HEALTH AFFAIRS

ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D.C. 20301

25 July 1983

BEFORE THE OFFICE OF THE ASSISTANT
SECRETARY OF DEFENSE (HEALTH AFFAIRS)
UNITED STATES DEPARTMENT OF DEFENSE

Appeal of

OASD (HA) File No. 83-15
FINAL DECISION

This is the FINAL DECISION of the Acting Assistant Secretary of Defense (Health Affairs) in the CHAMPUS Appeal OASD (HA) File No. 83-15. It is issued pursuant to the authority of 10 U.S.C. 1071-1089 and DoD 6010.8-R, chapter X. The appealing party is , a Residential Treatment Center (RTC) for adolescents. The appeal involves the 1979 termination by OCHAMPUS of as an authorized CHAMPUS provider for failing to meet the CHAMPUS standards and qualification requirements for psychiatric residential treatment centers serving children and adolescents. The Hearing File of Record, the verbatim transcript of testimony presented at the hearing, the Hearing Officer's Recommended Decision and the Analysis and Recommendation of the Director, OCHAMPUS have been reviewed. It is the Hearing Officer's recommendation that the CHAMPUS First Level Review Determination be upheld. That determination, in turn, upheld the initial OCHAMPUS decision to terminate as an authorized CHAMPUS provider. The Director, OCHAMPUS concurs in this Recommended Decision and recommends that it be adopted as the FINAL DECISION. The Acting Assistant Secretary of Defense (Health Affairs), after due consideration of the appeal record, substantially accepts the Hearing Officer's Recommended Decision.

The FINAL DECISION of the Acting Assistant Secretary of Defense is therefore to sustain the termination of as an authorized CHAMPUS provider. This FINAL DECISION is based upon the appeal record as stated above.

The record in this case is by far the most voluminous compiled in any CHAMPUS appeal to date. The verbatim hearing transcript totals 1,590 pages, and the documentary hearing exhibits total many more than one thousand documents. The Hearing officer's recommendation consists of 71 single spaced type-written pages, plus several pages of exhibit indices. Because of these unique factors, this FINAL DECISION will not follow the usual course of discussing the factual background, issues and findings of fact in detail. Rather, because the Hearing Officer's Recommended Decision is substantially adopted as the FINAL DECISION it is being incorporated herein and is attached as a part hereof.

What follows is intended to augment or supplement the Recommended Decision and to discuss those issues which require additional elaboration or comment. The recommendation of the Hearing Officer on one issue has been rejected herein.

FACTUAL BACKGROUND

, which was established in 1973, became a CHAMPUS approved provider in 1974. It is a residential program primarily intended to redirect the lives of troubled adolescents. Most of the juveniles treated at have been involved in legal difficulties and many are referred to as a direct result of court proceedings. The record documents that many of the juveniles placed in programs are hard to place or hard core delinquents for whom the only alternative is some form of institutionalization.

The methods employed by include a residential program in which youths live together in group homes, wagon trains, wilderness training and other unique outdoor oriented experiences, which are provided in various combinations. The program is perhaps most notable for its wagon train program which has received a good deal of attention in the national press, including a Life Magazine story and a CBS Reports television special which are included in the hearing record.

The various programs administered by are the vehicle for what acknowledges is a unique approach to dealing with troubled youth. The program philosophy is derived in part from American Indian traditions which included a rite of passage or " " for Indian youth. youth experience a similar severe physical and emotional challenge in the form of wilderness survival training or wagon train adventures. Certain ceremonies and rites are also incorporated which are intended to impress upon the youth the significance of the challenges they meet and the accomplishments they make in the program.

Most CHAMPUS beneficiaries were involved in the residential program. Therein, a number of youths live together in a residential setting with a staff member who is designated as house-parent. Additional staff serve as youth counselors, family counselors and treatment directors. A full-time staff psychiatrist has usually been associated with

treatment methods center around milieu therapy. There is little formal, scheduled individual or group psychotherapy provided. Rather, houseparents and other staff provide a milieu in which an individual's problems are addressed as they manifest themselves within the group. Strict conduct and performance standards are established. When an individual deviates from those standards, he or she is confronted by staff and other residents in an attempt to obtain an immediate resolution of the aberrant behavior. Such confrontations often involve very close physical proximity to the youth coupled with

loud speaking or shouting. Actual physical contact occurs but usually only in effort to control a youth who reacts physically to the confrontational episode. In this manner youths are forced to deal with their behavior in an immediate and emotionally charged confrontation with authority.

was initially certified as a CHAMPUS provider during a period in which there were literally hundreds of CHAMPUS authorized residential treatment centers. These ran a spectrum from well established and prestigious institutions to what an OCHAMPUS witness characterized as small "mom and pop" operations. In addition, CHAMPUS had. relatively few standards for certifying or evaluating such institutions. As a result CHAMPUS came under increasing pressure from Congress and the Department of Defense to control the costs of adolescent residential treatment and insure the quality of care being provided to CHAMPUS beneficiaries. Consequently, in 1976 CHAMPUS developed and implemented program standards for RTC's.
began its participation with CHAMPUS under those standards at that time. In 1977 CHAMPUS promulgated DoD 6010.3-R which more specifically defined the CHAMPUS psychiatric benefit and established the CHAMPUS standards for psychiatric residential treatment centers with a regulatory basis. The standards were published as an appendix to the Regulation. As a result of the promulgation of these standards, there was an immediate "weeding--out" of many facilities which could not meet the standards. For example, the standards require that a facility De certified by the Joint Commission for the Accreditation of Hospitals (JCAH). Immediately, all facilities that could not meet this requirement lost CHAMPUS authorization. In addition, in 1977, CHAMPUS began a series of on-site surveys of residential treatment centers to insure compliance with the newly published standards.
experienced such a survey in September, 1977.

The OCHAMPUS concern for compliance with the CHAMPUS standards stems from early 1977. At that time questions about the credentials of individuals providing primary psychotherapy and the quality of the treatment records maintained by were raised. Discussion resulted in an April, 1977 commitment to meet CHAMPUS standards. Dialogue between OCHAMPUS andcontinued until the eventual June, 1979 termination.

In the fall of 1977, OCHAMPUS conducted an onsite survey of
which found a number of areas of noncompliance with CHAMPUS standards, including CHAMPUS staffing and record keeping requirements.

In early 1978 OCHAMPUS conducted a resurvey of . Most areas of concern had been resolved, with the significant exception of concern for the quality and involvement of
professional staff. Again, discussions between and OCHAMPUS ensued concerning the means by which could be brought into compliance with CHAMPUS standards. OCHAMPUS made it clear that a number of specific staff positions

would have to be upgraded to the level of certified therapists. It was also emphasized that merely hiring qualified people alone would not be sufficient.
would have to insure that these qualified people would have significant direct involvement in the treatment of patients and in the supervision of primary treatment staff. The record confirms that these requirements represented a significant modification in the treatment approach, which relied heavily on the use of "child care specialists" who lacked professional qualifications and whose primary training was received on-the-job at .

The record documents that subsequently took a number of steps to improve the quality of its treatment staff. These consisted primarily of recruiting and hiring of new staff members. OCHAMPUS resurveyed in November, 1978. Again, significant deficiencies in the qualifications of professional staff providing primary therapy were found. As a result of these resurvey findings in early 1979, was given its choice of two reorganizational options. First, retain present organization but upgrade all family counselor positions to the level of certified therapists. Second, reorganize by upgrading the qualifications of treatment directors and shift the responsibility for primary therapy from the family counselors to them. In the view of OCHAMPUS the second option, which was the one chosen by represented a major shift in organization and program emphasis.

Shortly after these developments OCHAMPUS became aware of a number of serious allegations raised against the program. Those allegations had essentially three sources: newspaper articles appearing in the Arizona Daily Star, a Tucson newspaper; reports provided by U.S. Army officials at Fort Huachuha, Arizona, primarily dealing with the complaints relating to the case of a single CHAMPUS beneficiary enrolled at
and preliminary findings of a Defense Audit Service report dealing with certain financial aspects of CHAMPUS psychiatric benefits. These sources raised serious allegations concerning treatment program, staffing and financial practices. In response to these allegations OCHAMPUS conducted another onsite visit and a fact-finding survey which essentially confirmed the allegations. Consequently, OCHAMPUS immediately suspended ccst-sharing of new admissions and requested to show cause why it should not be terminated as an authorized CHAMPUS provider.
responded to the OCHAMPUS allegations, and a discussion meeting was held in May 1979. OCHAMPUS did not find that responses adequately resolved the issues which had been raised and therefore terminated authorized provider status on June 11, 1979. A right of appeal of the OCHAMPUS termination decision was extended in the termination letter. It is as a result of exercise of those appeal rights that this case is now before the Assistant Secretary of Defense (Health Affairs) for a FINAL DECISION. The OCHAMPUS Formal Review Decision upholding the initial termination was issued in June, 1980. Upon further appeal a hearing was held in Tucson, Arizona, before an independent Hearing Officer in April

and June, 1982. It is the Recommended Decision isssued as a result of that hearing that we now adopt: as the agency's FINAL DECISION.

ISSUES AND FINDINGS OF FACT

The Hearing Officer correctly identified the principle issue as relating to the "……nature of the psychiatric treatment program provided by for CHAMPUS beneficiaries, and whether those services adequately complied with the requirements of the CHAMPUS regulation governing the eligibility of a provider to serve as a Residential Treatment Center...." The Hearing Officer appropriately discussed the evidence of record on this issue at great length. His recommended finding on this issue is that " did not in June, 1979 provide an acceptable medical/psychiatric program for youth so as to qualify for continuation as an OCHAMPUS approved Residential Treatment Center for children and adolescents." He concludes, therefore, that the OCHAMPUS "action to terminate as an authorized provider was warranted and proper" and recommends that the initial termination and Formal Review Decision be affirmed. I concur with the findings, recommendations and rationale of the Hearing officer on the primary issue and hereby adopt them as the agency FINAL DECISION.

There is one detail in the Hearing Officer's discussion of the evidence considered which requires clarification. In his summary of the position on page 9 of the Recommended Decision, the Hearing Officer makes the following statement: "The Defense Audit Service investigators examined very closely the confrontation approach used by , and the psychiatrist who participated in that investigation determined that use of confrontation was appropriate." I do not find that this statement accurately represents either the position or the evidence of record. The record does document an investigation of by the Arizona Department of Economic Security (DES), which included a review of the treatment program. The Defense Audit Service (DAS) inquiry was limited to claims submission and payment practices and other financial_ matters. There was likely a confusion in the acronyms for these two agencies (DAS vs. DES) which resulted in this error in the Recommended Decision. I find that the Hearing Officer intended to refer to the Arizona Department of Economic Security in making the statements quoted above.

ANCILLARY ISSUES

The Hearing Officer separately addressed the thirteen specific issues which had been identified by OCHAMPUS and as being germane to the termination of by OCHAMPUS. Twelve of these were identified by OCHAMPUS as reasons for the termination of . The thirteenth issue was identified by as relating to alleged malevolent motives on the part of OCHAMPUS in the termination. Some of these issues will be discussed separately herein.

l. Most Favorable Rate

OCHAMPUS cited for violating its participation agreement by charging a lower rate to the Arizona Department of Economic Security (DES) than to CHAMPUS. The participation agreement required that CHAMPUS beneficiaries be billed at the facility's most favorable rate, i.e. no higher than the lowest rate charged to any other category of beneficiary. The evidence of record establishes that billed CHAMPUS beneficiaries at a rate higher than that which was afforded to beneficiaries of the Arizona Department of Economic Security it violation of the participation agreement. The explanation proffered by was that for a number of years DES had been underfunded by the State of Arizona, and State funding was not adequate to meet the costs of providing care to DES children.

The record also substantiates that was involved with others in the successful litigation of this matter with the State. Based upon the evidence of record, I find that violated the participation agreement by not providing CHAMPUS the most favorable rate. I also find, however, that there were mitigating circumstances which would likely have warranted OCHAMPUS granting a waiver of the most favorable rate requirement in the participation agreement in this particular situation. The record does not document that such a waiver was requested by prior to the termination by OCHAMPUS. For this reason I have determined to accept the Hearing Officer's recommendation that the finding on this issue be in favor of . I do not, however, accept the Hearing officer's rationale for this finding. He based his recommendation upon findings (1) that DAS audits of CHAMPUS management of fiscal relationships with RTC's had found shortcomings and (2) another RTC had been allowed by OCHAMPUS to similarly violate its participation agreement without specific corrective action. Absent the mitigating circumstances described above, neither of these rationale would warrant a finding in favor of . The actions taken by OCHAMPUS to enforce the most favorable rate provision represented action corrective of the kind of shortcoming complained of in the DAS audit. Also, it would not be correct to excuse the wrongdoing of one offender simply because another offender had not similarly been held accountable.

