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RESIDENTIAL PROGRAMS

Selected Cases of Death, Abuse, and Deceptive Marketing

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Mr. Chairman and Members of the Committee:

Thank you for the opportunity to continue the discussion of private residential programs for troubled youth that we began last fall.[1] In the context of this and our prior testimony, we are using the term residential program to refer to those private entities across the country and abroad that call themselves wilderness therapy programs, therapeutic boarding schools, academies, behavioral modification facilities, ranches, and boot camps, among other names. Many of these programs are privately owned and operated. Private residential programs typically market their services to the parents of troubled teenagers—boys and girls with a variety of addiction, behavioral, and emotional problems—and provide a range of services, including drug and alcohol treatment, confidence building, and psychological counseling for illnesses such as depression and attention deficit disorder. Parents trying to help their troubled child may also seek help from referral services and educational consultants, which generally purport to assess the needs of the child and recommend an appropriate program.

Many cite positive outcomes associated with specific types of residential programs. However, in our previous testimony, we identified thousands of allegations of abuse, some of which resulted in death, at residential programs across the country and in American-owned and American-operated facilities abroad. We also examined 10 closed civil or criminal cases where a teenager died while enrolled in a private program and found significant evidence of ineffective management in most of the 10 cases, with program leaders neglecting the needs of program participants and staff. This ineffective management compounded the negative consequences of (and sometimes directly resulted in) the hiring of untrained staff; a lack of adequate nourishment for enrolled children; and reckless or negligent operating practices, including a lack of adequate equipment.

Due to your continuing concern about the safety and well-being of youth enrolled in private residential programs, and to assist the Committee in its consideration of the need for federal legislation in this area, you requested that we (1) identify and examine the facts and circumstances surrounding additional closed cases where a teenager died, was abused, or both, while enrolled in a private program; and (2) identify cases of deceptive marketing or other questionable practices in the private residential program industry.

[1]GAO, *Residential Treatment Programs: Concerns Regarding Abuse and Death in Certain Programs for Troubled Youth*, GAO-08-146T (Washington, D.C.: Oct. 10, 2007).

To identify case studies, we reviewed numerous closed criminal or civil cases in which a court or state agency was asked to decide whether a private residential program was responsible for the death or abuse of an enrolled teenager. We also reviewed administrative cases where state agencies made rulings regarding the death or abuse of a teenager. When identifying cases, we specifically excluded public programs such as state-sponsored foster programs, juvenile justice programs for delinquent youth, or programs that exclusively treat psychological disorders or substance abuse in a hospital setting. We also excluded cases related to the programs we examined for our October 10, 2007, testimony. We focused on deaths or instances of abuse between the years 1994 and 2006 to illustrate the long-standing issues presented by private residential programs. We limited our cases to closed criminal cases and, thus, did not include ongoing cases from the last several years. We selected eight cases—four cases of death and four cases of abuse—based on several factors including the victim's age, the program location, the type of program the victim attended, and the date of death or abuse. We then examined, in more detail, the facts and circumstances of the case. To validate the facts and circumstances, and to the extent possible, we conducted interviews with related parties, including current and former program staff and officials, attorneys and law enforcement officials involved in the cases, and the parents of the victims. Further, we reviewed available documentation to support the facts of each case including, but not limited to, marketing materials, police reports, autopsy reports, and state agency oversight reviews and investigations.

To identify cases of deceptive marketing or other questionable practices in the private residential program industry, we used a variety of approaches and investigative techniques. Posing as fictitious parents with fictitious troubled children, our undercover investigators made telephone calls to a nonrepresentative selection of 10 private residential programs and 4 referral services. Like legitimate parents with troubled teenagers, we identified these programs and referral services through Internet searches and magazine advertisements. To assess the accuracy and reasonableness of the information we obtained during each undercover call, we performed additional follow-up work that included, but was not limited to, making additional undercover calls; comparing the information we received with other marketing information provided by the program; reviewing relevant laws, regulations, and trade organization statements; performing announced, agreed upon site visits (i.e., not undercover); and speaking with cognizant state and federal officials, including the Internal Revenue Service (IRS).

We performed our work from November 2007 through April 2008 in accordance with the quality standards for investigations set forth by the President's Council on Integrity and Efficiency. As we noted in our prior testimony, it is important to emphasize that residential programs are intended to help youth with serious

problems, including life-threatening addictions and diseases. We did not attempt to evaluate the benefits of residential programs in dealing with these serious problems. In addition, it is not possible to generalize the results of our investigation as applying to all residential programs, whether privately or publicly funded, or referral services and educational consultants and others in the residential program industry. Moreover, it is difficult to develop a picture of the overall industry, its practices, and efforts to oversee it. For example, while states often regulate publicly funded programs, a number of states do not license or otherwise regulate certain types of private programs. GAO is completing a more comprehensive review of state and federal oversight of residential programs and expects to issue a report soon.

Summary of Investigation

In the eight closed cases we examined, ineffective management and operating practices, in addition to untrained staff, contributed to the death and abuse of youth enrolled in selected programs. In the most egregious cases of death and abuse, the cases exposed problems with the entire operation of the program. The practice of physical restraint also figured prominently in three of the cases. The restraint used for these cases primarily involved one or more staff members physically holding down a youth. Examples of some case studies follow:

- A 16 year-old male who suffered from asthma and chronic bronchitis complained of chest pain and had difficulty breathing for several weeks. Staff at the Arizona boot camp he was attending punished him for refusing to do an assigned task and forced him to do push-ups and carry cinder blocks; meanwhile, a program nurse told him the breathing problems were “in your head.” In March 1998, the victim died from an accumulation of infectious pus in his chest, and an autopsy found more than 70 injuries, including blunt-force injuries, on his body—indicating he had been physically abused before his death.

- A teenage male was required to attend a behavior modification program in New Jersey for 4 years, and was held against his will after he turned 18. Records show that the victim was restrained more than 250 times while attending the program. Incident reports filed by program staff document that after he had turned 18, the victim was restrained on 26 separate days, with at least two restraints lasting more than 12 hours. Restraints were imposed any time he showed reluctance to participate in the program, and for other reasons; on one occasion, he said he was wrapped in a blanket and tied up after attempting to escape the program.

