U.S. DEPARTMENT OF JUSTICE
UNITED STATES ATTORNEY
DISTRICT OF RHODE ISLAND

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May 13, 2024

By First Class Mail and Electronic Mail

The Honorable Daniel J. McKee
Governor, State of Rhode Island
82 Smith Street
Providence, RI 02903

Director Ashley Deckert
Rhode Island Department of Children, Youth and Families
101 Friendship Street
Providence, RI 02903

Re: United States' Investigation of DCYF's Behavioral Health System Under Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act

Dear Governor McKee and Director Deckert:

After an extensive joint investigation, the United States Department of Justice and the U.S. Department of Health and Human Services (collectively, "the United States") conclude that the Rhode Island Department of Children, Youth and Families and the State of Rhode Island (collectively, "the State") violated Title II of the Americans with Disabilities Act (ADA), 42 U.S.C. § 12132, and Section 504 of the Rehabilitation Act of 1973 (Section 504), 29 U.S.C. § 794, by failing to provide services to children with behavioral health disabilities in the most integrated setting appropriate to their needs. This failure results in children being routinely and unnecessarily segregated in an acute-care psychiatric hospital. Consistent with Title II and Section 504 regulations, we provide this letter to notify the State of the United States' conclusions, the facts supporting those conclusions, and the minimum remedial measures necessary to address the deficiencies.[1]

[1] *See* 28 C.F.R. § 35.172; 45 C.F.R. § 80.7(d).

The United States' investigation focuses on a population of children with behavioral health disabilities[2] who are in the care and custody of the Rhode Island Department of Children, Youth and Families (DCYF).[3] These children are routinely admitted to Emma Pendleton Bradley Hospital ("Bradley Hospital" or "Bradley"), a private, acute psychiatric hospital located in East Providence, Rhode Island, that serves children and adolescents with serious behavioral needs and who are in need of short-term stabilization, assessment, and treatment for suicidal, aggressive, self-injurious, or other similar behaviors.[4] While Bradley Hospital inpatient admissions are designed to last one to two weeks, children in DCYF care and custody frequently end up staying for weeks, months, and in some cases, more than a year. Although the needs of children with behavioral health disabilities could be met in settings less restrictive than hospitals, these children languish at Bradley Hospital simply because DCYF has failed to ensure sufficient capacity of community-based services and prompt and effective discharge planning.

The unnecessary segregation of children in the focus population at Bradley Hospital who could be served in a more integrated and less restrictive setting violates the ADA and Section 504. As explained further below, the State could reasonably modify its service system to provide the care that these children need in more integrated settings even though the appropriate level of care for many of these children would be long-term, high-intensity, and specialized. The State can fulfill its obligation to serve children in DCYF care and custody in the most integrated setting appropriate to their needs by making reasonable modifications to its service system that are aligned with its own law and policies.[5]

I. Investigation

The U.S. Department of Health and Human Services ("HHS") initiated an investigation of DCYF in late 2021 upon receiving complaints regarding excessive lengths of stay for children in DCYF custody admitted to Bradley Hospital. The U.S. Department of Justice joined HHS's investigation in July 2022. As part of the investigation, the United States interviewed DCYF personnel, community-based providers, advocates, law enforcement officers, Family Court staff,

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[2] Children with behavioral health disabilities are individuals up to the age of 21 who have a diagnosable serious emotional disturbance, mental illness, and/or substance use disorder. This population includes children with co-occurring intellectual or developmental disabilities.

[3] As explained in Section III, DCYF is the state agency in Rhode Island with responsibility for child welfare, juvenile corrections, and children's behavioral health services. In addition to children in the care and custody of DCYF, the investigation includes children who access services through DCYF's Children's Behavioral Health (CBH) pathway. CBH allows a parent to access behavioral health services, including residential services, for a child with a serious emotional disturbance or intellectual developmental disability without relinquishing custody, control, and care of the child.

[4] *See* https://www.lifespan.org/centers-services/child-adolescent-inpatient-program (last visited May 6, 2024).

[5] *See, e.g.*, R.I. Gen. Laws §§ 42-72-5(b)(27), 42-72-5.2 and Section IV of this letter.

family members and foster parents of children with behavioral health disabilities, and children who had been hospitalized at Bradley. In response to requests from the United States, DCYF produced various data, documents, and medical records. The United States reviewed thousands of documents and data produced by DCYF, including case records for a sample of children who were hospitalized at Bradley.

The United States thanks everyone who participated in the investigation for their cooperation and candor and acknowledges the courtesy and professionalism of all the DCYF officials and counsel involved in this matter.

II. Legal Framework

A key purpose of Section 504 is to provide individuals with disabilities equal opportunity to participate in programs and activities that receive federal financial assistance by requiring among other things that they be carried out in a manner consistent with the principles of "inclusion, integration, and full participation" of individuals with disabilities.[6] Congress enacted the ADA in 1990 "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities."[7] In enacting the ADA, Congress found that "historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem."[8]

Title II of the ADA and Section 504 both require public entities to administer their services, programs, and activities for people with disabilities in the most integrated setting appropriate to their needs.[9] This requirement is known as the "integration mandate." The "most integrated setting" is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible."[10] Public entities must make reasonable modifications to policies, practices, or procedures when necessary to avoid discrimination, unless the entity can demonstrate that doing so would fundamentally alter the nature of the service, program, or activity.[11]

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[6] 29 U.S.C. § 701, *as amended*.
[7] 42 U.S.C. § 12101(b)(1).
[8] *Id.* § 12101(a)(2).
[9] 28 C.F.R. § 35.130(d) (ADA); *see also* 45 C.F.R. §§ 84.4(b)(2), 84.52(a)(3) (Section 504); *Parent/Prof'l Advocacy League v. City of Springfield* (934 F.3d 13, 18-19 (1st Cir. 2019) (holding that "the most integrated setting is defined as a setting that enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible"); *Pashby v. Delia*, 709 F.3d 307, 321 (4th Cir. 2013) (holding that both Title II and Section 504 "impose the same integration requirements").
[10] 28 C.F.R. pt. 35, app. B, at 711 (2020).
[11] 28 C.F.R. § 35.130(b)(7).

