care should include promotion of health, early diagnosis of disease or disability, prevention of disease, immunizations, access to medicines, when needed, regular check-ups, dental care, and behavioral health care. Health care should be accessible, age-appropriate, and responsive to the child's culture. No child should be denied access to these resources for a healthy childhood.*[2]

In order to meet the mental and behavioral health needs of our children and youth, there must be a robust and sufficient amount of high-quality and developmentally-, culturally- and trauma-responsive mental health and behavioral health prevention, community-based services that include early identification and treatment services, 24/7 respite and crisis intervention services, intensive in-home treatment services and when it is needed, high quality trauma-responsive 24-hour residential treatment interventions.

"The primary purpose of residential services is to provide specialized therapeutic services in a structured environment for children with special developmental, therapeutic, physical, or emotional needs."[3] CWLA agrees with the testimony of expert witness Ms. Manley:

> "Residential treatment facilities have an important role in the provision of care for young people with complex behavioral health care needs when they have a clinical or behavioral health treatment need that cannot be met in a family and community setting due to the intensity of their treatment and supervision needs. In those instances, we need the care to be delivered in trauma-responsive environments that embrace parent and caregiver engagement throughout the treatment intervention and continually focus on best practice. These residential treatment facilities can have a significant benefit to the young person and their family." (From Ms. Manley's written testimony.)

Residential services are a small but important part of the full array of services. "[Residential] Services and programs today are viewed as part of a comprehensive, integrated system designed to support and assist families and ensure safety, permanency, and well-being for children."[4]

There are many providers and programs providing or striving to provide trauma-responsive, time-limited, effective residential care. They are informed by the emerging literature highlighting promising practices in residential interventions:

> "[A]ssociated with positive benefits, such as: actively engaging youth and families, ensuring active school and community connection, and keeping residential intervention

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[2] Ibid, p. 30.
[3] Child Welfare League of America. CWLA Standards of Excellence in Residential Services. Washington, D.C. 2004. P. 20.
[4] Ibid, p. 2.

> as short as possible (Blau, Caldwell & Lieberman, 2014; Frensch & Cameron, 2002; James, 2011; James, Zhang, & Landsverk, 2012; Nofle et al., 2011). Exemplary leaders are not only heeding this information, they are becoming "… the new generation of passionate, hardworking leaders willing to "do whatever it takes" to build a new model for residential…" (Blau, Caldwell & Lieberman, 2014, p. 228). They are taking bold action to improve their service and achieve better results. They are creating meaningful, positive outcomes by: promoting time spent at home and in the community (Huefner, Pick, Smith, Stevens, & Mason, 2015); minimizing lengths of stay; engaging families during and after residential intervention (Casey Family Programs, 2016); and actively supporting staff and persons-served in relevant, important ways (Blau, Caldwell & Lieberman, 2014; Levison-Johnson & Kohomban, 2014)."[5]

The Building Bridges Initiative developed a guide, *Implementing Effective Short-Term Residential Interventions*, produced by the Building Bridges Initiative with funding from the Annie E. Casey Foundation to provide residential intervention providers and state oversight agencies with information about the key strategies for effectively transforming residential interventions to deliver quality shorter-term 24-hour residential interventions and provided examples of agencies that have been implementing the essential elements, which are effective leadership, family and youth engagement and inclusion, workforce development, practice strategies and tools, using data to inform practice, quality improvement, and fiscal strategies.[6]

The following agencies illustrate the elements with examples of actions they have taken: The Children's Village (New York), KVC Health Systems (Kansas), Sweetser (Maine), Damar Services (Indiana), Kairos (Oregon), Youth Development Institute (YDI) (Arizona), Excelsior Youth Centers, Inc., (Colorado), Warwick House (Pennsylvania), Catholic Charities (Maryland), and Epworth Children and Family Services (Missouri).[7]

CWLA's Standards note that residential treatment should be family-centered:

> "Family-centered practice is at the heart of good residential services. According to a GAO report, one of the key elements to a successful residential care program was the involvement of family members in the formal treatment approach (1994). Family involvement is important in achieving family reunification and helping children and families maintain an optimum level of reconnection."[8]

We aspire to someday have a mental and behavioral health service system in which all children and families have access to the services they need in their homes and at the time that they need them, and thereby reduce and potentially eliminate the need for any type of 24-hour residential intervention, however, society is still far from achieving this goal. Until such time as the full

