



For Many Residential Programs, Regulatory Framework in H.R. 911 Would Be Duplicative and Ill-Suited to Those Served

Well-intentioned Legislation Should Ensure Baseline Regulation for All Residential Treatment Programs By Focusing On Those Not Already Covered By Existing Federal Laws; For Others, Changes Should Be Adopted Through Those Laws

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SUMMARY

The Senate is currently considering legislation passed by the House in February that would establish a baseline level of regulation for all residential treatment programs (as defined by the bill) for children.² This legislation (H.R. 911, The Stop Child Abuse in Residential Programs for Teens Act of 2009) was adopted after the Government Accountability Office (GAO) uncovered incidents of abuse at a number of wilderness programs and boot camps in 2007.³

The authors of this legislation should be commended for their efforts to ensure appropriate minimum regulation for all residential treatment programs for children, particularly the wilderness and boot camp programs that are its primary focus.⁴ Unfortunately, in its current form, this legislation would create a duplicate regulatory system for many other residential treatment programs that are already significantly regulated under existing federal and/or state laws.⁵

This second, one-size-fits-all regulatory system would be poorly suited to the needs of children in these already-regulated facilities. It would:

- Create duplicate regulatory responsibility for federal and state agencies that, in many cases, do not now regulate such facilities and that lack the expertise and knowledge to do so properly; and

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² For the purposes of this paper, residential treatment programs are defined as programs that provide treatment or behavioral modification in a residential environment as described by the bill.

³ U.S. Government Accountability Office, "Residential Treatment Programs: Concerns Regarding Abuse and Death in Certain Programs for Troubled Youth," October 10, 2007 (GAO-08-6146t). Available online at:

<http://www.gao.gov/new.items/d08146t.pdf>.

⁴ Wilderness programs and boot camps are the first two types of programs listed as covered under H.R. 911, § 2(4)(A)(i).

⁵ Reviews of existing licensing, regulation and related practices for programs focused on mental health and/or child welfare can be found in: Henry Ireys, Lori Achman, and Ami Takyi, "State Regulation of Residential Facilities for Children with Mental Illness," Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2006. Available online at: <http://www.samhsa.gov/News/NewsReleases/residfacilchildrenFinal.pdf>; and June Gibbs Brown, "State Oversight of Residential Facilities for Children," U.S. Department of Health and Human Services, Office of the Inspector General, May 2000. Available online at: <http://www.oig.hhs.gov/oei/reports/oei-02-98-00570.pdf>.

- Impose burdensome, possibly inappropriate, in some cases contradictory new standards and enforcement and reporting requirements for many already-regulated facilities, diverting limited resources from, and in certain cases possibly jeopardizing, the health and safety of children in their care.

These issues should be addressed by:

- **Ensuring that all residential facilities are appropriately licensed.** H.R. 911 provides a baseline level of regulation for residential treatment facilities for children. This blanket regulation should be preserved to ensure coverage of all programs not already appropriately regulated and licensed under existing state and federal laws. For more complete coverage, Congress should also consider covering residential treatment programs for adults.
- **Exempting facilities already covered under a list of applicable federal laws.** To avoid redundant and possibly contradictory regulation of already-licensed facilities, H.R. 911 should exempt programs funded and regulated under federal child welfare laws (Title IV-E of the Social Security Act), Medicaid, juvenile justice laws (Juvenile Justice and Delinquency Prevention Act),⁶ IDEA, SAMHSA-funded programs (Public Health Service Act), or state laws that meet or exceed the standards of H.R. 911.
- **Regulating facilities already covered by applicable federal laws through those laws.** For programs provided an exemption under existing federal laws, those laws should be reviewed and updated where needed to ensure the minimum health and safety of children in residential treatment programs operated under their purview. To avoid duplicate and potentially contradictory enforcement, any new standards for these programs should be administered by state agencies with appropriate expertise and jurisdiction and integrated into existing reporting and enforcement requirements.