The Supreme Court addressed the general parameters of the integration mandate in the 1999 landmark case *Olmstead v. L.C.*, which holds that unjustified isolation is a form of discrimination based on disability.[12] Under *Olmstead*, states must provide community-based services to people with disabilities when three criteria are met: (a) such services are appropriate; (b) the affected people do not oppose community-based treatment; and (c) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of other people with disabilities.[13]

The Court explained in *Olmstead* that unnecessary institutionalization "perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life."[14] The Court also recognized the harm caused by unnecessary institutionalization when it found that "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."[15]

The integration mandate applies not only to people with disabilities who are currently segregated, but also to those at serious risk of segregation.[16] If a State fails to reasonably modify its service system to provide services in the most integrated setting appropriate, it violates Title II of the ADA and Section 504.[17] Courts have found that an expansion of existing services is, or is likely to be, a reasonable modification, particularly when the modifications align with the jurisdiction's own stated plans and obligations.[18] States may be required to provide reasonable modifications—such as expanding community-based services—even if that requires the state to increase the financial resources it devotes to these services.[19]

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[12] 527 U.S. 581 (1999).
[13] *Id.*
[14] *Id*. at 600.
[15] *Id*. at 601.
[16] *See, e.g., Waskul v. Washtenaw Cty. Cmty. Mental Health*, 979 F.3d 426, 460 (6th Cir. 2020); *Steimel v. Wernert*, 823 F.3d 902, 912 (7th Cir. 2016); *Davis v. Shah*, 821 F.3d 231, 263 (2d Cir. 2016); *Pashby v. Delia*, 709 F.3d at 321-22; *M.R. v. Dreyfus*, 663 F.3d 1100, 1116-17 (9th Cir. 2011), *amended on other grounds by* 697 F.3d 706 (9th Cir. 2012); *Kenneth R. v. Hassan*, 293 F.R.D. 254, 260 (D.N.H. 2013). *But see United States v. Mississippi*, 82 F.4th 387, 391-98 (5th Cir. 2023) (holding that the risk of institutionalization, without actual institutionalization, does not give rise to discrimination under Title II).
[17] *See Olmstead*, 527 U.S. at 607; 28 C.F.R. § 35.130(b)(7).
[18] *See, e.g., Olmstead*, 527 U.S. at 597; *Radaszewski v. Maram*, 383 F.3d 599, 611-12 (7th Cir. 2004); *U.S. v. Florida*, No. 12-cv-60460, 2023 WL 4546188 at *54-55 (S.D. Fla. July 14, 2023), *appeal filed*, July 17, 2023; *Haddad v. Arnold*, 784 F.Supp.2d 1284, 1304-05 (M.D. Fla. 2010); *Disability Advocates, Inc. v. Paterson*, 598 F. Supp. 2d 289, 316-19 (E.D.N.Y. 2009).
[19] *E.g.*, *Frederick L. v. Dep't of Pub. Welfare*, 364 F.3d at 487, 494-96 (3d Cir. 2004) (collecting cases).

III. Factual Findings

A. The Rhode Island Department of Children, Youth, and Families[20]

DCYF is the state agency in Rhode Island with combined responsibility for child welfare, juvenile corrections, and children's behavioral health services. DCYF is one of the four health and human services agencies under the umbrella of the Executive Office of Health and Human Services (EOHHS), which is responsible for managing and providing strategic leadership to the four departments, including DCYF. EOHHS also is designated as the single state agency responsible for administering the Medicaid program, the State's largest funding source for children's behavioral health services.

Under Rhode Island law, DCYF is the "single authority to establish and provide a diversified and comprehensive program of services for the social well-being and development of children"[21] of Rhode Island such that each child "reach[es] their full potential."[22] DCYF's obligations extend to the development of "specialized comprehensive mental health services" for children in Rhode Island, as well as "the delivery of appropriate mental health services" to children with serious emotional disturbances and "children with functional developmental disabilities."[23] State law requires DCYF to "develop and maintain" a comprehensive set of services for all Rhode Island children that supports children to live in family and community-based settings and ensures that effective services are provided in the least restrictive settings possible to prevent psychiatric hospitalization.[24] The objective of those obligations under Rhode Island law is consistent with the purposes of the federal integration mandate under the ADA, its implementing regulation, and the *Olmstead* decision.

Children may come into the care of DCYF in several ways. One way is through the Division of Family Services (DFS) if a Child Protective Services investigation makes a

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[20] The United States' investigation evaluated DCYF's compliance with federal law concerning the services provided to children with behavioral health disabilities. The United States cites Rhode Island state law in this section only to describe DCYF's comprehensive role in providing such services and not to evaluate DCYF's compliance with state law.
[21] R.I. Gen. Laws § 42-72-2(5). Rhode Island law defines the children whose care DCYF must coordinate as "any person under the age of eighteen (18)" *and* children over 18 "who continue to receive services from [DCYF] and/or who are defined as emotionally disturbed and/or as children with functional developmental disabilities." R.I. Gen. Laws § 42-72-3(2).
[22] R.I. Gen. Laws § 42-72-5(a).
[23] R.I. Gen. Laws §§ 42-72-2(2)(vi); 42-72-5(b)(24). Such persons are those up to age 21 who have continuously received DCYF services before age 18; have diagnoses of emotional, behavioral, or mental disorders persisting for more than one year; require multi-agency intervention; and whose disability has resulted in or risks out-of-home placement. *Id*.
[24] R.I. Gen. Laws §§ 42-72-5(b)(27), 42-72-5.2. *See also*, DCYF, The Division of Community Services & Behavioral Health (CSBH), https://dcyf.ri.gov/programs-and-services/behavioral-health, (last visited May 6. 2024).