- In February 2006, a 16-year-old male with a history of asthma became unresponsive while being restrained at a Pennsylvania treatment facility. He

died 3 hours later in a hospital. An investigation into the death found that the facility had documentation of the victim's history of asthma, and that its training manual for restraint procedures cautioned against the risk of decreased oxygen intake during restraints for youth with asthma. However, all three staff members involved in the restraint that led to the victim's death told investigators that they were unaware of any medical conditions that needed to be considered when restraining the victim.

In three of the eight cases we examined, the victim was placed in the program by the state or in consultation with state authorities.

Posing as fictitious parents with fictitious troubled teenagers, we also found examples of deceptive marketing and questionable practices in the private residential program industry. Deceptive marketing included potential fraud, false statements, and misleading representations related to a range of issues including tax deductions, education, and admissions policies. We also found undisclosed conflicts of interest. Examples of deceptive marketing included the following:

- One Montana boarding school told us that parents must submit an application form in order for their child to be considered for admission in the program. However, after a separate call by a fictitious parent, a program representative e-mailed us that our fictitious daughter had been approved for admission into the program and subsequently sent an acceptance letter. This acceptance into the school was based on a 30-minute telephone conversation. We did not fill out any application form.

- The Web site for one referral service we called says: "We will look at your special situation and help you select the best school for your teen with individual attention." However, we called this service three times using three different scenarios related to different fictitious children, and each time the referral agent recommended a Missouri boot camp. Investigative work revealed that the owner of the referral service is married to the owner of the boot camp, but this relationship was never disclosed during the call, raising the issue of conflict of interest.

- The representative for a 501(c)(3) foundation suggested our fictitious parents take advantage of a fund-raising approach that is potentially a fraudulent tax scheme. The representative said that this "popular" option would allow friends, family, business acquaintances, churches, and other organizations to make tax-deductible donations that would then be credited to our fictitious child's tuition in a private program. After we briefed an IRS official on the representation by this foundation, he told us that the foundation is potentially committing tax fraud and that those who obtain tax benefits for donations in

the suggested manner may be responsible for back taxes, as well as penalties and interest.

A link to selected audio clips from these calls is available at: http://www.gao.gov/media/video/gao-08-713t/

Background

Since the early 1990s, state agencies and private companies have set up hundreds of residential programs and facilities in the United States. Many of these programs are intended to provide a less restrictive alternative to incarceration or hospitalization for youth who may require intervention to address emotional or behavioral challenges. A wide array of government or private entities, including government agencies and faith-based organizations, operate these programs. Some residential programs advertise themselves as focusing on a specific client type, such as those with substance abuse disorders or suicidal tendencies.

As we reported in our October 2007 testimony, no federal laws define what constitutes a residential program, nor are there any standard, commonly recognized definitions for specific types of programs. For our purposes, we define programs based on the characteristics we have identified during our work. For example:

- Wilderness therapy programs place youth in different natural environments, including forests, mountains, and deserts. According to wilderness therapy program material, these settings are intended to remove the "distractions" and "temptations" of modern life from teens, forcing them to focus on themselves and their relationships. These programs are typically 28 days in length at a minimum, but parents can continue to enroll their child for longer at an additional cost.

- Boot camps are residential programs in which strict discipline and regime are dominant principles. Many boot camps emphasize behavioral modification elements, and some military-style boot camps also emphasize uniformity and austere living conditions. Boot camps might be included as part of a wilderness therapy school or therapeutic boarding, but many boot camps exist independently. These programs are offered year-round and some summer programs last up to 3 months.

- Boarding schools (also called academies) are generally advertised as providing academic education beyond the survival skills a wilderness therapy program might teach. These programs frequently enroll youth whose parents force them to attend against their will. The schools can include fences and other security measures to ensure that youth do not leave without permission.

While these programs advertise year-round education, the length of stay varies for each student; contracts can require stays of up to 21 months or more.

- Ranch programs typically emphasize remoteness and large, open spaces available on program property. Many ranch programs advertise the therapeutic value of ranch-related work. These programs also generally provide an opportunity for youth to help care for horses and other animals. Although we could not determine the length of a typical stay at ranch programs, they operate year-round and take students for as long as 18 months.

See appendix I for further information about the location of various types of residential programs across the United States. In addition to these programs, the industry includes a variety of ancillary services. These include referral services and educational consultants to assist parents in selecting a program, along with transport services to pick up a youth and bring him or her to the program location. Parents frequently use a transport service if their child is unwilling to attend the program.

Private programs generally charge high tuition costs. For example, one wilderness program stated that their program costs over $13,000 for 28 days. In addition to tuition costs, these programs frequently charge additional fees for enrollment, uniforms, medical care, supplemental therapy, and other services—all of which vary by program and can add up to thousands of extra dollars. Costs for ancillary services vary. The cost for transport services depends on a number of factors, including distance traveled and the means of transportation. Referral services do not charge parents fees, but educational consultants do and typically charge thousands of dollars. Financial and loan services are also available to assist parents in covering the expense of residential programs and are often advertised by programs and referral services. See appendix II for further information about the cost of residential programs across the United States.

