Warehoused:

Inappropriate Institutionalization of Texas Foster Youth

A Disability Rights Texas Investigative Report

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ABOUT DISABILITY RIGHTS TEXAS

Disability Rights Texas ("DRTX") is the Protection and Advocacy System ("P&A") for the State of Texas, whose purpose is to protect and advocate for the legal and human rights of individuals with disabilities. *See* Tex. Gov. Exec. Order No. DB-33, 2 Tex. Reg. 3713 (1977) and Tex. Att'y Gen. Op. No. JC-0461 (2002); *see also* Developmental Disabilities Assistance and Bill of Rights Act of 2000, 42 U.S.C. §§ 15041 *et seq*.; Protection and Advocacy for Mentally Ill Individuals Act, 42 U.S.C. §§ 10801 *et seq*.; and Protection and Advocacy for Individual Rights Act, 29 U.S.C. § 794e. DRTX has an Institutional Rights and Civil Liberties Team, which monitors, among other places, facilities housing foster youth with disabilities. DRTX's monitoring consists of investigating allegations of abuse and neglect, responding to rights violations, and providing general advocacy services on behalf of persons with disabilities confined in facilities. DRTX also has a Foster Care Team, which accepts court appointments from state district courts to act as attorneys *ad litem* for foster children with disabilities who are in the Permanent Managing Conservatorship ("PMC") of the Department of Family and Protective Services ("DFPS"). In this capacity, DRTX foster care attorneys practice in counties around the state, both representing children in child welfare matters, and representing foster children in ancillary litigation such as special education proceedings and Medicaid appeals.

DRTX attorneys and advocates have a wealth of experience advocating for children, and more specifically foster children with mental health and behavioral health needs and intellectual and developmental disabilities. Due to the scope of its practice, DRTX advocates and attorneys have visited most congregate care facilities and psychiatric hospitals around the state. These teams have operated for over a decade, allowing us to witness both the long-term effects of foster care on children, and how the Texas child welfare system interacts with other state-run systems.

The recommendations set forth by Disability Rights Texas in this report are intended to provide solutions that allow foster youth to receive supports and services that maximize their growth and success.

Stakeholders interested in discussing these findings and recommendations are encouraged to contact Disability Rights Texas.

Visit DRTx.org or call (512) 454-4816 and ask for Beth Mitchell or Cindy Gibson.

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** The names of foster youth in the real stories provided throughout this report have been changed to protect the individual's privacy.*

1. INTRODUCTION

Over the past year, in the course of monitoring private psychiatric hospitals, DRTx identified numerous foster youth who were initially admitted to psychiatric hospitals for five- to seven-day emergency stays, but remained for months after professionals determined they were ready for discharge. Review of hospital and Department of Family & Protective Services ("DFPS") records as well as interviews with hospital administrators indicated that many of the identified youth stayed in psychiatric hospitals long after their physicians and Superior STAR Health, the State managed care entity, determined they were stable and no longer met criteria for inpatient psychiatric services.

The sole reason for inappropriate continued inpatient care of these children was the inability of DFPS to timely identify appropriate placement. Rather than utilizing hospital settings as short-term emergency interventions, DFPS treats them as alternate placements. This normalization of keeping children in hospital settings for months has transformed hospitals into extended placements for foster youth, a practice that is detrimental to the youth and costly for the State.

Based on these observations, DRTx conducted an investigation to determine the scope of the problem, identify factors leading to the problem of unnecessary hospitalization of foster youth, and provide recommendations for ending this damaging practice.

This damaging practice has persisted for far too long. More than thirteen years ago the Austin American Statesman wrote an article outlining many of the identical concerns raised in this Report.[1] Citing this article, the Texas Comptroller in 2006 conducted an extensive analysis of the issues raised in the Statesman article, which ultimately identified many of the same findings and recommendations made in this Report.[2] It is the goal of Disability Rights Texas by releasing this Report to ensure that these children are not forgotten yet again.

2. INVESTIGATION

The average length of stay in an acute care facility for adolescents is five to seven days with some outliers on either side.[3] This stabilization period is no different for foster youth, yet based on DRTx's investigation and testimony from private psychiatric hospital administrators, at least a third of foster youth who enter psychiatric facilities remain unnecessarily hospitalized for months beyond medical necessity.[4] The only documented barrier to their discharge after stabilization is DFPS's failure to identify an appropriate placement.[5]

After five days, Annie's treating psychiatrist determined that she was ready for discharge. Despite being discharge ready, she remained in the hospital for over three additional months due to lack of placement. During that time, she fell behind in school. Hospital administrators stated that she decompensated due to remaining hospitalized too long, which resulted in her being restrained fourteen times and receiving emergency medication sixteen times.

