June 20, 2024

U.S. Senate Committee on Finance
Attn: Editorial and Document Section
statementsfortherecord@finance.senate.gov
SENT ELECTRONICALLY

Re: Statement regarding Youth Residential Treatment Facilities

Dear Chairman Wyman, Ranking Member Crapo, and Finance Committee Members,

Indiana Disability Rights (IDR) is Indiana's federally mandated protection and advocacy system. IDR upholds the rights of individuals with disabilities through various statutory responsibilities, including activities from informal advocacy and legal representation to monitoring facilities that serve individuals with disabilities. Recently, IDR concluded a five-year project focusing on private secure facilities (PSFs) that serve youth between the ages of six and 21 years. Some of Indiana's 22 PSFs are singularly designated as private residential treatment facilities (PRTFs), while others provide treatment through multiple licenses.

While IDR continues working with state agencies and PSF leadership to improve conditions for youth in these facilities, the information obtained through its project may be of value to the U.S. Senate Committee on Finance. Specifically, IDR offers this statement in response to the Committee's June 12, 2024, hearing, *Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions*. The statement is organized by five major themes IDR investigators routinely identified at PSFs:

- **Unsafe and unhealthy living environments.** Policymakers could ameliorate this problem by clearly articulating minimum standards for safe and healthy home-like residential treatment facilities, as well as mandate the imposition of sanctions on facilities that fail to comply with these basic standards.
- **Violation of residents' rights, including the improper use of restraints.** Policymakers should consider strengthening the requirement that youth in residential treatment programs receive information about their rights on a single occasion, and instead require rights information to be provided, and reiterated, in various formats, to ensure youth comprehension. Policymakers could also significantly eliminate opportunities for harm by banning the use of prone restraints in youth residential treatment facilities.
- **Insufficient programming, including inadequate educational opportunities.** Policymakers could help ensure that youth at residential treatment facilities receive their right to a free and appropriate public education (FAPE) by enacting a minimum length for daily educational programming and establishing basic standards for the classroom environment that are conducive to learning. It may even be helpful for policymakers to reiterate that school-aged youth are entitled

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to a FAPE, regardless of their placement in residential programming. Further, policymakers should incentivize community-based (rather than facility-based) programming, as facility-based programs often create barriers that make it difficult for youth to reintegrate in their local community post-treatment.

- **Inadequate staffing and ineffective leadership.** Policymakers could address staffing shortages and improve the quality of direct care by both increasing funding for staff hiring and recruitment and establishing minimum professional qualifications for direct care staff. Similarly, policymakers could meaningfully address ineffective facility leadership by establishing minimum clinical qualifications for the role of residential treatment facility director.
- **Insufficient regulatory oversight.** Policymakers should consider clarifying current laws to ensure that the youth residential treatment facility oversight entity, as well as its responsibilities, are unambiguous to all stakeholders. Policymakers may also consider instituting an automatic and mandatory admission hold on a residential treatment facility during any period that it is subject to sanction(s) imposed by the oversight entity.

Unsurprisingly, these themes largely echo the concerns shared by fellow protection and advocacy systems throughout the country.

The five themes are discussed in greater detail below, based upon information that IDR investigators gathered during the five-year PSF project. Each theme has a designated section within this Statement, identified with bold text. The italicized text within each section indicates IDR's suggestions for policy improvement.

Unsafe and Unhealthy Environments

IDR investigators observed a wide variety of PSF living environments. Nearly all PSFs in the state fail to offer youth a home-like environment. Common areas almost always have hard plastic, weighted furniture, arranged in rows. (See Figure 1.) Twin beds – or smaller – are also made of hard plastic, with a thin, worn pad serving as a mattress. During one visit, a 17-year-old showed IDR investigators how his feet hung over the end of his bed – by almost a foot – and his shoulders spanned its entire width. Many other youth reported discomfort and trouble sleeping to investigators.

Figure 1. Hard plastic chairs arranged in rows.

Instead of a home, many PSFs resemble detention facilities. These PSFs have steel doors with small, narrow windows. Sometimes these doors are locked by keys kept by staff. Other PSFs feature a central command center, from which locked doors throughout the facility can be opened remotely.