There are no federal oversight laws—including reporting requirements—pertaining specifically to private residential programs, referral services, educational consultants, or transportation services, with one limited exception. The U.S. Department of Health and Human Services oversees psychiatric residential treatment facilities (PRTFs) receiving Medicaid funds. In order to be eligible to receive funds under Medicaid, PRTFs must abide by regulations that govern the use of restraint and seclusion techniques on patients. They are also required to report serious incidents to both state Medicaid agencies and, unless prohibited by state law, state Protection and Advocacy agencies. In addition, the

regulations require PRTFs to report patient deaths to the Centers for Medicare and Medicaid Services Regional Office.[2]

Cases of Death and Abuse at Selected Residential Programs

In the eight closed cases we examined, ineffective management and operating practices, in addition to untrained staff, contributed to the death and abuse of youth enrolled in selected programs. Furthermore, two cases of death were very similar to cases from our October 2007 testimony, in that staff ignored the serious medical complaints of youth until it was too late. The practice of physical restraint figured prominently in three of the cases. The restraint used for these cases primarily involved one or more staff members physically holding down a youth. Ineffective operating practices led to the most egregious cases of death and abuse, as the cases exposed problems with the entire operation of the program. Specifically, the failure of program leaders to ensure that appropriate policies and procedures were in place to deal with the serious problems of youth; ineffective management practices that led to questionable therapeutic or operational practices; and the failure of the program to share information about enrolled youth with the staff members who were attending to them created the environments that resulted in abuse and death. Moreover, in cases involving abuse, the abuse was systemic in the program and not limited to the incident discussed in our case studies. In three of the eight cases we examined, the victim was placed in the program by the state or in consultation with state authorities.[3]

See table 1 for a summary of the cases of death we examined.

[2]42 C.F.R. §§ 483.350 - .376.

[3]For an illustration showing the states where victims resided and the location of the programs they attended, both for this testimony and our October 2007 testimony, see app. I.

Table 1: Summary of Eight Closed Cases (Four Deaths)

Case	Victim information	Program Attended	Date of death	Cause of death	Case details
1	Male, 16, California resident	Arizona boot camp	March 1998	Empyema (accumulation of infectious pus in the chest)	□ Victim suffered from asthma and chronic bronchitis □ For a period of several weeks, victim complained of chest pain and difficulty breathing, but a program nurse said that his breathing problems were in his head □ Staff punished him for refusing an assigned task, and forced him to do push-ups and carry cinder blocks □ Victim eventually became unresponsive, at which point staff finally realized that his condition required medical attention □ Victim was declared dead at a hospital □ Autopsy found more than 70 injuries, including some from blunt force, on his body, indicating that the victim had been physically abused before his death
2	Male, 14, Texas resident	Texas wilderness therapy program	Sept. 2004	Cardiopulmonary Arrest	□ Victim's hiking group became lost and spent several unforeseen hours in temperatures that reached 98 degrees (a reported heat index of near 105 degrees) □ During the hike, victim stopped and complained that he was too hot and tired and refused to go on, but he was encouraged to continue □ Victim said he didn't feel well and was dizzy, then stumbled and fell □ Staff thought he was "faking" □ When victim began to vomit, staff rolled him on his side □ Victim stopped breathing and was later pronounced dead □ Died on federal land

Case	Victim information	Program Attended	Date of death	Cause of death	Case details
3	Male, 12, Texas resident	Texas residential treatment center	Dec. 2005	Suffocation	• Victim was angry and started banging his head against the ground • A 5 feet 10 inch, muscular staff member placed the 87-pound victim into a facedown restraint • Several witnesses claimed they saw the staff member lying across the back of the victim • Victim complained he couldn't breathe and eventually became unresponsive, at which point the staff member removed the restraint • After the victim had lain unresponsive for about a minute, the staff member rolled him over and found that he was pale • Attempts to revive victim failed
4	Male, 16, Pennsylvania resident	Pennsylvania psychiatric residential treatment center	Feb. 2006	Abnormal heartbeat	• Victim was placed under "intense observation" for attempting to run away from the program • Victim was ordered to put the hood of his sweatshirt down so that staff could see his face, but victim refused • Three staff members brought the victim to another room and placed him in restraint face down • After 10 minutes of the restraint, victim complained that he couldn't breathe • Despite staff attempts to make the victim more comfortable, victim became unresponsive • Victim died at the hospital 3 hours later from an abnormal heartbeat • Program was aware victim suffered from asthma, but staff members who restrained the victim claimed they were not aware of this

Source: Records including police reports, legal documents, and state investigative documents.

See table 2 for a summary of the cases of abuse we examined. For reporting purposes, we continue the numbering of case studies in this table, starting with five.

Table 2: Summary of Eight Closed Cases (Four Abuse)

Case	Victim information	Program attended	Date(s) of abuse	Case details
5	Male, 14-18, New York resident	New Jersey residential behavior modification program	1994 to 1998	□ Victim and parents were interviewed separately by staff during his first visit to the program □ Victim encountered 6 hours of intense questioning during which he felt forced to confess to activities he says he did not take part in, such as illegal drug use and sex □ Victim was restrained more than 250 times while attending the program; in at least two cases restraint lasted longer than 12 hours □ One method of restraint included wrapping the victim in a blanket and tying him up □ Victim was required to attend the program for 4 years and was held against his will after his 18th birthday
6	Male, 17, Washington resident	Mississippi faith-based academy and boot camp	April 1999	□ Victim jumped off a building and broke his left arm; the bone of his arm was exposed, but he was not given medical attention for 2 weeks □ Students and staff harassed the victim, with some boys subjecting him to physical abuse □ On one occasion, victim was beaten unconscious by staff and other students □ On another occasion, a staff member's pit bull bit the victim in the crotch □ Victim had previously attended boarding school in case 7
7	Male, 15, California resident	Utah boarding school	Nov. 2004	□ Victim was verbally abused and punched, kicked, and slapped by other students, under direction of one of the school's owners □ Victim was hit and pushed down stairs by the same school owner □ On multiple occasions throughout his stay in the school, victim was locked in a bathroom and a closet and forced to sleep on a shelf as punishment
8	Male, 14, California resident	Colorado boarding school	May 2006	□ Staff member assaulted victim by grabbing him by the arm, pushing him into a stairwell, and slamming his face into a wall □ Victim's face was visibly bruised, including a black eye □ Victim was forced to kneel on the floor for hours with his knees at the point where the floor meets the wall and his nose touching the wall

Source: Records including police reports, legal documents, and state investigative documents.

The following three narratives describe selected cases in further detail.