THE PROBLEM OF UNLICENSED AND UNREGULATED RESIDENTIAL TREATMENT PROGRAMS

Residential treatment programs provide a critical level of support and services for children with high treatment needs. These programs are often operated by highly trained, and in many cases professionally licensed, staff who provide needed treatment and care. Such programs provide a safe and structured environment, including controlled oversight of medications where needed.⁷ For many children, a lack of access to such care could result in injury to themselves or others, clinical deterioration or dysfunction that can be expensive to remediate, educational delays or failure, unemployment, incarceration, or homelessness.⁸

The needs and vulnerability of children in such facilities, along with the skills and training required to provide them with appropriate care, all indicate that **every residential treatment facility in the United States should be fully and adequately licensed and regulated.** Unfortunately, as has been documented in several reports by the Government Accountability Office, this is not always the case.

⁶ House Education and Labor Committee staff have said on at least one occasion that most juvenile detention facilities would not be covered by H.R. 911, but § 2(4)(A)(ii)(I) of the bill clearly indicates that it covers residential facilities that operate with a focus on children with behavioral problems. Such children are a primary population served by the wilderness programs and boot camps that are central to H.R. 911. There is no reason to presume from the language in the bill that boot camps and wilderness programs would be covered, but more traditional juvenile detention facilities, which address similar populations and were covered in related GAO reports, would not be. If the House had intended to exempt such facilities, they could have been included along with hospitals among the list of programs explicitly exempted. They were not.

⁷ Abt Associates, "Characteristics of Residential Treatment for Children and Youth with Serious Emotional Disturbances," (Summer 2008), p. 8. Available online at: http://www.naphs.org/documents/AbtFINALReport.8.4.08_000.pdf.

⁸ *Ibid.*, pp. 8, 12, 18.

In some states, purely private facilities that do not receive public funding are exempt from such licensing and regulation.⁹ Unlike many publicly-funded programs, which typically receive placements from a state or local governmental agency, these purely private programs are often marketed directly to parents.¹⁰ In some states, not only are the facilities themselves unregulated or loosely regulated, so too are the educational consultants, referral services, and transportation services that connect and transport children to them.¹¹ In some cases, states do not even collect data about these facilities.¹²

Beyond purely private facilities, some states (Arizona, Arkansas, Iowa, Maine, Missouri, and South Carolina) provide exemptions to faith-based facilities.¹³ Some exempt government-operated facilities.¹⁴ Some exempt certain kinds of facilities, such as juvenile justice facilities and private schools and academies.¹⁵ Even where licensing and regulatory requirements exist, they can often be highly uneven, allowing residential programs to “license shop” among different regulatory requirements by self-identifying themselves as a certain type of facility.¹⁶ Even in the case of publicly-funded residential programs, the delegation of significant regulatory authority to states has resulted in uneven regulatory requirements from one state to another.¹⁷

In general, this patchwork of exemptions and uneven state regulation has resulted in protections for children that are appropriate in some cases, but inappropriate in others. This strongly suggests the need for a baseline level of regulation for all residential treatment programs like that provided in H.R. 911.

THE PROBLEM OF DUPLICATE, ONE-SIZE-FITS-ALL REGULATION FOR PROGRAMS ALREADY REGULATED AND LICENSED

While the need to ensure proper regulation and licensing for all residential treatment programs for children is clear, H.R. 911 overreaches by failing to exempt programs that are already subject to very significant regulatory and licensing requirements.¹⁸ For these programs, H.R. 911 will establish a duplicate regulatory structure that will unnecessarily divert needed resources and may, in some cases, establish one-size-fits-all standards that are wholly inappropriate to the specific needs of the regulated facilities and the children in their care.