Foster youth have to contend with not only the regular dangers at private psychiatric facilities but also endure additional harms due to their unnecessary extended stays. Newspapers published a series of articles identifying the myriad of dangers they uncovered over the past five years at private psychiatric hospitals. For example, two former patients brought a lawsuit against Dallas Behavioral HealthCare Hospital, citing predatory business practices after being held without court orders and without their consent.[6] The hospital is also losing its Medicare funding after suspected sex between minors and patients left untreated, among other violations.[7] Timberlawn Behavioral Health System in Dallas announced it would close on February 1, 2018, after multiple incidents of rape and suicide in the last several years.[8] In December 2018, Sundance Behavioral Hospital in Fort Worth closed three facilities and surrendered its license after the recent indictment "on 20 counts of violating the Texas Mental Health Code over accusations that it held patients involuntarily and illegally."[9]

Most recently, the *Austin-American Statesman* reported on Georgetown Behavioral Health's (GBH) troubled history, detailing multiple lawsuits from former employees who were terminated, allegedly after reporting poor facility conditions or employee misconduct such as punching a minor patient in the head. [10] This minor was also a foster youth. GBH has racked up previous fines from the Health & Human Services Commission, the state agency responsible for licensing and inspecting private psychiatric facilities, for failing to protect patients from a number of violations. It is facing a new $180,000 fine for not

Sam was admitted to GBH with an original estimated length of stay (ELOS) of five to seven days. On his ninth day of hospitalization, his ELOS was extended to seven to ten days. On his tenth day, he still had not spoken to CPS about his discharge. On the eleventh day, a GBH staff person punched Sam in the face. The staff member was only fired after Health Facility Compliance investigated the incident.

properly monitoring patients, which resulted in two patients having sex.[11] The *Statesman* article specifically highlights that since 2015, DFPS has paid GBH more than one million dollars to care for foster youth.[12]

Beyond these typical dangers, children who remain institutionalized beyond medical necessity for numerous reasons often decompensate, most of which are byproducts of the fact that psychiatric hospital are not generally equipped for lengthy stays. Because psychiatric hospitals are designed for crisis stabilization and short-term stays, they are ill equipped to address the underlying trauma that children in foster care experience. Children often come in to the foster care system dealing with trauma related to abuse and neglect, which can be exacerbated when they are forced to remain in institutional care as other children enter for short periods and leave. Compared to children who were not in foster care, one study found that children from the foster care system who were admitted to psychiatric hospitals were admitted at younger ages and were more likely to be readmitted within two years.[13] Additionally, they were more likely to be diagnosed with externalizing disorders (e.g., ADHD, oppositional defiance disorder, conduct disorder) than the control group and were twice as likely to be restrained while hospitalized.[14]

Further, children who were hospitalized expressed fears related to being in a strange environment, loss of self-determination, and disruption to routines and relationships.[15] Thus not only are Texas foster children coming into their hospitalizations with a history of trauma, but they are also incurring further emotional damage in addition to the other identified damaging cognitive and behavioral effects of institutionalization beyond medical necessity.

Further, institutionalization beyond medical necessity can have a negative effect on the education of foster youth. A recent article highlighting the issue of prolonged psychiatric hospitalization of foster youth in Illinois noted that some children received, at most, a couple of hours of low-quality educational instruction per day, often without teachers.[16] This lack of adequate instruction leads to situations where children are forced to repeat grades.[17]

Hospital administrators in Texas frequently witness the harmful effects of lengthy, inappropriate hospital stays on foster youth. During a 2018 Texas House Appropriations Subcommittee hearing, hospital administrators testified about the experiences of children in DFPS custody at their facilities. Roy Hollis, CEO of Houston Behavioral Health Hospital, reflected on the difficulties foster youth face when they are discharge-ready but remain in the hospital due to lack of placement: “[t]hey see their peers come and go. Every week there is a turnover in who these children deal with and some of them are there for up to

three months or more… They see other children who have parents and family members who come and support them and these children have no one that comes to visit… We bring these kids in and stabilize them and then as it goes along they are destabilized and revert back to the same maladaptive skills and behaviors that they had on admission."[18] In his later testimony, he also noted that foster children miss school the entire time they are hospitalized, putting them further behind than they already were in most cases; they are constantly let down by DFPS caseworkers who can't or don't follow through on placements or other promises; and hospital staff have trouble contacting caseworkers.[19]

Chris Bryan, Vice President at Clarity Child Guidance Center, testified about the harm to foster youth who are medically cleared for discharge but remain at the Center due to lack of placement options: "[the hospital] is not a least restrictive environment… And some of these kids actually deteriorate while they are in placement with us and we have to readmit them to acute care. That's obviously problematic. Child welfare advocates generally feel that this type of [hospital] placement causes them to slip behind socially and developmentally from their peers."[20] She calculated that a third of foster youth at Clarity during fiscal year 2016 and most of 2017 remained in acute care on "temporary" placement status despite no longer requiring inpatient care.[21]

