

**Testimony of Reagan Stanford, Abuse and Neglect Managing Attorney  
for Disability Rights Arkansas**

**“Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions”**

**Senate Finance Committee**

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**Chairman Wyden, Ranking Member Crapo, and members of the Senate Finance Committee, thank you for the opportunity to testify here today. My name is Reagan Stanford, I am the Abuse and Neglect Managing Attorney at Disability Rights Arkansas (DRA). DRA is the Protection and Advocacy agency in Arkansas. The Protection and Advocacy (P&A) system is a federally mandated network of legally based agencies that advocate for and protect the rights of individuals with disabilities. Under federal law, P&As have authority to access facilities in which individuals with disabilities reside, and access relevant records.**

**In my role, I oversee a team that uses that access authority to monitor conditions and investigate abuse and neglect at facilities across the state. DRA’s goal is to ensure that individuals receive the services they need in a safe and therapeutic environment, wherever that may be. Over the past five years, one of the focuses of our work has been the 13 psychiatric residential treatment facilities (PRTFs) in Arkansas.**

Through our years of spending time inside these facilities, reviewing records, and speaking with children, guardians, and staff members, we have seen firsthand how deeply flawed the overall residential treatment model is, the pervasive nature of abuse and neglect, and the low frequency and often low quality of services provided.

DRA’s work began to focus on youth behavioral health treatment after receiving complaints about a single PRTF. Our investigation into those complaints revealed widespread concerns that included: repeated substantiated instances of staff physically abusing children, buildings in such disrepair they created safety hazards, a high rate of peer violence , an overall lack of therapy, a lack of activities and engagement, and inadequate educational services. The issues were so pervasive and so obvious that it was difficult to understand how this provider was allowed to continue operating or why children were still being placed there. As we expanded our monitoring to additional PRTFs, we found similar issues at additional facilities. Because of what we observed, were told by residents, and heard from staff, we followed up with numerous investigations. What began as an investigation at a single facility grew into a sustained presence and interaction with all 13 providers.

What we heard directly from children included, “this place is re-traumatizing me,” “it feels like they don’t really care about us,” “we hardly learn skills here to function outside of here,” “this place would be more helpful to me if there were more groups,” “this place is toxic, unstable,

unhygienic, and unfair,” “peers are fighting everyday,” “it’s mentally draining,” and “we sit around all day and it feels like no one cares about us.” What we observed confirmed what we were hearing.

We began identifying and requesting information from every entity that has any oversight authority or may otherwise interact with these providers. Even with our knowledge and familiarity with the providers and state agencies generally, identifying what existed was a tedious process. Some requests were unfilled because the exact name of a document was not included, some because the facility was operating under one name and registered with Medicaid under another. Documents we did receive were often incomplete or so lacking in detail that it was impossible to make necessary connections between documents.

What this process revealed was that while government agencies had substantial documentation of abuse and neglect existing at these facilities, it would be extremely difficult and time consuming for anyone that was considering placement at a particular facility to obtain this crucial information. This lack of transparency is even more challenging for out-of-state parents, guardians, and placement agencies. Many of them were contacting our office to inquire about facilities, because they do not have the time or resources to identify the multiple different oversight authorities in every state, their specific roles and the documentation they produce, and the overall licensing structure and level of accountability facilities are being held to. Many more do not reach us and are relying on the representations of the facility, unaware they are sending children to facilities with extensive records of abuse and neglect.

Because every parent, guardian, and child deserves to have as much information as possible in order to make informed decisions about care before admission, we created an Arkansas PRTF database. This database, organized by facility, makes all incidents reported to state licensing, all reports and surveys from oversight agencies, and all police reports for calls related to the facility available to the public. The database can be accessed at [disabilityrightsar.org/prtf](https://disabilityrightsar.org/prtf). We are expending our limited resources to do what the government could and should be doing.

We later added information about the type and level of services provided at each facility. Provider websites, marketing materials, and recruiters often provide only vague statements about treatment and do not offer specifics on what the child will actually receive, what their day-to-day life will be like, or the level of professionals they will interact with or receive services from on a day-to-day basis.

**The results of this ongoing work make clear that youth residential facilities cannot provide an adequate therapeutic and educational environment.** Across Arkansas, facilities are rife with countless examples abuse, violence, and neglect. In just the last year examples of physical abuse endured by children include: a staff member struck a child three times in the face with a closed fist leaving the child with bruising and redness to their face and bleeding from their ear; staff drug a child across the ground outside, fracturing his arm; a staff member grabbed a child in a chokehold, pushed them into a bathroom, and remained in the bathroom with the child,

with the door closed 5 minutes, where he is alleged to have continued his assault on the child that resulted in a black eye and markings and scratches on his neck; and staff kned a child in the groin. Additionally, four staff members at a facility showed pornographic images or videos to residents, including one staff member showing a resident a homemade video of him engaged in oral and sexual intercourse; two staff members made minimal efforts to intervene and allowed a child to be “taunted, punched, and kicked” by peer for over 15 minutes; and a child was held down on a bed by peers and sexually assaulted. These examples are illustrative of what occurs and do not represent the full extent of what is reported or all of the abuse and neglect that goes unreported. Children are being raped, they are being physically assaulted, they are not being protected.