determination of abuse, neglect, or dependency. Although legally in DFS custody, these children may be living with one or both of their parents, a legal guardian, a relative or unrelated foster parent, or in a congregate care setting. According to its website, the role of DFS "is to assist families in accessing the services and supports needed to ensure the safety and well-being of children in their own homes or those needed to safely return and maintain children in the family home."[25] In some cases, when that cannot be accomplished, DCYF will secure alternative placements for children, such as foster care, adoption, or legal guardianship.

Children and families may also access DCYF services through a children's behavioral health (CBH) pathway administered by the Community Services & Behavioral Health (CSBH) Division's CBH Unit. Through CSBH, parents may access behavioral health services from DCYF (including residential services) to address a child's serious emotional disturbance or intellectual or developmental disability without relinquishing custody, control, and care of the child.[26] CSBH completes a Level of Need assessment[27] for the child, and then makes referrals and coordinates in-home services/wraparound supports available through DCYF if the current home-based services do not seem adequate to meet the needs of the child and family. If CSBH has exhausted home-based solutions with the family, CSBH will refer children to residential treatment placements and participate with the family in the admission to and transition from residential treatment.

In 2016, DCYF formed a Central Referral Unit to coordinate and process referrals for congregate care placements and community-based services. DCYF contracts to provide 122 different types of services, 34 of which are considered community-based services.[28] Such services include, but are not limited to, Family Centered Treatment, Functional Family Therapy, Multi-Systemic Therapy, Trauma Systems Therapy, and Preserving Families Network. Additionally, children in DCYF's care also qualify for behavioral health services such as Enhanced Outpatient Services (EOS) and Home-Based Therapeutic Services (HBTS) under Rhode Island's Medicaid State Plan. However, most of these services are not available in sufficient quantity or intensity, as detailed below in Section V, and there are long waits for children to access such services. Furthermore, we found that DCYF is not actively monitoring the capacity or taking systemic steps to proactively address the insufficient capacity of its current network of community-based providers to fully meet the demand for various community-based services.

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[25] *See* https://dcyf.ri.gov/services/division-family-services (last visited May 6, 2024).
[26] *See* DCYF Operating Procedure 100.0330, available at https://datadcyf.ri.gov/policyregs/children_s_behavioral_healthcare_coordination.htm (last visited May 6, 2024).
[27] *See* https://dcyf.ri.gov/behavioral-health/assessments.php (last visited May 6, 2024).
[28] https://dcyf.ri.gov/services/behavioral-health/central-referral-unit (last visited May 6, 2024).

For children in its custody, DCYF offers therapeutic foster care—(TFC) —placements with families that have specialized training and receive clinical and support services to care for children with behavioral health disabilities. However, DCYF conceded that the number and variety of individuals or families willing to support children under a TFC model has greatly diminished in recent years after DCYF revised its reimbursement policies. In August 2020, DCYF revised its rate structure to allow for a tiered reimbursement methodology based on each child's acuity/level of need, but in the process also decreased rates, including the higher rate it was previously paying for individuals trained to provide TFC to children who have higher behavioral health support needs. Because the change in reimbursement policy no longer incentivized placements of children with intense behavioral health support needs, providers reported losing half of their available TFC parents.

B. Children in DCYF Care Admitted to Bradley Hospital

For the period covered by the United States' investigation—January 1, 2017, through September 30, 2022 (the "relevant period")— a staggering 527 children either in DCYF's care and custody or receiving services voluntarily through DCYF's CBH pathway were admitted to Bradley Hospital. Bradley serves only children with high-acuity behavioral and/or mental-health needs. The objective of hospitalization at Bradley is to stabilize children and adolescents who are in crisis. Bradley has three inpatient units: 17 beds in the Children's Services Unit for children ages 3 to 12 years; 34 beds in the Adolescent Inpatient Services Unit for children ages 13 to 18 years; and 19 beds in the Center for Autism and Developmental Disabilities Unit (CADD) for children between the ages of 4 and 21 years who present with serious behavioral/psychiatric disorders in additional to a developmental disability, such as autism, or intellectual disability.

