

A RESPONSE TO A GOVERNMENT ACCOUNTABILITY OFFICE (GAO) REPORT (10 OCTOBER, 2007)

"Residential Treatment Programs: Concerns Regarding Abuse and Death in Certain Programs for Troubled Youth."

November, 2007

Objectives

The Government Accounting Office (GAO) recently released an official report entitled, "Residential Treatment Programs: Concerns Regarding Abuse and Death in Certain Programs for Troubled Youth" (GAO-08-146T; 10 October, 2007). The 38-page report states it found "thousands of allegations" of abuse.¹ The GAO found these allegations in state and federal records, pending civil and criminal trials, and various Internet sites. It did not "attempt to evaluate the benefits of residential treatment programs or verify the facts regarding the thousands of allegations it received."² The report is ripe with broad-brush condemnations of the private teen treatment industry. And those conclusions are reached without a single interview of anyone in the industry, or with any of the tens of thousands of adolescents the industry has helped.

Given the incomplete and one-sided nature of the report, the purpose of this point-by-point response is to provide additional information from objective sources in an effort to provide a more fair and balanced snapshot of the residential treatment industry. The following facts, citations and information presented in this response are all substantiated by official public documents and eyewitness testimony, which may be supplied upon written request.

The GAO Report: A Response and Rebuttal

Problems with Methodology

Issue 1 ... *Fails to Define Purpose: Meaning of "Widespread"?* (p. 1)

- Verifying allegations of abuse cannot be equated with verifying incidents of abuse. The report states that "it is important to emphasize that allegations should not be confused with proof of actual abuse." (p. 12) However, the report repeatedly states that it found "thousands of allegations of abuse," and, as noted above, that it made no attempts to verify the validity of these allegations.
- GAO does not define "widespread." Besides the "thousands" of allegations of abuse, how many cases of abuse/death have there been versus how many teens have completed treatment safely and successfully? To characterize something as "widespread," the GAO would need to show the actual size or scope of the problem.
- GAO did not seek to determine how many of these allegations were duplicates. (p. 13)

Issue 2: *Unidentified, Unbalanced Sources*

¹ *GAO Highlights*; (GAO-08-146T) 10 October, 2007; p. 1

² *ibid.*

- GAO conducted numerous interviews, but does not say who it interviewed other than “relevant experts.”³ This needs to be defined, and the experts need to be unbiased. Further, persons other than “experts” would be helpful in reviewing treatment centers – including former students and their parents, staff members, etc. GAO did not seek a response from the teen treatment industry. In explaining its 10 case studies, GAO stated it interviewed related parties, including current and former program staff and officials, attorneys and law enforcement officials, and the parents of the victims.
- Besides these unbalanced interviews, GAO gathered its information from second-hand sources (“relevant studies and documents”), Internet searches, statistics gathered by a voluntary data collection, and court documents. (p. 1) The report offers no citation or substantiation of these resources, and no indication of the reliability of the information gained from these sources.
- The report claims to have identified claims of abuse and death in court cases. (p. 12) Specifically, it points to a case that is still pending where parents alleged abuse. This source can only be valued anecdotally as it is biased and unadjudicated.
- The report also claims to have interviewed attorneys who represent youth that have alleged abuse. (p. 13) Again, like the parents, this is a biased group.
- The report also gathered information from “various web sites advocating for the shutdown of certain programs.” (p. 13) The report does not cite these websites, nor offer any evidence of their credibility. The report mentions in only one sentence that there are some websites that promote closing these programs.
- Each of these sources is one-sided and unproven. While they may be an important component of the overall picture, they only offer a piece of the puzzle.

