



Fact Sheet: Children in Residential Treatment Centers

I. Tens of thousands of children with mental health needs are being placed in expensive, inappropriate and often dangerous institutions.

The number of children placed in residential treatment centers (or RTCs)¹ is growing exponentially.² These modern-day orphanages now house over 50,000 children nationwide.³ Children are packed off to RTCs, often sent by officials whom they have never met and who have probably never spoken to their parents, teachers or social workers.⁴ Once placed, these kids may have no meaningful contact with their families or friends for up to two years.⁵ And, despite many documented cases of physical and sexual abuse and neglect, monitoring is inadequate to ensure that children are safe, healthy and receiving proper services in RTCs.⁶ By funneling children with

¹ According to the Surgeon General, a RTC is a “licensed 24-hour facility (although not licensed as a hospital), which offers mental health treatment.” U.S. Department of Health and Human Services. 1999. *Mental Health: A Report of the Surgeon General*. Washington, DC: Author. Available at: <http://www.surgeongeneral.gov/library/mentalhealth/chapter3/sec7.html#treatment>.

² In 1982, when Jane Knitzer wrote the seminal book, *Unclaimed Children*, the growth in the RTC industry was only beginning. Ms. Knitzer wrote that: “In contrast to the minimal efforts to create nonresidential services, 18 of the 44 states responding to our survey were working to increase residential care.” Knitzer, J., *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Care*, Children’s Defense Fund, 1982, at 45. By 1986, the number of children in RTCs had grown to 25,334, an increase of more than 30% over a three year period. Rivera, V.R. & Kutash, K. (1994), *Components of a System of Care. What Does the Research Say?, Residential Services: Psychiatric Hospitals and Residential Treatment Centers*, at 8, Tampa, FL: University of South Florida, Florida Mental Health Institute: The Research and Training Center for Children’s Mental Health. This growth is continuing. *See infra*, at note 3.

³ Latest Findings in Children’s Mental Health, *Nearly 66,000 Youth Live in U.S. Mental Health Programs*, Vol. 2, No. 1 (Summer 2003). In 1997, the year in which the most recent data was available, over 42,000 children were living in RTCs. Given the growth of children living in RTCs, see *supra* note 2, this figure is likely well over 50,000 now.

⁴ Reports to staff attorneys at the Bazelon Center for Mental Health Law. For example, in Washington, D.C., children are certified to go to RTCs by a “Multi-Agency Planning Team” process (or MAPT process). The MAPT meetings often do not include the voices of the people who know the child and family best.

⁵ Ohio Rights Service Review of Fifteen Children’s Mental Health Facilities (October 2004) (on file with the Bazelon Center)

⁶ *See infra* at sections I(C) and I(D).

mental illnesses into the RTC system, states fail—at enormous cost—to provide more effective community-based mental health services.⁷

A. RTC placements are often inappropriate.

RTCs are among the most restrictive mental health services and, as such, should be reserved for children whose dangerous behavior cannot be controlled except in a secure setting.⁸ Too often, however, child-serving bureaucracies hastily place children in RTCs because they have not made more appropriate community-based services available.⁹ Parents who are desperate to meet their kids' needs often turn to RTCs because they lack viable alternatives.¹⁰

To make placement decisions, families in crisis and overburdened social workers rely on the institutions' glossy flyers and professional websites with testimonials of saved children.¹¹ But all RTCs are not alike.¹² Local, state and national exposés and litigation “regarding the quality of care in residential treatment centers have shown that some programs promise high-quality treatment but deliver low-quality custodial care.”¹³ As a result parents and state officials play a dangerous game of Russian roulette as they decide where to place children, because there is little public information available about the RTCs, which are under-regulated and under-supervised.

To make it worse, far too many children are placed at a great distance from their homes. For example, most District of Columbia children in RTCs are placed outside the District—many as far away as Utah and Minnesota.¹⁴ Many families, especially those with limited means, find it impossible to have any meaningful visitation with their children.

⁷ This development of long-term residential care occurred at the expense of community-based alternatives. Jane Knitzer, as far back as 1982, noted that: “In general, funds were used to develop long-term residential care, with few efforts to support or create emergency shelters, respite care programs, or specialized foster care for disturbed children and adolescents.” *Unclaimed Children*, supra note 2, at 46. Further, the Surgeon General noted that one of the primary reasons that RTCs are considered to be justified is because community-based alternatives are lacking. See *Mental Health: A Report of the Surgeon General*, supra note 1.