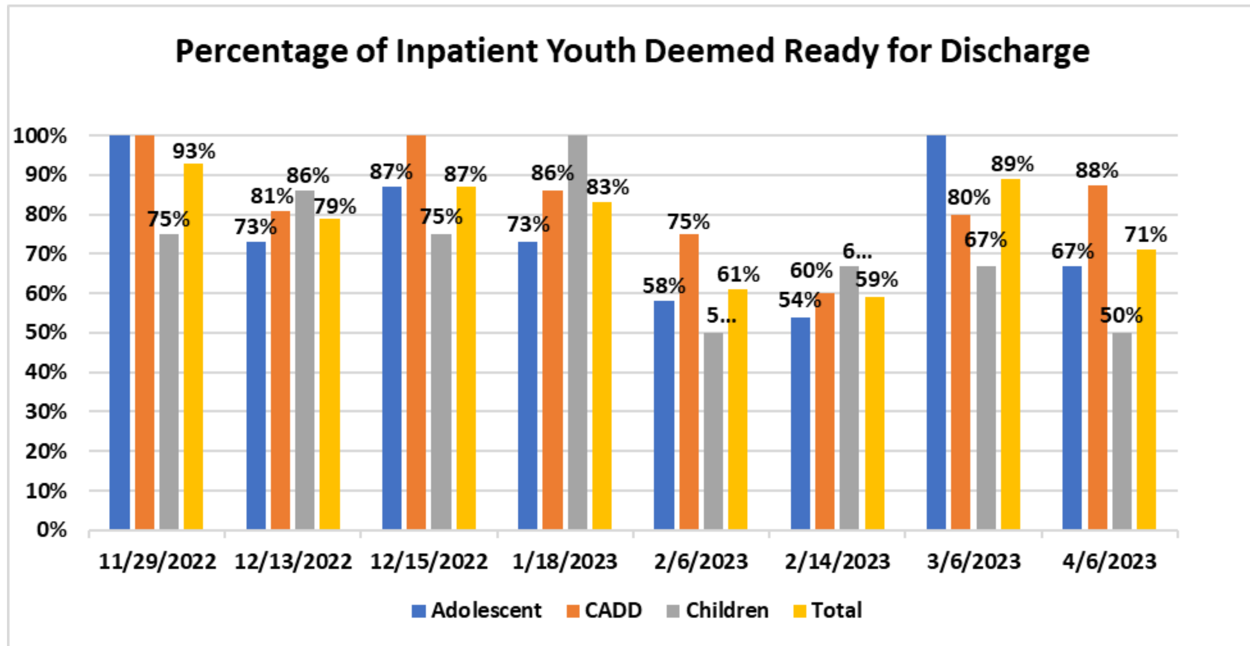
Bradley Hospital admissions are focused on providing short-term stabilization services designed to last one to two weeks. Children who are in DCYF's care, however, stay at Bradley for much longer. According to the DCYF data for children hospitalized at Bradley during the relevant period, the average length of Bradley hospitalization for children in DCYF's care was 51 days per admission. Of the 527 children admitted to Bradley during the relevant period, 116 were hospitalized in a single admission for more than 100 consecutive days; 42 were hospitalized for more than 180 days; and seven children were hospitalized for more than one year.

Nearly 40 percent, or 197 of the 527 children, were hospitalized at Bradley more than one time during the relevant period. And 129 of those children were re-hospitalized at Bradley fewer than 30 days after being discharged. Because many children had multiple admissions within that time frame, the average total time spent admitted to Bradley Hospital was 92 days per child. One child who was first admitted at nine years old spent a total of 826 days admitted across five admissions within the time frame. Another child who was first admitted at fourteen years old had eleven separate admissions totaling 706 days within the time frame. There were also five patients who were only four years old at the time of their first admission, one of whom spent 126 days hospitalized across four admissions within the five-year time frame.

C. Inadequate Discharge Planning for Hospitalized Children and Access to Community Based Services

As noted, the goal of hospitalization at Bradley is to stabilize a child in crisis and then discharge the child to a less restrictive care setting that will meet that child's needs. DCYF is responsible for coordinating discharges of children in its care and custody from Bradley Hospital to placements with appropriate services in less restrictive settings. Although DCYF contends that it starts planning discharges upon a child's admission to Bradley, and that its personnel are continually having discharge planning discussions both internally and with Bradley personnel, we found that DCYF's discharge planning consisted merely of making referrals for placements and services, with little to no evidence of efforts to identify, expedite, prioritize, or facilitate the needed post-discharge services.

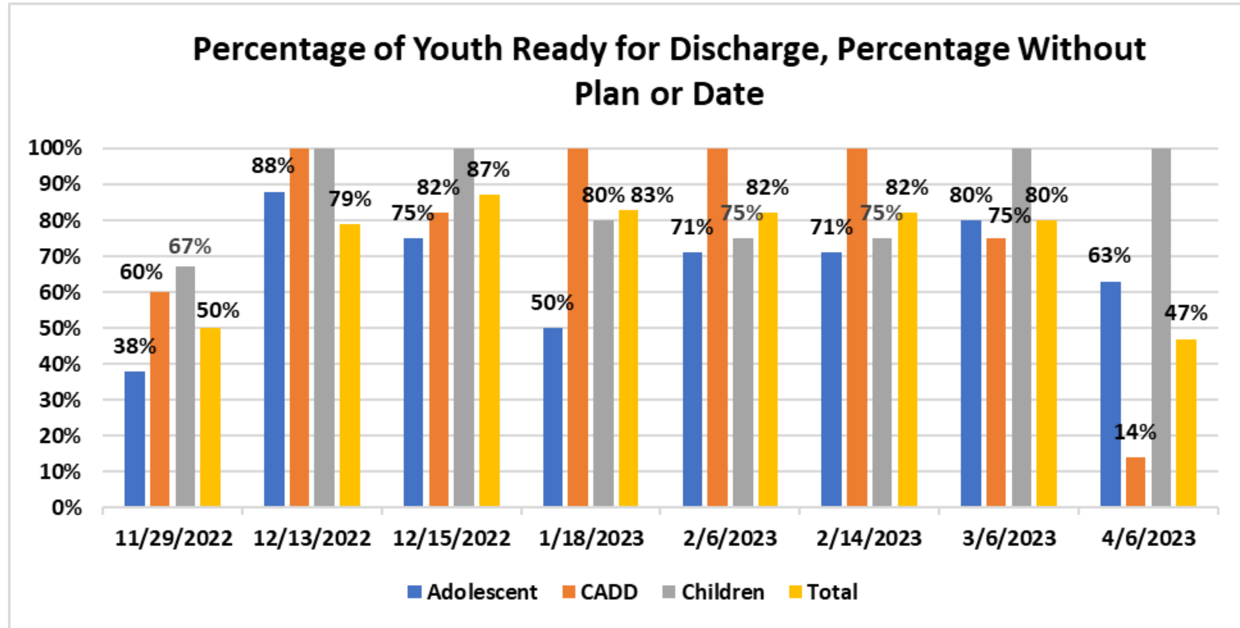
In November 2022, several months after the United States opened its investigation, DCYF began internally reporting the number of children hospitalized at Bradley's Adolescent, Children's, and CADD Units, and how many of those children were deemed ready for discharge but awaiting post-discharge services, as of the date of each internal report. As the following chart shows, during the reporting period, between November 29, 2022, and April 4, 2023, the vast majority of children were deemed ready for discharge but remained hospitalized at Bradley while awaiting post-discharge services.