2. Waiver of Beneficiary Cost-Share

OCHAMPUS had also alleged that had frequently adopted a policy of waiving beneficiary cost-share in violation of CHAMPUS regulations and policy. The Hearing officer recommended that this issue be dismissed primarily because of findings of the Defense Audit Service that such practices were widespread among residential treatment centers and that OCHAMPUS had not been sufficiently vigorous in enforcing cost-share requirements. DAS also made a number of recommendations as to the approaches it believed appropriate in enforcing the cost-share requirement. These DAS findings and recommendations became the subject of considerable debate within OCHAMPUS and the Office of the Secretary of Defense. Subsequent to the termination of

, the enforcement of cost-share collection requirements was relaxed pending a thorough study of this issue. This study has resulted in a renewed determination vigorously to enforce the cost--share requirements of the CHAMPUS law and regulations. Because of the unsettled nature of the Department of Defense policy with respect to cost-share requirements at the time of and subsequent to the termination of , I have determined to accept the Hearing Officer's recommendation that this issue be dismissed for the purposes of this appeal. However, I do not accept his rationale that this dismissal should be predicated upon a finding that cost-share violations were widespread among residential treatment centers and action had not been taken to amend regulations to provide a more equitable system.

The DAS finding of widespread violations has been helpful in identifying areas requiring enforcement emphasis. OCHAMPUS Vas at the time of the termination and is currently empowered to enforce the cost-share requirement and take appropriate action when violations occur. These actions include the recovery of CHAMPPUS benefit funds when it is determined that cost--share violations have resulted in increased program costs. While for sound policy reasons a number of DAS audit recommendations for regulatory changes have not been adopted, the Department of Defense is committed in its resolve to conserve program resources through the vigorous enforcement of cost--share requirements. DAS audit findings and recommendations do not in themselves establish program policy and should not be viewed as weakening the existing authority to enforce program requirements.

3. Camping

DoD 6010.8-R specifically excludes "all camping even though organized for a specific therapeutic purpose ... and even though offered as a part of an otherwise covered treatment plan or offered through a CHAMPUS approved facility. On the basis of this authority, CHAMPUS has not approved the Wagon Train and other similar programs. CHAMPUS also excluded payment for the survival experience which is a part of the residential program. OCHAMPUS alleged that had improperly billed CHAMPUS for periods of time in which CHAMPUS beneficiaries were away from the residential facility. These episodes were frequently not shown on the claims and supporting documents submitted to CHAMPUS. The evidence of record supports this allegation, and it was not substantially disputed by

The major dispute on this issue revolves around the definition of "camping." has maintained that their wilderness experience should not be considered "camping" but rather a "therapeutic absence." Therapeutic absences are generally considered to be those which take a patient away from the control and custody of an inpatient facility, i.e. home visits. The wilderness experience does not fall into this category. Beneficiaries on a wilderness experience are away from the residential facilities but remain

In the control and custody of staff who accompany them on the experience. Irrespective of this, however, the Regulation specifically excludes therapeutic absences of longer than 12 hours in duration. Therefore, even if the wilderness experience could qualify as a "therapeutic abscnce," it would be excluded under that provision because it exceeds 72 hours in duration.

alternatively asserted that the wilderness experience should not be considered "camping" in the context of the CHAMPUS exclusion. In connection with this issue requested the "OCHAMPUS definition" of camping in one of its prehearing interrogatories. The OCHAMPUS response is as follows:

> OCHAMPUS has not published an official definition of "camping." However, in t--he context of a residential treatment setting camping would generally be considered to be an outdoor overnight -activity arranged for the patients by the facility as part of the facility program, which usually takes place away from the facility's home base.

I find this definition to be a reasonable interpretation and application of the term in the context of the CHAMPUS exclusion.

argued that the camping exclusion should not apply to the wilderness program because it was considered to be an essential and highly therapeutic part of the overall modality employed by .I agree that this experience is an important part of the program. It provides a central or pivotal experience which is the focus of much of the program's philosophy. It is, in the words of the Hearing officer, "no summer camp or vacation experience." However, these factors are not determinative of the issue. The question to be resolved is whether in the context of the CHAMPUS exclusion this program element is considered to be "camping" irrespective of its significance or therapeutic intent or content. There has been much professional debate as to the therapeutic value of camping or wilderness programs. CHAMPUS has chosen to exclude them as a program benefit, and I find that the wilderness program falls within that exclusion. For this reason I do not accept the Hearing officer's recommendation on this issue. The Hearing officer's rationale appears to be based upon a finding that the program does not equate to a "summer camp or vacation experience" and that it is an integral part of the treatment modality. While I agree with these conclusions, I do not agree that a finding in favor of flows from them. The CHAMPUS exclusion specifically applies to camping programs with therapeutic purpose and content and to those which are an integral part of an otherwise covered treatment plan. It applies to the wilderness experience.

The Hearing Officer also asserts that the testimony of Dr. , the OCHAMPS Medical Director "...appears to support the Hearing Officer's conclusion that the camping exclusion ... did not properly apply to the wilderness experience. " I have reviewed that testimony. Dr. emphasized that CHAMPUS is not allowed by its regulation to pay for camping irrespective of its therapeutic content. He also discussed a number of treatment programs, including , which utilize a camping, wilderness or adventure experience as a part of a therapeutic program. He stated that a number of these programs can have real therapeutic value. He expressed reservations about the therapeutic value of the experience because of a lack of professional staff involvement. He stated that he could "probably drum up an argument for those above ... (him) that this was more than a mere camping experience, if there was an intensive level of professional psychotherapeutic staff available …….". It appears that Dr. may favor a change in the CHAMPUS regulation to allow coverage of some camping programs with sufficient therapeutic content. He did not testify that the wilderness experience or any of the other therapeutic outdoor adventure programs would qualify as exceptions to the OCHAMPUS camping exclusion. The main thrust of Dr testimony concerned his reservations about the therapeutic value of the wilderness experience because of a lack of professional psychiatric staff.

For the reasons stated, the Hearing Officer's recommendation on this issue is rejected. I find that did submit CHAMPUS claims which failed to disclose that CHAMPUS beneficiaries were away from the residential facility engaged in portions of the program which were not covered by CHAMPUS. This issue should be sustained.

4. Alleged OCHAMPUS Antagonism Toward Treatment of Children Placed in RTC's with Involvement of Courts

This is the 13th issue which was identified by and addressed at the hearing. The Hearing officer carefully considered the evidence of record and found the allegation of bias or prejudice on the part of OCHAMPUS to be without merit. I concur in the Hearing Officer's finding on this issue. OCHAMPUS and the Department of Defense are fully committed to providing maximum benefits to CHAMPUS beneficiaries within the legal regulatory and budgetary constraints imposed upon the CHAMPUS. This is true irrespective of any possible court involvement of a juvenile beneficiary. As a medical benefits program CHAMPUS continues to provide residential treatment center care to those beneficiaries who can benefit from appropriate medical care available in such facilities.

The Hearing Officer's Recommended Decision requires correction of one minor detail in this area. On page 69 of the Recommended Decision he makes the following statement: "OCHAMPUS also contended that the action of the Department of Defense in issuing a Notice of Proposed Rule Making to eliminate RTC coverage demonstrated the Department's bias." This was not a contention

of OCHAMPUS but of . Therefore " " should be substituted for "OCHAMPUS" in that sentence. The contention was rejected by the Hearing Officer and I agree. The referenced Notice of Proposed Rule Making was withdrawn after consideration of public comments. Rather than demonstrate bias, it demonstrates a willingness and flexibility on the part of the Department of Defense to respond in such areas in a manner that is in keeping with the best interests of CHAMPUS beneficiaries and is consistent with the mandates under which the program operates.

The termination of was taken, not out of bias against that program or the kind of beneficiaries treated therein, but out of concern that did not meet certain fundamental standards required by CHAMPUS for appropriate medical care. is a program which has been found to have many laudatory aspects. Its termination by CHAMPUS should not be taken as a blanket condemnation. While not qualifying as an appropriate medical or psychiatric treatment program under CHAMPUS, can provide an important alternative for troubled youth.

SUMMARY

In summary, it is the FINAL DECISION of the Acting Assistant Secretary of Defense (Health Affairs) to adopt the Recommended Decision of the Hearing Officer with the noted exceptions. It is the specific finding of the Hearing officer, adopted herein, that the OCHAMPUS action to terminate as an authorized provider was warranted and proper. Consequently, the June 11, 1979 Initial Decision terminating as an authorized CHAMPUS provider and the June 30, 1980 OCHAMPUS Formal Review Decision are affirmed. The appeal of is therefore denied. The Director, OCHAMPUS shall review the case record and take appropriate action under the Federal Claims Collection Act in regards to any CHAMPUS payments which are determined to have been erroneous under the findings adopted herein. Issuance of this FINAL DECISION completes the administrative appeals process as provided under DoD 6010.8-R, chapter X, and no further administrative appeal is available.

John F. Beary, III, M.D.
Acting Assistant Secretary

JAN 2 0 1983

RECOMMENDED DECISION

In the Appeal of:

TUCSON, ARIZONA

and
OFFICE OF CIVILIAN HEALTH AND MEDICAL PROGRAM
OF THE UNIFORMED SERVICES
AURORA, COLORADO
* * * * * * * * * * * * * * * * *

This case is before the undersigned Hearing Officer pursuant to request for hearing on the formal review determination of June 30, 1980. issued by the Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) which sustained the termination of as an authorized CHAMPUS Residential Treatment Center (RTC) originally announced in the OCHAMPUS letter dated June 11, 1979.

timely requested a hearing, which was held pursuant to Regulation DOD 6010.8-R, Chapter X, Section F, Paragraph 4, Tucson, Arizona, on April 26-29 and June 28-30, 1982. was represented by Edward A. Linden, Esq., of Tucson, Arizona. OCHAMPUS was represented by Robert L. Shepherd, Esq., of Aurora, Colorado. Post hearing briefs were timely filed by the Parties: Mr. Linden's was received by the Hearing officer on September 22 and Mr. Shepherd's on October 1, 1982.

The transcript of the hearing totals 1,590 pages; numerous exhibits were introduced by both parties at the hearing to supplement the existing appeal record of more than a thousand documents. Although it was not required to do so, OCHAMPUS furnished without charge, a complete set of the transcript for use in preparing post hearing brief.

ISSUES

The General Issue before the Hearing Officer is whether the termination of as an authorized OCHAMPUS provider (Residential Treatment Center) by OCHAMPUS on June 11, 1979, was justified by the evidence; this includes review of the facts available to OCHAMPUS during the period of April through June, 1979, plus those adduced as a result of the appeal process through June 30, 1980, when the Formal Review termination decision was announced.

The Specific Issues to be decided are those identified in the Formal Review determination letter dated June 30, 1980, signed by the Acting Deputy Director of OCHAMPUS, as follows:

1. Most Favorable Rate
2. Camping
3. Erroneous Payments and Overpayments
4. Emergency Reports and Records
5. Staff Composition and Organization
6. Staff Development
7. Patients' Rights
8. Admission, Referral and Discharge Policies
9. Assessment and Treatment Planning
10. Patient Clinical Records
11. Dietetic Services
12. Physical Plant

raised a "Thirteenth Issue" in its prehearing brief; "Did OCHAMPUS, in point of fact, systematically endeavor to undermine the Program not for the twelve stated reasons but for a reason which OCHAMPUS knew it could not attack honestly or directly: that is, did OCHAMPUS have an arbitrary and capricious antagonism toward funding the care of the types of children accepted by the Program, which prejudice has absolutely no legal foundation?"

LAW AND REGULATIONS

Regulation DOD 6010.8-R is promulgated under the authority of, and in accordance with, Chapter 55, Title 10 U.S. Code.

Because so many portions of Regulation DOD 6010.8-R are involved in this proceeding, it is preferable to list those pertinent regulatory provisions, rather than to quote them in their entirety. It is the Hearing Officer's view that the following provisions of the CHAMPUS regulations are for application in this case:

Chapter I, Section D.
Chapter II, Section B, Subsections 14, 45, 76, 101, 147, 155, and 170. Chapter IV, Section A, Subsection 1; Section B, Subsections 1 b (4) (e) and (f), and Subsection C 3 i (1) and (2). Chapter IV, Section F; Section G 67.
Chapter VI, Section A 4 a; Section B 3 a and d (2); Section B, Subsection 4 e.
Chapter X, Section C 2 b and C 3 b; Section F 16 i. Appendix A.

