

## Residential Treatment Centers: Not a Solution for Children with Mental Health Needs

Parents of children with mental health needs do what any parent would when a child is in trouble: they look for help. When they do so, families in crisis are too often seduced by the high-gloss marketing efforts of a well-financed industry promoting an intervention—residential treatment center care—for which scant evidence of long-term effectiveness exists and significant potential for abuse and neglect is evident. (Regarding scant evidence of long-term effectiveness, see, e.g., Barbara J. Burns et al., *Effective Treatment for Mental Disorders in Children and Adolescents*, 2 CLINICAL CHILD AND FAMILY PSYCHOLOGY REVIEW 199, 209–10 (1999); regarding the more than forty published reports of abuse within residential treatment centers, see, e.g., Scott Higham & Sewell Chan, *Poor Care, Abuses Alleged at Riverside*, WASHINGTON POST, July 15, 2003, at A1.)

Residential treatment centers are secured facilities for children and adolescents with significant behavioral, emotional, and mental health needs. Up to 50,000 children a year are now housed in residential treatment centers. (Kathleen J. Pottick & Lynn A. Warner, *Nearly 66,000 Youth Live in U.S. Mental Health Programs*, LATEST FINDINGS IN CHILDREN'S MENTAL HEALTH, Summer 2003, at 1.)

Such an industry seemingly should be held accountable or at least heavily regulated. Regrettably, for kids with serious emotional disturbance, their parents, and advocates—neither is the case. Although highly public media accounts have documented abuse and neglect in these facilities, little or no public oversight is in place. (See generally Anthony Meza-Wilson & Christy Harrison, *Safe Choices for Troubled Teens* (posted Aug. 12, 2004), at [www.askquestions.org/articles/teens/SafeChoices.pdf](http://www.askquestions.org/articles/teens/SafeChoices.pdf).) The lack of public

oversight of residential treatment centers also means that the full scope of the abuse and neglect problem is unknown and that the problem may be even more widespread than reported. A bill—End Institutionalized Abuse Against Children Act, H.R. 1738, 109th Cong. § 1 (2005)—introduced in Congress in April 2005 would add regulations where few exist.

These harms come at great cost—facilities charge up to \$90,000 per year per child (see Higham & Chan, *supra*)—and eat up nearly one-fourth of the national outlay on child mental health care. (U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 169 (1999).) By funneling children with mental illnesses into the residential treatment center system, states undercut more effective community-based mental health services.

Poor children are disproportionately institutionalized in residential treatment centers. Medicaid and state mental health agencies pay for approximately 31 percent of residential treatment center care, and other public agencies, often the domain of children in poverty, pay for another 50 percent. (For the most recent data, see SURVEY AND ANALYSIS BRANCH, CENTER FOR MENTAL HEALTH SERVICES, SURVEY OF MENTAL HEALTH ORGANIZATIONS AND GENERAL HOSPITAL MENTAL HEALTH SERVICES (1998). Child-serving agencies place many children in residential treatment centers that are far from home; this makes having meaningful contact with their children difficult for families of limited means and reduces the efficacy of treatment and increases its cost. (Scott Higham & Sewell Chan, *District Reexamines Out-of-Town Centers, Potential Impacts of Proposed Budget Cuts to California's Juvenile Justice-Involved and At-Risk Youths with Mental Health Problems*, FOCUS (National Council on Crime and Delinquency, Oakland, Cal.), July 16, 2002, at 2.)

There is hope. Children's mental health needs can be met in ways that do not require placement outside of the

child's community, in ways that do not put the child at risk, and in ways that provide better services and cost less. Community-based alternatives—such as wraparound and therapeutic foster care—produce better short- and long-term results and are less disruptive to children and families.

**Christine F. Vaughn**

Skadden Fellow/Staff Attorney, Bazelon Center for Mental Health Law, 1101 15th St. NW, Suite 1212, Washington, DC 20005; 202.467.5730 ext. 115; [Christine@bazelon.org](mailto:Christine@bazelon.org)

## Help for Immigrant Youth?: The Dream Act

The Development, Relief, and Education for Alien Minors (Dream) Act is a bipartisan federal legislation that would permit high school graduates who came to the United States as children and have lived in the United States for at least five years to apply for temporary "conditional" legal status. Once their application is approved, such students would be able to make their status permanent by attending college or serving in the military for at least two years. The Dream Act also would eliminate a federal provision—8 U.S.C. § 1623—that discourages states from providing in-state tuition rates to immigrant students. Since 2001, nine states—California, Illinois, Kansas, New Mexico, New York, Oklahoma, Texas, Utah, and Washington—have enacted legislation tailored to comply with Section 1623 while permitting most undocumented immigrant students who have attended and graduated from their schools to pay in-state tuition. A majority of undocumented immigrants live in these nine states. As of July 2005, only one legal challenge has been mounted to these state laws; the court dismissed the case, in part because plaintiffs—students who were not offered in-state tuition—did not have standing and in part because they had no private right of action under Section 1623. (*Day v. Sebelius*, No. 04-4085-RDR (D. Kan. July 5, 2005) (order and memorandum) (Clearinghouse No. 55,894.)