Percentage of Inpatient Youth Deemed Ready for Discharge

Dates	Adolescent	CADD	Children	Total
11/29/2022	100%	100%	75%	93%
12/13/2022	73%	81%	86%	79%
12/15/2022	87%	100%	75%	87%
1/18/2023	73%	86%	100%	83%
2/6/2023	58%	75%	50%	61%
2/14/2023	54%	60%	67%	59%
3/6/2023	100%	80%	67%	89%
4/6/2023	67%	88%	50%	71%

The data also revealed that the majority of the children who were hospitalized did not have any concrete plan for discharge services despite being deemed ready for discharge.



Out of Youth Ready for Discharge, Percentage Without a Plan or Date

Dates	Adolescent	CADD	Children	Total
11/29/2022	38%	60%	67%	50%
12/13/2022	88%	100%	100%	79%
12/15/2022	75%	82%	100%	87%
1/18/2023	50%	100%	80%	83%
2/6/2023	71%	100%	75%	82%
2/14/2023	71%	100%	75%	82%
3/6/2023	80%	75%	100%	80%
4/6/2023	63%	14%	100%	47%

DCYF does not plan for hospital discharges in a way that places children in the most integrated setting appropriate to meet their needs. DCYF's failure to look for placements in a family home leads both to delayed discharges and to inappropriate placements post-discharge, which, in turn, often leads to subsequent hospitalizations. DCYF issues referrals for hospitalized children in a rapid-fire, haphazard manner without regard to providers' specializations or capacities. DCYF files show that, instead of finding the appropriate placement for the child's needs, DCYF issued the same six to eight referrals for most children regardless of an individual child's behavioral health needs. Many of the children languishing at Bradley and ready for discharge remained there because the referral agency declined the DCYF's referral for services because the agency's services were not appropriate for the level of care that the child needed.

As DCYF's own records reveal, what drives its referral decisions is mere availability of resources rather than the appropriateness of the setting.

In some cases, although DCYF plans for services post-discharge, the agency fails to effectively communicate and coordinate those plans with the families and providers. Some families were referred to EOS when their child was ready to leave the hospital, but were not informed until after discharge that the waitlist for EOS was several months long. Children discharged from Bradley have appeared on providers' doorsteps accompanied by referral paperwork even though the provider never received any prior notice of the referral. For example, one provider reported that DCYF brought an adolescent female to the provider for a foster home placement late at night. DCYF, however, had not identified or made any referrals for behavioral health services and supports for the child post-discharge. In the absence of any accompanying community-based services, the child's level of need exceeded what the foster care placement could provide. Instead of locating community-based services for the child so that she could remain in the foster setting, DCYF diverted the child to a congregate care residential setting.

Due to this lack of planning and coordination, children's discharges are delayed. Furthermore, they are at increased risk of re-hospitalization upon discharge. Keeping a child hospitalized for an extended period when their needs could be served in a less restrictive and more integrated setting only serves to exacerbate the child's acute needs, and children with extended stays experience a much more difficult time during their hospitalization. The medical records demonstrate this point: the longer children stay at Bradley, the more their behavior deteriorates. The records show that extended hospitalization often traumatizes the children as well as their families.

IV. DCYF Violates the Integration Mandate of the ADA and Section 504.

DCYF violates Title II of the ADA and Section 504 because it fails to serve children with behavioral health needs in the most integrated setting appropriate to their needs. Children with behavioral health disabilities both in DCYF's direct care, as well as children whose families have contacted DCYF for assistance to access services, end up hospitalized at Bradley for unnecessarily long stays despite being determined ready for discharge and appropriate for a more integrated setting. DCYF's failure to appropriately plan discharges and ensure sufficient capacity of community-based services and therapeutic foster care prolongs hospitalization and leaves children at serious risk of re-hospitalization once they are finally discharged from Bradley.

A. DCYF is a public entity, and Bradley Hospital is a segregated setting.

DCYF is a "public entity" within the meaning of Title II of the ADA.[29] As a recipient of federal financial assistance from HHS, DCYF is also subject to the requirements of Section 504[30]. DCYF's services, programs, and activities, including child protective services, family services,

[29] 42 U.S.C. § 12131(1)(B).
[30] 29 U.S.C. § 794.

foster care, and children's community and behavioral health services, are thus subject to the requirements of both Title II of the ADA and Section 504.[31] DCYF is prohibited under Title II and Section 504 from discriminating on the basis of disability and must administer services in the most integrated setting appropriate to the needs of qualified children with disabilities.[32]

As a psychiatric in-patient hospital, Bradley Hospital is a segregated setting. Children hospitalized at Bradley are separated from their families and communities and rarely interact with people without disabilities, other than paid staff. Children's movements and daily activities are restricted and regimented.

B. Community-based services are appropriate for the overwhelming majority of children in DCYF care and custody who are hospitalized at Bradley.