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[5] Building Bridges Initiative, (2017). Implementing Effective Short=Term Residential Interventions: A Building Bridges Initiative Guide https://buildingbridges4youth.org/wp-content/uploads/2022/05/BBI-Short-Term-Residential-Intervention-Guide1.pdf
[6] Ibid, p. 1.
[7] Ibid.
[8] Child Welfare League of America. CWLA Standards of Excellence in Residential Services. Washington, D.C. 2004. P. 22.

array of high-quality and developmentally-, culturally- and trauma-responsive mental health and behavioral health services – including prevention, community-based services that include early identification and treatment services, 24/7 respite and crisis intervention services, intensive in-home treatment services – exist and are easily and readily accessible in the communities in which the families live, high quality trauma-responsive 24-hour residential interventions are still needed.

The Report Findings and Recommendations

The findings of the report raise vital concerns about the way that behavioral health services are sometimes provided to children and youth. The young people highlighted in the report and in the testimonials offered on film and in documents submitted to the Committee too often come to these residential treatment programs when families feel they have nowhere else to turn to help the most important part of their lives, their child.

The instances of abuse outlined in the report, including physical abuse, sexual abuse, and improper and harmful use of restraint and seclusion, are evidence that there is significant need for reform to provide the care that our children and youth deserve. The CWLA National Blueprint states that children have a right to be protected from abuse:

> "***Children must be protected from abuse, neglect, maltreatment, exploitation, and abduction***. *These rights include protection from all forms of child abuse, neglect, exploitation, and cruelty, including the right to special protection in times of war… It is the responsibility of governments to legislate these protections and enforce societal adherence to its responsibility to protect children. It is also the responsibility of governments to intervene on behalf of children when parents or other caregivers violate their rights to protection.*[9]

There are steps that Congress can take to address the issues raised in the report. CWLA emphasizes that strong investment is needed to make any real progress; Chairman Wyden, Ranking Member Crapo, and Members of the Committee expressed an interest in bipartisan solutions – until Congress fully funds and incentivizes community- and home-based care for everyone who needs it, regardless of the type of insurance coverage they have, there will be no true improvement in the overall wellbeing of our nation's children and youth. Any bipartisan solution or agreement will need to include significant new funding.

We wish to offer comments and recommendations in the following areas.

Lack of sufficient range of high-quality community-based mental and behavioral health prevention, early intervention and treatment services.

As was mentioned by Committee members during the hearing, our nation has failed to live up to the promise of President Kennedy's 1963 Community Mental Health Act, which was meant to

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[9] CWLA National Blueprint for Excellence in Child Welfare. Child Welfare League of America. Washington, D.C. 2013. pp. 31-32.

deinstitutionalize mental health services and create a community-based alternative. While we have largely closed the large facilities and hospitals that existed in the 1960s, we have not succeeded in replacing them with the needed robust array of services in the community. 61 years later, it is time for Congress to make fulfilling this promise a national priority.

There is a significant lack of mental and behavioral health services for children, youth, and their families across the nation, and even where they exist, these services can be difficult to access due to issues such as the lack of providers with the relevant expertise and in the geographic areas where they are needed, low payment rates, Managed Care limited provider networks, insurance reimbursement barriers, and long wait times. Without a robust array of developmentally- and culturally- and trauma-responsive services that are accessible when and where they are needed it is impossible to address the growing mental health and behavioral concerns of all children and youth in this country. This lack of services makes it difficult for caregivers and child welfare agencies alike to access the services needed for children and youth in their care.

The National Blueprint also recognizes the rights and responsibilities of parents, maintaining that parents are typically the most qualified to ensure the rights and needs of their children are met:

> *The rights of children cannot be advanced in isolation. Rather, children's rights must reflect and respect the critical roles and responsibilities of the parents and family members who care for them. In most instances, parents are uniquely qualified to advance the rights of children and to act in their best interest. As such, parents are afforded the right to raise their child according to their beliefs; however, they may not violate the fundamental rights of that child. As such, the rights of children and parents are interconnected. It is the responsibility of every parent, family, and caregiver to recognize and protect children's rights, and it is the responsibility of individuals and entities to work together to give families/parents optimum tools, supports, and opportunities so that they can fully assume responsibility for advancing the rights of their children.*[10]

CWLA affirms that parents should be afforded every opportunity to provide and care for their children and youth in their homes. Our child- and family-serving systems must prioritize children remaining in their homes whenever it is safe for them to do so; to fully protect this right, parents and caregivers must have full and complete access to mental and behavioral health services when and where they need them.