Living unit bathrooms feature showers rife with mold and mildew. (See Figure 2.) It was not uncommon for investigators to find exposed electrical and plumbing components. Moreover, many PSF bathrooms posed multiple opportunities for

youth to hang, choke themselves, or otherwise engage in self-harm.

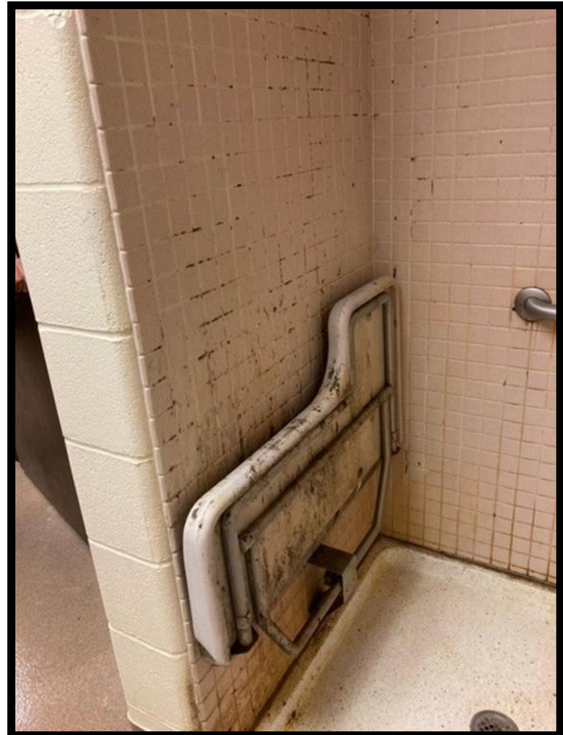


Figure 2. Shower chair covered in mold.

Indeed, safety hazards are a common problem at PSFs. Despite locked, heavy steel doors in some areas, IDR investigators – and youth – found other means for easy elopement from the PSF campus. While the weighted furniture is designed to dissuade its use as a weapon, it conversely creates an unacceptable barrier when located in front of fire exits. In fact, when investigators raised this concern with PSF leadership, it was conceded that the arrangement was intentional, to make it more difficult for youth to escape. Thus, it appears that many PSFs fail to engage in comprehensive safety planning, instead cobbling solutions together as issues arise. This approach may jeopardize safety more than the status quo.

Importantly, Indiana's PSFs are, in general, woefully unprepared for fire emergencies. Some PSFs do not require youth to fully participate in fire drills. Other PSFs feature bedroom units that are (un)locked only from the outside, preventing youth from independently exiting their bedroom during a fire. Some PSFs do not provide fire extinguishers in locked living units. At one PSF, staff could not find the fire extinguisher, nor the key to unlock it, despite having signed an acknowledgment that they received fire safety training the previous day.

IDR suggests the adoption of more explicit mandates for the provision of a home-like environment. Moreover, unless state oversight agencies sanction residential treatment facilities for failing to provide a healthy environment for residents, IDR fears safety lapses will continue to jeopardize youth safety.

Violation of Residents' Rights

Interviews with youth, conducted by IDR investigators during the PSF project, reveal that many lack a basic understanding of their rights. Although PSF administrators stated that youth are given DCS's Bill of Rights for Youth in Residential Treatment upon admission, few youth recalled receiving it. Several of those who remembered receiving the Bill of Rights shared that they did not understand it.

Despite their constitutional and conditional rights, many youth in PSFs lack daily opportunities to exercise autonomy. Clothing choices may be limited; several PSFs require youth to wear uniforms. The PSF schedule dictates when youth go to bed and rise. Many PSFs prepare a single entrée for each meal, leaving youth without nutritional alternatives. Outdoor activities are limited to whatever options the PSF makes available; few PSFs offer playground equipment, walking paths, and sports equipment. Moreover, youths' right to receive visitors and make phone calls is regularly denied by PSF staff, either due to allegations of youth misbehavior or staff inability to assist with the endeavor.