Problems with Statistical Analysis

Issue 3. “GAO found thousands of allegations of abuse” (p. 1)

- If there were indeed such an alarming number of allegations, where, when and to whom were they reported? The report cites no specific study or cases. It did not say how many actual cases (ending in death) there were to consider; this matters because it would show the scope of the problem – were there 12 total deaths, and they studied 10, or were there 10,000 total deaths and they studied 10? Any teen death is tragic. Still, a report based on statistics must be examined in context of statistics. The report does not discuss general teen suicide statistics, the suicide rate of teenagers under the care of doctors or therapists, or the suicide rate of these programs in general. Perhaps, in fact, the suicide rate at these programs is significantly lower than the average rate of teen suicides which occur at home.
- The report does not define “abuse” in any meaningful way – i.e., what must occur to constitute abuse? Many teen treatment centers include elements of military-style behavioral discipline, limiting contact with family or friends, or therapeutic physical containment. Parents are advised of this prior to admission. This leads

³ *ibid*, p. 1

- one to ask, “Would any one of these constitute abuse, if a teen complained about it?”
- A 2005 report from the Department of Health and Human Services found that about 60 percent (60.3%) of the reports of abuse in the United States were found to be unsubstantiated.⁴ How does that finding affect this report?
 - Of the “thousands” of allegations, the report focused on ten cases that ended in death.

Issue 4. *“33 states reported 1,619 Staff members involved in incidents of abuse (p. 1)*

- This information comes from the most recent National Child Abuse and Neglect Data System (NCANDS) data (p. 12). Submission of data to this database is voluntary.
- This statistic does not distinguish staff members in private facilities from staff members at public facilities, yet the GAO report inexplicably focuses its critique on private facilities. (p. 2)

Issue 5. *“GAO found significant evidence of ineffective management in most of the 10 cases” (p. 1)*

- GAO does not indicate the size of the pool from which it drew these 10 cases. It is impossible to know if ineffective management (even assuming it was indeed ineffective) in 10 cases is a lot, or is a commendably small percentage.

Issue 6. *“When identifying our cases, we specifically excluded teenager deaths at public programs” (p. 2)*

- What is the rationale for excluding public programs (local, state and federal) from this study? Would not public programs and their programming, procedures and statistics provide a fair benchmark for comparison?
- Despite excluding this information in its anecdotes, GAO did not (reportedly could not) exclude this information from its statistics. This obviously skews the statistics’ reliability, as it is impossible to know how the “allegations of abuse” were distributed between public and private facilities. The report (p. 3) admits it *“could not determine what percentage of the thousands of allegations ... are related to [private] programs.”*

⁴ U.S. Department of Health and Human Services, Administration on Children, Youth and Families. *Child Maltreatment 2005* (Washington, DC: U.S. Government Printing Office, 2007).

Issue 7: *Cases selected on the basis of factors including victim age, program location, type of program the victim attended, and date of death.*

- Why these particular factors? Why do they matter to the study? Are they trying to be representative, or more general? No explanation is offered as to how various criteria might affect the report.

Issue 8: *Statistics not viewed in backdrop of average statistics*

- The report acknowledges that teen treatment programs serve a high-risk group, providing an alternative to "incarceration or hospitalization" for teens with a "variety of addiction, behavioral, and emotional problems" (p. 1) who sometimes have "life threatening addictions and diseases" (p. 2). It does not seem to account for the unfortunate fact that some of these risks are statistically likely to play out.
- The report does not say how many students there are in such programs nationwide, or how many of them commit suicide, or how many of them die from other causes. Thus it is impossible to compare these numbers to an average teen death rate, and the breakdown of causes. This lack of information leaves open the possibility that there are fewer teen suicides in these programs than the national average would suggest.

Report Over Generalizes

Issue 9: *Over Generalizing Types of Programs*

- The report discusses that there is no standard licensing scheme, nor is there a standard definition for the various types of programs (p. 5), yet it characterizes the types of programs as if they were all more or less identical. It describes features, such as a student-written journal that is read by staff, or security measures, or living conditions, and suggests that these are consistent across all programs. (pp. 6-11)

Issue 10: *Sweeping Statements*

- The report uses sweeping statements like "in some cases, program leaders gave their staff bad advice." (p. 13) Advice may have been "bad" when given the benefit of hindsight, but the report does not consider the context of the advice or the facts known at the time it was given.
- The report indicates that some leaders did not have the credentials in therapy or medicine they claimed. False advertising is of course inappropriate, but the report suggests that individuals without appropriate credentials cannot provide "proper treatment." (p. 13) This overlooks the fact that many uncredentialed individuals have extensive experience and may be able to provide "proper treatment." Furthermore, it fails to consider that in many cases, parents who use treatment programs may have tried various credentialed therapists or doctors and found them ineffective.