DFPS's practice of keeping foster youth institutionalized longer than medically necessary not only harms the child, but is costing the State millions of dollars. When foster youth no longer meet medical necessity for inpatient care, our review has found that Superior STAR Health pays for up to fifteen "placement days" to allow time for DFPS to identify and coordinate placement. When those days are exhausted without identifying placement, DFPS is required to execute a child-specific contract to pay for the youth's continued stay in inpatient care settings. In fiscal year 2017, DFPS spent over $8.8 million in general revenue dollars inappropriately institutionalizing 584 foster youth after medical necessity for a total of 13,821 days. That averages out to $642.54 per child per day. In 2018, DFPS spent over $5 million in the first three quarters of the fiscal year institutionalizing 392 foster youth after medical necessity for a total of 7,913 days, averaging out to $643.96 per child per day.

In summary, DRTx's review and investigation found a large number of foster youth in DFPS conservatorship with behavioral health needs experience unnecessary and extended psychiatric hospitalizations. These hospitalizations reverse most of the therapeutic benefit obtained in the initial days of stabilization and often cause long-lasting adverse behavioral and educational effects. DFPS's use of psychiatric hospitals as long-term placements for foster youth comes at a great human and financial cost to the State of Texas and children in foster care.

3. Findings

Lack of Oversight of Foster Youth Hospital Admissions

Prior to September 1, 2018, admission of foster youth to a psychiatric hospital happened in one of two ways: either both the child and DFPS agreed to the admission or there was a court order for inpatient mental health services.[22] During the 85th Texas Legislative session, the legislature amended the Texas Mental Health Code, and now admission of foster youth requires neither the youth's consent nor judicial review; instead, DFPS caseworkers now have the ability to request voluntary admission of the child to an inpatient mental health facility whether the child agrees to be admitted or not.[23] Despite this change, the statute still does not authorize foster or residential care providers to voluntarily admit a foster youth to a hospital, and they are explicitly prohibited by DFPS policy from doing so. In fact, the DFPS form designating an individual as a medical consenter for a foster youth specifically states that "[t]he medical consenter does not have the authority to consent to the voluntary admission of a child to a facility for inpatient mental health treatment."[24]

Bobby was improperly admitted to the psychiatric hospital by his foster care providers without contacting DFPS. Upon admission, they informed the facility that he could not return and they did not want any future contact. The hospital was not able to contact Bobby's caseworker to obtain informed consents until seven days after his admission, causing him to go without medication.

This recent law change removes judicial oversight from the inpatient process and disempowers foster youth from taking an active role in decisions about their healthcare. It also places a greater responsibility on DFPS caseworkers to ensure admissions are appropriate; yet, DFPS has not stepped up. In the cases we reviewed, one third of foster youth were unlawfully voluntarily admitted to a psychiatric hospital by foster or residential care providers who, after admitting the foster youth, walked away and wanted nothing more to do with the youth. It often took psychiatric hospital staff one to two days, and as long as seven days, to reach DFPS regarding the admission. This delay could be detrimental. Though the hospital had admitted the youth, there was no one to consent to medication or other treatment, meaning a foster youth could go days without necessary psychotropic medications as well as other appropriate care and treatment.

DRTx's investigation revealed that once reached by hospitals, the DFPS caseworkers rarely show up in person at the psychiatric hospital to talk with foster youth and determine if inpatient admission and psychotropic medications are appropriate. Instead, the majority of DFPS caseworkers approved the admission by phone, despite the admission being illegally started by a foster parent or residential placement washing their hands of a child. This phone approval violates state law, which requires a voluntary admission be

consented to in writing and signed by the parent, guardian or managing conservator.[25] It also results in a DFPS caseworker not engaging with the foster youth or the hospital during a period of time when a child is most in need—when he or she is experiencing a psychiatric emergency. A psychiatric hospitalization is a significant event, during which the guardian must be involved from beginning to end. Just as a parent cannot delegate their parental responsibilities during a psychiatric hospitalization, neither should DFPS.

It should be additionally noted that proposed 86(R) S.B. 218 would exacerbate this problem by allowing a caregiver who has been caring for a foster youth for six months or more to voluntarily admit the foster youth.[26] Once the admission process was completed, the caregiver would still be free to walk away as all did in the cases we reviewed, but the urgency for the hospital's reaching the DFPS caseworker would be lessened and the foster youth would still be left with no one engaged in their treatment.

Inappropriate Assessment Process

Now that a foster youth has no input into his or her "voluntary" admission and DFPS is rarely immediately aware of a foster youth's initial "voluntary" admission to inpatient care by a foster or residential provider, the only process left to ensure the child's inpatient psychiatric admission is necessary is the statutorily required physician's pre-admission assessment.[27] These assessments frequently leave much doubt as to whether admission is the best option for the foster youth. Most often, a physician completes the assessment via telemedicine. In the majority of the cases DRTx reviewed, the assessing physician had no specialty dealing with children or psychiatry; instead, over half of the doctors who completed the admission assessments were internists, family doctors, anesthesiologists, or practiced in other unrelated fields.