⁸ Duchnowski, A.J., Hall, K. S., Kutash, K., and Friedman, R. (1998) The Alternatives to Residential Treatment Study, in *Outcomes for Child and Youth with Behavioral and Emotional Disorders and Their Families*. See also *Mental Health: A Report of the Surgeon General*, supra note 1.

⁹ *Mental Health: A Report of the Surgeon General*, supra note 1, (“Concerns about residential care primarily relate to criteria for admission . . .”).

¹⁰ Lou Kilzer, Desperate Measures, *Rocky Mountain News*, July 2, 1999, available at: <http://www.denver-rmn.com/desperate/site-desperate/front-pg.htm>.

¹¹ *Id.*

¹² *Mental Health: A Report of the Surgeon General*, supra note 1, (“Settings range from structured ones, resembling psychiatric hospitals, to those that are more like group homes or halfway houses.”); Rivera, V.R. & Kutash, K. (1994), *Components of a System of Care. What Does the Research Say?*, Tampa, FL: University of South Florida, Florida Mental Health Institute: The Research and Training Center for Children’s Mental Health.

¹³ Jane Knitzer noted this fact in 1982 in *Unclaimed Children*, supra note 2, at 46. The calls for reform have only increased as the population of children served in RTCs has grown. See *infra* at note 29 and accompanying text.

¹⁴ Scott Higham and Sewell Chan, District Reexamines Out of Town Centers, *The Washington Post*, July 16, 2003, available at: <http://www.washingtonpost.com/ac2/wp-dyn?pagename=article&contentId=A61386->

B. Evidence is limited on the effectiveness of RTCs.

Children frequently arrive at RTCs traumatized by the process that delivered them there. Children placed in RTCs are often forcibly removed from their homes in the middle of the night by “escort companies.”¹⁵ Other times, children are placed in RTCs not by their parents or doctors, but by overburdened child-serving state agencies, who know little about the children’s individual needs.¹⁶

Even more appalling is the fact that many children’s conditions do not improve at all while at the RTC and most do not sustain any gains they made once they return home.¹⁷ In fact, there is little evidence that placing children in RTCs has any positive impact at all on their mental health state¹⁸ and any gains made during a stay in an RTC quickly disappear upon discharge, creating a cycle where children return again and again to RTCs.¹⁹

There are many reasons why RTCs fail to deliver the results they promise, but most center on the type of services provided, the environment they are provided in and the lack of family involvement.

First, the reality of what occurs within an RTC is often quite different from the highly individualized, highly structured programs that are advertised. The RTCs often provide less intense services and the staff are often under-trained.²⁰ Children spend much of their day with staff who are not much more qualified than the average parent and they spend less time face-to-face with psychiatrists than they would if they were being served in appropriate community settings.²¹

The environment is also problematic because children in RTCs enter a situation where their only peers are other troubled children, which has been shown to be a major risk factor for later

[2003Jul15¬Found=true](#). See also, D.C. Department of Mental Health Data from 2003 Children in Residential Treatment Centers (on file at the Bazelon Center).

¹⁵ Kilzer, *supra* note 10.

¹⁶ *Supra*, note 4.

¹⁷ *Mental Health: A Report of the Surgeon General*, *supra* note 1.

¹⁸ Burns, B.J., Hoagwood, K. & Maultsby, L.T., Improving Outcomes for Children and Adolescents with Serious Emotional and Behavioral Disorders: Current and Future Directions. (“A dominant observation is that the least evidence of effectiveness exists for residential services, where the vast majority of dollars are spent.”); Chamberlain, P. , Treatment Foster Care, US Department of Justice, Office of Juvenile Justice and Delinquency Prevention, *Juvenile Justice Bulletin*, December, 1998.

¹⁹ Brown, E.C. & Greenbaum, P.E., Reinstitutionalization After Discharge from Residential Mental Health Facilities: Competing Risks Survival Analysis.

²⁰ Kilzer, *supra* note 10.