Case Study: Ryan Lewis & Alldredge

Issue 11: *Report Suggests Blame Lies With Facility When It May Not Have Been Given All the Information*

- The report is clear that a third-party, hired educational consultant unrelated to the program recommended the program to the parents, after discussing with the parents Ryan's conditions. This educational consultant had used the facility previously, and found success as evidenced by numerous other referrals to Alldredge.⁵
- The report does not say to what extent the parents informed the program about Ryan's conditions. Their application included mention of two incidents where Ryan threatened self-harm, but did not actually harm himself. These should not rationally be construed as suicide attempts. The psychiatrist report provided by the parents also did not mention that Ryan was a suicide risk. This report focused on Ryan having a difficult time with peer relationships, family dynamics, depression and self-esteem. The program was not told or given a written report from a mental health professional stating that the parents were not taking seriously a possible diagnosis of bipolarity. There is no government data available on the annual numbers of attempted teenage suicides. However, other research indicates that there are an estimated 8-25 attempted suicides for each teen suicide death.⁶
- The GAO report states that "the program did not have any procedures for addressing suicidal behavior even though it had marketed itself as being able to provide appropriate therapy to its students." (p. 24) The program did have procedures for dealing with suicide patterns, and they were followed in this case.⁷ Ryan was found to be future-oriented, not withdrawn or euphoric, demonstrating appropriate affect, had easy interaction with peers and instructors, and evidenced empathy for other students. This information was gleaned by five staff members who observed Ryan from morning until night on the day of the incident. If these positive signs had not been observed, alternative procedures would have been immediately implemented. There was no concrete evidence that his death was intentional and in fact, could have been accidental. That was corroborated by a renowned clinical psychologist who investigated the death and concluded that it was not intentional and that the facility was not at fault.⁸

Issue 12: *Sensationalization of Non-Essential Information*

- The report indicates that the owner did not have any formal training to provide therapy. The field of wilderness therapy emerged in the 1980's. Mr. Mitchell was

⁵ Sworn testimony of Alldredge Admissions Coordinator

⁶ "Family First Aid (web site) <http://www.familyfirstaid.org/suicide.html>

⁷ Sworn testimony of Alldredge Wilderness Instructor

⁸ Investigation Report of Licensed Clinical Psychologist

one of the pioneers in the concepts and methods of this discipline.⁹ He has decades of experience in wilderness therapy programs, which has only recently become a course option at a select group of colleges and universities. As testament to Mr. Mitchell’s expertise in this field, many of his wilderness therapy ideas and practices have been adopted into other wilderness programs. It is important to understand here that wilderness therapy is not just classical therapy with a therapist counseling students in a wilderness setting.¹⁰ In fact, some wilderness models do not require an accredited therapist or counselor in the field.

Issue 13: *The Other Side of The Story*

- The report repeatedly states that the parents told the GAO that Ryan had attempted suicide twice. It does not explain these attempts. “His parents specifically called these actions “meltdowns” as a part of temper tantrums when he could not get a B-B gun on one occasion or a dog on another occasion,” said Mr. Mitchell.¹¹ “Ryan got upset on one occasion and threatened to put a fork in an electrical outlet. He did not do so and was not injured. On the second meltdown he got upset and put a cord around his neck. Again, he was not injured. The Lewises took him to a clinic where he was evaluated and sent home that day. He was not held for overnight observation and Alldredge received no record of any follow-up treatment.” These actions by Ryan do not constitute “suicide attempts” *per se* and there was no self-harm.¹² He may have been seeking special attention, trying to scare his parents, or attempting to get his way. Consider also that the Lewises sought professional, licensed treatment in evaluating and treating Ryan. And the response they received was that Ryan’s risk of self-harm was not significant enough for admission as an in-patient. The parents did not claim that he received follow up treatment for attempted suicide or self harm.
- The record talks about Ryan “cutting” himself the day before the suicide. The report does not define cutting. The cuts were superficial cuts or scratches that did not draw blood and did not even require a band-aid.¹³ This fact was corroborated by both the autopsy report and by statements from emergency medical personnel dispatched to the scene. By discussing this incident in the same paragraph with, and in greater detail than, the actual suicide, the report gives the impression that

⁹ Note: Mr. Mitchell founded and directed the SUWS Adolescent Program 1982. He has presented a paper at an APA annual conference and co-authored a chapter in an APA published textbook.