JURISDICTION OF THE HEARING OFFICER

This Hearing Officer was appointed by letter dated October 30, 1980, from the Chief, Appeals and Hearings of OCHAMPUS to (1) conduct a complete and fair hearing in order to give both parties an opportunity to present all their evidence relevant to the issues in this proceeding; (2) to consider carefully the evidence presented by the parties; and (3) to prepare a Recommended Decision for a resolution of the dispute herein, which decision will be made by the Assistant Secretary of Defense for Health Affairs in Washington, D.C.

The CHAMPUS Regulation, Chapter X, as implemented by the Hearing Officer's Handbook issued by OCHAMPUS on March 3, 1978, provides in Paragraph 2005:

> "Authority of the Hearing Officer. The Hearing Officer in exercising the authority to conduct a CHAMPUS hearing is to comply with Chapter 55 of Title 10, United States Code and the CHAMPUS Regulation (DOD 6010.8-R), as well as with policy statements, operating manuals, CHAMPUS handbooks, instructions, procedures, and other guidelines issued by the Director OCHAMPUS (or appropriate designee) in effect at the time the service and/or supply was provided. A Hearing officer may not establish, amend, question or challenge policy, procedures or instruction, but is to render a decision as to whether or not the initial determination in the case in question was made in accordance with said Regulation, policies, procedures, instructions, etc."

Thus, it must be noted, the Hearing Officer has no authority to consider any question as to the propriety or reasonableness of any provision of the CHAMPUS Regulation issued by the Department of Defense. Such issues may be raised only in a United States District Court.

EVIDENCE CONSIDERED

The Hearing Officer has considered all the documents described in the List of Exhibits attached to this Recommended Decision, the testimony at the hearing, the documents presented by the parties at the hearing, and the arguments of both Counsels.

SECTION I - PRINCIPAL ISSUE

Inasmuch as the preponderance of the documentary evidence submitted prior to and at the hearing, and the vast majority of the testimony at the hearing, plus the arguments presented by the parties in their post-hearing briefs, related to the question of the extent to which the program during the two years preceding June 1979 was in compliance with the OCHAMPUS Regulations concerning the nature of the medical (psychiatric) program to be administered by a Residential Treatment Center for the treatment of emotionally disturbed youth, this will be the principal thrust of this Recommended Decision. If the program did not meet the requirements of the DOD Regulations to become and maintain its status as an authorized provider of medical (psychiatric) services for dependents of active duty and retired military personnel, it is of less importance that the other allegations of violations of CHAMPUS Regulations by be established by the evidence.

Accordingly, first consideration will be given to the evidence concerning nature of the psychiatric treatment program, provided by for OCHAMPUS beneficiaries, and whether these services adequately complied with the requirements of the CHAMPUS Regulations governing the eligibility of a provider to serve as a Residential Treatment Center and receive government funds for treatment provided to the CHAMPUS beneficiaries.

Requirements For Medical Program By RTC's

The Department of Defense issued Regulation DOD 6010.8-R on 10 January 1977, as authorized by 55 USC, which described the CHAMPUS program as: "A program of medical benefits provided by the Federal Government under public law to specified category of individuals…" The remainder of the Regulation discusses the details of a health benefits program in terms that make it clear that the program is not a rehabilitation program or a social welfare program of any kind, but is intended to be solely a health benefits and medical treatment program fully paid from federal funds. The sections of the Regulation dealing with psychiatric care, and particularly Residential Treatment Centers for emotionally disturbed children make it clear that "psychiatric services" means individual or group psychotherapy; and that RTC's do not provide domiciliary and/or custodial care, but rather must be able to provide a total therapeutically-planned group living and learning situation within which individual psychotherapeutic approaches are indicated. It also provides that private RTC's must be accredited by the Joint Commission on Accreditation of Hospitals under the Commission's Standards for Psychiatric Facilities serving Children and Adolescents, and have entered into a Participation Agreement with OCHAMPUS which requires that the RTC will comply with the OCHAMPUS Standards for Psychiatric Residential Treatment Center Serving Children and Adolescents.

Thus it is clear that, to qualify as a CHAMPUS-approved RTC, a provider must furnish either individual or group psychotherapy, which is integrated into a total therapeutically planned group living and learning situation.

In Appendix A to the CHAMPUS Regulation are found the CHAMPUS Standards for psychiatric RTC's serving children and adolescents. This requires on page 4 that "Medical and psychiatric responsibility for each patient, as well as the treatment program, shall rest with the qualified psychiatrist or physician," as later described on page 7 "the staff shall include a person(s) professionally qualified to provide psychiatric services." Further, a physician must be licensed to practice in the state and be a psychiatrist with three years of experience in the assessment and treatment of children and/or adolescents having psychiatric disorders; there must be 24-hour coverage each day of the week by a psychiatrist; and the psychiatrist must play an active and continuing role in the development and monitoring of the entire treatment program, as well as the individual treatment program for each patient.

Other professional staff is required, in sufficient numbers to carry out particular goals and policies of the RTC; these include PhD Clinical Psychologists. MSW Social Workers, Registered Nurses, and other specialists who meet professional standards established in the Regulation.

Additionally, Mental Health and Child Care Staff are required in appropriate numbers for duty 24 hours each day, to provide adequate around the clock attention to the patients. Other staff are also required, to provide maintenance, dietetics and housekeeping services for the RTC's facilities.

Position of Ochampus

OCHAMPUS contended that the problems with began in September 1977, when after an onsite survey by OCHAMPUS inspectors, the Agency came close to terminating

due to major deficiencies in its medical (psychiatric) treatment program. In December, OCHAMPUS suspended new admissions for 45 days. In January, 1978, OCHAMPUS conducted a resurvey at request; most deficiencies were found corrected, except for the most important one--inadequate staffing by qualified professional personnel to conduct a medical program. The suspension was continued, and was allowed to submit a plan for compliance, with interim compliance to be achieved in 30 days and full compliance in 60 days, by March 31, 1978. In November 1978, a validation resurvey was conducted by OCHAMPUS; the surveyors found that direct patient care was still being provided and supervised by unqualified staff--the central issue of concern to OCHAMPUS all the time. Two options were then given to , to retain certification: (1) Upgrading all Family Counselors or (2) upgrading Treatment Directors. selected the second option, which required a substantial change in its organization and philosophy; thereafter, case management and therapeutic treatment would have to be shifted from Family Counselors to Treatment Directors.

In April 1979, serious questions surfaced regarding and its program, involving questionable therapy techniques, patient abuse and payment irregularities. These questions resulted from a series of newspaper articles, complaints from military sources, and an audit by the Defense Audit Service. An onsite survey was conducted, and the inspectors found that most of the allegations were accurate. Thereafter on April 5, 1979, OCHAMPUS issued an "Order to Show Cause."

On June 11, 1979, OCHAMPUS terminated as an authorized provider, because it felt had not adequately explained the allegations raised against them by the various sources.

OCHAMPUS contended that the principal issue in this case is the "non-medical nature of the program." Ancillary issues were those outlined in the list of twelve Issues set out earlier in this Recommended Decision.

In its post-hearing brief, OCHAMPUS strongly disputed the issues raised by that OCHAMPUS wanted to terminate because it had grown too big and would be more difficult to get rid of; that OCHAMPUS did not understand or approve of treatment methods; that one of the reasons of termination was that had adopted a policy of frequently waiving beneficiary cost shares; that OCHAMPUS had never "buried the hatchet" in a dispute which arose over the issue of preauthorization which affected all RTC's, but after objection by , the implementation was delayed; and the "Thirteenth Issue" resulted from a bias on the part of the Department of Defense and OCHAMPUS against the kind of patients which were treated at .

OCHAMPUS also denied having taken any improper action in the release of information to the public concerning the termination, when it released the June 11, 1979 termination letter at the request of San Diego officials. Inasmuch as the Freedom of Information Act required the release of information on Agency decisions, OCHAMPUS determined that the June 11 termination letter was releasable to the public, but ensured that the requester understood that the basis of the termination was disputed by and that the termination was under appeal, and also that a requester could. obtain additional- information if he specifically requested; but no requests for additional information were received by OCHAMPUS.

The Agency concluded that OCHAMPUS had never acted in bad faith in its dealing with and had no preconceived bias either for or against . It recognized that rehabilitation program is unique and unconventional, but believe that, because of its structure, its medical treatment practice and philosophy, and its treatment pattern, does not qualify as an OCHAMPUS authorized provider of medical care.

It concluded that the administrative record compiled in this case supports OCHAMPUS' actions, but that has attempted to direct attention away from the real issue involved by attacking the motives and integrity of OCHAMPUS, through innuendo and unsupported statements. The Agency requested that the Hearing Officer find that the termination decision in June, 1979, and the Formal Review determination in June, 1980 be affirmed, and that the Hearing Officer recommend to the Assistant Secretary of Defense for Health Affairs that appeal be denied.

Position of .

Counsel pointed out that the relationship between and OCHAMPUS in 1974 was relatively smooth for the first four years. During that time earned repeated accreditations from the Joint Commission on Accreditation of Hospitals (JCAH). Moreover, growth was tremendous, as a result of its innovative treatment approaches, its high visibility, and its "for-profit" tax stance. Thus it was intensely scrutinized by both private organizations and governmental agencies; however, except for CHAMPUS, these challenges have been won in every case, and investigators were consistently impressed by the extremely effective treatment alternatives which provided to behaviorally and emotionally disturbed youth.

After the initial dispute began with the October, 1977 onsite survey, took immediate corrective action; and requested a resurvey which was conducted during January 1978 by a staff member and an outside consultant in Child Psychiatry retained by OCHAMPUS. These surveyers found that every deficiency had been corrected with the single exception of staff composition.

contended and still contends that OCHAMPUS' Staff composition standard was vague, but it endeavored in good faith to comply with OCHAMPUS' mandate, and it instituted a vigorous recruiting program to increase the number of credentialed staff.

After the November 1978 survey, when OCHAMPUS surveyors determined that was still not in compliance with the OCHAMPUS Standards, it was the only remaining subject of dispute between the parties. As to that issue, OCHAMPUS offered two options, either of which would bring into compliance with the standards. After choosing the second option, hired new staff members and changed the positions of several staff members already employed, to meet the requirements of the second option, and by the deadline for compliance of the staff composition status all Treatment Director positions were filled by appropriately credentialed staff.

During April 1979, three OCHAMPUS officials visited Arizona to investigate after receiving a complaint about a patient named , to look into a series of newspaper articles about , which had appeared in the Arizona Daily Star, and in connection with the DAS audit

of that had been conducted shortly before. was kept in the dark about the allegations in the newspaper, and also the identity of the individuals who made them. It contended that the issue of whether had achieved compliance with the second option relating to staff composition was essentially ignored during this investigation.

Soon thereafter however, on April 25, 1979, OCHAMPUS demanded that show cause why it should not be terminated as an OCHAMPUS provider; while there were five general allegations of non-compliance with OCHAMPUS standards, the is sue of staff composition--which had theretofore been the only area of alleged non-compliance--was conspicuously absent.

Then on June 11, 1979, was terminated as OCHAMPUS provider, reportedly on the basis of five general allegations of non-compliance, which were based on unsworn statements taken from a handful of disgruntled former employees.

During the Formal Review requested by OCHAMPUS cited the twelve issues which justified OCHAMPUS' actions, and on June 30, 1980, the termination was confirmed. Thereafter requested a hearing.

contended that OCHAMPUS failed to address seriously the majority of the twelve issues, and concluded that there are only two issues which are disputed: 1) Staff Composition and 2) Confrontation Therapy.

As to staff composition, contended that the OCHAMPUS standards do not suggest the patient to professional staff ratio desired; further, OCHAMPUS survey methods were based on a high degree of subjectivity in determining compliance with the standard, "when evidence adduced at the hearing shows that had sufficient number of other professional staff to carry out the goals and policies of the treatment center." It pointed out that Dr. Eckhardt, an expert in child psychiatry and an impartial witness, should be compared with OCHAMPUS expert witness, Dr. Alexander Rodriguez, who was not Board-certified in child psychiatry nor general psychiatry, and was also not disinterested in the outcome of the case, because of his current position as OCHAMPUS Medical Director.

It pointed out that when Dr. Eckhardt signed the January, 1978, survey report, he was either inadvertently or advertently misled regarding the existence of OCHAMPUS staff-to-patient ratio by the lay member of the team, an OCHAMPUS official, and he understood that his partner believed there was a numerical deficiency, while he did not see the matter as a clinical deficiency. Thus, Dr. Eckhardt found no deficiency concerning staff composition.

Secondly, the fact that had been continuously accredited by the 'JCAH, which was one of the requirements for all CHAMPUS providers status, indicated that was at all times in compliance with the OCHAMPUS staff composition standard. JCAH required that RTC's adhere to a medical model, which meant that RTC's were required to provide an appropriate level of psychiatric services. Moreover, the testimony of OCHAMPUS' own witnesses supported contention that OCHAMPUS' staff composition standard was unreasonably vague and subjective.