Children in DCYF care and custody stay hospitalized for extended lengths of time, not because of medical necessity, but because of DCYF's failure to secure appropriate services to allow a child to safely live with his or her family or in another community setting.

As discussed in Section IV.C above, DCYF's own data reveals that the majority of children subjected to extended stays at Bradley were inappropriately hospitalized at Bradley well after the hospital's staff determined that they were ready for discharge. Community-based services were—and remain—appropriate for many of the children hospitalized at Bradley. In many cases, prior to admission or in the week following admission, there were referrals and recommendations for community-based services; even so, the child would stay hospitalized for several months. In other cases, treating providers at Bradley Hospital explicitly recommended that the child be referred to a therapeutic foster care placement – that is, placement with a family that has specialized training to care for children with behavioral health disabilities. In many of these cases, however, the children instead remained hospitalized for months after the recommendation was made.

For example, one child in the foster care system was hospitalized at Bradley when she was five years old. This child had been diagnosed with numerous behavioral disabilities, including PTSD from having been sexually abused at a young age, and she was admitted to the hospital after she had exhibited sexualized and aggressive behaviors towards younger children in her foster home. During her hospitalization, Bradley Hospital staff recommended to DCYF that she be discharged and transitioned to a therapeutic foster environment without other children. Records indicate the child remained at Bradley Hospital for another three months waiting for a foster home placement. Then, at age six, the child was ultimately discharged to a residential treatment facility where she was exposed to behavior of significantly older youth, which was inconsistent with what her Bradley treating providers had recommended.

[31] *See* 42 U.S.C. § 12132l; 29 U.S.C. § 794.
[32] 28 C.F.R. § 35.130(d).

C. The impacted children and their families do not oppose community-based services.

Given the choice of having their children stay at Bradley or receiving care in a family home, impacted families prefer the latter option. As one witness who works with a wide range of providers attested, and consistent with all of the parents and foster parents interviewed, families would overwhelmingly prefer to have their children at home with sufficient supports. Many providers interviewed similarly stressed that the children and families they serve prefer community-based services over hospitalization.

The reasons for these families' preference for community-based services are obvious. Children prefer the convenience, comfort, and independence of receiving services in their communities and schools, which allows them to live at home, spend time more freely with family and friends, and enjoy greater privacy than congregate-care providers can offer.

Documentation produced by DCYF during the United States' investigation contained a surprisingly limited amount of information about children's and families' preferences for care settings. In documentation recording some preference, however, children and their families unanimously preferred community-based providers. Moreover, for children in DCYF custody, DCYF's own mandate under state law is to pursue the least restrictive placement, effectuate community placements, and pursue alternatives to hospitalization.[33]

One child – who has developmental disabilities and is non-verbal – spent more than one year at Bradley Hospital. During that time, she had limited opportunities to visit with her family, made even more limited during lockdown periods due to the COVID-19 public health emergency, and no opportunities whatsoever to visit with any peers or extended family. She did not attend school during that time and never left the hospital grounds. She waited at the hospital for over a year, not because she needed hospital-level services, but because less-restrictive, community-based services that met her needs were not available. Her family was devastated that their child was living in the hospital and attempted to advocate with DCYF staff and others to have her discharged to a less-restrictive setting. After the child was finally discharged, she was able to transition to a more integrated, community-based setting with appropriate supports. While the child cannot verbalize her feelings, her parents shared that years after she was discharged, she continues to become visibly upset if she even sees Bradley through the car window in the distance, and they have to detour to avoid upsetting her.

Another youth[34] spent seven months at Bradley and described how their mental health began to regress during their hospitalization. They said that being around other adolescents exhibiting suicidal ideation actually gave them additional ideas about how to harm themself. Although in DCYF's custody, they rarely saw the DCYF worker assigned to their case, and, when they did, they pleaded with the worker to let them leave the hospital. Following seven

[33] R.I. Gen. Law § § 42-72-4(b)(14), 42-72-5.2.

[34] This youth uses they/them pronouns.

months at Bradley, the youth was sent for an *additional thirteen months* to an out-of-state residential facility. DCYF fails to ensure access to the community-based services it offers, resulting in unnecessarily lengthy and repeated hospitalizations.

DCYF is responsible for securing appropriate community-based placements for children in its care and custody. As described in Section IV, DCYF is required to develop a continuum of care that is "family centered and community based" and to "encourage the use of alternative psychiatric and other services to hospitalization."[35] However, children who are appropriate for community-based services are instead subjected to lengthy, unnecessary hospitalizations at Bradley Hospital because DCYF does not provide children with behavioral health disabilities the community-based services they need to avoid such hospitalizations.

1. Community-Based Services

The demand for community-based services for children with behavioral- and mental-health disabilities greatly exceeds the current supply, and many children require hospitalization because of the insufficient supply of community-based services in the State. DCYF itself admits that when it comes to "outpatient" care—i.e., community-based services—there are few options in Rhode Island. Moreover, of those options that do exist, waitlists are pervasive.

Prior to their admission to Bradley Hospital, several of the impacted children were on waitlists for community-based services. Records also establish that, for some of those families who did receive services prior to hospital admission, the services were of insufficient quantity or intensity. Due to their inability to access needed community-based services for their children, families turned to DCYF's CBH unit and Bradley Hospital. Once hospitalized, Bradley explicitly recommended that many of these children receive community-based care upon discharge. Yet, despite these recommendations, many children stayed at Bradley longer than necessary or entered other segregated residential facilities upon discharge because there were too few community-based clinical services available to support the children when they returned home. When a child is discharged to a setting that is not appropriate to meet her behavioral health needs, she is often later re-hospitalized.