Recommendation: The Committee should invest in and support the full array of services offered by the behavioral health system, address barriers to accessing existing services, fund the expansion of options available through Medicaid, and expand funding for prevention related services accessible for all children, youth, and their families in the Mental Health Block Grants which currently are restricted for the population of children and youth with a serious emotional disturbance/disorder. This investment will help ensure children and families are getting the help when they need it in their homes and communities and reduce the need for any care or treatment outside of the home and reduce any unintended consequences.

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[10] Ibid, p. 26.

Recommendation: Ensure that commercial insurance plans cover the full range of effective children's mental and behavioral health services. Although children and youth in foster care are Medicaid eligible, 54% of the children and youth in the U.S. are covered by private insurance. Private insurance plans do not cover the range of specialized community-based mental and behavioral health services for children, youth, and families to the same extent as Medicaid, often imposing strict time limits on the few services they do cover. Because of this gap, families are forced to go into debt, seek out public insurance, or forgo care until the concerns result in a crisis. This coverage gap exacerbates the difficulties that families face in accessing the support they need and pushes families to child welfare's door. This gap also pushes families to utilize privately funded unlicensed "bootcamp" types of residential facilities, similar to those referenced in the testimonials. Congress must ensure parity between public and private insurance coverage of mental and behavioral health services for children, youth, and their families.

Lack of oversight, accountability, and authority from Federal agencies

CWLA thanks the Committee for highlighting the need for better mental and behavioral health care for youth and for bringing to light the system that has been created to bypass the needed state and federal oversight that is tasked with ensuring children and youth are receiving the highest quality services possible.

In their comments, both Ms. Stanford and Ms. Larin highlighted the lack of Federal and state oversight and action in providing accountability to programs and organizations operating residential treatment services. Medicaid gives a lot of attention to state and program spending and exercises authority when funds are misspent, or when there are many fatalities in nursing and adult care facilities, but it does not provide the same level of scrutiny when youth residential treatment facilities are found to be out of compliance or when abuses are discovered.

The report also recognizes that private equity firms are purchasing human services, including residential treatment programs, to make a profit. These entities created for the intent of enriching their shareholders do not have the commitment to child and youth wellbeing as a top priority and don't adhere to best practices in service delivery, inclusion of the youth and family in decision-making, and staffing decisions. Two of the companies in the report, Acadia and Vivant, are owned by private equity firms.

Recommendation: Congress must empower and require states to license and provide regular and strict oversight of all youth residential treatment facilities, regardless of their funding stream. If a program is receiving federal dollars, there are multiple mechanisms for oversight that can be strengthened, including additional responsibility on Federal and state agencies. In past years CWLA worked with members of Congress such as Congressman George Miller (D-CA) as he attempted to address the challenge of regulating unlicensed youth bootcamps and wilderness camps that avoid federal funding and as a result avoid federal oversight. In many of these instances States have the final authority; however, Congress could direct the Department of Health and Human Services (HHS) to provide guidance to states or incentivize states directly to implement and enforce regulations on any program that cares for and serves youth.

Recommendation: Congress should establish an interagency task force to explore what protections the federal government can put on publicly traded entities to protect the safety and wellbeing of the young people served by private-equity-owned youth residential programs.

Recommendation: Congress should commission an independent study of the effect of private equity firms on human services, including the impact on the workforce and the quality of the services delivered. Many states are examining the impact of these firms including Maryland which recently passed a bill directing a similar study on the effects of private equity firms on health care markets.[11] Some Senators are also examining legislative efforts at the federal level and we urge the Finance Committee to take a closer examination of these legislative strategies.

Use of restraint and seclusion, including medical restraint.

The report and the hearing highlighted the case of 16-year-old Cornelius Frederick, who was restrained for tossing bread at another youth and who tragically died because of the restraint. Using physical restraint and seclusion can be dangerous and even deadly for young people, and it is more likely to occur when staff who are using these methods do not have adequate experience and training in helping youth self-regulate and effective de-escalation techniques.