¹⁰ See curriculum for Wilderness Therapy, Naropa University, Boulder, Colorado

¹¹ Sworn testimony of Mr. and Mrs. Lewis

¹² Investigation Report of Clinical Psychologist. After reviewing transcripts of witness interviews, autopsy report, personnel records, Ryan Lewis’s journal, application for admission submitted by Lewis’s psychologists, psychiatrist and other mental health professionals. This clinical psychologist has directed Clinical Training for therapists at a major university, is a full Professor of Psychology at another major university, has consulted for inpatient and out patient mental health facilities, has published over 120 referred articles and 6 scholarly books. Member of the APA Council of Representatives.

¹³ Sworn testimony of three eyewitness Wilderness Instructors

Ryan tried to significantly harm himself, and that the knife incident was a suicide attempt. However, the report clarifies in a footnote that "cutting is a common practice of superficially cutting oneself to draw attention and is often associated with adolescent mental health and behavioral issues. It is not considered an attempt to commit suicide." Ryan told the instructors that he had scratched himself because he wanted to go home.¹⁴ Nevertheless the next day Ryan was watched carefully from morning to night and a group process was held wherein his attitudes and feelings were explored.¹⁵ On the day of his death Ryan stated he was looking forward to some time with Mitchell the next day.¹⁶

- The report describes the knife scenario as follows: "On the day before he killed himself, while participating in the first phase of the program (survival training), Ryan deliberately cut his left arm four times from wrist to elbow using a pocket knife issued to him by the school. After cutting himself, Ryan approached a counselor and showed him what he had done, pleading with the counselor to take the knife away before he hurt himself again. He also asked the counselor to call his mother and tell her that he wanted to go home. The counselor spoke with Ryan, elicited a promise from him not to hurt himself again, and gave the knife back. The next evening Ryan hung himself with a cord not far from his tent." This version of the knife episode sounds very dramatic, and needs to be considered side-by-side with the staff members' version which is a much more objective description of actual events: "Ryan showed the scratches to the instructors and said he wanted to talk. The instructors observed the scratches had not drawn blood and decided that it needed no bandage of any kind. The instructors had extensive wilderness first responder and first aid training. Ryan then told the instructors that he scratched himself because he wanted to go home. In an effort to console him, the instructors talked with Ryan for an estimated 20 minutes. Ryan said he could be trusted not to cut himself, and he asked to demonstrate his honesty. The knife was given back to him for 10 or 15 minutes during which the instructor supervised him the entire time. He did not hurt or even attempt to hurt himself during this time. As per protocol, the knife was then turned in to the instructor, and all student knives were collected for the evening. Ryan had a quiet and uneventful night. He made no mention of the scratches the next morning to anyone."¹⁷ It is important to note here that in most treatment facilities—be they in wilderness or in a 24-hour in-patient medical facility—one of the most common behaviors among troubled adolescents today is scratching or cutting. Most all of these actions at self-harm are for a living purpose, that is, to relieve pain, stress or get someone's attention. The report does not acknowledge this fact and makes no attempt to present a balanced or confirmed view.
- The report notes that the owner and another counselor visited Ryan's campsite the day he died. During this visit, field staff told them about the self-inflicted injury and statements Ryan had made the night before. According to Ryan's father, the