As to the question of whether had complied with the option it chose by the April 1979 deadline, to upgrade all Treatment Director positions to mental-health professional licensure

status, OCHAMPUS had not provided evidence to dispute assertion that the terms of the second option were fully met by the deadline date. Instead, two witnesses, including Dr. Rodriguez, testified that would have been "structurally" in compliance with the staff composition standard if they had upgraded all Treatment Director positions by the April '79 deadline. But OCHAMPUS never made a good faith effort to appraise staff composition in April, 1979, but instead concentrated on the charges found in the Arizona Daily Star articles, and made little if any effort to verify compliance with the second option. Moreover, the team did not give an opportunity to counter the statements that were placed in the files by OCHAMPUS for the purpose of the present appeal, until more than a year later.

concluded that the only issue in dispute from late 1977 until 1979, the issue of staff composition, was virtually lost in OCHAMPUS' groundless allegation against resulting from' the Arizona Daily Star articles.

As to the confrontation therapy issue, it was stated has found that confrontation therapy is an absolutely essential therapeutic approach for successfully treating the youngsters placed in who suffer from severe emotional problems and who are almost always recidivistically delinquent as well. Most had been placed in other facilities and under some kind of treatment, including long-term psychoanalysis or drug therapy, such as were utilized in mental and penal institutions, and had not benefitted therefrom. The confrontation therapy consisted of having an adequately trained person who knows the patient confront him or her on an issue, and insist that he or she attempt to deal with the particular issue at the time it arose. This commonly results in a tremendous amount of resistance on the part of the patient, but ends with a resolution of the issue to the satisfaction of both patient and therapist.
believed that its use of confrontation therapy, in tandem with more traditional psychotherapeutic approaches, is the main reason for its success in rehabilitating hundreds of severely disturbed young people. It pointed to a series of surveys made by Behavior Research Associates, a professional survey organization, and to Dr. Rodriquez' testimony that “ stacks up pretty well" in comparison with outcomes achieved by other psychiatric and social rehabilitation programs.

As to the charge that confrontation therapy resulted in physical abuse to the youth, pointed out that Dr. Rodriguez testified that he agreed with the opinions expressed in the June, 1979, termination letter, but admitted that there are other psychiatrists who disagree with his views on the subject of confrontation therapy. It pointed out that it did not wish to attack Dr. Rodriguez, but thought that he testified unrealistically, in that the use of confrontations sometimes results in the need for vigorous physical restraint, but no OCHAMPUS Official has ever contested claim that its placements benefit tremendously from the care and treatment provided by . Moreover, the confrontation technique which Dr. Rodriguez found to be potentially abusive is viewed by many psychiatrists to be totally non-abusive, especially when contrasted with the use of tranquilizing drugs or mechanical constraints; but with certain types of troubled children, confrontation is often the treatment of choice. Dr. Eckhardt testified, reminded, that with this type of children, confrontation is much more effective -than something which alters their state of consciousness.

contended that the many instances of alleged abuse of youth in the program occurred daring confrontation episodes, which were addressed in each and every incident in "the seventh issue," Exhibit Nine. Moreover, witnesses at the hearing, both from inside and outside its program, testified that does not abuse children in its care. As to the incident, OCHAMPUS officials testified that the reason for the team's visit to Arizona was a complaint of abuse concerning , but after the investigation of that incident was completed, the team was unable to substantiate a finding of abuse.

Further, in 1978 the Arizona Department of Economics Security(DES) decided to investigate every child care agency in the state, and the Deputy Director personally conducted the investigations of the three highest-profile RTC's in Arizona, including . This investigation lasted for ten months, utilizing the services of over thirty (30) staff members; in addition, they involved the Attorney General's office and the Auditor General's office. Deputy Director Mathis testified that many of the allegations his group investigated came from the same handful of disgruntled former employees whose contentions were first relied upon by the Arizona Daily Star reporter as authority for his negative newspaper series concerning . He ultimately found the allegations against to be without substance, whereas the two other Arizona RTC's which received special scrutiny were closed down as a result of the investigation.

Further, the Defense Audit Service investigators examined very closely the confrontation approach used by and the psychiatrist who participated in that investigation determined that use of confrontation was appropriate.

argued that its program was, at the time of its termination, an extremely fine program for the treatment of emotionally disturbed young people, and that all the alleged violations of OCHAMPUS standards were shown as essentially groundless. As to the principal issue, staff composition, OCHAMPUS was unable to explain its vague standards; moreover, even psychiatrists can easily reach differing conclusions as to what constitutes adequate RTC staffing. Similar sharp differences of opinion among psychiatrists apply to the issue of confrontation therapy.

maintained that, most disturbingly, the evidence showed a pattern of bad faith on the part of OCHAMPUS officials. It alleged that OCHAMPUS arbitrarily interpreted its staff composition standard to allege noncompliance on the part of . But even then, in April, 1978, OCHAMPUS failed to verify whether had achieved compliance with its staffing standards, but instead entered into a "suspicious alliance" with Reporter Bob Lowe of the Arizona Daily Star, and accepted, without question or verification, unsworn adverse statements from individuals of dubious reliability. Thus believed that OCHAMPUS and Lowe improperly collaborated and conspired to "build a case" against .

said it was shocked when the June, 1979, termination letter was sent to Bob Lowe and published in the Arizona Daily Star before it was received by , further, was never provided a meaningful opportunity to explain and rebut groundless allegations against it. Additionally, the information adduced by during its appeal showed that

OCHAMPUS was biased against RTC's, particularly those which primarily served emotionally disturbed youth who were involved in the juvenile justice system.

concluded that it had shown that the OCHAMPUS termination of as an OCHAMPUS-approved provider on June 11, 1979, was erroneous in light of all the facts and all applicable law, and requested that the Hearing Officer determine that the OCHAMPUS termination was improper and that should be reinstated as an OCHAMPUS-approved provider, contingent upon its satisfaction of all existing OCHAMPUS eligibility requirements, and that the Hearing Officer "grant all further relief that he may deem just and proper."

Summary of the Evidence

Because the evidence in the record of this proceeding is so massive and comes from such a wide variety of sources, it is considered desirable to discuss the evidence on a more or less chronological basis.

Dr. Lloyd Eckhardt was the first expert in the field of child psychiatry; his opinion is found in the Facility File,Exhibit 48. Dr. Eckhardt described his participation in the survey of in January, 1978. Dr. Eckhardt had been employed by OCHAMPUS as a consultant to participate in that survey for the purpose of determining the degree of compliance with OCHAMPUS' requirements. He was a disinterested witness, and a Board-certified Psychiatrist. His testimony at the first session of the hearing, in which he discusses this report of the survey team, will be summarized later.

The second expert opinion is the report of the Peer Review-conducted by three Board-certified Child Psychiatrists which is Exhibit 22 of the Peer Review File. Their conclusions were based on records furnished by OCHAMPUS, which included the qualifications of employees, the description of the program, and individual patient case records, plus the appeal record. These expert reviewers concluded that: (1) the records did not document claim that primary psychotherapy was provided to patients by qualified psychotherapists; (2) there was insufficient qualified professional staff; (3) that "confrontational.therapy" was not adequately defined and was not consistently employed; and (4) that the inservice professional training program, as described by was insufficient. Moreover, the three Reviewers found that the records did not document that primary psychotherapy was provided to patients by the Treatment Director, which refutes the contention that it was in compliance with Option 2 which required upgrading of Treatment Directors to conduct psychotherapy. Their answer to Question Number Six: "the individuals classified as family counselors, youth counselors, and house parents are in general not professionally qualified to perform psychiatric service. There is no documentation that direct therapy is provided by properly recognized professionals with degrees in psychiatric social work, psychology or psychiatry." Finally, they answered Question Seven: "There are insufficient qualified professional staff."

John P. Collins, former Juvenile Judge for Pima County, who served in that capacity from 1972 to 1978, testified at very great length concerning his administration of the juvenile program in Tucson during his tenure. He expressed the opinion that 99.9 percent of youths he saw suffered from underlying emotional

problems, and also that an alternative to might well have been a mental hospital or a reform school. He said all the kids had emotional problems if not psychiatric problems. He said his court had a medical staff, an administrative assistant who had previously worked in a mental health center. He also had two different directors, both of whom had Masters of Social Work degrees and extensive training in the psychiatric field. The Judge was primarily dissatisfied with OCHAMPUS because of the protracted time it took to get financial approval, and conceded that he did not understand the medical nature of the OCHAMPUS program. He said he believed was the outstanding program in the nation for handling troubled youth.

On cross examination he did not know the full name for CHAMPUS, but knew that they served kids they "deemed to have a medical problem" but said "no two people in the juvenile field always agreed on what a medical problem is" and commented "that's why they have psychiatrists." He said what OCHAMPUS called psychiatric problems did not always measure with what he calls psychiatric problems. He never learned how OCHAMPUS decided on the eligibility of a kid for medical treatment, but left that to others on his staff. Asked again about the 99.9% figure, he said it was not a fact, it was his opinion; he recognized he is not competent to diagnose such problems in children. He said he believed "all of us are crazy between X and 100%, and you can't tell where to put the X on the bottom of the continuum." He said he agreed with Dr. Karl Menninger that "the people who say that kids need a heavy psychiatric program don't know what the hell they are talking about." After leaving the bench he became in-house Counsel to at $60,000 a year, and stayed there for about a year, but subsequently severed that connection.

David Feigenbaum, who had B.S. and M.S. degrees in counseling, and was getting his M.S.W. the month of the hearing. He had worked for for three and a half years, ending in July 1977, (before the staffing issue arose). He entered on duty as a family counselor, and later was director of schools. In his opinion, he said a very high percentage of the kids he works with and families he has worked with have shown to have some emotional difficulty in functioning in the community and in the home, upward to 90%. "When kids commit acts, they're waving a red flag for help, or for someone to stop them or someone to take notice; if you don't feel too good about yourself, you go out to prove to everybody how bad you really are." He said some of the kids at had been through psychiatrists, psychologists, clinical social workers and had run the gamut of therapy before they came to but they had escalated to the point of possible incarceration by the Department of Corrections. He is currently working with an alternative program to to avoid residential treatment, and all but one of the fifteen he has on his current case load have emotional problems including suicidal tendencies and negative feelings against their parents. He said military personnel at Davis Monthan Air Base in Tucson had shown some reluctance to go to the Base Mental Health Clinic because of repercussions that might happen to their service record. Although the Base had out-patient mental health facilities, there were no in-patient facilities there. He said military dependents are no different from children of national corporations, that move people around every couple of years. During the three years he was with he saw continual improvements, not only in the facility but also the professionality of the staff improved a great deal, and part of the reason was "effort to be acknowledged by then greater psychological community" and surveys by national children's organizations were accepted by as constructive criticism, and improvements were made.

On cross examination he said his Bachelor's was a degree in the field of Education, and his Master's was in Counseling and Communications. As a family counselor of (before he had an MSW), he was in charge of two group homes, and worked with a Psychiatrist on staff and treatment guidelines, treatment plans, and weekly staff meetings. He was responsible for resolving issues between the youth and their families, and conducted both individual and family counseling. Asked if' he felt that most children involved in delinquent acts had underlying emotional problems, he said he did, and expressed the opinion that these children could or could not have emotional problems which carried a medical diagnosis. Ninety-five percent of the time, he said no diagnosis was given, or could have been given. He said in his practice "the delineation between a behavior disorder and a psychiatric disturbance was not made." The Federal guidelines in the Special Education Act state that "for a number of reasons if a kid cannot emotionally handle the normal classroom situation he can't qualify to have a psychological or psychiatric evaluation. All of the kids at had passed that evaluation and it was done by evaluators outside of .

Michael Crackovaner, the Administrative Director of testified primarily concerning administrative matters. In his early service with he had been a Youth Counselor (house parent,) and described their function. The Youth Counselor is responsible for carrying out the day-to-day programming of the kids "…daily living, recreation, to and from school, after school; he is involved in the whole milieu of creating, of parenting a child and creating an environment where a kid could become amenable to treatment." He said the Youth Counselor is one of several people who is responsible for carrying out the treatment modality. He used the term interchangeably with House Parent, as a Youth Counselor "would be like a house uncle or a house aunt" but basically they performed the same functions in terms of the treatment team. He said a house parent had the responsibility of carrying out the treatment plan, of responding to questions that the child presents. He added "I think this is a difficulty we have had over the years with some CHAMPUS personnel in explaining the organizational model." A family counselor works with the families of five or six kids in a particular group home and is the link between the Treatment Director and House Parents and the Psychiatrist in terms of carrying out the treatment plan and issue some of the specific directives. . . . "That rule is something, too, that underwent a number of different changes over the years as we try to understand what it was that OCHAMPUS wanted us to do, to be in compliance with standards that they felt that were not being complied with, apparently."