Case 3 (Death)

The victim, who died in 2005, was a 12-year-old male. Documents obtained from the Texas Department of Family and Protective Services indicate that the victim had a troubled family background. He was taken into state care along with his siblings at the age of 6. According to child protective service workers who visited the family's home, the victim and his siblings were found unsupervised and without electricity, water, or food. Some of the children were huddled over a space heater, which was connected to a neighbor's house by extension cord, in order to keep warm. As a ward of the state, the victim spent several years in various foster placements and youth programs before being placed in a private residential treatment center in August 2005. The program advertised itself as a "unique facility" that specialized in services for boys with learning disabilities and behavioral or emotional issues. The victim's caretakers chose to place him in this program because he was emotionally disturbed. Records indicate that he was covered by Medicaid.

On the evening of his death, the victim refused to take a shower and was ordered to sit on an outside porch. According to police reports, the victim began to bang his head repeatedly against the concrete floor of the porch, leading a staff member to drag him away from the porch and place him in a "lying basket restraint" for his own protection. During this restraint, the 4 feet 9½ inch tall, 87-pound boy was forced to lie on his stomach with his arms crossed under him as the staff member, a muscular male 5 feet 10 inches tall, held him still. Some of the children who witnessed the restraint said they saw the staff member lying across the victim's back. During the restraint, the victim fought against the staff member and yelled at him to stop. The staff member told police that the victim complained that he could not breathe, but added that children "always say that they cannot breathe during a restraint." According to police reports, after about 10 minutes of forced restraint, the staff member observed that the victim had calmed down and was no longer fighting back. The staff member slowly released the restraint and asked the victim if he wanted a jacket. The victim did not respond. The staff member told police he interpreted the victim's silence as an unwillingness to talk due to anger about the restraint. He said he waited for a minute while the victim lay silently on the ground. When the victim did not respond to his question a second time, he tapped the victim on the shoulder and rolled him over. The staff member observed that the victim was pale and could not detect a pulse. All efforts to revive the victim failed, and he was declared dead at a nearby hospital.

When the staff member demonstrated his restraint technique for the police, they found that his technique violated the restraint policies of the program. These

policies prohibited staff from placing any pressure on the back of a person being restrained. The report added that this staff member was reprimanded for injuring a youth in 2002 as a result of improper restraint. After this incident, program administrators banned the staff member from participating in restraints for 1 month. The reprimand issued by program administrators over this incident noted that the staff member had actually trained other staff members in performing restraints, making the matter more serious. The police reports also cite one of the staff member's performance evaluations that noted that he had problems with his temper. According to the reports, one of the youth in the program said the staff member could become agitated when putting youth in restraint.

Although the Texas Department of Family and Protective Services alleged that the victim's death was due to physical abuse, the official certificate of death stated that it was an accident and a grand jury declined to press charges against the staff member performing the restraint. However, the victim's siblings obtained a civil settlement against the program and the staff member for an undisclosed amount. The program remained open until May 2006, when a 12-year-old boy drowned on a bike outing with the program. According to records from law enforcement, child protection workers, and the program, the boy fell into the water of a rain-swollen creek and was sucked into a culvert. He died after several weeks on life support. The Texas Department of Family and Protective Services cited negligent staff supervision in its review of this second death and revoked the program's license to operate as a residential treatment center. However, the program's directors also ran a summer camp for children with learning disabilities and social disorders licensed by the Texas Department of State Health Services, until they resigned from their positions in March 2008.

Case 4 (Death)

The victim was 16 years old when he died, in February 2006, at a private psychiatric residential treatment facility in Pennsylvania for boys with behavioral or emotional problems. He was a large boy—6 feet 1 inch in height and weighing about 250 pounds—and suffered from bipolar disorder and asthma. The cost for placement in this facility was primarily paid for by Medicaid.

According to state investigative documents we obtained, the victim was placed in intensive observation after he attempted to run away. As part of the intensive observation, he was forced to sit in a chair in the hallway of the facility and was restricted from participating in some activities with other residents. On the day of his death, staff allowed the victim to participate in arts, crafts, and games with the other youth, but would not let him leave the living area to attend other recreational activities. Instead, staff told the victim that he would have to return to his chair in the hallway. In addition, staff told him that he would have to move his chair so that he could not see the television in another room. The victim complied, moving his chair out of view of the television, but put up the hood of

his sweatshirt and turned his back toward the staff. The staff ordered him to take down his hood but he refused. When one of the staff walked up to him and pulled his hood down, the victim jumped out of his chair and made a threatening posture with his fists, saying he did not want to be touched. The staff member and two coworkers then brought the victim to another room and held him facedown on the floor with his arms pulled up behind his back. The victim struggled against the restraint, yelling and trying to kick the three staff members holding him down. After about 10 minutes, the victim became limp and started breathing heavily. He complained that he was having difficulties breathing. One staff member unzipped his sweatshirt and loosened the collar of his shirt, but rather than improve, the victim became unresponsive. The staff called emergency services and began CPR. The victim was taken by ambulance to a hospital, where he died a little more than 3 hours later. In the victim's autopsy report his death was ruled accidental, as caused by asphyxia and an abnormal heartbeat (cardiac dysrhythmia).

Following the victim's death, an investigation by the Pennsylvania Department of Health found that the policies and procedures for youth under intense observation do not prohibit them from watching television, nor do they require that youth keep their face visible to staff at all times. The investigation also found that the facility had documentation of the victim's history of asthma, and that its training manual for restraint procedures cautioned against the risk of decreased oxygen intake during restraints for children with asthma. However, all three staff members involved in the restraint told investigators that they were unaware of any medical conditions that needed to be considered when restraining the victim. In addition, the investigation found that the facility did not provide timely training on the appropriate and safe use of restraint. The state's Protection and Advocacy organization, Pennsylvania Protection & Advocacy, Inc. (PP&A), conducted its own investigation of the facility and found that staff members inappropriately restrained children in lieu of appropriate behavioral interventions, which resulted in neglect and abuse. Of the 45 residents interviewed by PP&A investigators, 29 said that staff at the facility subjected them to restraints. The residents reported that the restraints could last as long as 90 minutes and caused breathing difficulties. They also stated that staff often placed their knees on residents' backs and necks during restraints. One resident reported that the blood vessels in his eyes "popped" during a restraint. Another resident said that his nose hit the ground during the restraint, causing him to choke on his own blood. Further, some of the residents reported that staff provoked them and that staff did not make any effort to de-escalate the provocations before implementing a restraint.