A facility in Arkansas where multiple riots occurred and at least three staff members were found to have sexually assaulted residents was eventually placed on a probationary license status by the state Child Welfare Agency Review Board. This is the first time the board, which is independent of DHS and statutorily comprised of providers representative of the residential and placement agencies regulated, has ever taken significant action against a facility. During the 10-month probationary period, the facility had unstable leadership, cycled through several CEOs, and received at close to 70 additional citations. Despite this, the board lifted their probationary status.. Additionally, they were never required to alert guardians of current or prospective residents of their probationary status or halt or slow admissions. They continued and still continue to receive Medicaid funded placements.

But it is important to not focus so intensely on cases of extreme abuse that we are lulled into believing that the issue is a few bad actors and not the model. Far more common is the systemic, general lack of a therapeutic environment, active treatment, and educational services. The widespread nature of these issues is what makes clear that this model does not work.

What my conversations with guardians, state officials, and providers has revealed is that there is this pervasive assumption that some children need such “intensive services,” that they cannot be served in the community. This idea is accepted and repeated even in literature and reports that are critical of residential treatment. It is so ingrained and generally accepted that no further thought is given to what “intensive services” actually means or why such services can only be provided in a residential setting.

Residential treatment is often seen as the pinnacle of treatment, the best and most intensive services a state has to offer. After a child discharges from residential treatment, states are left feeling as though they have little or nothing left to offer. The failures of the treatment facilities to provide a safe and therapeutic environment, individualized intensive services, and meaningful discharge planning and follow through are imputed to the child. The child is often seen as the failure, not the treatment facility. And because they are viewed as the failure, all too often the child gets cycled back into a residential placement.

The restrictiveness of the placement is assumed to positively correlate with the level of services provided. In fact, the most restrictive placements generally offer a level of care that could be replicated or surpassed on an outpatient basis. The “intensive services” that most PRTFs, acute, and sub-acute programs provide consist primarily of 50 minutes of individual therapy a week, between one and four hours of group therapy a week, between one and four family therapy sessions a month, and medication management. At most, that comes to approximately 5 hours of therapeutic services per week, which is less than is provided by many community-based models, but at a much higher price. They are reimbursed at the same base rate, regardless of the level of services provided.

Treatment in these facilities is not individualized and is overwhelmingly not specialized. Many of these facilities purport to treat a wide range of conditions, everything from depression to conduct disorders to schizophrenia. Yet the services children receive are almost indistinguishable from each other. Providers often point to treatment plans developed for children as evidence of the individualized nature of treatment. These plans often contain generalized goals and generally prescribe individual or group therapy as the method of achieving the goals. The groups they attend, the behavior management structure they are held to, the point or level system they are subjected to, are all the same.

Interaction with clinicians or mental health professionals is limited. Although these programs are required to be operated “under the direction of a physician,” a contracted physician that spends maybe a few hours a week at the facility and is on-call to authorize physical restraints, chemical restraints, and the use of seclusion over the phone, is generally fulfilling that requirement. Groups are often run by behavioral health aides and not licensed therapists.

Children cycle through these facilities without receiving required supports or being evaluated for special education services. Even if the child had an individualized educational plan, 504, or behavior plan prior to admission, these plans are rarely implemented in the facility. Instead, they attend “school” at the facility in classrooms that combine multiple age, grade, and ability levels. In most facilities, classroom instruction is minimal and much of a student’s education is necessarily self-directed through the completion of packets of worksheets. For older children, classes frequently do not align with graduation requirements and therefore credit is not received when they return to their home school district, particularly if they are returning to another state.

Children share bedrooms with peers and spend most of their time idle in communal spaces under the supervision of entry level care staff, never alone but rarely engaged. Insufficient staffing levels and inadequate staff training lead to a reliance on restraint, seclusion, and increasingly law enforcement. They are not forming healing bonds with adult staff and are often cut off from their families at home. The word that most comes to mind when I think of time spent inside these facilities is chaos. All together this creates an environment that is incompatible with what children need to learn, grow, and thrive.

Not only are these facilities ill-equipped to address the complex trauma of many of the children placed, the added trauma children experience within facilities follows them through life and is compounded by society's refusal to acknowledge the detrimental effects these placements can have. Children that experience added trauma while in congregate care are the norm and not the exception. Far too many children are directly subjected to physical, sexual, and verbal abuse. Even more are impacted by the abuse they witness. We do not believe that a child should ever have to endure or witness abuse in order to access services.