William C. Scott, an employee with since October 1977, testified that he had a Bachelor's degree in Dairy Education and a Masters in Social Work, with experience in YMCA and pretrial disposition work for a Family Court. At he was a Youth Counselor, Family Counselor, and a Treatment Director. He said youth accepted into the program were reviewed by the treating staff and the Medical Director made the initial psychiatric evaluation and diagnosis during the first few weeks of treatment. A comprehensive treatment plan was then established, which was subject to at least quarterly reevaluation. Mr. Scott provided some individual counseling and therapy to youth, and did supervisory duties as well. These included supervising the treatment of all patients in his phase of the Program, directing staff training and reporting procedures, and communicating between the group home personnel and the Medical Director. He said in his opinion the treatment program followed a medical model. Asked to define the term, he said "to me the medical

model is having the preliminary therapist, that being the Medical Director in charge of all treatment of all patients and overseeing all treatment, and in his initial diagnosis and evaluation and assessment was the primary focus of all this treatment, and that all treatment decisions, evaluations were subject to his approval and his knowledge." Asked if this type of medical model was what the JCAH was looking for in residential psychiatric facilities, he said "as far as I knew we met or exceeded their standards for the type of model we used." As to the relationship between milieu therapy and individual therapy in the program, he said individual therapy was not usually provided on a regularly scheduled basis, and milieu therapy allowed the youth the controlled environment to be able to see if he could effect the changes that had been talked about in individual sessions and to see if he could modify some of his difficulties. These complemented each other, with individual therapy being just one facet of the entire program. He said the Medical Director/Psychiatrist provided individual psychotherapy to youth prior to the June 1979 termination of and that therapy notes were made during psychiatric counseling sessions. However, therapy notes on every occasion in which a staff member came in contact with the youth were not made, because many of the individual sessions were impromptu and short in duration, and it would have been self-defeating to spend a lot of time making notes at the time. These records were synthesized in monthly progress reports. Asked if he had a problem, as a professional, with the fact that a good part of the direct patient care at is often provided by staff who are not degreed mental health professionals, he answered in the negative, saying "I believe in any field you can train competent people to be effective…child care workers, and that the key to that is supervision by professionals, and also the training that goes along with that." He said a comprehensive program includes a lot of different people, not just degreed professionals, to promote the effective treatment of emotionally disturbed kids, especially the patient population found at . He thought it was proper, therapeutically speaking, for the non-degreed staff to utilize the techniques of confrontation, as "I don't believe it really takes a whole lot of training and a whole lot of credentials to confront an individual over a simple matter such as not doing a proper job on a work chore or something, and that, once again, the major confrontations and major points of emotional difficulty were not approached by line treatment staff without either prior knowledge by myself or the Treatment Directors." He said there were different special types of techniques and confrontation used for different types of kids. For example, "Between a very self-destructive depressed young person with suicidal ideation, the confrontation was still necessary but did not have to be as aggressive, perhaps, and would definitely be, start out to be more nurturing and caring and definitely making sure that the resolution was real clear and that the basic relationship between the staff and the patient remained intact. Following that, to make sure that there were no repercussions by the patient such as attempted suicide." Asked if there were a standard length of treatment at , he said there was none, but that the patient was expected to make a commitment for a specific period of at least one year, and to agree to abstain from certain things such as drugs and alcohol, in order to realize the seriousness of the situation; he felt that without such a commitment there would not be any change. He said the recommendations of the Staff Psychiatrist were 'not subject to the approval of or to be countermanded by any other staff person. He said by the April 25, 1979, -dead line given by OCHAMPUS to to comply with their mandate, as far as he knew, all Treatment Director positions were upgraded to MSW, PhD Psychologists, or some equivalent Masters or Doctorate degree.

On cross examination he said he was not a certified social worker by ACSW. He described the Medical Director's involvement in the assessment process by saying the Medical Director would review the appropriateness of the acceptance of a patient into the program initially, based on information provided following the initial interviews, which were conducted by the program director or family counselors, and the Medical Director was in charge of initial psychiatric interviews and evaluations, which were usually conducted during the first three or four weeks. The Psychiatrist did not see them within the first 72 hours, and they were admitted to the program without his having seen them. He himself provided the individual counseling and therapy to patients, rarely on a scheduled basis, but the program involved non-scheduled therapy as a part of the milieu therapy. He said he felt followed the medical model, despite the fact that the patient did not see a psychiatrist regularly, but only briefly at intervals of 3 to 6 weeks; the individual decision of the Medical Director governed the number and frequency of contacts between the Medical Director and the patient. Asked if it was consistent with the medical model for the Medical Director to make at least weekly notations in his progress notes, he said "Well there's millions of medical models. In my opinion of a medical model, it did not have to be weekly." He said the Medical Director was present at least once a month at the weekly training sessions and would sometimes take an active role by instructing, answering questions and observing the training process. Asked if he thought it would be appropriate in the medical model for the Medical Director to have direct supervision over treatment staff, he said, "Well I think the supervision comes from my opinion of medical model, you have the primary therapist who is making the primary medical diagnosis and that is being carried out by all the staff, either professional or nonprofessional, that are involved with the patient." He said the Medical Director scheduled regular therapy sessions with patients if he felt that was needed, and then he would schedule the patient to return in a week or a month or every week or every two weeks, or a quarterly evaluation if he felt that was necessary, but regularly scheduled sessions were not available to all patients. He felt that system to be consistent with the standard of care as generally practiced in the United States. If the Medical Director felt it could be accomplished with a patient in a program setting he did not need to include individual psychotherapy on a regularly scheduled basis, and that was consistent with his understanding of a medical model. Asked to describe confrontational therapy, he. said, "Its being very direct between the staff and the therapist, the therapist and the patient as far as the behavior that has been noticed, as far as the responsibilities that have or have not been followed. It is setting direct limits and upholding them. . . .Through a variety of, well, consequences, disciplines, peer pressures, group and individual therapy as far as why a patient was not upholding his part where he needed to, and etc. There are a variety of disciplinary measures." Asked where in the medical literature confrontational therapy is described as treatment modality, he said he didn't know and that he was not at all familiar with the medical literature with respect to confrontational therapy. Asked about the controls that put on physical confrontation, he said that "Staff members are limited as to how far they can go with physical confrontation, and any time he found the confrontation process to be not in line with proper treatment of the patient and the patient's best interest, he would question the motives and the intents of the staff member involved and make sure that it did not occur again. The controls ultimately flowed from the Medical Director, who would not be involved in all cases, but certainly in those of any serious nature, such as a youth requiring physical restraint or that involved any violent or bizarre behavior to the point of being dangerous, or had been mishandled in any way by any staff, in which case he would involve the Medical Director, and he would receive the Psychiatrist's recommendation on what

actions need to be taken at the time to resolve the situation; in some cases the Psychiatrist would see the patient as soon as possible. He said that confrontational therapy in one form or another was employed with virtually all patients treated at . However, had never authorized corporal punishment as a necessary tool nor as a clinical tool, nor was there any clinical justification for rubbing a patient's face in the sand; there was some clinical justification for cutting a patient's hair, where the patient agreed to do so as a part of a commitment to improve his performance; however, no child's hair was cut without his permission. He said he heard of that technique being used in other places, but did not think it was a generally accepted practice, nor was it generally used at , it was an extreme treatment and something not entered into lightly. Asked about any clinical justification for grabbing or pulling a patient's hair, he said there was justification if there was going to be a violent or very destructive act, and the hair is what you happen to grab onto at the time, to prevent injury to the patient or to other patients or to staff. As to the way patients are placed "on the ground," it is done trying to limit the patient's ability to harm himself or anyone else, and trying to limit the physical nature of the youth's aggression at that time. The action was taken in the safest way possible, and with as little force as necessary to accomplish the resolution of the situation. A "physical" is where a staff member is required to limit physical actions of a patient, which occurs anytime a staff member touches a patient in a confrontive situation. These are justified, he said, in cases of extreme violence, obstructive behavior where a patient needs to be restrained for his own safety and well being as well as that of other patients and staff members. This also includes extreme instances of destruction of property and instances of withdrawal, such as refusal to speak or to acknowledge the presence of the staff; in such case the staff would lift the chin of the patient so there would be contact if he kept turning away toward the wall.

Ronald C. Payette testified that he has a B.A. in Psychology, seven years of service in the Army, and worked as a cottage counselor for the Department of Corrections while attending Arizona State University and receiving a Master's in social work, then two years later received a ACSW certification for independent practice, followed by 14 years experience in that field. At present he is Director of Treatment at the Jay McCaffery School, a residential treatment center for children and adolescents located in Tucson. His school is approved by the JCAH for severely emotionally disturbed and psychotic children and adolescents between 8 and 18; with the average length of treatment of 16 months and a license for 31 patients. The school is an OCHAMPUS-authorized provider of services, and has been for 8 years. It was approved by JCAH approximately 7 years before, when CHAMPUS imposed that requirement. He testified that his patients do not differ in any substantial way from the patients, except that McCaffery does not take delinquent children; it takes only children with a psychiatric label, as opposed to a legal label, as a delinquent. They want to take a sociopathic child, and those can come from any sector of referral. Although some have been legally adjudicated delinquent by a juvenile court, some of their patients are not psychiatrically delinquent. He expressed an opinion that almost every child who is labeled delinquent is emotionally disturbed as well, except for the sociopaths, who are not many in number. Mr. Payette had never had any financial or any other type of connection with . After the requirement of the JCAH approval was imposed by OCHAMPUS, the number of RTC's dropped from about 1400 to 60 throughout the United States. He said there are very few rules that OCHAMPUS applies to his facility other than compliance with JCAH standards; the only one

he could recall was the length of patients' leave; all other programatic or clinical rules and regulations strictly follow the JCAH standards. Asked about the OCHAMPUS requirement for psychiatric referral to an RTC, he said most of the children admitted had already been referred by a psychiatrist in Arizona, and then they are reviewed by the McCaffery School psychiatrist for validation of diagnosis of patient and ongoing treatment after they have been admitted. The only requirement he was aware of about early examination by the house psychiatrist was the JCAH requirement that you have a temporary treatment plan within 72 hours, but no requirement of the psychiatrist's involvement in that plan; OCHAMPUS had never suggested to them that they take such an action. Over 50 percent of his patients come to him through the juvenile court center or the state, and many have the delinquency label or an "incorrigible" label; many of those have been funded by OCHAMPUS and none have been refused by OCHAMPUS. He said in his mind there was a feeling that OCHAMPUS had some reservation about kids who were involved with a Court. He said he was involved in the dispute over OCHAMPUS' recent attempt to eliminate RTC's as providers, based on what was published in the Federal Register, where the thinking of the OCHAMPUS was explained. He said an emotionally disturbed child will often manifest other more serious problems by committing anti-social acts, and that's why they often end up in the juvenile justice system; however, if you select ten case files at random, you couldn't tell the source from which they were referred. He gave the professional opinion that a great majority of adolescents who commit delinquent acts have underlying emotional problems. In the eight years that McCaffrey has been an OCHAMPUS provider, they have had only one on-site visit to his knowledge, and that was in 1975. There was not much of an inspection at that time whereas the JCAH survey is very comprehensive; it takes approximately 3 days and they check some 1600 items.

Frank A. Petroni, PhD in Psychology, testified that he has spent a number of years in behavioral research, including 3 years at the Menninger Clinic doing studies with troubled adolescents, and with the Family Health Center at the University of Minnesota. He was a principal in the firm called Behavioral Research Associates in Tucson, which did evaluations of agencies and institutions working with some form of intervention in the area of mental health. Around 1975 he was asked by to study their program. They developed a plan for studying and evaluating the program and to measure changes effected by the program in terms of the lives of the youth which were affected by it. There were written reports for 1977, 1978 and 1979, some of which were looking at different aspects of the program, although a similar model was utilized throughout. It was his impression that most of the people they saw at "would fall into the category of having ego strength difficulties, that is, they had very poor self-images of themselves, lack of confidence and psychological types of variables, and a great deal of psychological variables. . .” He believed that most of the youth at found their way through the courts in one way or another, and their psychological makeup was pretty much the same, in terms of the kinds of trouble they had been in. One year they studied the OCHAMPUS group as compared with other children in the program, and found that the OCHAMPUS families took more advantage of the counseling and participated oftener in family counseling, with some slight improvement in terms of a six-months evaluation of their children. He said their results consistently demonstrated that there was overall improvement in the areas they were looking at with respect to the children, following six months and then following one year after discharge from and he expressed the belief that the positive changes were long-term in nature. They did not measure specifically the results

of the confrontation techniques, but he expressed his personal opinion that it was just as effective as any other therapeutic strategy. He said the milieu approach utilized by was similar to that used in Menninger's' Adolescent Clinic, which is a very good approach for total treatment, and includes confrontational techniques and "everything that would do the trick." He said he observed the youth in the group homes, and believed that that fit in with the half-way house concept. His studies led him to conclude that the program was effective, especially so with OCHAMPUS families because of the way the families participated, and they were learning new ways to deal with their own problems and their own kids; when they were denied CHAMPUS funding, they lost a valuable alternative to dealing with their youth.