Some of the problems in H.R. 911, as passed by the House, include:

- **Poorly-Fitting, One-Size-Fits-All Standards:** While well-intentioned, many of the standards included in H.R. 911 are poorly designed and not well suited to every type of residential treatment program. For example, the bill includes what appears to be a reasonable requirement for children in covered programs to have access to telephones and to make calls with as much privacy as possible.¹⁹ This standard was included so children could contact their families²⁰ or hotlines to

⁹ U.S. Government Accountability Office, “Residential Facilities: State and Federal Oversight Gaps May Increase Risk to Youth Well-Being,” April 24, 2008 (GAO-08-696t), p. 1. Available online at:

<http://www.gao.gov/new.items/d08696t.pdf>.

¹⁰ U.S. Government Accountability Office, “Residential Programs: Selected Cases of Death, Abuse and Deceptive Marketing,” April 24, 2008 (GAO-08-713T), pp. 16-20. Available online at:

<http://www.gao.gov/new.items/d08713t.pdf>

¹¹ Ibid., p. 7.

¹² GAO, op. cit. (9), p. 3.

¹³ GAO, op. cit. (9), p. 8.

¹⁴ U.S. Government Accountability Office, “Residential Facilities: Improved Data and Enhanced Oversight Would Help Safeguard the Well-Being of Youth with Behavioral and Emotional Challenges,” May 2008 (GAO-08-346), pp. 20, 55.

Available online at: <http://www.gao.gov/new.items/d08346.pdf>.

¹⁵ GAO, op. cit. (9), p. 3.

¹⁶ GAO, op. cit. (9), p. 9; GAO, op. cit. (14), p. 42.

¹⁷ GAO, op. cit. (9), p. 15, summary page.

¹⁸ Op. cit. (5).

¹⁹ H.R. 911, § 3(a)(1)(E).

²⁰ House Education and Labor Committee, “Stop Child Abuse In Residential Programs for Teens Act of 2008,” (Report 110-669: May 22, 2008), p. 17.

report abuse.²¹ However, as written, this standard is not appropriate in all cases. In juvenile justice facilities, for example, unmonitored phone calls can result in serious security breaches that can endanger children both inside and outside the facility, resulting in possible harassment, violence, exchange of contraband items, and other illegal activities.²² Some have debated whether the House-passed bill would cover juvenile detention facilities, even though the statutory language strongly suggests that it would.²³ Even if not, facilities whose primary focus is providing substance abuse treatment for children would certainly be covered,²⁴ and in many cases the dangers would be similar. This example illustrates the problem of one-size-fits-all standards and how empowering an agency with insufficient expertise and a poor understanding of the many different kinds of residential programs can result in well-intentioned policies that could nevertheless endanger some children.²⁵

This is not the only example. Another standard prohibits the use of restraint and seclusion techniques beyond those allowed for community-based facilities under the Public Health Service Act.²⁶ CMS was directed to develop regulations for these facilities over 8 years ago, but as of this writing, CMS has not even released interim regulations.²⁷ How much longer will these regulations be delayed by expanding their applicability to programs outside CMS's expertise and jurisdiction? What will be in these new standards, and how appropriate will they be for all residential programs? In the meantime, how many children in programs already covered by the Public Health Service Act will be affected by delaying the regulatory process further?

Another of the bill's standards prohibits the withholding of medical care necessary to maintain a child's mental health.²⁸ It is not clear, however, how this standard would be reconciled with the apparently contradictory prohibition on mandatory medications for children with disabilities who are enrolled in residential programs funded under the Individuals with Disabilities Education Act (IDEA).²⁹

Other standards in the bill will create significant paperwork requirements that will divert resources from needed care. One requirement adopts a "guilty until proven innocent" standard by requiring a covered program to, within 48 hours, notify all parents or legal guardians of enrolled children if it is being investigated for alleged child abuse or neglect.³⁰ The same requirement would also apply

²¹ H.R. 911, § 3(a)(1)(E).