IDR investigators also found that PSFs often have inadequate mechanisms for youth to get their concerns addressed. Resident councils are a rarity at Indiana PSFs but provide a strong opportunity for youth to practice self-advocacy and communication skills. Further, although PSFs are required to have grievance procedures, these procedures are often insufficient to afford youth due process. Many PSFs lack a mechanism for youth to anonymously submit grievances. Some PSFs require youth to submit their grievance to direct care staff, rather than the ultimate recipient. This procedure allows direct care staff, who are occasionally the subject of grievances, to review (and screen) the grievance. Youth told IDR investigators that they had seen direct care staff destroy grievances or route them to parties other than the intended recipient. Youth reported rarely receiving grievance responses and, even then, only a few PSFs provide youth with an appeal procedure. PSFs also tend to only accept written grievances and fail to offer reasonable accommodations to that policy.

IDR suggests strengthening the notification mandates regarding the rights of residents in youth treatment facilities. In addition to providing youth with written information about their rights at admission, when they are likely overwhelmed, facilities should distribute rights information to youth again one week after admission. Providing this information a third time, 30 days post-admission, would reiterate the importance of resident rights, as well as allow youth to consider how those rights apply to their day-to-day experience in the facility. Additionally, because youth have different learning styles, providing rights information in more than one format – including in writing, by video, and through oral instruction – would help ensure that youth understand their rights.

Relatedly, IDR investigators found that many PSFs improperly used restraints, either by overreliance on their use to control youth or by failing to follow relevant procedure in their application. During the project, investigators uncovered numerous youth injuries that were caused by the inappropriate use of restraints. Such injuries included closed head injuries, skull fractures, Salter-Harris Type II limb fractures, lacerations that required sutures, and contusions. Beyond physical harm, youth also reported that restraint sometimes causes humiliation and exacerbates the effects of prior trauma.

Investigators found that many PSFs still allow staff to perform prone restraints on youth, despite serious danger and risk of death. Research shows that prone restraints greatly exacerbate the likelihood of positional asphyxiation. When staff do not execute prone restraints procedures in a particular manner, the likelihood of injury and death are heightened even further.

Moreover, investigators found that direct care staff at most PSFs regularly initiate restraints – as well as seclusion and impose precautions – on youth without approval from a physician, nurse, or other licensed mental health professional. This finding exposes two deeper concerns. First, direct care staff sometimes use restraints in response to non-dangerous behaviors, for example simple verbal outbursts or throwing paper. Second, clinical staff is rarely readily available to youth and direct care staff. Although the law requires that a nurse or therapist observe secure holds within PRTFs, these professionals are often unavailable in the moment that direct care staff determine the need for a secure hold exists. Indeed, IDR investigators were present on multiple occasions during which neither a nurse nor therapist was even on the PRTFs' campus.

IDR suggests that a prohibition on the use of prone restraints in residential treatment facilities that receive federal funding is low-hanging fruit for policymakers. The likelihood of serious harm outweighs the benefit of prone restraints; direct care staff can place youth in less dangerous secure holds. Banning the use of

prone restraints in facilities receiving federally funds would discontinue the practice in most youth residential treatment facilities, as well as likely prompt state oversight agencies to adopt relevant statutory language and apply it statewide.

Insufficient Programming

During the project, IDR investigators determined that education is rarely prioritized by PSF leadership. Generally, to provide education to the children in their care, Indiana's PSFs either partner with a local school corporation or become accredited schools. Unfortunately, these practices typically segregate youth, who are often instructed in or near their living unit and prevented from interacting with peers without disabilities.

IDR investigators also found that PSF administrators and teachers lack critical knowledge about the education programs for which they are responsible. For example, some administrators were unable to tell investigators how their education program was credentialed by DOE. Further, administrators regularly reported difficulty obtaining complete youth education records from their prior school. Although the youth's very presence in a PSF indicates the presence of a disability that would qualify them for an individualized education program (IEP), most PSFs reported that students are not provided with special education services because no IEPs are available. Similarly, teachers shared with investigators that they did not know whether youth had previously received special education services.