¹⁴ *ibid.*

¹⁵ Sworn testimony of three eyewitness Wilderness Instructors and Mr. Mitchell

¹⁶ Testimony of eyewitness Wilderness Instructor

¹⁷ Sworn testimony of three eyewitness Wilderness Instructors

owner then advised field staff that Ryan was being manipulative in an attempt to be sent home, and that the staff should ignore him to discourage further manipulative behavior. Immediately after the briefing, Mr. Mitchell and instructors conducted a three-plus hour group session.¹⁸ In this session Ryan was carefully observed and evaluated as to his participation and affect. Mr. Mitchell denies telling the staff to simply ignore Ryan, and in fact it was the staff that told Mr. Mitchell that Ryan said he scratched himself so he could go home. But he did suggest that Ryan needed to be observed to see if he was trying to attract attention or creating a reason to go home. Mr. Mitchell also stated that since Ryan was not making an issue of the scratches that morning, that he should be observed during the day to see if he would bring it up, but not to draw Ryan's attention to the scratches.¹⁹ Ryan was watched carefully from morning to night, and although he interacted with staff and students during the day he did not bring up the scratches. He did ask Mr. Mitchell questions about the school phase and whether he could have a bike there. Ryan also said that he was looking forward to seeing Mr. Mitchell the next day.²⁰ It is possible that Ryan was indeed scratching himself to create attention or get permission to go home. If that was indeed the case, scratching himself was not a precursor to committing suicide. Regardless, the staff spent all day observing and interacting with Ryan to more carefully evaluate his emotional well-being.

Issue 14: Drawing Flawed Conclusions from the Court Case

- The report indicates that the owners and the program were indicted by a grand jury on criminal charges of child neglect resulting in death. However, this is the same courtroom in which the official court transcripts record the judge remarking that, "any prosecutor was not worth his salt if he could not get a ham sandwich indicted."²¹ Subsequently, the prosecutor offered the program to plead *nolo contendere*, which is not a guilty plea and does not require admitting guilt. This plea is used when a defendant does not want to spend large sums of money and time to defend a case, but instead turns itself over to the mercy of the court. The program director would not accept the prosecutor's offer unless the program was able to write the *nolo contendere* plea in order to insure that the program did not admit to any wrongdoing. The judge accepted the plea, its language and a corporate resolution explaining the business reasons behind making the plea.²² No trial was held, and the program agreed to pay a \$5,000 fine. The program director suggests that the \$5,000 fine represents the court's skepticism of the merits of the entire case.
- The report notes that the program remains open and operating. However, soon after the incident, an unnamed source told the Charleston area media that the program had been shut down. Despite the fact that the program was never shut

¹⁸ *ibid.*

¹⁹ Sworn testimony of three eyewitness Wilderness Instructors

²⁰ *ibid.*

²¹ Taken from the actual court transcript!

²² Written Plea and Resolution accepted by the court

- down, Charleston area newspapers falsely reported that the program had been shut down. Even when the error was pointed out the newspapers never followed up with a retraction.²³ Somehow these 7 year old false reports continue to have a prominent place on the web. Despite such shameful muckraking Alldredge continues to thrive. It is important to note here that following Ryan’s death the DHHR contracted with a clinical psychologist, Dr. Richard Workman, to spend several days at Alldredge and evaluate the program. His written report stated that the program was the most effective of its kind that he had seen, and that he recommended the facility not be forced to change its programming.²⁴
- The report indicates that ownership has changed hands, with approval from the state. However it makes no mention of the fact that, following this case, the facility and the state were in disagreement about which state agency had jurisdiction to regulate the program. To reconcile this disagreement the facility agreed with the West Virginia DHHR to jointly create rules of operation for the facility to follow until legislation regulating wilderness programs in West Virginia was passed, and/or the facility became licensed by the DHHR.²⁵ The facility was not licensed because West Virginia did not have rules and regulations governing wilderness programs. The facility had been regulated by the West Virginia Department of Education because it provided a high school curriculum. The West Virginia DHHR audited the program periodically and in fact commended it in writing for being in compliance with this agreement.²⁶ The report also fails to mention that the facility assisted the state legislature in drafting rules and regulations to govern wilderness programs in West Virginia.
 - At no time has the facility admitted any legal fault in this case, and no court has found it guilty or culpable for any wrongdoing. While expressing sorrow for this tragedy, the actions by Alldredge have borne out as being reasonable under the circumstances.²⁷ The facility has admitted moral responsibility for Ryan Lewis’ plight, because its overarching objective is the well being of every student in the program, irrespective of the outcome. Nevertheless, surreptitious, false and sensationalized statements continue to be published and perpetuated on the Internet. The GAO’s report fails to acknowledge or address this.
 - The report fails to mention that the facility has not received a claim of any kind since this February, 2001 incident, and that an estimated 30% of the over 1,000 enrollments since 2001 have come from loyal alumni.²⁸ In fact, alumni have created with their own initiative and funding a 501(c)(3) Alumni Foundation in support of the Alldredge programs.²⁹ Also of note is the fact that the president of that association is father of a son who was in Ryan’s wilderness group at the time