For example, at one hospital, the admitting physician in multiple cases DRTx reviewed is a physician who is located in another city, certified in internal medicine with clinical interests in hypertension, diabetes, chronic obstructive pulmonary disease, coronary artery disease, kidney disease, gastrointestinal conditions, anemia, skin allergies, and wound care – with no specialties involving children or psychiatry. Furthermore, in every case that DRTx reviewed where the youth had prior mental health treatment, neither the hospital assessment professional nor the assessing physician attempted to contact the youth's caseworker. Thus, they failed to obtain relevant information or collaborate with providers with knowledge relevant to the decision whether to admit the youth or attempt a less-restrictive intervention.

No Attempt to Identify Less Restrictive Alternatives

When a foster youth has psychiatric needs, a less restrictive intervention may be more appropriate than hospitalization. Crisis Services Redesign was undertaken by the Texas Department of State Health Services and funded by the Texas Legislature over a decade ago.[28] The goal of Crisis Services Redesign was to provide immediate, effective, evidence-based intervention during a mental health crisis to reduce the clinical seriousness of the event and the likelihood that a person will experience effects of chronic disease and need long-term supports. Its major components include crisis hotline services, psychiatric emergency services with extended observation (23 to 48 hours), crisis outpatient services, community crisis residential services, mobile outreach services, and a crisis intervention team. The model also includes collaboration with local law

enforcement, emergency rooms, the courts, social service agencies, and local mental health authorities.

Yet despite the efforts of the public mental health system to appropriately respond to mental health emergencies and divert individuals from unnecessary hospitalization, no such effort is made for foster youth. Despite the fact that the cases that DRTx reviewed often involved repeated admissions to psychiatric care, DFPS and medical records did not reflect any effort to divert foster youth from inpatient admission.

Lack of Involvement by DFPS Caseworkers

Beginning the moment a foster youth is admitted to a psychiatric hospital, DFPS is required to visit the youth weekly, notify others who have a role in ensuring the youth's needs are met, coordinate education services, and immediately start planning for placement after discharge.[29] In a majority of the cases we reviewed, not only did DFPS not visit the youth weekly, they repeatedly failed to return phone messages from hospital staff informing them that the youth was either admitted or ready for discharge.

Because many foster youth do not receive appropriate, less-restrictive psychiatric care and thus repeatedly cycle into psychiatric hospitals, finding new placements upon discharge is difficult. Yet records indicate that DFPS rarely starts immediately planning for placement after discharge. Instead, DFPS appears to over-rely on costly placement days and child-specific contracts for inpatient care rather than act with a sense of urgency regarding placement, causing significant delays in a foster youth's discharge once inpatient care is no longer medically necessary.

Even when a possible placement is identified, in the cases we investigated, there were often still delays for getting the youth discharged. DFPS can make additional preparations as soon as a youth is admitted in order to speed up the process. For example, several placement recommendations were delayed for weeks or longer due to the child needing a psychological evaluation arranged by DFPS prior to moving to an identified placement. DFPS is well aware that a psychological evaluation is necessary for the type of placement being considered for the child, yet in our investigation we found that DFPS waits to arrange for the evaluation until after the specific placement is identified, even though caseworkers know it can take weeks to schedule a psychologist to see the child and sometimes weeks more to get a written report back.

Nancy is 10 years old. The psychiatric hospital repeatedly contacted the DFPS caseworker for updates on placement. Over two weeks after the hospital informed DFPS that Nancy was discharge ready, DFPS informed the hospital that they could not find placement for Nancy without a psychological evaluation, which could only be completed by a DFPS contracted-provider. Her discharge was unnecessarily delayed for an entire month while waiting for a psychological evaluation.

Exacerbating these delays is the frequent turnover of DFPS caseworkers, an additional problem both hospitals and foster youth identified in interviews. Medical records and DFPS records validated this concern. Both hospital staff and foster youth expressed frustration that, due to turnover, youth often fall through the cracks and experience significant delays in placement-search activities.