No criminal charges were filed in regard to the victim's death. The victim's mother filed a civil suit over her son's death against the facility, which is

currently pending. Her son's death was not the only fatal incident at this facility. Only 2 months before the victim's death, in December 2005, a 17-year-old boy collapsed at the facility after a physical education class, and later died at a nearby hospital. His death was attributed to an enlarged heart. This facility remains open.

Case 5 (Abuse)

This abuse victim was sent to a private drug and addiction treatment program in July 1994 at the age of 14. He was attending public school in the major metropolitan area where his family lived. The abuse victim told us that he had problems at school, including poor grades, truancy, a fight with other students, and that he had been suspended. After the victim was questioned by police about an assault on a girl at his school, a family friend with ties to the behavior modification program recommended the program to the victim's parents. According to the victim, his first visit to the school turned into an intense intake session where he was interviewed by two program patients. Although the victim denied using drugs, the interviewers insisted that he was not being honest. After about 6 hours of questioning, the victim told the interviewers what he thought they wanted to hear—that he was smoking pot, did cocaine, and cut school to get high—so that he could end the interview. The interviewers used these statements to convince the victim's parents to sign him into the program for immediate intervention and treatment. He ended up staying in the program for the next 4 years—even after he turned 18 and was held against his will.

According to program records, the program's part-time psychiatrist did not examine or diagnose him until he had been in the program for 14 days. This lack of psychological care continued, as program records indicate he was examined by the psychiatrist only four times during his entire stay. He was restrained more than 250 times while in the program, with at least 46 restraints lasting one hour or longer. The victim said some restraints were applied by a group of four or five staff members and fellow patients. According to the victim, they held him on his back, with one person holding his head and one person holding each limb. These restraints were imposed whenever the victim showed any reluctance to do what he was told, or, the victim told us, for doing some things without first obtaining permission from program staff. On one occasion, while he was staying with a host family and other patients, he attempted to escape from the program. The victim claims that they restrained him by wrapping him in a blanket and tying him up. According to the victim, when he turned 18, he submitted a request to leave the program but his request was denied because he had not followed the proper procedure and was a danger to himself. For expressing his desire to leave the program, he was stripped of all progress he had made to that point, and was prevented from further advancing until the program director decided he was be eligible. Incident reports filed by program staff document that after he had turned

18, the victim was restrained on 26 separate days, with at least two restraints lasting more than 12 hours.

According to program rules, failure of the parents to follow program rules and fully support and participate in the program would jeopardize their son's treatment and progress and put him at risk of expulsion. Having been led to believe that the program was the only way to help him overcome his alleged addictions and problems, his family complied with the program's demands. Moreover, the program required parents and siblings over age 8 to attend twice weekly group therapy meetings. According to the victim, these meetings lasted for many hours, sometimes stretching into the early morning. He added that when the victim's father refused to attend the therapy meetings for fear of losing his job, the program told him to quit. When he would not quit his job or miss work to attend the meetings, the victim said that the program convinced his mother to leave her husband. After his parents separated, the program would not allow the victim to have contact with his father. The victim said that the program never told the victim's family that all the drug tests they performed on him returned negative results, including the initial tests done when he entered the program.

In February 1998, the State of New Jersey terminated the program's participation in the Medicaid program, holding that the program did not qualify as a children's partial care mental health program because of its noncompliance with client rights standards and its failure to meet various staff requirements, such as staff-to-client ratios and requisite education and experience levels for staff. The program subsequently closed in November 1998, citing financial problems. About a year later, in September 1999, an administrative law judge rejected an appeal by the program to overrule the state's termination of its Medicaid participation. The judge noted in his decision that the program effectively operated as a full-time residential facility. Moreover, he noted that all group staff at the program were either current or former patients, and only two members of the program staff met the educational requirements to qualify as direct-care professionals.

The victim filed a civil lawsuit against the program, director, and a psychiatrist, which resulted in a $3.75 million settlement. Other civil suits filed by former patients included one patient who was committed to the program at the age of 13 and spent 13 years in the program. This patient reached a similar settlement against the program, director, and psychiatrists for the sum of $6.5 million. In addition, a third former patient secured a $4.5 million settlement against the program, director, and psychiatrists.

Deceptive Marketing and Questionable Practices in Selected Programs and Services

Posing as fictitious parents with fictitious troubled teenagers, we found examples of deceptive marketing and questionable practices related to 10 private residential programs and 4 referral services. The most egregious deceptive marketing practices related to tax incentives and health insurance reimbursement, and were intended to make the high price of the programs appear more manageable for our fictitious parents. We also found examples of false statements and misleading representations related to a range of issues including education and admissions, as well as undisclosed conflicts of interest. In addition, we identified examples of questionable practices related to the health of youth enrolled in programs and the method of convincing reluctant parents to enroll their children. Although general consumer protection laws apply to these programs and services, there are no federal laws or regulations on marketing content and practices specific to the residential program industry.

A link to selected audio clips from these calls is available at: http://www.gao.gov/media/video/gao-08-713t/. See table 3 for a selection of representations made by programs and referral agents.