In response to the absence of complete student records, some PSFs require youth to wait up to 30 days post-admission before attending academic programming, with the expectation that additional records may arrive within the 30-day time span. Other PSFs integrate access to academic programming within their system of rewards and punishments; when youth fail to abide by the rules, they are prohibited from attending school. Clearly, these practices violate the constitutional right of youth to receive a free appropriate public education.

Before leaving this topic, IDR notes that DOE-placed youth tend to remain in residential programming far longer than necessary. IDR investigators met several DOE-placed youth who remained in residential treatment, despite having lived at the facility for more than a decade. Although their treatment goals had been met, DOE had not worked with the youths' respective support systems to identify an appropriate placement and engage in discharge planning.

IDR suggests that the Committee consider strengthening legal mandates regarding the education of students in residential treatment facilities. Specific items to consider include: setting a minimum length of educational programming each day (as students observed during the project rarely spent more than a few hours on daily academic activities); requiring students to be educated in a setting conducive to learning; and reiterating that special education services must be delivered to students in residential treatment facilities.

Investigators also found that many PSFs fail to meaningfully acknowledge and address the trauma experienced by youth, either individually or programmatically. It is important to remember that youth placed in residential treatment facilities almost always have experienced significant trauma. Some have been subjected to abuse and neglect. Some have been removed from the care and custody of their parents. It is ironic, then, that many PSFs fail to address youth trauma in even the most basic manner. Fundamental

needs – like adequate sleep, nutritious meals, and outdoor play and exercise – are not universal in youth residential treatment programs.

Investigators also discovered that some PSFs practice punitive measures when youth engage in inappropriate behavior. Youth regularly reported that, despite having progressed to the second or third phase of a treatment program, a single indiscretion would delay further progress for up to 21 days. Other PSFs automatically demote youth to the prior treatment phase if youth err. These practices seem to primarily benefit the facility's finances, rather than youth mental health and well-being.

Investigators further witnessed youth get stuck at various places within PSF treatment programming. Because many youth in residential treatment have been removed from parental and/or foster care, they often lack somewhere safe to go when their treatment is complete. Without assistance to find a home, these youth linger in PSFs long after their treatment goals have been achieved, in violation of their rights and unnecessarily costing tax revenue. Moreover, unnecessary delays in residential discharge can prompt symptoms and behaviors to reemerge and, subsequently, extend the rationale for continuing to provide residential care. Indeed, sometimes youth are transferred out-of-state to extend residential treatment, which further removes them from their community and support system, potentially exacerbating misbehavior.

During the project, IDR investigators met one youth, placed at a PSF by Indiana's Department of Child Services (DCS), who had lived there for more than two years, without any discharge discussion or planning, despite having met their treatment goals. Even more alarming, investigators encountered multiple youth placed by Indiana's Department of Education (DOE), who have resided in their respective PSFs for 10 or more years. Clearly, these youth are not receiving the attention they need and deserve.

IDR suggests that the Committee solicit ideas to ensure that youth in residential treatment facilities have every opportunity to progress, as well as avoid barriers in the treatment process where youth may get stuck. Requiring periodic assessment of the need for residential treatment, beyond the single, currently required 30-day assessment, may bring greater attention (and resources) to this issue. Additionally, encouraging and facilitating the development of community-based treatment settings, as opposed to large residential institutions, may help avert the extended stays (and consequent decompensation) of youth placed in residential treatment programs.

Inadequate Staffing and Ineffective Leadership

Each of Indiana's 22 PSFs struggle to hire and retain quality staff. Staff shortages regularly cause PSFs to fall out of compliance with mandatory youth-to-staff ratios. The practical consequences include the inability of staff to safely and effectively supervise youth in their care. IDR has observed that the lack of sufficient staff has resulted in increased injury rates among both youth and staff.

PSF administrators report that they lack funds to hire experienced staff. As a result, the PSF workforce is generally young and inexperienced. It is not uncommon for staff to call in at the last minute, arrive late, and leave early. Staff immaturity also contributes to inappropriate responses to youth behaviors, including name-calling, the inappropriate use of restraints, and physical abuse. In short, the characteristics of certain staff increase the likelihood that youth in treatment will be injured. Further, the ensuing chaos makes it even more difficult for administrators to retain and recruit additional staff.