> *James is a 17-year old male who was admitted to a private psychiatric hospital. His parents refused to pick him up when the physician determined that James was ready for discharge. James entered DFPS conservatorship and remained at the hospital for twelve more days while DFPS looked for placement. Instead of finding an appropriate placement, DFPS voluntarily admitted James to a State Hospital, where he remained for another 39 days. Superior STAR Health refused to authorize his admission or additional placement days at the state hospital, due to lack of medical necessity.*

Hospitals are required to discharge patients who no longer meet criteria for commitment.[30] This can feel like an impossible requirement for hospital staff when the DFPS caseworker informs them that the youth cannot leave the hospital because there is nowhere for them to go. At this point staff often begin calling DFPS multiple times a day to check on placement status. Caseworkers can be notoriously difficult to reach, and DRTx has reviewed records where caseworkers do not return calls for days at a time.[31]

DRTx observed that when a hospital pushes hard enough to discharge a child, DFPS resorts to searching for another psychiatric facility that will admit the child despite the admitting hospital and Superior STAR Health's determination that the youth no longer meets criteria for inpatient hospitalization.

Inappropriate Discharge Process

The change in the Mental Health Code now provides DFPS with the sole authority to provide oversight and periodically review the continued need for inpatient treatment of a foster youth and notify the facility administrator if there is no longer a continued need for hospitalization.[32] Of all of the cases DRTx investigated, not a single DFPS worker notified the hospital administrator that the youth no longer needed to be hospitalized. Instead, the hospital repeatedly called DFPS to assist with appropriate discharge. DFPS' response was to pay out State dollars for the youth to remain hospitalized long after a physician determined that the youth was ready for discharge. As discussed later in this report, this change in law is unconstitutional.

DFPS' Current Efforts

DFPS reports that they have made changes this fiscal year in an effort to address the problem of foster youth remaining hospitalized for lengthy periods. Some of these efforts include hiring seven new caseworkers to liaison with psychiatric hospitals to assist with discharge and placement; and a new requirement that Residential Treatment Centers

(RTCs) must allow residents who are transferred to psychiatric hospitals to return to the RTC once stabilized. Additionally, DFPS continues to utilize a team within the State Office to assist with and monitor placement searches. Importantly, none of the identified efforts have yet yielded data that would gauge the effectiveness of the changes. While DRTx appreciates the willingness of DFPS to collaborate with DRTx and other stakeholders to address the issues contributing to unnecessary hospitalizations of foster youth, we believe due to the size and scope of this problem, significant and sustained improvements can only be addressed systemically and will require statutory and regulatory changes. This can only be accomplished by multiple agencies working collaboratively with stakeholders and legislators to identify and fully implement innovative solutions.

4. RECOMMENDATIONS:

In light of our findings, DRTx submits the following recommendations.

Require that a psychiatrist assess foster youth prior to admission to inpatient care.

Voluntarily admission to private psychiatric hospitals does not currently require an evaluation by a psychiatrist. Rather the law allows only a physician with no specific training to conduct the evaluation. Given that children in foster care often have complicated personal and trauma histories, a psychiatrist (preferably a child psychiatrist) should evaluate the child to determine the need for inpatient treatment prior to their being admitted to a psychiatric hospital.

An additional mechanism to ensure hospitalization is necessary is to require Local Mental Health Authorities to determine whether inpatient care is the least restrictive option before admission. The Local Mental Health Authority review is required for all other hospital admissions where the State of Texas is financially responsible.

Prohibit DFPS from voluntarily admitting foster youth to psychiatric hospitals.

The United States Supreme Court established that individuals, including children and wards, have an inviolable constitutional liberty interest in freedom from involuntary commitment for mental health care without due process of law.[33] This constitutional right prevents parents and guardians from having the sole authority to commit their children or wards to an institution.[34]

Because foster youth do not have the benefit of a parent with a "unique and traditional role" in caring for them[35] and, as wards of the State, there is no parent-child relationship,[36] the authority to admit foster youth to inpatient care should be more akin to adults with guardians. Courts have concluded that guardians do not have authority to commit an individual and instead more stringent due process requirements are required, like judicial review, to commit the individual.[37] Consistent with this case authority, Texas's guardianship laws do not provide a legal guardian the right to voluntarily admit a ward into an institution, save and except during an emergency.[38] Instead, a guardian must seek judicial review, where the ward receives full due process protections, to have his/her ward involuntarily committed.[39]

The circumstances of foster youth are more similar to adults with guardians than to children raised by natural parents; therefore, Texas should disallow DFPS from voluntarily admitting foster youth to a psychiatric hospital and instead require a court order committing the individual to a psychiatric facility.

Prohibit DFPS from using child-specific contracts to unnecessarily keep a foster youth hospitalized after they no longer meet commitment criteria.

Even if the foster youth was lawfully admitted to an inpatient facility, the youth's constitutional right to liberty is still violated if they remain confined in a mental health

facility beyond when it is medically necessary.[40] In order to ensure that a person does not remain confined in a mental health facility beyond when it is medically necessary, courts require at least periodic reviews by a treating professional to determine the necessity of continued confinement.[41] These treating professionals' decisions must be followed, without regard to whether the parent or guardian agrees with the recommendations of the physician.[42] To ensure foster youth constitutional rights are not repeatedly violated, DFPS should be prohibited from leaving a foster youth in the hospital after the treating physician determines inpatient care is not the least restrictive environment or using State resources to pay for unnecessary confinement.