Table 3: Cases of Deceptive Marketing and Questionable Practices

Source	Representation	Comments
1. 501(c)(3) charity foundation	Foundation representative described a funding mechanism whereby (1) parents solicit friends, relatives, and others to make financial donations to the foundation and have them specify on their donation checks a numbered code representing the child; (2) the foundation tracks the donation amount on behalf of the child, then deducts an administrative fee and pays the program the remaining donation amount on behalf of that child; and (3) friends and family deduct the charitable donations on their tax return	An IRS official told us that the foundation is potentially committing tax fraud and that individuals who follow the program's recommendation may be responsible for back taxes, as well as penalties and interest for taking an improper charitable deduction
2. Montana boarding school	Program representatives told one fictitious parent that an application form must be filled out before a child is admitted to the boarding school	After a call to this program by a different fictitious parent, we received an acceptance letter for our fictitious child even though we never applied for admission
3. Texas wilderness program	Program representative stated that earth science credits earned in the program are "fully transferable" and that other institutions "can't deny" the credit	Education credits can be denied by schools for any reason and are not intrinsically transferable

Source	Representation	Comments
4. Texas wilderness program (same as case no. 3)	Program representative said that the program will provide parents with a detailed bill after their child completes the program and that health insurance companies will reimburse expenses	Representatives for both a health care insurer and a behavioral health company told us that parents who follow this advice run a real risk of not being reimbursed, especially if the health insurance company requires pre-approval of counseling or other mental health services
5. Texas wilderness program (same as case nos. 3 and 4)	Program representative said a trade organization, the National Association of Therapeutic Schools and Programs (NATSAP), "absolutely" performs inspections of the program	NATSAP does not perform inspections of its member programs
6. Referral service "A"	Referral agent stated that behavioral modification schools are "specialty schools" and that tuition costs are tax deductible under Section 213 of the Internal Revenue Tax code	The two programs recommended by the referral agent do not appear to meet the requirements of IRS regulations for special schools; according to an IRS authority on Section 213 with whom we spoke, this is questionable tax advice and parents should consult a tax advisor
7. Referral service "A"	The referral agent warned our fictitious parent that his wife might "freak out" about sending her daughter to a boarding school, and stated: "I want you to tell her it's a college prep boarding school… if she thinks that you want to send her daughter to a place where there are drug addicts and people that are all screwed up, she will look at you and say 'no way'"	In order to secure the business of our fictitious parent, the referral agent gave us questionable ethical advice
8. Referral service "B"	Referral agent stated that the program he recommended "feed[s] the child a whole-grain diet" and that along with exercise and rest, "the bipolar, the depression, those kind of things, they just go away after awhile"	Although diet and sleep may be beneficial, there was no discussion during the call for a health care provider to confirm the child's diagnosis of bipolar disorder or depression and whether to continue medication
9. Referral service "B"	Web site for this referral service states: "We will look at your special situation and help you select the best school for your teen with individual attention"	Referral agents recommended the same Missouri boot camp to three different fictitious parents with three fictitious children having very different problems; the referral service is owned by the husband of the woman who owns the Missouri boot camp, but the conflict of interest was not disclosed
10. Referral services "A" and "C"	When investigators called the phone number of referral service "A" the receptionist answered the call using the name of referral service "C"	Referral services "A" and "C" represent themselves as separate entities, with separate names, Web sites, phone numbers, and magazine advertisements, suggesting that they provide objective advice

Source: GAO.

Case 1: One of our fictitious parents called this foundation pretending to be a parent who could not afford the cost of a residential program for his child. A representative of the foundation explained that their "most popular" method of fund-raising involved the friends and relatives of the enrolled youth making tax-deductible donations to the foundation, which in turn credited 90 percent of these "donations" specifically to pay for tuition in a program the child was attending.

The foundation assigns a code number to each child, which parents ensure is listed on the donation checks. The representative also provided a fund-raising packet by mail that instructs the parents of troubled teens: "You are able to contact family, friends, business acquaintances, affiliates, churches, and professional/fraternal organizations that you know. Don't forget corporate matching funds opportunities from your employer too." The packet also included two template letters to send in soliciting the funds. According to an IRS official with the Tax Exempt and Governmental Entities Division, this practice is inappropriate and represents potential tax fraud on the part of the foundation. Furthermore, those who claim inappropriate deductions in this fashion would be responsible for back taxes, as well as penalties and interest. Based on this information, we referred this nonprofit foundation to the IRS for criminal investigation.

Case 2: The program representative at a Montana boarding school told our fictitious parent that they must submit an application form before their child can be accepted to the school. However, after a separate undercover call made to this school by one of our fictitious parents, the program representative e-mailed us stating that our fictitious daughter had been approved for admission into the program and subsequently sent an acceptance letter. The acceptance letter stated that our fictitious child "has been approved for our school here in Montana." This admission was based entirely on one 30-minute telephone conversation, in which our fictitious parent described his daughter as a 13-year-old who takes the psychotropic medication Risperdal, attends weekly therapy sessions, has bipolar disorder, and been diagnosed with Reactive Attachment Disorder. We did not fill out an application form for the school. Moreover, this program had previously recommended that our fictitious parents seek advice from the 501(c)(3)foundation discussed in Case 1 to help finance the cost of the program. It appears that parents do not have assurance about the integrity of the admissions process at this boarding school.

Case 4: One fictitious parent asked the representative for a Texas wilderness therapy program whether there was any possibility that a health insurance company would cover the cost of the program. The representative replied that, at the completion of the program, the bookkeeper for the program would generate an itemized statement of billable charges that could be submitted to an insurance company for reimbursement. She emphasized that we should not call ahead of time to seek pre-approval, because then we would be "up the creek." She added that this was "just the way insurance companies like it" and stated that health insurance companies reimburse "quite a bit." She gave an example of one insurance company that reimbursed for over $11,000—almost the entire cost of the 28-day wilderness program. Representatives for both a health care insurer and a behavioral health company told us that parents who follow this advice run a

real risk of not being reimbursed, especially if the health insurance company requires pre-approval of counseling or other mental health services. In this case, our fictitious parent was being led into believing that a large portion of the tuition for the program would be covered by health insurance even if pre-approval for the charges was not obtained in writing in advance of the services.