²² State of Maryland Office of the Attorney General, Juvenile Justice Monitoring Unit, "Baltimore City Juvenile Justice Center Special Report," February 10, 2009. Available online at:

http://www.oag.state.md.us/JJMU/reports/BCJJC%2010_7%20Incident.pdf; See also Montana Department of Corrections, "Facts and Frequently Asked Questions: Inmate Phones." Available online at: <http://www.cor.mt.gov/Facts/InmatePhones.mcp.x>.

²³ Op. cit. (6).

²⁴ H.R. 911, § 2(4)(a)(2)(ii)(II).

²⁵ A similar argument can be made about the congressional committee and staff responsible for drafting this legislation. The House Education and Labor Committee lacks primary jurisdiction over child welfare, Medicaid, and SAMHSA-related programs. There is little reason to presume that this committee and its staff are best qualified to devise standards for those programs.

²⁶ H.R. 911, § 3(a)(1)(C) and 42 U.S.C. 290jj, available online at:

http://straylight.law.cornell.edu/uscode/html/uscode42/usc_sec_42_00000290--jj000-.html.

²⁷ CMS released final regulations for hospitals in December 2006 (42 CFR 482.13; 71 FR 71377), but has not yet done so for community-based facilities. Interestingly, in its final regulations for hospitals, CMS made the following comment (71 FR 71380): "We have decided that it would not be appropriate to adopt a detailed, technical approach that would create an identical standard for all of the providers with which CMS has agreements. Instead, the needs of specific treatment populations and settings should drive the types of standards developed. Therefore, we do not plan to adopt the hospital requirements verbatim for other provider types." The hospital regulations can be found online at: <http://www.napas.org/issues/an/rs/regulations/Final%20Rule%20-%20Hospital%20Conditions%20of%20Participation%20Patients%27%20Rights.pdf>.

²⁸ H.R. 911, § 3(a)(1)(B).

²⁹ 20 U.S.C. § 1412(a)(25). Available online at:

http://straylight.law.cornell.edu/uscode/html/uscode20/usc_sec_20_00001412----000-.html.

³⁰ H.R. 911, § 3(a)(1)(N).

to any other violations of federal or state licensing standards established under the bill, even those that are purely administrative in nature.³¹

Another standard would require facilities to notify all parents and legal guardians of enrolled children every time there is a change in any staff member's qualifications, roles or responsibilities – a requirement that would impose a tremendous paperwork burden with every new hire, promotion, or change in professional licensing.³²

Each of these examples illustrates the challenges of developing a single set of standards that are equally applicable to all residential programs, regardless of the differences in the type of program, services delivered, and the characteristics of the children being served. These are not academic issues. Implemented poorly, these standards can have significant adverse consequences for children in care.

- **Broad Additional Federal Standard-Setting Authority:** Beyond the standards mentioned above, H.R. 911 would further empower the Administration for Children and Families (ACF) within the U.S. Department of Health and Human Services to set any additional standards it deemed appropriate to provide for basic health and safety of children at covered residential programs.³³ Even though they are not currently within the jurisdiction or expertise of ACF, this broad authority would apply to programs operated with funding under federal juvenile justice programs,³⁴ IDEA, Medicaid, or SAMHSA-related programs. Is it realistic to believe that this single federal agency will be able to develop appropriate and universally applicable regulations for facilities that are providing complicated and specialized treatments that are wholly outside its area of expertise?
- **Hindrance of Higher or Better Designed Federal, State or Local Standards:** The House Education and Labor Committee's report on similar legislation in 2008 indicated that the standards in H.R. 911 are intended to be a floor, not a ceiling.³⁵ Unfortunately, the standards in H.R. 911 will almost certainly be viewed as sufficient in many or even most cases and, as a result, their existence may undermine or at least complicate other federal, state or local efforts to develop higher, different, or more appropriate standards that would better protect children in residential care. Moreover, the standards in H.R. 911 seem likely to override and force the alteration of many existing state and local standards, even if they are better than (but sufficiently different from) these new federal standards.
- **Unresolved Patchwork Coverage:** H.R. 911 only applies to programs that focus on serving children with various emotional, behavioral, or mental health issues.³⁶ It does not cover other programs for children that lack such a focus, even though they may provide many children with the same or similar services, possibly by staff with lower levels of training. The bill also does not cover residential programs providing services primarily to adults, many of whom may be just as vulnerable as children in similar programs. As a result, H.R. 911 is likely to leave many programs uncovered, a problem it was intended to resolve.