Increase involvement of DFPS judges and attorneys ad litem.

Aside from notice to the court and the ad litem, no specific process other than routine status hearings approximately every six months exists for child protection courts to review the status of hospitalized foster youth. Yet, a foster youth who is hospitalized is considered to be experiencing a psychiatric emergency. As set forth previously, due to the frequent lack of DFPS involvement and the hospitals inability to discharge a foster youth without the agreement of DFPS, it is possible for a youth to be indefinitely hospitalized without meeting continued commitment criteria. To protect these youth's constitutional rights as well as their future well-being, the child protection courts should require status updates every two weeks until the child is discharged to ensure that DFPS is making a concerted effort to identify appropriate placement and is addressing the factors that led to the need for inpatient treatment. This change would also result in additional contact with attorneys ad litem who are required to meet with the child once before each court hearing.[43]

Develop alternatives to inpatient treatment.

To reduce the frequency of admission of foster youth to psychiatric hospitals and to reduce the reliance of DFPS on residential treatment centers as placements, the Legislature should require that the Health and Human Services Commission, in collaboration with Superior STAR Health, the local mental health authorities, DFPS and relevant stakeholders, develop a comprehensive, collaborative crisis model with a priority on preventing inpatient psychiatric hospitalization and placement disruption. The model should also address the need for step-down services and supports for the foster care providers after a child is discharged from the hospital. A goal of the design should be to better coordinate and manage services to prevent future crises.

While this effort is gaining momentum, it must be done carefully. One recently proposed amendment to the Texas Administrative Code would expand eligibility for the Intensive Psychiatric Transition Program (IPTP) for foster youth, removing the requirement that they be in conservatorship for ninety days before entering the program and allowing a child to remain in IPTP for an additional thirty days.[44] While on its face, the change would allow more children to take advantage of specialized care for longer time periods and perhaps help prevent inpatient psychiatric hospitalizations, DFPS is primarily seeking residential treatment centers and other large group homes to contract to provide IPTP services, including out-of-state providers.[45] Methods which do not prioritize small settings for treatment as close to a youth's home as possible should not be prioritized, as the

youth will still not be guaranteed long-term, individualized treatment in a location where they can maintain contact with family, attorneys ad litem, and CASA representatives.

Identify and/or develop alternative placement approaches.

With the millions of dollars DFPS spends every year on unnecessary hospitalization, DFPS could instead designate the money to "follow the person" and be used for appropriate therapeutic alternatives. Significant supports and services in the community would cost less than $642 per child per day, the amount DFPS spends to execute a single child-specific contract for a foster youth to stay in inpatient care settings. These funds could be more productively utilized to create more appropriate placements and/or improve services and supports in their homes to prevent placement disruption. DFPS should develop placements for youth with emotional disorders similar in nature to Home and Community Based Services (HCS) homes currently available to people with intellectual disabilities.[46] This model would allow for more individualized services and supports while providing for a smaller, more homelike setting for youth.

Additionally, rather than restricting child specific contracts to only institutional placements, child specific contracts should be used to fund home-based community services and supports, including one-to-one care, to prevent placement disruption.

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[1] Andrea Ball, *Unwelcome, Kids Languish in State Wards; Texas Agency Can't Find Homes for Youths Fit to Leave Mental Hospitals,* AUSTIN AMERICAN-STATESMAN, October 30, 2005, at A1.

[2] OFFICE OF TEX. COMPTROLLER OF PUBLIC ACCOUNTS, TEXAS HEALTH CARE CLAIMS STUDY—SPECIAL REPORT ON FOSTER CHILDREN (2006), pgs 13-26.

[3] Roy Hollis CEO Houston Behavioral Healthcare Hospital in Houston testimony to Texas House Appropriations Subcommittee on Charge 18F of Article II 3/21/18, http://tlchouse.granicus.com/MediaPlayer.php?view_id=40&clip_id=14859 @ 1:45:00 ("Hollis Testimony").

[4] Christine Bryan Vice President of Information Technology and Public Policy, Clarity Child Guidance Center testimony to the House Committee On Public Health Charge 3 – Services For Children With Mental Illness May 17, 2018, http://tlchouse.granicus.com/MediaPlayer.php?view_id=40&clip_id=15143 @1:17:34, ("Bryan Testimony") (One third of foster youth at Clarity during fiscal year 2016 and most of 2017 remained for weeks and months after the physician determined they were ready for discharge.); Hollis testimony (Although foster youth stabilize in five to seven days, their average length of stay is 61 days to due to lack of placement.