Current DCYF-contracted providers offering long-term, intensive, high-acuity, community-based care do not serve a sufficient number of children to avoid the unnecessary hospitalization of children in the focus population. For those home and community-based services that do exist in Rhode Island, there are fewer providers who possess the specialized training necessary to provide the intense behavioral health supports needed by the focus population. For various community-based programs, the State has failed to ensure adequate reimbursement rates for providers of home and community-based behavioral health services. The insufficient funding, in turn, has led to providers being unable to meet demand for community-

[35] R.I. Gen. Laws §§ 42-72-5(b)(27); 42-72-5.2, and Section III of this Report.

based services, resulting in gaps in the service array and extended waits for behavioral health services. DCYF has not leveraged federal funds or resources across state agencies to invest in building the capacity of providers to support youth with intense behavioral support needs. Additionally, DCYF has not implemented alternative strategies to prevent hospitalizations or accelerate placements of the focus population, resulting in an overreliance on extended hospitalizations at an acute-care psychiatric hospital.

One exception to these deficiencies has been the State's contract with two service providers to establish a statewide Mobile Response and Stabilization Services Program in November 2022. Mobile crisis services reduce the number of families who call 911 during a crisis and then have their child hospitalized. While this is a constructive step, this program is only starting to fill what has been previously described as an utter void in crisis services for children with behavioral-health disabilities during the relevant period.

2. Therapeutic Foster Care (TFC)

For those children who are in DCYF care and custody, DCYF fails to maintain an adequate network of TFC placements. As the records for several children hospitalized at Bradley demonstrate, Bradley made recommendations to DCYF to discharge children to therapeutic foster care settings in the community. Despite those recommendations, however, DCYF either chose not to seek such placements or could not find placements due to a shortage of available therapeutic foster care placement options. In all of the cases reviewed with such recommendations, the children remained at Bradley Hospital for months while waiting for a TFC placement, then DCYF placed the child in a residential treatment facility.

As described in Section IV.A, revisions to DCYF's reimbursement policies have shrunk the population of families willing to accept foster-care placements—one of the most significant sources of community-based services for children with behavioral health disabilities. As a result of this decreased network of TFC placements, children who could be served in family homes with therapeutic foster care families have instead remained hospitalized at Bradley. Further, when children are finally discharged, they are often transitioned to residential settings, that are more restrictive than what the child needs or lack the capacity to support children with intense behavioral support needs, thus ultimately placing these children at risk of re-hospitalization.

D. DCYF could make reasonable modifications to care for children in a family home setting, and to minimize the frequency and length of hospitalizations.

States must reasonably modify their service systems to avoid discrimination on the basis of disability.[36] DCYF could reasonably modify its existing community-based programs, without fundamentally altering its current system, to prevent unnecessary segregation of children with behavioral health needs at Bradley. Such modifications would allow children to live and thrive

[36] 28 C.F.R. § 35.130(b)(7)(i); *Olmstead*, 527 U.S. at 603, 607.

with their own families or in a therapeutic foster home instead of entering or remaining in Bradley Hospital just to access appropriate care.

DCYF already offers a service array to meet a range of behavioral health needs and to prevent unnecessary and prolonged hospitalizations. According to DCYF's website, CSBH encourages services to prevent hospitalization and maintains a comprehensive system of care to ensure effective services are provided in the least restrictive setting that is clinically appropriate.[37] As discussed above, community-based services, mobile crisis services, and therapeutic foster care are accessible to some children. But the reality is that these existing programs are limited in scope to address the children who languish at Bradley Hospital ready for discharge but with no appropriate and available community services to effectuate a safe transition.[38] EOHHS and DCYF have acknowledged the importance of behavioral health services for children in preventing hospitalizations and the limited existing capacity. DCYF is collaborating with EOHHS to leverage federal funds to support the expansion of a number of community-based service models. They have also expressed an intention to expand existing programs and expansion of existing state programs is a reasonable modification, especially when such programs are consistent with the jurisdiction's plans and obligations.[39]

Rhode Island spends significant resources on hospitalization for children with behavioral health disabilities. In just one fiscal year, July 1, 2020 – June 30, 2021 (FY 2021), the State spent over $13.6 million in Medicaid dollars on psychiatric hospitalizations for children in DCYF care. During FY 2021, the State spent nearly $27 million on residential treatment facilities for children in DCYF care. Because community-based services are less expensive than hospitalizations and residential services, shifting spending toward community-based services is both reasonable and more cost-effective. Beyond yielding more positive long-term health and quality of life outcomes, home and community-based placements also cost less over time than institutional care. With respect to the impacted population and costs associated with various residential placements in FY 2022, in-state residential treatment facilities can cost as much as $990 per placement per day, versus $48 to $125 per day for therapeutic foster care placements depending on acuity/tier level.[40] Intensive home and community-based services, such as Multi-Systemic

[37] DCYF, The Division of Community Services & Behavioral Health (CSBH) (last visited May 6, 2024), https://dcyf.ri.gov/programs-and-services/behavioral-health.

[38] *See Olmstead*, 527 U.S. at 603 n. 14 ("States must adhere to the ADA's nondiscrimination requirement with regard to the services they in fact provide.").

[39] *See Olmstead*, 527 U.S. at 603 n. 14 ("States must adhere to the ADA's nondiscrimination requirement with regard to the services they in fact provide."); *see, e.g., Henrietta D. v. Bloomberg*, 331 F.3d 261, 280-81 (2d Cir. 2003) (upholding as a reasonable modification an order requiring agency to follow existing law and procedures); *Haddad v. Arnold*, 784 F. Supp. 2d 1284, 1304-05 (M.D. Fla. 2010) (providing a service already in a state's service system to additional people is not inherently a fundamental alteration).