On cross examination he said most of the 70 to 80 of the research studies and evaluations he had done at the Meninger Clinic concerned troubled adolescents, both females and males, and one study was a Residential Treatment Program in a psychiatric hospital, which used confrontation, group therapy, individual therapy, with the youth being released for short stays in the community and then come back in. He said his firm was no longer in existence, and that he and one other PhD in psychology had opened the company, and employed research associates and other staff which totaled from 6 to 8 people. They had a contractual arrangement with . He said the data collecting was done by employees, who had been trained by his firm, but they were not treatment people. The same employees made reports addressed to state county agencies. In a later followup study, some questions were asked by staff members by telephone survey, and all others were personally collected by staff. On redirect he said that employees could not have influenced the results of the interviews. They also did studies for various school systems in Arizona, the Arizona Mental Health Center's Halfway House program and three other halfway house programs.

Donald B. Mathis, Deputy Director of the Arizona Department of Economic Security (DES) testified that his agency operates a wide variety of human services programs, from child welfare to unemployment insurance, throughout the State of Arizona, and that he is the day-to-day manager of the Department. He testified as to his investigation of the complaints about his testimony was consistent with the claims made by under the heading "Position of . His professional experience included service as a counselor at the Brown Schools in Texas and as a consultant to Daytop Village in New York in the late sixties; he did not know whether Daytop was an authorized OCHAMPUS provider at that time, but doubted it. He is a member of the President's Commission on Juvenile Delinquency and Youth Crime, and worked with the Human Resources Administration of the City of New York. Of the three RTC's in Arizona he personally investigated, two 'were closed and the third was . As to former employees who had made derogatory statements about and its program, he said "they proved to be bitter people who were angry enough to be willing to create stories out of the whole cloth or to characterize events in very negative ways that could not be corroborated." He said in his opinion, staff members were qualified for and dedicated to their jobs, and whenever a problem had arisen had been very responsive to criticism and suggestions. He said provided professional services to severely troubled young people. Asked if they were of a quality to those provided by state mental hospitals, he said "I would say better."--Asked if program was medically oriented, he said "I would say psychiatrically oriented, but non-drug oriented." He said after talking with graduates of

programs and members of their families, "I'm very impressed with their success rate."

On cross examination he said the investigation began as a routine, periodic investigation, "but continued longer than usual because of the allegations from the former employees which were being aired in the press at that time." He said DES licensed as a "residential treatments facility" meaning that children with psychological problems were referred to such centers for treatment. These are children who cannot be placed in a foster home due to their psychological-problems. He said took most of the kids who had been placed in other treatment facilities that had not worked out, or what his workers referred to as "multiple losers." But seemed to be able to get a success rate with the losers and do a good job, because of its intensive treatment programs. Asked if is licensed by the State of Arizona as a psychiatric facility, he said "Not as a psychiatric hospital, as a residential treatment program for foster children." Asked if that was considered to be a psychiatric residential treatment program, he said "Yes, and no. Yes, in that it is a psychiatric program. No, in that--in the sense that we don't license psychiatric hospitals." He said some of the facilities that were licensed by the state were heavily psychiatric, and some were psychological or behavior modification centers, and so would not be strictly spoken of as psychiatric. Asked how he distinguished between a psychiatric facility and a psychological facility, he said "Primarily that the treatment program is under the direction, supervision, and control of the psychiatrist." He characterized treatment as being under the control and prescription of a psychiatrist; thus it was a psychiatric facility, in his judgment. Asked what specific inquiries were made during the investigation into the clinical aspects of program, he said "There are no psychiatrists at DES, and psychiatrists from other parts of state government were brought in to participate. He said they found the treatment programs were signed off and supervised by a psychiatrist, but it was not the traditional psychiatric therapy as a treatment philosophy. Asked if he understood that relies very heavily on nonprofessionals to carry out therapy aspects of their program, he said he did, and knows that not all employees at are psychiatric social workers or psychiatrists. The kind of program they operate doesn't require that. "As long as they are supervised by professionals, I think it meets that test. I think it meets the professional test," He said the program is not structured as a model of a one-on-one therapy in the orthodox psychiatric social workers' sense. Instead, a prescription is written by a psychiatrist which is carried out by a variety of different people. Further, the psychiatrist maintains control by prescribing, reviewing and dealing individually, where appropriate, with the child. The psychiatrist looks to the team of people to carry put the prescription; that team is composed of individuals from horse wrangler and other people who interact with the patients on a daily basis; these people are not acting as therapists, but are interacting with the patients and providing feedback. He said that the traditional labels do not apply to therapy. He found their program to be innovative, but not completely unique, as others were similar, including Daytop in New York, Rhode Island and Pennsylvania, which is similar in terms of the social psychological history of the kids, in terms of confrontation, in terms of high impact experiences, in terms of psychiatric orientation, and in terms of the role of the psychiatrist in the organization. Asked if the youth counselors and other nonprofessionals carried out the therapy as prescribed by the psychiatrist, he said "in some measure" meaning that they are members of the team. Further, the house parents are responsible for resolving problems

between the patients and reporting back to the psychiatrist as to what is going on "in terms of additional prescriptions from the psychiatrist." Asked if the house patients were playing a therapeutic role in the program, he said he had a problem responding to the question because the counsel kept saying "therapeutic" in the sense of someone being a therapist per se. Counsel for OCHAMPUS said "That's exactly what I'm talking about, and you're not talking about therapy?" He said "I'm talking' about what the collective experiences, therapy and not necessary carried out in the traditional manner on a one-to-one basis by a psychotherapist." He is also familiar with the role of the Family Counselor, to work with the family to assist in improving their relationship with each other; he also serves as a facilitator and information gatherer, and to some extent in the role of a counselor to the patients. Asked about the qualifications of the various staff levels, and which of them were qualified as professional therapists within the system, he said "the counselors tended to be the professionals. House parents tended to be not quite the same background." Asked what he considered to be professionals, he said "MSW's, BS in social work, and other fields of psychology." Asked if he believed that meets the standard of care generally practiced in the United States for psychiatric residential centers, he answered in the affirmative, and said he based his opinion on having worked with licensed psychiatric hospitals; he believed there were more psychiatric controls at than there were at some of the licensed hospitals. Asked if he considered himself to be professionally qualified to make a judgment upon the standards of medical practice in the United States, he answered in the negative. He said they studied the efficacy and the propriety of confrontational methods employed by and found them to be appropriate, workable and successful, and these confrontational approaches were involved with most of the patients upon the prescription of a psychiatrist, through individual treatment plans, which also direct other forms of therapy. He said there could be prohibitions on confrontation in the psychiatrist's prescription, but he had not personally observed such a treatment plan. Asked if he concerned himself with the medical propriety of the confrontation therapy employed by , he said "Oh I'm not a medical doctor. I don't purport to talk medical propriety. I think there is a wide range of opinion about that. Professionals don't all agree, the ones I have been concerned with on the subject." Asked if that question was considered in the investigation of he said it was, and the psychiatrist he used on the team believed that confrontation therapy was appropriate.

On redirect he said he considered confrontation technique preferable to the utilization of drugs or mechanical restraints. He also said he believed in an environment such as persons with equivalent job experience (MSW's, psychiatric nurses, PhD's in psychology, and other master's level persons) could be just as effective as persons who had academic degrees. This is because trains its staff to perform appropriately within their program. He said some of the ex-employees he had interviewed were MSW's who could not get beyond the therapy they learned in school, and these were the classic Freudian psychotherapists who would probably not be comfortable at .

Ms. Lu Kruger testified that she has received an MSW in 1951 and had worked in several family agencies. In for seven years, she had worked with psychiatrists and psychologists. Her positions at were:

Treatment Director and Guidance Counselor at the school; she was involved largely in staff training all during that period. She said the Psychiatrist sees the children soon after they enter the program; the Treatment Director works in close harmony with the Psychiatrist and the child care staff works with the Treatment Director, so the communication goes back and forth within the staff and also to the school personnel working with the Treatment Director to take care of the daytime hours. The Treatment Directors receive their treatment prescriptions from the Staff Psychiatrist. For six and a half years she had served as "child advocate" handling complaints from the children at any time day or night, investigating such complaints and bringing them to a satisfactory conclusion for the kids. There is a child advocate in each of county programs. Asked if the types of youth served by are really emotionally disturbed, she said "Yes, very definitely." She added that most MSW's and other social workers don't like to deal with that type of youth and have a misunderstanding of confrontation techniques, instead of using prescheduled therapy sessions. She said as a mental health professional she believed that confrontation was necessary with the types of children treats, as they have had many types of therapy which did not work for them, and so they are really at the end of the road; if something didn't happen to change their lives they wouldn't have any hope for the future, so the methods uses are absolutely essential. She said drugs and restraints and that sort of thing are just a "holding pattern" and do nothing to improve them. Instead, technique requires them to face issues before there is time for confusion or a buildup of anger, and the children come to a very secure feeling, in knowing that if they're getting out of control, they're not going to be allowed to hurt themselves or do anything that is going to be harmful. She said she'd seen a few isolated violations of patient rights, but these were simple human mistakes by staff members which were easily straightened out, and forceful corrective action was taken by management, including suspension or termination.

On cross examination she said she was not ACSW; she took nine or ten years out to have her own family, between the time she completed the MSW and joining . As to the psychiatric evaluation, the Psychiatrist meets with the youth and some of the staff, and writes a diagnosis and suggestions for treatment, and then discusses the matter further with the staff. The appointments are usually for an hour, but if more time is needed, it is taken. This was done generally in the first two weeks and not more than a month; and with some, the first day or two. She said the principal complaints she had received of physical abuse were when the child was "put to the floor" by three or four staff, and the child felt that it should be one youth to one staff. As to verbal abuse, she said uses words in every confrontation, and some of the youth don't like some of the words, such as swear words, that are used. Further, some black youth do not like to be called "boy," and become angry because she calls them all "boys and girls," but she had never heard a complaint about a youth being called a "nigger." Asked if the girls complained about being called "whore or slut," she said sometimes staff talks to a girl and asks her if she realizes her actions make people think that she is a whore or a slut, but none have been so accused. Asked if she had observed medication being used by , she said it was never used for controlling behavior of patients. Asked if she had ever observed a patient at who was psychotic but was not on medication, she said she didn't believe so, as doesn't take just anybody, since anyone in need of drugs would have been identified as such by a psychiatrist before they were referred to . Asked if

all the children were contacted by a psychiatrist before they come to she said "not all, although I think a large majority of them see psychiatrists."