There are many providers who are not using or have focused on reducing and eliminating the use of restraint and seclusion, and instead turned to entities such as Building Bridges Inc. and the National Association of State Mental Health Program Directors that offer training in the evidence-based Six Core Strategies for Reducing Seclusion and Restraint Use© for help with improving the quality and effectiveness of their residential interventions. CWLA informed the early work of identification of strategies to reduce the use of restraints and seclusion. As long as funding sources such as Medicaid, Title IVE, the Department of Education, Managed Care, private insurance, and private pay allow for the use of restraint and seclusion, the risk of harm to the children and youth served in programs using these types of coercive non-trauma responsive practices will persist with the strong likelihood of serious injuries and deaths.

Recommendation: Congress should direct each system with oversight authority for child and youth serving programs, including the child welfare, mental health/behavioral health, juvenile justice, and education systems, to work towards reducing and eliminating the use of restraint and seclusion and coercive practices in their programs through publishing guidance, sharing best practices, and any other means at their disposal.

Recommendation: Congress should incentivize states to reduce and eventually eliminate the use of restraint and seclusion and coercive practices in their residential treatment programs. In 2022, the Michigan Department of Health and Human Services finalized a rule prohibiting these practices in child-caring institutions for children in foster care.[12]

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[11] Beard, K. "A closer look at state lawmakers' efforts to bring down health-care costs." Washington Post. June 24, 2024. https://www.washingtonpost.com/politics/2024/06/24/how-some-states-hope-lower-health-care-costs/

[12] Final Rule on Restraint and Seclusion. Department of Health and Human Services. Children Services Agency. Division of Child Welfare Licensing. May 24, 2022.

The report also calls attention to the overuse of psychotropic medications as a means of medical restraint for youth with mental and behavioral health diagnoses. Over the years we have worked with Congress and this Committee to strengthen oversight of children's health, particularly the use of psychotropic medication. Efforts included new state plan requirements in the 2006 Child and Family Services Improvement Act (PL 109-288), the 2008 Fostering Connections to Success Act (PL 110-351), the 2011 Child and Family Services Improvement and Innovations Act (PL 112-34). We also participated in a Senate Finance Committee roundtable discussion in 2013. In addition, Senator Tom Carper (D-DE), a Senate Finance Committee member, focused the attention of the Seante Homeland Security and Government Oversight on this issue in 2015.

Some states' child welfare agencies such as MA, NJ, and TN have put together excellent protocols and processes for medication management and oversight. However, for programs that are not subject to licensing and oversight requirements, no one is holding them accountable to properly prescribing and administering medication. Ultimately this points to the need for greater and better access to quality mental and behavioral health services.

Implementation of QRTPs

In the Family First Prevention Services Act of 2018, the Senate Finance Committee created the Qualified Residential Treatment Program (QRTP) to help ensure that when youth need to access residential treatment, they are provided with the best possible care and services. Implementation of QRTPs has been an opportunity to make important reforms in residential care.

As we indicated in our endorsement letter of FFPSA in 2016, we are committed to working with Congress and the Administration on some of the most challenging implementation issues, "mak[ing] sure that the oversight and implementation of the residential care parts of this law are carried out in the most effective way possible." As part of that commitment, we want to work with you to make sure that the QRTP is implemented in the way the committee and bills' sponsors envisioned through appropriate regulation and oversight.

The most significant barrier states and counties experience in implementation of QRTPs has been Medicaid's IMD exclusion. Under Title IXX of the Social Security Act, Medicaid defines facilities that provide diagnosis, assessment, and treatment interventions with more than sixteen beds as Institutes of Mental Disease (IMDs). It prohibits the use of Medicaid funding for any medical or therapeutic services while the patients are in these settings. The Centers for Medicare and Medicaid Services (CMS) has indicated that residential facilities meeting the QRTP requirements, as written in Title IV-E law, are to be classified as IMDs. This determination means that a youth in a program that meets the QRTP provisions, who is by definition a youth with higher needs, cannot be covered by Medicaid for any reason, even for emergency physical health needs.

Recommendation: The Committee should clarify that QRTPs are exempt from the IMD exclusion so that the rigorous requirements under the QRTPs can be implemented; there is precedent for Congress exempting young people and other vulnerable populations from the IMD exclusion. We believe we can find common ground and a bipartisan solution on an issue that

must be addressed if we are to ensure high quality service provision for youth in residential treatment programs.