[5] *Id.* DFPS revised their Residential Child Care Contracts in December 2018 to require "Children in a placement with a General Residential Operation (GRO) offering treatment services who are admitted to a psychiatric hospital must return to the GRO following stabilization and discharge from the hospital." *See* DFPS website https://www.dfps.state.tx.us/Doing_Business/Purchased_Client_Services/Residential_Child_Care_Contracts/documents/24_Hour_RCC_Requirements.pdf, p. 59. This change effectively requires foster youth who were sent to a psychiatric hospital from an RTC to be able to return to the RTC upon discharge. In the early months since this change took effect, DRTx has anecdotal

evidence that the stays of foster youth may be decreasing on average, but their stays are still 3-4 times longer than the average stay.

[6] Todd Unger, *Lawsuits: Patients held against their will at Dallas Behavioral Hospital*, WFAA story, Jan. 18, 2018, *available at* https://www.wfaa.com/article/news/local/dallas-county/lawsuits-patients-held-against-their-will-at-dallas-behavioral-hospital/287-509340994.

[7] Will Maddox, *Local Psych Hospitals are in Trouble, Furthering Mental Health Shortage*, Healthcare Magazine, Dec. 27, 2018, *available at* https://healthcare.dmagazine.com/2018/12/27/local-psych-hospitals-are-in-trouble-furthering-mental-health-shortage/.

[8] Glenn Hunter, *Timberlawn to Voluntarily Close on Feb. 1*, Healthcare Magazine, Jan. 21, 2018, *available at* https://healthcare.dmagazine.com/2018/01/21/timberlawn-to-voluntarily-close-on-feb-1/.

[9] Deanna Boyd, *North Texas mental health hospitals close in wake of criminal indictments*, Fort Worth Star-Telegram, Dec. 5, 2018, *available at* https://www.star-telegram.com/news/local/crime/article223432380.html.

[10] Andrea Ball, *Psychiatric hospital facing lawsuit, state fine*, Austin American Statesman, Jan. 24, 2019, *available at* https://www.statesman.com/news/20190124/psychiatric-hospital-facing-lawsuit-state-fine.

[11] *Id.*

[12] *Id.*

[13] *See* Joe Persi & Megan Sisson, *Children in Foster Care: Before, During, & After Psychiatric Hospitalization*, 87 CHILD WELFARE, 79, 79-83 (Jul. 2008).

[14] *See id.*

[15] *See* Imelda Coyne, *Children's Experiences of Hospitalization*, 10 J. CHILD HEALTH CARE 267, 326 (2006).

[16] Duaa Eldeib & ProPublica Illinois, *The Kids Who Are Cleared to Leave Psychiatric Hospitals—But Can't*, THE ATLANTIC, Jun. 5, 2018, *available at* https://www.theatlantic.com/family/archive/2018/06/kids-psychiatric-hospital-illinois/561572/. In addition to negative effects on education, The Atlantic found the same detriments to children in Illinois as DRTx has seen in Texas: slipping behind peers in behavioral and social development, the denial of the child's right to live in the least restrictive setting, harmful decompensation, and unnecessary burden on tax payers.

[17] *Id*.

[18] Hollis Testimony.

[19] *Id.*

[20] Bryan Testimony.

[21] *Id.*

[22] TEX. HEALTH & SAFETY CODE § 572.001(c) (2013), *amended by* TEX. HEALTH & SAFETY CODE § 572.001(c) (2018).

[23] TEX. HEALTH & SAFETY CODE § 572.001(c).

[24] *See* Form 2085-B at https://www.dfps.state.tx.us/site_map/forms.asp.

[25] TEX. HEALTH & SAFETY CODE § 572.001(b).

[26] S.B. 218, 86th Leg. § 1.

[27] TEX. HEALTH & SAFETY CODE § 572.001(c-2).

[28] *See* Kristopher Ferguson, *Crisis Services Redesign Implementation Overview Texas Department of State Health Services Mental Health & Substance Abuse Division*, (2007), *available at* https://slideplayer.com/slide/8361091/; *see also* Texas Department of State Health Services website https://www.dshs.texas.gov/mhsacsr/Mental-Health-and-Substance-Abuse-Crisis-Services-Redesign.doc?terms=crisis.

[29] *See* Texas Department of Family and Protective Services website https://www.dfps.state.tx.us/handbooks/CPS/default.asp, sections 6151 and 11600.