The standards in H.R. 911 are only one problem. Another is the bill's duplicative enforcement process. This includes:

- **Duplicate, Direct, and Ongoing Federal Enforcement:** H.R. 911 empowers the Administration for Children and Families (ACF) to directly review and investigate reports of child abuse and neglect at all covered residential programs in each state (including those normally operating

³¹ Ibid.

³² H.R. 911, § 3(a)(1)(H).

³³ H.R. 911, § 3(a)(1)(O).

³⁴ Op. cit. (6).

³⁵ "Though the Committee believes these standards are critical to the safety of kids in covered programs, it views these standards as very minimal and strongly encourages states to enact stronger and more comprehensive standards that will facilitate the provision of effective services." – House Education and Labor Committee, "Stop Child Abuse In Residential Programs for Teens Act of 2008," (Report 110-669: May 22, 2008), p. 19.

³⁶ H.R. 911, § 2(4).

outside ACF jurisdiction, including juvenile justice, Medicaid, IDEA, and SAMHSA-funded programs, as noted above) for at least two years.³⁷ Such enforcement would be in addition to any already-existing state oversight and inspection requirements.

After this initial two-year period has ended, and after ACF has determined that a given state has satisfied the various other regulatory aspects of the bill,³⁸ some regulatory authority would be passed back to the state, but not all.³⁹ ACF would still be charged with monitoring and referring credible complaints received on a newly-established toll-free federal hotline.⁴⁰ States would be required to keep ACF informed of any fatalities⁴¹ or patterns of violations⁴² at facilities within the state. ACF would then conduct annual reviews to assess the state's response to such incidents⁴³ as well as unannounced site visits.⁴⁴ If ACF determined that state enforcement was not adequate, ACF would assume authority for joint inspections conducted with local agencies for a period of not less than one year.⁴⁵ The bill further provides federal civil penalties of up to \$50,000 per violation⁴⁶ and subsequent referral to the U.S. Department of Justice when ACF believes such penalties have not resulted in appropriate remedies.⁴⁷

- **Duplicate State Enforcement:** H.R. 911 requires states to designate a single agency to oversee state standards developed under the act.⁴⁸ As noted by GAO, in many states the enforcement of existing standards is divided among several state agencies.⁴⁹ This can include state agencies charged with overseeing child welfare, mental health, juvenile justice, and education programs.⁵⁰ In such states, H.R. 911 will produce duplicate state-level enforcement for many residential programs. Such oversight would involve the development of new, possibly duplicative state regulations,⁵¹ data collection efforts,⁵² inspections,⁵³ and sanctions.⁵⁴ All of these mechanisms would be subject to federal review by the Administration for Children and Families, regardless of the type of facility or the qualifications of ACF to provide oversight for such facilities.⁵⁵

RECOMMENDATIONS

Addressing insufficient regulation for some facilities while avoiding counterproductive duplicate regulation for others is not impossible. Both of these problems can be addressed by amending H.R. 911 to exempt certain categories of programs governed under existing federal statutes and instead addressing them through those statutes, with oversight provided by federal and state agencies with existing jurisdiction.

As it reviews and acts further on this legislation, Congress should consider:

³⁷ H.R. 911, § 3(b)(1)(E).

³⁸ H.R. 911, § 114(c) of § 7(a).

³⁹ H.R. 911, § 114(d) of § 7(a).