Lloyd 0. Eckhardt, M.D., testified that he completed residency in pediatrics and in child psychiatry, and is a Board certified Child Psychiatrist. He taught at the University of Colorado for seven years, was consultant to the Children's Adolescent Treatment Center and the State Hospital in Colorado. He was asked by OCHAMPUS to participate in a survey of program in January 1978. He accompanied George Bair, who was to look at the staffing patterns, and Dr. Eckhardt was to look at the clinical aspects of the program. He was to visit the cottages, talk with some of the youth, and confer with the Medical Director. He said he considered this an opportunity to look into an interesting alternative to youth who were referred by courts, which had been generally ineffective. OCHAMPUS emphasized that because the program took a lot of court-referred youth, one of the main emphases for the survey team was to be sure that the youth met the OCHAMPUS criteria. Mr. Bair indicated that OCHAMPUS officials believed that staffing patterns at were inadequate. In his report, he found that the clinical aspects of the program were of "extremely high quality." He and Mr. Bair visited a cottage and talked with the house parents and with one of the kids. Asked if the family counselors he met were informed regarding the underlying psychodynamics of each child, he said they were well informed of the problems each particular child, had, and the children were aware that they were aware. Dr. Lazarus was the Medical Director at that time, and they talked about the youth. Dr. Lazarus appeared to be on top of the situation, and was on 24-hour call. Family counselors and house parents he met were well informed in terms of their group of kids. Asked about his feeling about staff which may not have had high credentials in traditional academic standards, he said he previously worked with paraprofessional people, and he was highly impressed with them and their working relationship they established with the kids even though they were not highly credentialed; also, when they had a problem which required some expertise in a given area, they could ask about it. He said that the system of having a Psychiatrist and under him a Treatment Director and treatment teams under him, as practiced at seemed workable; if there were major issues that required Dr. Lazarus' input he was able to do so, and the team understood what he was saying and was ableto implement what he was recommending. Asked if one psychiatrist was enough to handle the Arizona program, he said he did not feel that there were any questions that needed answers and no one to answer them. He added, "I thought there could have been more psychiatrists. I think, again, I think that's a chronic problem." He said although it was impossible for Dr. Lazarus to spend a given amount of time in the traditional sense to each child or each counselor, he was available for group meetings, or if there were a crisis he could intervene and help out. Asked if he concluded that was then adhering to a medical model, he responded in the affirmative, saying that used a chain of command that involved medical input from the top, but that the use of a Treatment Director as a primary therapist, providing psychiatric guidance to field personnel, did not undercut the medical model concept. He thought the "wilderness experience" was an extension of the therapeutic work that was going on, rather than a disjointed kind of experience, and it was certainly not a camping program which is a vacation to get away from stress and pressures. Instead, it was an opportunity for the kids to face themselves and to come to grips with some of the things they had learned in the program. He said he didn't see a lot of confrontation, but that sort of thing requires a great deal of restraint on the part of the staff, and that the child understand that this type of control is

available and will be used if necessary. He said that as far as he knew, psychotrophic medication was not used to control the youth, and he felt that confrontation with this particular group of youth is more effective than something that alters their state of consciousness. Also, mechanical constraints are "time-out" situations whereas the human to human interaction will "get them down" much more rapidly. Asked about, after four days of visit and seeing a number of things, the quality level he found at the program, he said "I thought it was a very high quality program. I thought it was one of the few programs that was really providing an opportunity, providing an alternative to incarceration. I was very impressed." Mr. Bair was looking at staffing patterns, but he was not as aware of OCHAMPUS criteria or the things Mr. Bair was looking for; he felt that Mr. Bair was impressed with the clinical aspects of the program. Asked if he found the program services to be professional and psychiatric in nature, he said "I really believe it's a medical model. I think it is dealing with emotional problems, so I think it is psychiatric." He thought it was superior to some of the State Hospitals with which he was familiar on the East Coast. Asked if each youth was receiving individualized treatment, he said "Each youth had an identified (staff) person, who provided individual therapy, for five or possibly ten minutes, but it was not the traditional hour or half hour." Asked if the youth he met were clearly in need of treatment for underlying emotional problems, he said he didn't see any youth that he felt were delinquent or had a conduct disorder, but "I thought there was a level of depression that they were experiencing that certainly contributed to their problems, and then there were a variety of other kinds of anxieties and psychological issues that they were dealing with, too; but I thought they certainly had emotional problems." He is familiar with JCAH standards, and said he believed that substantially complied with those standards, with respect to clinical records, treatment plans, and assessments. After the survey, he did not believe that would be terminated as an OCHAMPUS provider, because "I thought they were providing a medical service that was within the guidelines of what CHAMPUS was offering to other facilities throughout the country." Asked if he had seen anything superior to in the United States for severely emotionally disturbed children, he said "In terms of working with so called delinquents or conduct disoriented children, provides more than any program I have seen in the country."

On cross examination he conceded that he signed the survey report along with Mr. Bair, in which it stated that there was insufficient qualified treatment staff to provide psychiatric services, and that the staff did not meet the guidelines. He believed that Mr. Bair's review covered administrative details only. He understood that he was on the team to "see if it was a program that provided adequate psychiatric care in terms of the hierarchy, what kind of therapeutics in interventions were being made, and what residents or what the kids were feeling about the program. . ." His principal interest was the kind of alternatives provided, and whether this was an effective way of treating this particular kind of youth. He had never seen a program that encompassed so many different kinds of treatment modalities as . He said he spoke with Dr. Lazarus, to house parents, two or three counselors and one family therapist, and one or two teachers, plus a group in a circle meeting. He did not inquire as to their professional qualifications as such; he was more interested in getting an idea of what they knew about the kids they were taking care of. He spoke to Dr. Lazarus for about an hour and one of the counselors who drove him from home to home, and he was a Treatment Director but was serving as a guide; they talked about his role vis-a-vis the people they were meeting, and he asked some questions about the clinical aspects of the program. He

surveyed the role the Medical Director played, and Dr. Lazarus discussed two or three patients he was seeing on a regular basis, one of whom had been in a mental institution. He did not survey the training administered by Dr. Lazarus or anyone else on the staff. He was present during a therapeutic interview between the Medical Director and a patient, and the Counselor was present throughout the interview. The Counselor was new, but was impressive in her ability to work with Dr. Lazarus in terms of helping him get the information from the patient. Asked to describe the psychotherapy provided by the Medical Director to patients, he said it was limited to patients that required more intensive kind of contact, but was not as formalized as psychotherapy as is done in terms of private practice. He saw some kids when they needed to be seen, and others on a bi-weekly basis, and others just before they went on survival hike. Dr. Lazarus was responsible for all patients; this was a large number, in the neighborhood of a hundred and thirty, from memory. Asked if one psychiatrist could adequately provide for a hundred plus patients and approximately an equal number of staff dealing with families, supervision and training and so on, he said "I don't think one person could provide individual supervision or contact with that many people. I do think that one person as charismatic as Dr. Lazarus could, through group meetings and training sessions, provide the kind of impetus as he wanted his counselors to carry on. I think, here again, you're talking about large numbers, but I don't think that each of those kids or each family was in a crisis. It would be impossible to deal with a hundred and thirty crises at once, but I do think he was available for individual crisis, and I do think he responded to those. I think his staff also was aware of the kind of problems they could handle, and I think they did handle them." Asked if he had an opportunity to survey the initial and periodic patients of such assessments conducted by the Medical Director, he said he went over some problem-oriented patients' records, and found Dr. Lazarus' name frequently on the charts and there were usually dictated assessments by him. He reviewed eight or ten charts, selected by Mr. Bair, plus one or two others he wanted to see about which he was wondering in terms of the degree of psycho-pathology. Asked if he felt it to be appropriate for the Medical Director not to evaluate a patient for as much as six weeks after introduction into the program, he said "After all, Dr. Lazarus knew what was going on in terms of the patient population. I also--I may be mistaken in terms of he told me the information--but that prior to coming into the program that there had been a medical and psychological assessment provided by somebody, and this had been made available to Dr. Lazarus. . . and he would have read it. He may not have seen the patient for a given period of time."

As to confrontation therapy at he said it was very, very quick, and very much to the point, with the kid knowing what the confrontation was about, and hopefully learning something from it. He saw no punitive or abusive kinds of confrontation. Asked about what he felt about pushing a person to the ground or against a wall, he said that was permissible only to help a child and restrain him, but that he thought provocation of a patient by yelling at him was "uncalled for;" neither was any kind of goading or provocation called for. As to cursing, it is uncalled for, but it is something that is human, and the kid may sometimes get to a point where the counselor may say something that he regretted later. Asked if he considered to be a typical juvenile delinquent rehabilitation program similar to his previous experience, he said "the reason I found it so fascinating was that I saw it as an alternative to incarceration, which I do not think has any treatment aspects to it."

On redirect, he was asked to review the report which he signed which says, "there is a deficit in the number of qualified treatment staff to provide psychiatric services. Current structuring and composition of treatment staff does not approach a medical psychiatric facility wherein individual psychotherapeutic approaches are integrated." He said that deficiency did not, to him, eliminate from being in the medical model, for he understood Mr. Bair to say the regulations require a certain ratio of professional people to clients, and if that didn't exist, it didn't meet the standards. This report did not address the quality of care or the expertise of Dr. Lazarus, nor the level of care of the patients. He said the report was that a subjective finding of Mr. Bair insofar as what OCHAMPUS was looking for. Asked if, when he testified as to alternative to incarceration, was he including incarceration in mental health institutions or only correctional incarceration, he replied, "I meant correctional incarceration. I think there are children who have antisocial behavior that are incarcerated in mental institutions because they have significant psychological problems that require closed setting." He added a lot of the children who went through would have been in mental hospitals.

In response to a question from a Hearing Officer he said he signed the team's report, based on the definition that Mr. Bair was working on, which indicated a deficiency. He did not conclude there was a clinical deficiency, but a deficiency in the ratio between numbers of patients and numbers of staff, rather than quality of performance.

Stephen R. Rogers, Executive Director of testified at some length concerning the history and philosophy of . The only testimony he offered with respect to the psychiatric standards for RTC's and qualifications of the staff was as follows: JCAH inspected the Colorado Springs facility and he found total compliance and the inspectors were extremely impressed, giving them a very rare two-year certificate. The Psychiatrist in charge of the team, from Menninger's Clinic, told him "Don't stop what you're doing." He said JCAH inspections helped quite a lot, such as replacing light bulbs, cleaning door sills, and how to keep records. Mr. Rogers attended the University of Massachusetts for 4 years taking business courses, and playing football followed by professional football experience. He worked for a number of years in recreational departments and home detention programs for youth. On cross examination he said had been ranked Number One in the country after a survey made by the Delta Institute of Coronada, California, Exhibit 20.

The Delta Institute report prepared by Evan A. McKenzie, MA, J.D., dated August 18, 1981 devotes six pages to . In the opening paragraph it says, "It is certainly not primarily a hospital or a school. To characterize it as a therapeutic community might not be entirely inappropriate, except that it is not a system in which the kids are expected to control each other. The adults are clearly in control. Consequently, the therapeutic community label does not really fit, despite the community nature of the program." It points out that is not one, institution but many, with different kinds of programs, to provide a continuum of placements designed to makeup a single treatment process; these include the diagnostic and evaluations center, the wagon train and wilderness camp, Homequest, outpatient program, a chain of group homes, and a set of learning centers. It pointed out that

"nearly all of them are court referrals, most of them are fairly serious offenders, and a substantial number are hard-core delinquent." It says that specializes in hard-to-place delinquents, the youth who has been shuffled around through a series of placements and has managed to beat them all by failing at them; this reinforces the youth's "failure identity" and refuses to let him fail, and he is forced to succeed in spite of himself, because he learns that it is impossible for him to intimidate the staff. There is a one-year commitment to abstain from drugs, alcohol and sex while in the program, and to work on understanding and resolving his "issues" or his problems with himself and his family. "Confrontation" is defined as "getting in the kid's face" and loudly telling him that he has let himself down. The staff does not let go of the problem until it comes to resolution through emotional catharsis on the part of the youth. If he becomes physically violent, he is "taken down" and "held." Holding is the only physical restraint used at . As the problem is resolved, the holding becomes affectionate and supportive; no form of physical punishment is permitted. Reviewer found that the philosophy is a combination of psychotherapeutic principles, parenting skills, and common sense, all clothed in the mysticism of Plains Indian philosophy. The primary goal of is to bring the youth into a state of self-control and enhanced self-esteem and consists of extremely intensive supervision of the youth's life to make him live up to his commitment on the outside. Families participate actively in helping the children resolve their problems and in seeing their own problems. (Inasmuch as OCHAMPUS youth were not sent on the Wagon Train, no comments on that program are relevant). It pointed out that the confrontive nature of the therapy has led to problems, because the issue has not been settled in professional or academic literature. The reviewer expressed the belief that "confrontation in some form is necessary for many of these youths, especially the hard core." It should be "merely the beginning of a therapeutic process which is really very sophisticated and supportive. . . . the more tender and nurturing side of the program consistently escapes notice!' It was also noted that is not alone in using confrontation, and cited Elan and Delancey Street as examples of the use of that technique. The reviewer concluded, "I feel that it holds promise for the youth with which we have to deal in San Diego" and encouraged Judge Adams to visit the program. He reported that Adams and a consultant did so and were encouraged by what they saw, and placed one youth in in a trial basis. He recommended that "his progress be monitored, and that steps be taken to look further into ways in which can be used as a treatment option for a larger number of San Diego youth!"

Mr. Ron Payette testified further, in the June session of the hearing, primarily with respect to the financial relationships between the Jay McCaffrey School and OCHAMPUS. He stated that the rate charge to DES and to CHAMPUS had differed over the years. This will be discussed later in this Opinion. Mr. Payette was shown the copy of the June 20, 1977 survey, which resulted in a finding that McCaffrey School was in compliance with OCHAMPUS standards for psychiatric Residential Treatment Centers; he did not know what the standards were and was not familiar with them nor the Regulations, nor was he familiar with the existence of Appendix A to those Regulations. It was his impression that the only requirement was that they follow JCAH standards.

