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Statement to the U.S. Senate Finance Committee
Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions
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Chairman Wyden, Ranking Member Crapo, and Members of the Committee, thank you for the opportunity to appear before you today to address youth residential treatment facilities, with a specific focus on failures and the evaluation of solutions. My name is Elizabeth Manley, and I am a Senior Advisor for Health and Behavioral Health Policy at the Innovations Institute at the University of Connecticut School of Social Work. In this capacity, I serve as a subject matter expert on children's behavioral health systems design, financing and implementation for state and local leaders; I currently work with several states and provider organizations on design, implementation, and best practices in mobile crisis response and stabilization services, home- and community-based services, and residential interventions for children and youth. I am the former Assistant Commissioner for New Jersey's Children's System of Care where I was responsible for the oversight of the full children's continuum of care inclusive of all residential treatment interventions.

Context:
First, I want to state, unequivocally, that all children, youth, and young adults with complex and intensive behavioral health challenges, need and deserve access to the most appropriate, least restrictive, high quality, and effective treatment and interventions. Our goal must be to support children and their families to receive services within their own homes and communities whenever possible, and provide individualized, strengths-based, culturally responsive care as early as possible. We must respond to their needs with urgency and elevate the voices of youth and families in every step of treatment planning and intervention.

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.

Challenges and Opportunities:
Factors that drive treatment failure within a residential treatment facility are not monolithic. The challenges are complex and require multiple strategies at the federal, state, local, and provider levels. States that use a systems approach to address the unique needs of youth with complex needs have demonstrated improvement in their ability to meet the needs of individuals with complex needs and systems involvement.

1) **Challenge: Residential facilities are challenged by insufficient infrastructure to support youth receiving care in their facilities.**

Opportunity: Residential treatment facilities need technical assistance and coaching to support internal assessments and ongoing continuous quality improvement related to policy, practice, oversight, and outcomes. This technical assistance is also critically necessary for oversight organizations—the State, local agencies and managed care companies responsible for authorizing care, contracts, and, ultimately, for outcomes—to support building and sustaining high quality interventions.

2) **Challenge: Not all children in residential facilities require those services and, across many residential treatment facilities, lengths of stay are often too long. Both factors can cause harm and trauma to youth and families and limit access to residential treatment for those who do need it, resulting in overstays in emergency departments, inpatient psychiatric hospitals, and other settings.**
Opportunity: States and communities must create clear care pathways to care and develop and sustain robust home- and community-based services and supports that address the developmental and behavioral health needs of children and youth.

3) **Challenge: Our financing incentivizes the wrong services and supports. We build beds because it is what we know how to do, not because it is always what is needed. Our financing is piecemeal and incentivizes states and communities to build and invest in beds, instead of the critical services and supports children and youth need before, during, and after a residential intervention.**
Opportunities: New Jersey has sustained the lowest per capita rate of group care utilization[i] by a child welfare system and lowest youth suicide rates,[ii] demonstrating that policy solutions that can be employed to support states to improve child and youth well-being, reduce overreliance on child welfare systems as a source of behavioral health care, and reduce group care. The service delivery is outlined in the 2022 Medicaid Federal Policy Guidance.[iii] Strategies to address these challenges include:

- Provide an enhanced Medicaid Federal Medical Assistance Percentage
- Encourage CMS, SAMHSA, and ACF to issue a joint bulletin supporting and providing technical guidance on the use of Medicaid lookalike numbers, single points of access with consistent and trauma-responsive screening and assessment tools, and braided funding.
- Support partnership between SAMHSA and the Center for Medicare and Medicaid Services to develop future system-of-care planning grants that explicitly support states in developing comprehensive systems of care for children's behavioral health alongside Medicaid as a sustainable funding source; and
- Revisit the findings from the PRTF Demonstration Waiver and explore opportunities to make PRTFs a permanent 1915(c) Waiver level of care.

The best way for Congress to direct federal resources to impact this issue is increased accessible, comprehensive, family- and youth-driven, community-based, trauma-responsive behavioral health care. Thank you for the opportunity to address you today and for your focus on this important issue.

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[i] In 2021, New Jersey had a child welfare group/institutional care rate of 8.1 per 100,000 children compared to a US rate of 44.5 per 100,000 children.

[ii] From 1999 to 2020, New Jersey had a youth suicide rate of 1.8 per 100,000 youth compared to a U.S. rate of 3.6 per 100,000 youth. Retrieved from https://www.ojjdp.gov/ojstatbb//victims/qa02704.asp?qaDate=2020&text=yes.

[iii] 2002 Federal Medicaid Policy. Retrieved from: https://www.medicaid.gov/federal-policy-guidance/downloads/bhccib08182022.pdf