All of this occurs without meaningful oversight at any level. With limited CMS regulation and oversight, most oversight falls to state agencies assessing compliance with state licensure, even though many providers operate in multiple states. The lack of urgency and thoroughness with which incidents are addressed by the providers themselves and by oversight agencies is deeply troubling. One facility in Arkansas broke four children's arms in restraints in a six-month period. Despite these alarming circumstances they did not engage in any significant self-correction and were not initially subjected to any corrective action by state or federal oversight authorities. It took pressure and detailed complaints from DRA for corrective action to eventually be put in place. There is also too heavy a reliance on national accreditation bodies such as the Joint Commission. These bodies are paid by the providers, perform onsite inspections only every three years, only have the authority to recommend changes, are opaque in their processes and responses to complaints, and have issued blanket accreditations covering facilities they have never visited.

What is clear is that often these facilities are operating as placement alternatives and not service alternatives. States have bought into and are now reliant on the residential treatment model, failing to adequately invest in community-based settings and services necessary to meet the need. States are so reliant on residential placements that they are hesitant or outright unwilling to hold the facilities accountable. In Arkansas, for example, the director of a Department of Human Services division that previously oversaw the licensing of residential treatment facilities joined a recorded technical assistance call specifically to warn providers that DRA had begun publishing additional information about their programs and reassure them that that she considered them to be "partners." You cannot effectively regulate something you are in partnership with. Health inspectors are not in partnership with the restaurants they inspect.

While access to information is absolutely vital and can impact placement decisions, no amount of forced transparency can lead to truly informed choice if there are no other options. As long as residential treatment remains one of the only options available to many families and placement agencies, facilities can rely on desperation placements and will continue to have little motivation to improve.

Through our work with the P&A network, we know that these problems are not specific to Arkansas. The conditions and systemic issues are well documented in countless reports by individual P&As and by the National Disability Rights Network's *Desperation without Dignity* Report. This is a national problem that demands congressional action, which can include:

**1. Increase investment in community-based services and concrete supports that can help prevent the use of congregate care.**

In Arkansas, the Medicaid reimbursement rate for PRTFs is \$502/day. Some states have a higher base rate and contract for even higher rates when sending children out-of-state. This state and federal funding could be much more appropriately invested in intensive, community-based services.

**2. Require meaningful outcome measures and** discontinue payments for models that do not provide active treatment and individualized services, **including residential treatment.**

The role of residential treatment on any continuum of care needs to be critically examined. Although there has been a focus and even insistence on evidence-based treatment in most other areas, there has been heavy investment in residential treatment despite the fact that there is no evidence to support its efficacy.

I have repeatedly asked providers in our state for information on how they are tracking outcomes and measuring the effectiveness of their programs. The most common response is that they have no control over where a child goes when they leave the facility and would not be able to find them to determine their status. So, not only are they not currently making efforts to study the effectiveness of their programs, they do not think it is even possible.

**3. De-incentivize out-of-state placements**

When children are sent out-of-state it makes it a) more difficult to maintain connections with family, b) more difficult for out of state agencies to monitor the facility and uphold their own state standards (which may be a higher standard than the receiving state), c) extremely difficult for meaningful discharge planning to occur due to the out of state facility not having relationships with providers or even understanding the community that the child is returning to, and d) it can allow a facility to evade regulation by shifting to court children from another state if one state stops sending children because of subpar conditions.

When states send children in their custody out of state, they are also paying not only the exorbitant daily rates of these facilities, but for caseworkers to fly out and visit, and for teams to travel to facilities to complete, at a minimum, annual inspections of care. This is all money and employee resources that could be going to fund and provide direct services in their home states.

Acadia Healthcare is so invested in the model of sending kids out of state for treatment that they built and are now expanding the capacity of a facility that only accepts out-of-state children. Due to a moratorium on the number of AR Medicaid PRTF beds in place long before the opening of Little Creek Behavioral Health in 2020, they are only licensed to serve out of state children.

**4. *Remedy the failures of oversight that exist at all levels.***

The very fact that protection and advocacy agencies are so involved in this arena is evidence of the extent of the problem. P&A's across the country have been monitoring, investigating, writing reports about, and advocating on behalf of clients within facilities. Protection and Advocacy agencies are a backstop. Our involvement is an indication of a failure of the intended government oversight mechanisms.

**5. *Create an easy to access and navigate system that accurately identifies all youth residential treatment facilities and publishes surveys conducted by state survey agencies, quality of care, and incident data.***

While the Quality, Certification & Oversight Reports (QCOR) database contains survey and complaints from PRTFs, the information is inaccurate and incomplete. For example, a 2022 Government Accountability Office Report studied PRTFs in Arkansas and Massachusetts despite the QCOR database listing that Massachusetts has no PRTFs dating back to 2010. The information actually contained in the QCOR is opaque, requiring technical knowledge of CMS to access and sort information. And the surveys themselves may not capture the true conditions and incidents at youth residential settings. The QCOR is not a mechanism for public accountability.

**6. *Invest in research and pilot programs to identify and validate effective treatment options.***