Workforce issues

The report highlights the ongoing challenge of the workforce. As you note in several parts of the report, there was a shortage of competent and qualified workers at some of these facilities.

The labor-intensive and emotional nature of child welfare and residential care work along with the extremely low level of pay leads to high levels of turnover, particularly with rising concern over secondary trauma, compassion fatigue, and burnout. Increased and high turnover rates and the resulting higher caseloads perpetuate the caseworker crisis, negatively impact children and families, as workers who are experienced leave and staff who are inexperienced and inadequately trained take their place. Wages for residential direct care workers are extremely low, resulting in the least experienced workers caring for youth with the most complex and difficult-to-meet needs. An additional concern is a trend of public child welfare agencies reducing the education and competency levels of child welfare caseworkers to quickly address high vacancy rates, further exacerbating the issue of staff who are inexperienced, and without the level of knowledge, competency and skills to provide quality services.

The Standards expound on the minimum professional and personal qualities that residential treatment staff should possess.

> "To carry out its mission, the agency must attract and retain a competent, culturally diverse workforce. Staff must be trained, skilled, and knowledgeable in their particular job responsibility, in culturally competent practice, and in working with the community. All personnel must have the maturity to make the required decisions and the personal qualities required to work with children and families. Staff members should have had life experiences that can help them to understand children and families, the local community, and the cultural experiences of those served."[13]

Title IV-B reauthorization, due this year, offers an opportunity to begin to address the workforce crisis by strengthening the workforce and increasing the pay of staff doing direct work with children, youth and their families.

Recommendation: Increase funding for workforce development and training. There is $20M designated for workforce development in Title IV-B, dependent upon caseworkers visiting families on a monthly basis. Once split among all the public child welfare programs, this $20M does not go nearly far enough to truly support the workforce. We recommend that Congress substantially increase this set aside, which states can use to promote recruitment and retention of child welfare workers, including direct care workers in residential treatment programs.

Recommendation: Promote recruitment and retention. Recruitment and retention of qualified child welfare workers are essential for establishing a well-staffed and well-trained workforce.

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[13] Child Welfare League of America. CWLA Standards of Excellence in Residential Services. Washington, D.C. 2004. P. 184.

High vacancy rates and unfilled positions lead to much higher stress for direct care workers in residential programs and can compromise safety for the youth in their care and the staff. There are several promising practices that are helping agencies address these key issues, and Congress should support states and counties in implementing and evaluating the effectiveness of these practices. Congress should create new competitive or formula grants in Title IV-B of the Social Security Act with additional funding for states to address both recruitment and retention.

Recommendation: Increase overall child welfare and mental and behavioral health funding. One of the key issues in both recruiting and retaining qualified caseworkers and direct care workers is low wages. Child welfare staff consistently point out that in many states and localities, entry-level child welfare positions pay no better than the local Target or Starbucks, even though the work is much more challenging and can change the life trajectory of children, youth and families. 74.7% of caseworkers earn an annual salary between $30,000 and $49,999, and frequently, direct care workers earn less than caseworkers.[14] Better compensation and benefits for staff would help address vacancies and turnover rates, but adequate funding for child welfare agencies is needed, as funding has not kept pace with the rising cost of living and inflation. In addition to delinking Title IV-E foster care eligibility from the 1996 AFDC standards, Congress should increase both mandatory and discretionary funding in Title IV-B programs.

It is appropriate for Congress to focus special attention on this workforce as it does in some other professional areas. A stable workforce in child welfare can and does result in better care in these facilities, a greater chance at permanency for children and youth, greater success in preventing family separation and greater ability to address prevention of child abuse and neglect.

Conclusion

CWLA again thanks Chairman Wyden, Ranking Member Crapo, Members of the Senate Finance Committee, and Committee staff for the publication of this important report, which illuminates the need for better oversight and enforcement in youth residential care. We stand ready to assist in implementing necessary reforms in service delivery and look forward to working with the Committee in improving the quality of mental and behavioral health care that is available to children, youth, and families. Thank you for your attention to these comments and recommendations.

[14] National Survey of Child and Adolescent Wellbeing. NSCAW II Baseline Report. Caseworker Characteristics, Child Welfare Services, and Experiences of Children Placed in Out-of-Home Care. Retrieved from: https://www.acf.hhs.gov/sites/default/files/documents/opre/nscaw2_cw.pdf