[30] TEX. HEALTH & SAFETY CODE § 574.028(c)(3).
[31] In late 2018, DFPS created a psychiatric hospital worker position to "enhance and streamline case planning and respond to the unique medical needs of children in psychiatric facilities." https://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/CPS/documents/2018/2018-09-28-CPS_Business_Plan_Report.pdf, p.10. As of November 2018, there were six workers assigned to 5 of DFPS' 11 regions. There is no data yet available for whether these positions are effective in decreasing the length of hospitalizations for foster youth.
[32] TEX. HEALTH & SAFETY CODE § 572.001(c-4).
[33] *Addington v. Texas*, 441 U.S. 418, 425 (1979) ("[C]ivil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection."); *Foucha v. Louisiana*, 504 U.S. 71, 80 (1992) ("Freedom from bodily restraint has always been at the core of the liberty protected by the Due Process Clause from arbitrary governmental action.").
[34] *Parham v. J. R.*, 442 U.S. 584, 600 (1979)(where state's juvenile commitment process allowed parents the right to institutionalize their children on the parent's consent alone, court concluded that children, in common with adults, have a substantial liberty interest in not being confined without being accorded due process); *Doe v. Austin*, 848 F.2d 1386, 1391 (6th Cir.1988) *cert. denied,* 488 U.S. 967 (1988)(adult with intellectual disability's voluntarily commitment by his legal guardian represents a "massive curtailment of liberty requiring due process protection").
[35] *Parham*, 442 U.S. at 585.
[36] *Id.* at 1393 (cites omitted).
[37] *See Clark v. Cohen*, 613 F. Supp. 684, 699 (E.D. Pa. 1985), ***aff'd,*** 794 F.2d 79 (3d Cir. 1986), *cert. denied*, 479 U.S. 962 (1986); *see also Bonnie S. v. Altman*, 683 F. Supp. 100, 101 (D.N.J. 1988)(finding that consent from appointed guardian was not required in order for plaintiffs to bring suit challenging their commitment to mental institution); *Doe by Doe v. Austin*, 848 F.2d at 1392–93 (Due process protections which are part of formal guardianship hearing do not vitiate need for hearing at time of commitment of adult with intellectual disability based on guardian's consent.).
[38] TEX. EST. CODE § 1151.053 ("[A] guardian may not voluntarily admit a ward to a public or private inpatient psychiatric facility operated by the Department of State Health Services for care and treatment or to a residential facility operated by the Department of Aging and Disability Services for care and treatment.").
[39] TEX. HEALTH & SAFETY CODE §§ 593.041-593.056 (statutory provisions governing the involuntary institutionalization of individuals with intellectual disabilities, setting forth, among other things, due process requirements in commitment proceedings).
[40] *O'Connor v. Donaldson,* 422 U.S. 563, 574 (1975).
[41] *Parham,* 442 U.S. at 617 (noting that a person's continuing need for commitment must be reviewed periodically by a neutral factfinder); *see also Matter of Harhut*, 385 N.W.2d 305, 312 (Minn. 1986); *Heichelbech v. Evans*, 798 F. Supp. 708, 713-14 (M.D. Ga. 1992) ***aff'd***, 995 F.2d 237 (11th Cir. 1993); *Doe v. Austin*, 848 F.2d 1386, 1396 (6th Cir. 1988), *cert. denied,* 488 U.S. 967 (1988); *Clark v. Cohen,* 794 F.2d 79, 86 (3rd Cir. 1986), *cert. denied*, 479 U.S. 962 (1986); *cf. Williams v. Wallis,* 734 F.2d 1434, 1438 (11th Cir. 1984); *Hickey v. Morris,* 722 F.2d 543, 549 (9th Cir. 1983).
[42] *Parham,* 422 U.S. at 607 (requiring admission procedures and procedures for continued commitment for children be conducted by a decision maker with the authority to refuse to admit or continue to commit the child who does not satisfy medical standards); *see also Sec'y of Pub. Welfare of Pa. v. Institutionalized Juveniles*, 442 U.S. 640, 647 (1979) (medical reviews sufficient where director of the hospital may release any child whenever institutional treatment is no longer medically indicated); *Clark*, 794 F.2d at 86 (medical and psychological reviews only satisfy due process when the reviewers have the authority to implement their recommendations); *Hickey*, 722 F.2d at 548-49 (review by staff physician able to exercise independent judgment is sufficient);

Williams v. Wallis, 734 F.2d at 1436 (periodic review by treatment team with superintendent having authority and power to release sufficient for due process).

[43] TEX. FAMILY CODE § 107.004(d)(1).

[44] 2019 TX REG TEXT 514994 (NS).

[45] DFPS Open Enrollment Opportunity website, https://apps.hhs.texas.gov/PCS/HHS0000159/.

[46] The Texas HCS program is a federal Medicaid waiver that provides services in three to four bed group homes. 40 TEX. ADMIN. Code § 9.153(19) (2013). When residing in an HCS group home, individuals are entitled to a plethora of services, including supervised and supported home living twenty-four (24) hours a day, seven days a week; direct personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene); assistance with meal planning and preparation; securing and providing transportation; assistance with housekeeping; day habilitation; supported employment; financial management services; assistance with medications and the performance of tasks delegated by a registered nurse; a social worker; behavioral support by a licensed professional; physicians; dietary services; and dental treatment. 40 TEX. ADMIN. CODE §§ 9.154(c) & 9.174.