Case 6: One referral agent we called stated that behavioral modification schools are "specialty schools" and that tuition costs are tax deductible under Section 213 of the Internal Revenue Tax code. The referral agent also stated that transportation costs related to bringing our fictitious child to and from the school were tax deductible under this section. However, the two programs recommended by the referral service do not appear to meet the requirements of IRS regulations for special schools. Our review of Section 213 of the Internal Revenue Tax code shows that it relates to medical expenses and specifies that, if medical expenses and transportation for treatment exceed 7.5 percent of a taxpayer's adjusted gross income, the excess costs can be deducted on Schedule A of IRS Form 1040. Even if these expenses were deductible under this section, only expenses above 7.5 percent of the adjusted gross income would be deductible, rather than the full amount as suggested by the referral agent. An IRS authority on Section 213 with whom we spoke stated that the referral service provided us with questionable tax advice and that parents should consult a tax advisor before attempting to claim a deduction under this section. Parents improperly taking this deduction could be responsible for back taxes, as well as penalties and interest.

Case 9: On its Web site, referral service "B" invites parents to call a toll-free number and states: "We will look at your special situation and help you select the best school for your teen with individual attention." Our undercover investigators called this referral service pretending to be three separate fictitious parents and described three separate fictitious children to the agents who answered the phone. Despite these three different scenarios, we found the referral service recommended the same residential program all three times—a Missouri boot camp. Our investigation into this referral service revealed that the owner of the referral service is the husband of the boot camp owner. This relationship, was not disclosed to our fictitious parents during our telephone calls, which raises the issue of a potential conflict of interest. It appears that parents who call this referral service will not receive the objective advice they expect based on marketing information on the Web site.

Mr. Chairman and Members of the Committee, this concludes my statement. We would be pleased to answer any questions that you may have at this time.

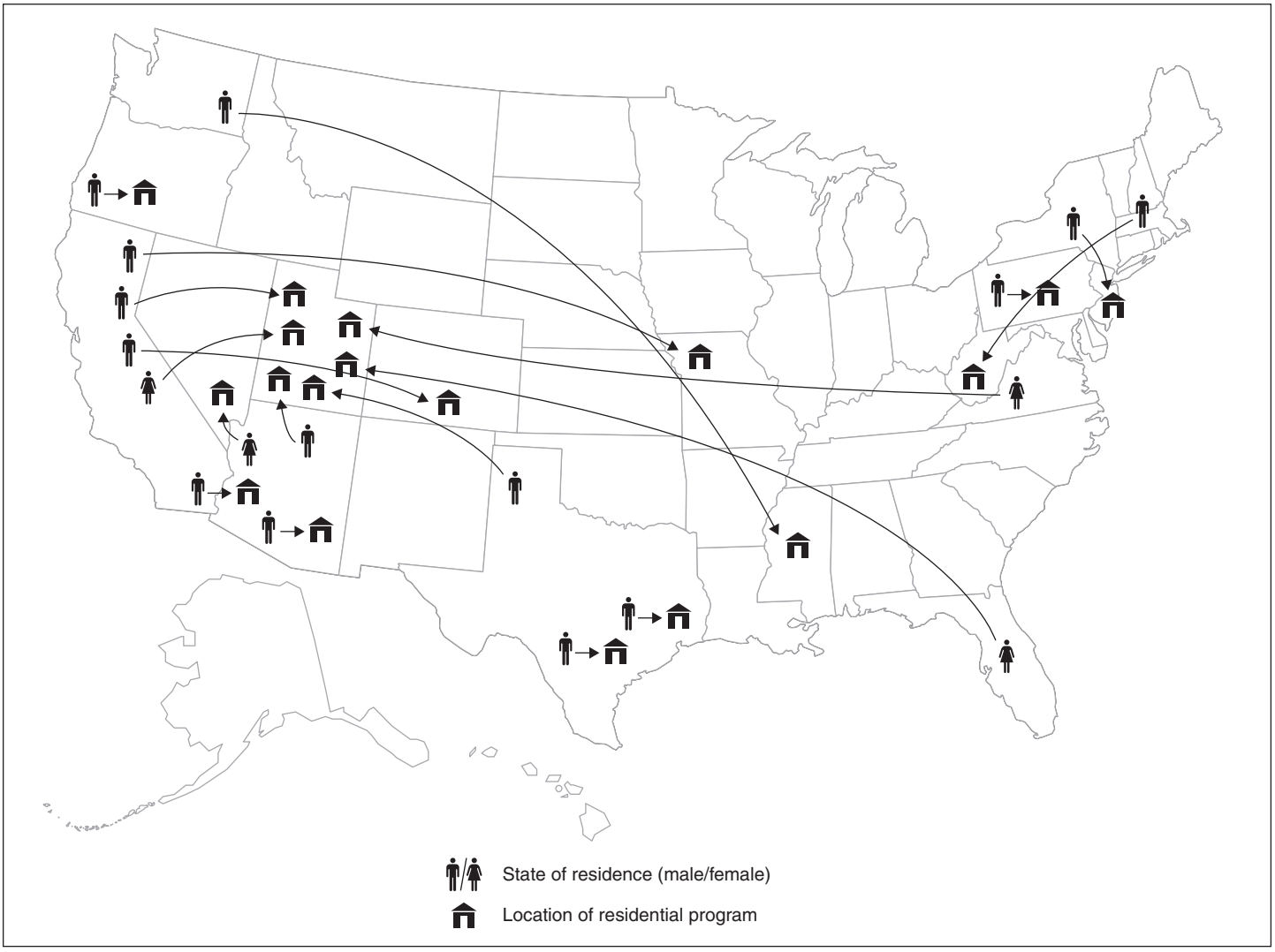
Contacts and Acknowledgments

For further information about this testimony, please contact Gregory D. Kutz at (202) 512-6722 or kutzg@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this testimony.

Appendix I: Private Residential Program Locations

In our examination of case studies for this testimony and our prior testimony, we found that the victims of death and abuse came from across the country and attended programs that were similarly located in numerous states. Figure 1 contains a map indicating where victims lived and the location of the program they attended.