IDR offers two potential opportunities to ease the staffing burden at youth residential facilities. First, the Committee might consider the effect of increasing reimbursement rates so that higher wages can be offered to more competent candidates for employment as direct care staff. Second, increasing the minimum education or professional experience requirements of direct care staff within residential treatment facilities may preclude the hiring of staff who are unprepared to meet essential responsibilities.

Throughout the PSF project, IDR investigators had to actively seek the attention of the facilities' chief administrator, titled the Chief Executive Officer at some facilities and the Executive Director at others. Through interviews with staff and youth, IDR investigators quickly learned that many interviewees had not met, or could not name, the facility's director. Often staff and youth reported that the director was predominantly involved in fundraising activities or other events involving community participation.

Notably, however, some PSFs were outliers with respect to this topic. Generally, those PSFs whose directors had clinical backgrounds (as opposed to sports coaching backgrounds) fostered greater rapport between direct care staff and administrators. Perhaps even more importantly, these PSFs tended to offer more trauma-informed programming, as well as shorter lengths of stay for youth.

Given the undeniable operational differences – and disparate outcomes – between PSFs headed by clinical mental health professionals and those headed by directors from alternate backgrounds, IDR suggests that policymakers consider mandating that directors of youth residential treatment facilities must have at least a bachelor's degree in a mental health or social services field. Too often, IDR investigators found that leadership experience in any field was accepted by those responsible for hiring PSF directors, leaving the directors unprepared to assist youth with disabilities. Directors from non-clinical backgrounds also tend to lack familiarity with reporting requirements and similar regulatory procedures.

Insufficient Regulatory Oversight

Neither Congress nor Indiana's General Assembly has designated a government agency with ultimate responsibility for the oversight of PSFs. Although DCS, DOE, the Indiana Department of Health, and Indiana's Division of Mental Health and Addiction are all involved, to various degrees, in the licensure or guidance of PSFs, their scope of involvement and level of authority are ambiguous. None of these agencies, for example, claim responsibility for the oversight of youth treatment, compliance with staffing ratios, programming, or the administration of grievances from youth or their families. A 12-year-old's suicide went unreported (and uninvestigated), reportedly because PRTF administrators did not know whom to notify. Neither has Indiana designated an agency to regularly visit and conduct compliance surveys at residential treatment facilities.

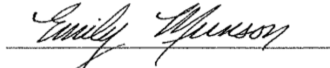
Although, as a direct result of IDR's PSF project, DCS has started visiting PSFs more frequently, it has been reluctant to advocate for the health and safety of youth placed by another entity. (DCS asserts it lacks authority to direct the PSF regarding non-DCS-placed youth.) Further, despite DCS's recent efforts to improve conditions for DCS-placed youth, PSFs throughout the state continue to operate in a noncompliant manner. And, while DCS's actions have led to the closure of a PSF and put other PSF licenses in probationary status in a few unambiguously egregious situations, the agency tends to focus on PSF adherence to the terms of its provider contract rather than consider, more broadly, the daily living conditions of youth. Indiana's tendency to prioritize particular components of youth residential treatment programs, as opposed to managing a comprehensive oversight system, is further evidenced by the fact that state

employees conduct routine surveys of PSF kitchens, to ensure proper sanitation and food safety practices, but conduct no surveys regarding PSF treatment conditions.

IDR suggests that the Committee might begin addressing oversight insufficiencies by requiring states that participate in Medicaid to clearly designate an agency with ultimate oversight authority for residential treatment facilities. That agency, among other authorities, would bear responsibility for sanctioning facilities that fail to comply with federal or state mandates. IDR also suggests that the Committee consider recommending the enaction of a law to prohibit residential treatment facilities from admitting patients, regardless of referral source, if the facility's relevant license is in probationary status or the facility is otherwise under a sanction period.

Thank you again for this opportunity to share concerns about the status of youth residential treatment programs, as well as to offer potential solutions for improving the experience of program residents. Should you or your staff have any questions about IDR's statement, please do not hesitate to contact Policy Director Emily Munson at emunson1@indianadisabilityrights.org. We eagerly await the Committee's response to the hearing and related statements.

Sincerely,



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