²¹ Client reports to Bazelon Center staff attorneys.

behavioral problems.²² Research has demonstrated that some children learn antisocial or bizarre behavior from intensive exposure to other disturbed children.²³

Children in RTCs are usually far from home, often out-of-state.²⁴ Removed from their families and natural support systems, they are unable to draw upon the strengths of their communities and their communities are unable to contribute to the children's treatment. Few children thrive when they are hundreds or thousands of miles from their parents, friends, grandparents and teachers. Few can flourish without the guidance of consistent parenting. Yet, we expect that our most vulnerable and most troubled youth will miraculously turn around in just such a situation. Instead, this isolation further reduces the efficacy and increases the cost of treatment.²⁵

The fact that children and their families are far from one another creates a host of problems. For one, it makes family therapy difficult or impossible. As a result, when children leave the RTC, they return to an environment that has not changed. Also, because the RTC environment is inherently artificial—children are not asked to negotiate the obstacles that occur within their family setting or deal with the difficulties that trigger their behaviors in their neighborhoods or schools—the child does not gain new skills to better negotiate life outside of an institution. As a result, neither the children nor their parents learn better ways to overcome the obstacles that lead children to be placed in an RTC in the first place. Without family involvement, successes are limited.²⁶

For the rare children who are able to overcome the obstacles discussed above, few can sustain the gains that they made. In one study, nearly 50% of children were readmitted to an RTC, and 75% were either reinstitutionalized or arrested.²⁷

C. Children suffer because there is no watchdog.

The RTC industry is largely unregulated.²⁸ RTCs need only report Major Unusual Incidents (or MUIs), but the interpretation of what constitutes a MUI and the reporting requirements vary

²² *Mental Health: A Report of the Surgeon General*, *supra* note 1.

²³ *Mental Health: A Report of the Surgeon General*, *supra* note 1.

²⁴ See, e.g., *supra* note 14 and accompanying text.

²⁵ National Council on Crime and Delinquency, *Focus Newsletter*, July 16, 2002 (“[Residential treatment centers] are usually some distance from the youth’s community, alienating the youth from his or her known environment and adding communication and travel costs to the families and communities.”)

²⁶ Myrth Ogilvie, *Transitioning From Residential Treatment: Family Involvement & Helpful Supports*, in *Focal Point* (2001), available at: <http://www.rtc.pdx.edu/FPinHTML/FocalPointSP01/pgFPsp01Transitioning.shtml>.

²⁷ *Supra* note 25.

²⁸ Since their inception, RTCs have been under-monitored. As Jane Knitzer noted in *Unclaimed Children*, *supra* note 2 at 46: “States have not emphasized continued monitoring of children’s care once they are in residential treatment.” Many RTCs are not accredited at all. Further, the RTCs that are certified are accredited by the Joint Organization on Accreditation of Healthcare Organizations (JCAHO), an independent, nonprofit organization. But as many have pointed out “JCAHO’s standards are geared mainly toward monitoring surgical and pharmacological procedures. And so RTCs, which are more like boarding schools than traditional hospitals, can become accredited under standards that

widely.²⁹ Some RTCs fail to report MUIs at all—and they do so with little consequence.³⁰ Vulnerable kids are placed far from home where parents, social workers, or the state can offer little oversight or protection. Worse, many of the facilities limit the ability of children to have contact with their parents for some period of time, further restricting the ability to monitor the facilities.³¹

D. Children are abused in RTCs.

Children placed in RTCs have been sexually and physically abused, restrained for hours, over-medicated and subject to militaristic punishments; some have died.³² The following are just a few documented examples of tragic occurrences at RTCs:

- Medication is often used (and overused) to control behavior.³³ Children have been permanently disfigured because of over-medication.³⁴
- In some programs, the children's shoes are confiscated to keep them from running away.³⁵
- There have been reports of behavioral 'therapies' being misused. As one author noted, "Such therapies do little more than systemically punish children, all under the guise of treatment"³⁶

have little to do with the daily programs and activities practiced in them." Meza-Wilson, A. & Harrison, C., Safe Choices for Troubled Teens: Residential treatment centers for troubled teens are plagued by allegations of abuse and ineffectiveness. But do anguished parents have an alternative?, August 12, 2004, available at: <http://www.askquestions.org/articles/teens/>.

²⁹ Ohio Rights Service Review, *supra* note 5.

³⁰ *Id.* Further, the Bazelon Center has been contacted by federally funded Protection and Advocacy organizations who never or rarely received MUIs from the RTCs serving children within their jurisdiction.

³¹ Friesen, B.J., Kruzich, J.M., Robinson, A., Jivanjee, P., Pullmann, M. & Bowles, C., Straining the Ties that Bind: Limits on Parent-Child Contact in Out-Of-Home Care, in *Focal Point* (2001), available at: <http://www.rtc.pdx.edu/FPinHTML/FocalPointSP01/pgFPsp01Straining.shtml>.