²³ The Charleston Gazette

²⁴ Written report of Richard Workman

²⁵ Written stipulation between the WV DHHR and Alldredge Academy

²⁶ Written correspondence from WV DHHR to Alldredge Academy

²⁷ Written report of Licensed Clinical Psychologist

²⁸ Alldredge Academy Admission Records

²⁹ See www.AlldredgeFamilyFoundation.org

of this tragic incident. This alumni association has reached out to the deceased boy's parents on several occasions but has had no response.³⁰

- The report also fails to indicate that the parents of the students in this group (after notification of the incident) elected to keep their children at the facility, and that those students successfully graduated.³¹ Nor does it mention that the West Virginia DHHR sent representatives to the facility on the day after the incident and found that the remaining students were not at risk.

Issue 14: *Relevance of Forest Service Allegations*

- In a case supposedly dealing with a suicide, toward the end of its report the GAO suddenly shifts gears and concludes by throwing in a note that Alldredge is not in compliance with U.S. Forest Service regulations, and has "not paid required permit fees in almost 8 years" (p25). Before answering this charge (see below) it should be noted that this is clearly an odd and highly unusual deviation. Why, in a case supposedly involving the safety of children, would one suddenly delve into fee compliance? It is clearly further evidence of an agenda-driven, incomplete and biased reporting effort by an entity charged with objective and honest investigations.
- Alldredge has documentation (letters and bank records) from the U.S. Forest Service showing that in fact Alldredge has paid all fees as calculated by the U.S. Forest Service from 1991 to the present day. The only possible exception is from the years 2003-04 where documentation is incomplete and/or missing. However, at no time does the Forest Service show Alldredge in arrears. This is corroborated in various correspondences from Laura Hise, Special Use Manager for the Monongahela National Forest. It should also be pointed out that Alldredge students rarely even use this public land other than to cross it and occasionally camp on it, preferring to camp with permission on private land.
- The GAO "investigation" of Alldredge facilities and programs was surreptitious and carried out in a completely unethical manner. GAO investigators initiated their work under false and misleading pretenses. For example, instead of telling Alldredge staff that the inspection and tour was optional, the three investigators from the GAO intimated that their visit required compliance. While stating that they were going to "take a few still photos,"³² they were instead caught shooting videotape. When confronted, the investigators admitted they had mislead Alldredge staff and videotaped students and facilities despite the specific request not to do so, and in complete violation of HIPPA privacy regulations. In general, the investigators were unprepared and had little knowledge of the industry and its practices.

Conclusion

³⁰ President, Alldredge Family Foundation

³¹ Alldredge Student Records

³² Memorandum, Jim Browning, 23 October 2007

Perhaps the most telling indication of the incomplete, biased and shoddy nature of this report comes from the report itself. After a titillating headline reading, "*Widespread Allegations of Abuse and Death at Residential Treatment Programs*," (p12) the report immediately contradicts itself by noting the limitations in collecting and accurately reporting data. It further enjoins the reader to not confuse "*proof* with actual abuse."

We couldn't agree more.

Why then did the GAO—an agency with a mandate for fairness, accountability and accuracy—spend taxpayers' time and money to produce what is, in essence, a sensationalized, tabloid-style report? Why did the agency resort to generalizations, assumptions, conjecture, unreliable sources and selective samples to impugn and demonize a proven and essential segment of the adolescent mental health industry?

To be fair, there have been a limited and regrettable number of serious accidents and deaths. The industry and the humans who administer it are not perfect. But the GAO does not provide one compelling shred of evidence nor justification for a blanket indictment or Senate hearing. When compared with the incidence of mortality in the general adolescent population, the industry's track record of treating its at-risk youth population is commendable if not remarkable. Yet, this grandstanding "investigation" would have the reader believe that the industry is rife with spurious entities filled with wanton disregard for the safety and well-being of the youth it treats.

Nothing, as this point-by-point rebuttal clearly point out, could be further from the truth.

**All facts in this rebuttal have been drawn from court documents and eye witness accounts.*