⁴⁰ H.R. 911, § 3(d).

⁴¹ H.R. 911, § 114(b)(4)(B) and § 114(d)(2)(A)(i) of § 7(a).

⁴² H.R. 911, § 114(b)(4)(A) and § 114(d)(2)(A)(ii) of § 7(a).

⁴³ H.R. 911, § 114(d)(2)(B) of § 7(a).

⁴⁴ H.R. 911, § 114(d)(2)(C) of § 7(a).

⁴⁵ H.R. 911, § 114(d)(3) of § 7(a).

⁴⁶ H.R. 911, § 3(b)(2)(A).

⁴⁷ H.R. 911, § 4.

⁴⁸ H.R. 911, § 114(b)(2)(A) and 114(c)(2) of § 7(a).

⁴⁹ GAO, op. cit. (14), p. 7.

⁵⁰ Ibid.

⁵¹ H.R. 911, § 114(b)(1) and § 114(b)(2)(B) of § 7(a).

⁵² H.R. 911, § 114(b)(2)(D) and § 114(c)(4) of § 7(a).

⁵³ H.R. 911, § 114(b)(2)(C) and § 114(c)(3) of § 7(a).

⁵⁴ H.R. 911, § 114(b)(2)(E) and § 114(c)(5) of § 7(a).

⁵⁵ H.R. 911, § 114(c) and § 114(d)(2) of § 7(a).

- **Ensuring that all residential facilities are appropriately licensed.** H.R. 911 provides a baseline level of regulation for residential treatment facilities for children. This blanket regulation should be preserved to ensure coverage of all programs not already appropriately regulated and licensed under existing state and federal laws. For more complete coverage, Congress should also consider covering residential treatment programs for adults.
- **Exempting facilities already covered under a list of applicable federal laws.** To avoid redundant and possibly contradictory regulation of already-licensed facilities, H.R. 911 should be amended to exempt facilities that meet state and federal standards required under one or more of the following laws, as determined by the state and / or federal agencies responsible for their implementation:
 - Individuals with Disabilities Education Act;
 - Juvenile Justice and Delinquency Prevention Act;
 - Medicaid;
 - Public Health Service Act;
 - Social Security Act, Title IV-E; or
 - state laws that meet or exceed the standards of H.R. 911.
- **Regulating facilities already covered by applicable federal laws through those laws.** Congress should review the standards for facilities that are already regulated under the above laws. Committees with appropriate jurisdiction should seek input from relevant federal and state agencies, representatives of facilities, and those being served. Any subsequent changes to federal law should be made through existing statutes, properly integrated with existing reporting and enforcement requirements, and tailored to the type of facility in question. Where appropriate, improvements in training⁵⁶ and enforcement⁵⁷ should be considered as a supplement or alternative to changes to existing law.

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About the Alliance for Children and Families and United Neighborhood Centers of America

The Alliance for Children and Families, a nonprofit association, was formed by the 1998 merger of Family Service America and the National Association of Homes and Services for Children. The Alliance represents over 370 nonprofit organizations across the nation that provide services and economic empowerment to children and families. Alliance agencies cover a wide spectrum of providers, including a diversity of faith-based organizations and nonsectarian agencies. Together, these organizations deliver more than \$2 billion annually in services to more than 8 million people in nearly 6,700 communities across the United States. More information about the Alliance is available at www.alliance1.org.

United Neighborhood Centers of America (UNCA) is a voluntary, nonprofit, national organization with neighborhood-based member agencies throughout the United States. Formerly known as the National Federation of Settlements and Neighborhood Centers, it was founded in 1911 by Jane Addams and other pioneers of the settlement movement. UNCA members build neighborhoods with neighbors. More information about UNCA is available at www.unca.org.

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⁵⁶ GAO, op. cit. (9), p. 6.

⁵⁷ GAO, op. cit. (14), p. 27.