³² See e.g., Scott Higham and Sewell Chan, Poor Care, Abuses Alleged at Riverside, *The Washington Post*, July 15, 2003, available at: <http://www.washingtonpost.com/ac2/wp-dyn?pagename=article&contentId=A56180-2003Jul14¬Found=true>; Kilzer, *supra* note 10; Associated Press, Death At Residential Treatment Center Ruled a Homicide, May 16, 2002, available at: http://www.geocities.com/ahobbit.geo/residential_treatment.html; Tim Weiner, Parents Divided Over Jamaica Disciplinary Academy, *The New York Times*, June 17, 2003; Ohio Rights Service Review, *supra* note 5; Tanya Eiserer, Death of teen at therapy facility investigated: Richardson 17-year-old died being restrained by staff in Hill Country, *Dallas Morning News*, October 17, 2002; Jorge Fitz-Gibbon, Leah Rae and Shawn Cohen, Treatment Often Hampered By Bureaucracy, *The Journal News*, June 23, 2002, available at: http://www.njournalnews.com/rtc/rtc062302_01.html.

³³ Higham and Chan, *supra* note 32.

³⁴ Reports to staff attorneys at the Bazelon Center for Mental Health Law.

³⁵ Kilzer, *supra* note 10.

³⁶ *Unclaimed Children*, *supra* note 2, at 46.

- Sexual abuse by staff members and other residents is all too frequent.³⁷ In one case, a 13-year old girl performed sexual favors for staff members in return for snacks and carryout food.³⁸ At one RTC, four boys were accused of trying to sodomize another with a cucumber.³⁹ At another, a 19-year-old woman was charged with sodomizing a 14-year-old girl.⁴⁰
- Physical abuse is also too frequent an occurrence. For example, a 13-year-old boy was forced against a wall and slammed to the floor by employees of an RTC.⁴¹
- Children are often restrained—sometimes for hours on end. The overuse of restraint has resulted in child deaths.⁴²

E. Tragic outcomes at great public expense.

RTCs have grown to a billion-dollar, largely private industry.⁴³ Residential treatment care is exorbitantly expensive—costing up to \$700 per child per day.⁴⁴ Annual costs can exceed \$120,000.⁴⁵ Most of the time, the public foots the bill for these services.⁴⁶ In fact, nearly one fourth of the national outlay on child mental health is spent on care in these settings.⁴⁷

II. Other Interventions Work Better for Less

Home- and community-based services are much more therapeutically effective than institutional services, and are also markedly more cost-efficient. As the Surgeon General reported, “the most convincing evidence of effectiveness is for home-based services and therapeutic foster care” and

³⁷ Kilzer, *supra* note 10.

³⁸ Higham and Chan, *supra* note 32.

³⁹ Fitz-Gibbon, Rae and Cohen, *supra* note 32.

⁴⁰ *Id.*

⁴¹ Higham and Chan, *supra* note 32.

⁴² Associated Press, *supra* note 32.

⁴³ Fitz-Gibbon, Rae and Cohen, *supra* note 32.

⁴⁴ Kilzer, *supra* note 10.

⁴⁴ Higham and Chan, *supra* note 32.

⁴⁵ Fitz-Gibbon, Rae and Cohen, *supra* note 32.

⁴⁶ *Id.*

⁴⁷ *Mental Health: Report of the Surgeon General*, *supra* note 1.

not for RTCs.⁴⁸ A comprehensive system of care would dramatically reduce the number of children in RTCs.⁴⁹

Community-based alternatives produce better short and long-term results and are less disruptive to children and families. These alternatives provide intensive mental health treatment, mobilize community resources and help children and their families develop effective coping mechanisms. Some models endeavor to “wrap services around” the child, while others emphasize multi-systemic therapy and crisis intervention. Randomized clinical trials found greater declines in delinquency and behavioral problems, greater increases in functioning, greater stability in housing placements and greater likelihood of permanent placement.⁵⁰ In Milwaukee, a wraparound project that has served over 700 youth involved in juvenile justice has shown similar promise; use of residential treatment has declined 60%, use of psychiatric hospitalization has declined 80%, and average overall care costs for target youth has dropped by one third.⁵¹

⁴⁸ *Id.*

⁴⁹ *Id.* The Surgeon General suggests that RTCs are often utilized because of the under-availability of community-based alternatives.

⁵⁰ Bruns, E.J., *Serving Youths with Emotional and Behavioral Problems in Maryland: Opportunities for the Use of the Wraparound Approach*, University of Maryland School of Medicine, Department of Psychiatry, September 17, 2003 (on file at the Bazelon Center).

⁵¹ *Id.* at 2.