Figure 1: Map of Case Study Victims from October 2007 Testimony and This Testimony

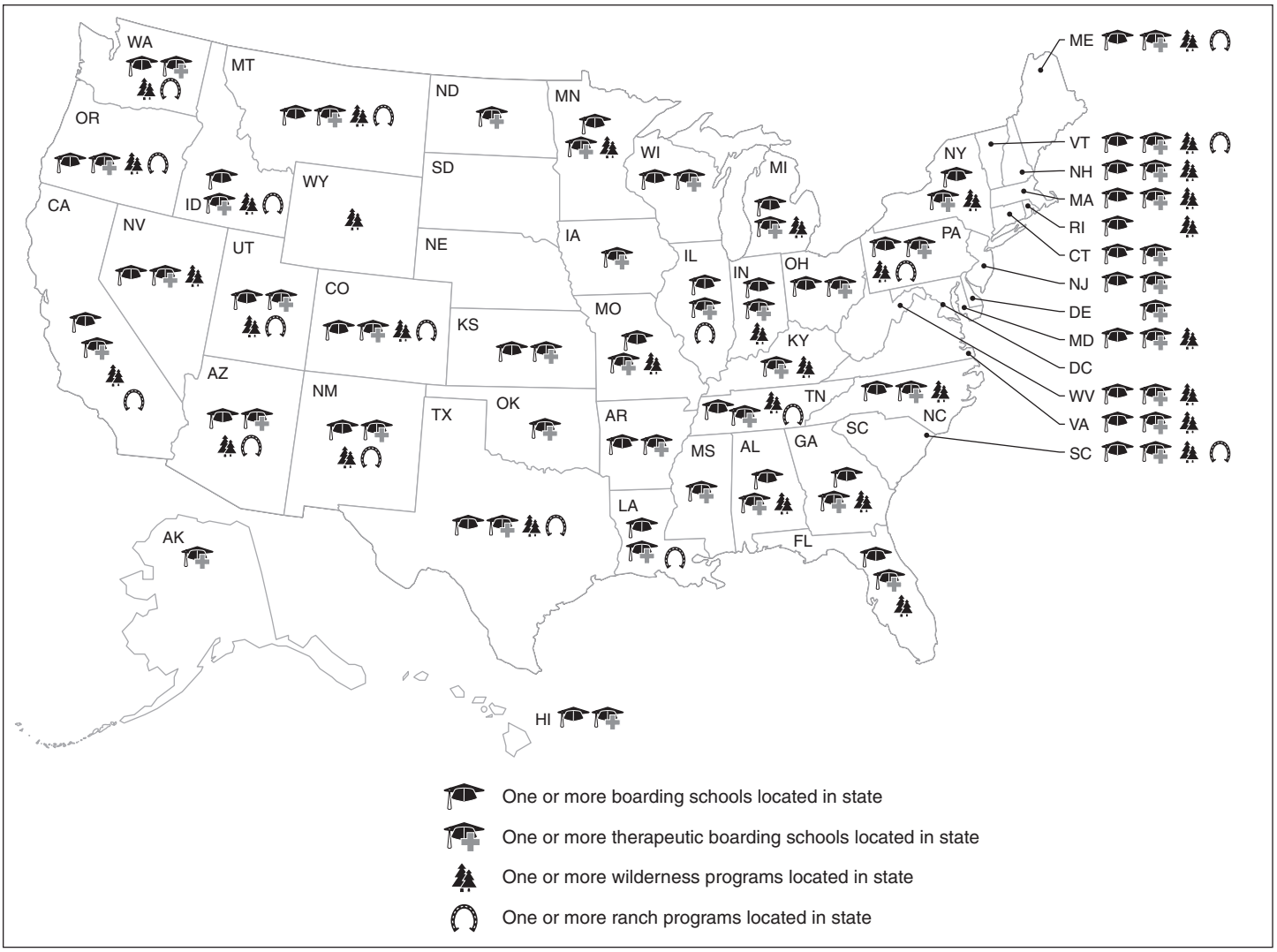


Source: GAO.

Note: The icons in figure 1 represent the state of residence for each case study victim and the state in which each residential program is located. The icons do not reflect specific geographic locations within states.

Private residential programs are located nationwide and rely heavily on the Internet for their marketing. Although Web sites list 48 of the 50 states where parents can find various types of programs, we found that they do not list programs in Nebraska and South Dakota, nor do they indicate the existence of programs in the District of Columbia. Notably, we did not find Web sites that list states with boot camps but instead instruct parents to call for locations and details. Figure 2 illustrates the types of programs and the states in which they are located, excluding boot camps.

Figure 2: Private Residential Programs Nationwide



Source: GAO analysis of information available on referral service Web sites.

Appendix II: Cost of Private Residential Programs

Our undercover calls to selected programs revealed that most private programs charge a high tuition for their services. Table 4 contains information related to the high cost of these programs based these phone calls.

Table 4: Basic Monthly Costs of Programs

No.	Type of program	Location	Source of information	Basic monthly cost
1	Boarding school	Georgia	Referral service	$3,166
2	Boot camp	Missouri	Referral service	4,500
3	Boarding school	North Carolina	Referral service	4,500
4	Boarding school	South Carolina	Referral service	3,166
5	Boarding school	South Carolina	Referral service	2,795
6	Boarding school	Colorado	Program	2,795 - 2,995
7	Boarding school	Georgia	Program	8,120[a]
8	Boarding school	Montana	Program	3,495
9	Boarding school	New York	Program	5,160
10	Boarding school	Tennessee	Program	8,700[b]
11	Boarding school	Utah	Program	6,500[b]
12	Wilderness program	Georgia	Program	12,600
13	Wilderness program	North Carolina	Program	13,020
14	Wilderness program	Texas	Program	13,020

Source: GAO analysis of information obtained during undercover calls to programs and referral services.

[a]This is for the first 90 days; the cost drops afterwards.

[b]This includes therapy.

According to program and service representatives with whom we spoke, the basic cost could be discounted. For example, one program told us if parents paid for a full year upfront, they would be given a $200-per-month discount. This does not include fees by transport services for taking a child to a program. Moreover, although program and service representatives quoted these as basic program costs, they also mentioned additional one-time charges, such as an enrollment fee that can be as much as $4,600, uniform costs, or other items such as supplies. In addition, some programs charge extra for therapy, including one-on-one therapy.

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