[40] *See* Milliman Client Report, Social and Human Service Programs Review: Reimbursement Rates, R.I. Office of the Health Insurance Commissioner (Mar. 29, 2023), available at

Therapy, Preserving Family Networks, and Functional Family Therapy ranged from $41 to $179 per day.[41] The national median for such costs for mental health services alone in psychiatric hospitals is $376 to $416 a day depending on acuity.[42] With respect to costs specific to Bradley Hospital, the daily rate for room and board (without costs for professional services) in its Children's and Adolescent Units is reported at $2,750 per patient.[43] Decreasing the reliance on hospitalizations as well as the length of stay could save the State millions of dollars every year, which could be reinvested back into building out increased community-based options and services for the focus population.

Moreover, taking these remedial measures would be consistent with the State's obligations under the Early, Periodic Screening, Diagnostic, and Treatment Services (EPSDT) provisions of the Medicaid Act because the services in question are medically necessary.[44] Pursuant to those provisions, the State has a separate legal obligation to provide children under the age of 21 with mental health screening tests to detect potential problems and identify any coverable services necessary to correct or ameliorate a mental illness or condition, regardless of whether that service is included in its State Plan or Medicaid Waiver programs.[45] This EPSDT obligation is broad, requiring Rhode Island as a Medicaid participant to provide all coverable medically necessary services, including in-home and community-based behavioral health treatment, to children in the Medicaid program.[46] The State also has the legal obligation to assure prompt, reasonable statewide access to community-based services provided under its Medicaid State Plan to everyone who meets Rhode Island's Medicaid eligibility criteria.[47] Though Rhode Island's Medicaid program includes some community-based services, as noted above, many

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https://ohic.ri.gov/sites/g/files/xkgbur736/files/2023-03/Social%20and%20Human%20Service%20Programs%20Review%20Report%201.pdf.

[41] *Id.*

[42] Journal of Hospital Medicine, Costs and Reimbursements for Mental Health Hospitalizations at Children's Hospitals, at 4 (Dec. 2020) available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8034672.

[43] *See* Bradley Hospital Charge Data, available at https://www.lifespan.org/patients- visitors/insurance-billing-and-financial-assistance/cost-care-and-price-transparency.

[44] 42 U.S.C. § 1396d(r)

[45] *See id.* § 1396d(r)(5).

[46] *Rosie D. v. Romney*, 410 F. Supp. 2d 18, 52-53 (D. Mass. 2006) ("[T]he EPSDT provisions of the Medicaid statute require, by their very language, comprehensive assessments of children with SED [serious emotional disturbance] . . . the EPSDT provisions of the Medicaid statute require provision of adequate in-home behavioral support services for SED children"); *see also* U.S. Department of Health and Human Services, Center for Medicaid and CHIP Services, CMCS Informational Bulletin: Leveraging Medicaid, CHIP, and Other Federal Programs in the Delivery of Behavioral Health Services for Children and Youth, at 3, 7 (Aug. 18, 2022), https://www.medicaid.gov/sites/default/files/2022-08/bhccib08182022.pdf.

[47] *See* 42 U.S.C. § 1396a(a)(8) (with reasonable promptness); 42 U.S.C. § 1396a(a)(1) (statewide); *see also* 42 C.F.R. § 435.930; *id.* § 431.50.

children in DCYF care and custody who need the services to avoid hospitalization cannot access them in sufficient intensity to meet their needs. Thus, it is a reasonable modification for the State to provide these services in the amount medically necessary, given the State's pre-existing obligation under the Medicaid program.

V. Recommended Remedial Measures

To remedy these findings, the State could serve children in the most integrated setting appropriate to their needs and comply with Title II of the ADA and Section 504 by reasonably modifying its service system. Remedial measures should include:

- Ensuring that existing community-based services, including intensive in-home and community services, crisis services, and therapeutic foster care, are accessible and available in sufficient quantity and intensity to prevent unnecessarily lengthy and repeated hospitalizations at Bradley; and

- Improving discharge planning to facilitate prompt discharge to the most integrated setting appropriate.

The proposed modifications are inherently reasonable because they build on DCYF's existing framework for providing services and align with DCYF's stated goals and existing obligations, including state law.[48]

VI. CONCLUSION

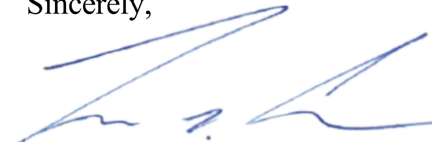
For the foregoing reasons, we conclude that the State fails to provide services to children with behavioral health disabilities in the most integrated setting appropriate to their needs, in violation of the ADA and Section 504. Because of deficiencies in its community-based service capacity and discharge planning and the way DCYF administers its children's behavioral health system, the State unnecessarily segregates children at Bradley Hospital rather than providing services in children's home and communities. Furthermore, DCYF's failure to coordinate and ensure appropriate discharge placements and access to needed community-based services places children at serious risk of re-entering the hospital and becoming segregated there again.

We look forward to working cooperatively with DCYF to reach a consensual resolution of our findings. We are obligated to advise you that if we are unable to reach a voluntary resolution, the United States may take appropriate action, including initiating a lawsuit, to ensure the State's compliance with the ADA. Please contact Amy Romero, Assistant U.S. Attorney,

[48] *See* Section IV(A); *see also Henrietta D.*, 331 F.3d at 272.

within ten days of receiving this letter if you are interested in working with the United States to reach an appropriate resolution along the lines described above.

Sincerely,



ZACHARY A. CUNHA
United States Attorney

MELANIE FONTES RAINER
Director, HHS Office for Civil Rights

cc: Richard Charest, Secretary, Executive Office of Health and Human Services