G. Dennis Adams, Superior Court Judge and for two years the Presiding Juvenile Judge in San Diego, California, testified at length concerning his interest in finding better alternatives for delinquent youth in his county, and his contacts with and opinion of the program. It was clear that he was wholly dissatisfied with the various treatment alternatives which were available at the time he became presiding judge of the juvenile court, and had done a great deal of work himself in surveying other opportunities for placement of delinquent children which came under his jurisdiction. One must admire his determination to improve the treatment of youth who are in trouble.

As to the medical nature of the problems of the children which came to his attention, he said the troubled youth which appeared before him had problems of both criminal behavior and dependency (the abandoned, the molested) rather the kids who have just committed a crime. Asked "Were all those kids who appeared before you, did you feel that most, if not all, suffered from underlying emotional problem? He said "Oh, I think that's fair." I'm sure you pick out one or two or three or four, but, I mean, of the thousands, its almost, its very common." He conferred with and listened to the views of various mental health experts, being in touch with psychiatrists in hundreds of cases, and calling them to ask specific questions about what could be done with the individual child. He said for many of the children, the state mental hospitals would also have been an alternative, but before then he used some of the high caliber mental health residential facilities such as Brown. Debereaux, and Marydale. He said they had two units, one in the welfare department and one in the probation department, "that the sole function was to monitor the kids we had in these 24-hour schools and make recommendations on where the kids should go." He said the vast majority of the crimes committed by the youth were property crimes, such as auto theft and burglary; they came out of broken families with a traumatic childhood, they failed in school, and failed in their family situation, and "trying to turn these kids around by putting them in a cell just, you know, just doesn't work. . . and besides that, its very, very expensive when you start looking at the bucks. Its incredible how expensive that is with something like is half again as cheap (when compared with the costs of the California Youth Authority CYA institutions.) Asked by Counsel "When you have (just to clarify the record,) when you have talked about incarceration of a young person, you have used interchangeably in your mind, correctional incarceration and mental health incarceration, as far as locking up kids?" He answered, "Yes, its the same." Asked "Are you bothered when a treatment facility, in conjunction with mental health people, utilizes a lot of staff who do not possess academic degrees? He answered in the negative, explaining that sitting down and talking through the problems of these kids doesn't work. You have to get a program to burn off the energy and develop the kinds of relationship between the kids and the adults that the kids can begin to do things so they can begin to feel good about themselves again; that's contrasted with sitting in a room with some learned professional, which he did not think helps the kids consistently and didn't work.

Asked to give an example of children under his jurisdiction, he told about a twelve-year-old who had become an accomplished burglar, had been through several 24-hour schools, the last of which he left on a counselor's motorcycle. He said it was an emotional problem. He was brutalized. He said 'He was brutalized." As a matter of fact, had him tested. He may even have

had some brain damage. . ." He said the youth would have ended up in the penitentiary if he had not found some method such as and after being at "He isn't even the same kid." He had been sullen, inarticulate, resentful, completely out of control, and he had become articulate and able to stand up in front of a group of adults and talk for fifteen minutes.

As to the DES audit conducted by Mr. Mathis and his staff, he said came up with a "pretty good bill of health," and he relied a great deal on Mr. Mathis.

On cross examination he testified that he considered incarceration in a state mental health facility approximately equivalent to incarcerating children in a confinement facility. The only difference was the motivations in the mental facility are not punitive. He said the most severely disturbed children would probably represent 10 percent of the total population of the mental health, and not all the kids are put into the mental health system of the State of California came through the juvenile court. But his testimony was limited to the ones who came through juvenile court. Asked if he had previously testified that "You thought it was O.K. for unqualified, I mean medically unqualified staff to be involved in the direct interrelationship with the juvenile patients" He said, "that is correct." Asked to elaborate, he said "Well it doesn't seem to me that these kids, they need a human being they can relate to and they can trust. I mean, that's probably the single thing they don't have most, and they need a relationship with an adult that they can feel good about, and you don't need a PhD to get that." Asked if he considered establishing a relationship of that kind to be medical treatment, he said "I don't know whether you consider it medical treatment or not, but it goes a long way to getting these kids so they can act civilized, which is what I'm looking at down the end to attempt to civilize them." As to the confrontation technique employed by medically unqualified staff members, he said in his opinion, only people who had been into this area a long time could touch the kids. Asked if that makes them medically qualified? He said "I don't know."

On redirect examination he said he understood that the persons who were on the front line dealing with children are under the supervision and work hand in hand with PhD psychologists, psychiatrists and whatever is needed for the particular child. He pointed out "Its very difficult the way that is spread out. They have real tough logistic problems with these kids. If you could put them all in one place, put all the staff together, you could treat this thing--that's hard to do when you're spread out all over the country. I understand they do the best they can under the circumstances."

Exhibit 17 is an affidavit from John R. Harden, a surveyor with JCAH since August 1976, who conducts surveys of residential psychiatric facilities throughout the country. Mr. Harden has a Master's degree in Public Health, and is working on a Doctorate in Forensic Psychology. He conducted two surveys at facilities for JCAH, the first a survey of the Tucson, Arizona program from February 27 to March 2, 1978. The second survey was of the Colorado Springs, Colorado program (which is not relevant to the issues in this proceeding) in February, 1979.

He said "During both surveys of programs, I found that had achieved substantial compliance with JCAH standards," and the Tucson program was awarded a two-year accreditation as a residential psychiatric facility, the second two-year accreditation received by the Arizona program. Its first two-year accreditation was in 1976 pursuant to the findings of recommendation of Edward Greenwood MD, a Child Psychiatrist affiliated with the Menninger Clinic in Topeka, Kansas. Mr. Harden found that the call-in care provided by the Arizona program was in substantial compliance with the standards of the accreditation manual for psychiatric facilities serving children and adolescents in 32 listed areas, only two of which, (e) clinical care and evaluation and utilization review studies and (n) treatment modalities, are relevant to the current discussion. The first element, clinical care evaluation and utilization review studies, was noted to have been "complied with, with certain exceptions." He said it was his perception that based on the 1978 findings, "was providing appropriate and necessary care to disturbed youngsters."

David A. Ruben MD, submitted an affidavit (Exhibit 18), stating that he is a child psychiatrist practicing in southern Arizona, with a medical degree from the University of Arizona, and completed his residency in General Psychiatry, and his fellowship in Child Psychiatry. He was Medical Director Staff Psychiatrist from August 1979 to December 1981, and since that date has acted as Consulting Psychiatrist on a part-time basis, until has been able to engage a full-time psychiatrist to replace him. Dr. Ruben came to two months after it was terminated; upon assuming the position in August 1979, he reviewed the clinical records of the patients then under treatment, who had been under the care of his predecessor, John L. Schorsch, MD. From his review of those records and his nversations with Dr. Schorsch and many other staff, he said "It is clear to me that Dr. Schorsch had been intensely involved in providing individual treatment to youth, in the supervision of treatment staff, and in providing effective in-service staff training." He stated that "has most definitely followed a medical model. The Medical Director--Psychiatrist has directed, and has the final authority concerning, all treatment provided to patients. In addition, psychological problems are identified as early as possible; and appropriate treatment is prescribed for each individual patient. Above all, and beyond the medical model mandated by JCAH and OCHAMPUS standards, had earlier incorporated, and still incorporates, other important approaches into its program. These include milieu therapy, provided in group homes and is a day-care program; very professional and effective confrontation of youth on various issues relevant to treatment, which confrontation occurs as issues arise; and extremely therapeutic impact-oriented wilderness survival experiences." He said "OCHAMPUS' allegations that staff are unqualified to provide treatment for youth placed in the program are totally erroneous." Although some staff do not have extensive traditional academic backgrounds, "all staff have proven themselves quite capable of providing effective treatment for patients. Indeed, it has been my observation that, no matter how highly credentialed they may be, staff are quickly terminated if they are unable to provide effective treatment; in mind, this is the 'credential' that is the most critical."

Dr. Ruben said he had learned that OCHAMPUS asserts that CHAMPUS eligible youth were involved in the juvenile courts in some manner, but were not suffering from emotional disturbances but rather from "character disorders." He said "OCHAMPUS' stand on this issue is simply inaccurate in a psychiatric sense. The acting-out behavior on the part of youth, which often comes to the attention of juvenile court judges, is almost always an indication of serious underlying emotional problems. In essence, the destructive behavior often manifested by a young person prior to his placement was and is logically and obviously attributable to underlying emotional disorders. The Diagnostic and Statistical Manual (DSM III) which is utilized by the American Psychiatric Association and Psychiatrists worldwide, definitely classifies such behavior as symptomatic of various psychiatric problems." He added "As a practicing psychiatrist who is totally familiar with program, I have found that provides highly effective treatment and care to deal with the serious and emotional problems of the youth placed in its program." Further, "based on my experience as a psychiatrist, and my familiarity with JCAH and OCHAMPUS standards, it is clear to me that the various programatic and clinic grounds set forth by OCHAMPUS in order to justify the termination of as an OCHAMPUS-approved provider, are totally without substance."

A copy of the Defense Audit Services' final report dated November 14, 1979, on the "Audit of Management and Administration of Psychiatric Benefits under the Civilian Health And Medical Program of Uniform Services" is Exhibit 19. A review of the report indicates that the Defense Audit Service found the OCHAMPUS and ASD(HA) offices to have fallen short of their responsibilities in administering the OCHAMPUS program with respect to Residential Treatment Centers for troubled youth and adolescents in the following areas: (1) Providers were not collecting, and in many instances making little or no effort to collect, beneficiaries' cost shares, which led to abuses in psychiatric benefits both to the providers of psychiatric care and to CHAMPUS beneficiaries; (2) because insufficient controls had been established to review the actual cost of psychiatric care, OCHAMPUS had permitted RTC's to bill a combined charge for all services, resulting in the payment to 3 RTC's of two hundred and fifty thousand dollars more than required by statutes; (3) (the single most important finding.) "OCHAMPUS could also reduce the costs of RTC care by better controlling the length of treatment and evaluating the results of treatment provided." (4) OCHAMPUS had no means of enforcing the policy that court-ordered care not be paid for. There were 10 recommendations addressed to ASD(HA) and 10 more addressed to OCHAMPUS. The thrust of the report is that the management of the CHAMPUS program needed to be tightened up considerably with respect to the payment of millions of dollars per year to Residential Treatment Centers for troubled children and adolescents. While the final report was dated November 14, OCHAMPUS had a draft of that report in its possession some time before they made the decision to terminate . The findings generally support the existence of financial practices throughout RTC's with which OCHAMPUS charged as violations, either of the statute, the DOD regulations, or Participation Agreement.

John Peters testified that he and his wife Vicky Peters (now a Lieutenant, USAF) were employed by in '78 and '79 as house parents for 7 months. He had had no prior experience, only a few psychology courses in college and had worked as a bartender and heavy equipment operator. They had 5 to 7 children;

their supervisor was Bill Scott, a Family Counselor. At times they had no Youth or Family Counselor from two to three months, so they did counseling with children and parents. Some of the kids had not seen the Psychiatrist in three months; they tried hard to get them to the Psychiatrist once a month, usually for fifteen to twenty minutes, and they would be present. No other medical treatment was provided.. He said because of the intensiveness of the work week and the high turnover of staff, most of the people stay only a short time, including Paul Duda, a clinical psychologist. Family counselor Rich Zaza was particularly abusive to the children. As to confrontations, they had no training on the subject, but received two demonstrations at the school. He said Dr. Duda worked primarily on paper work, and left because he was not effective, saying that he was tired shuffling papers.

Michael Kelly, age 24, was a former resident of Baker House from March 1975 through March 1976. He said he did not see a medical doctor before going into the facility and saw a psychiatrist one week after he entered. He said the psychotherapy consisted of group meetings at the house once a week with the houseparents and family counselor to talk about problems. There was a lot of screaming, abusive language and pushing by the staff, to "open up" the kids. He saw Dr. Lazarus two different times, each for one hour, it was not very pleasant, as both yelled and screamed at first. He was the boy whose head was shaved after he and another kid stole a car and Executive Director Bob Burton made a deal with him that if he was lying they'd shave his head; it turned out he was lying, Burton said "Shave his head." They did it with shears, but he did not resist. He had an altercation with another boy named _. who said he was Burton's favorite and the first resident. was violent and crazy about half the time and one time kicked him in the groin. A staff member about 23 tried to calm Billy down; someone else arrived a half hour later and took him to the hospital; surgery was performed and he lost a testicle. He said he attended two family counseling sessions, and there was a great deal of yelling at him and his parents; his parents dropped out and decided he shouldn't see his parents any more. On cross examination he said before going to he had been labeled "incorrigible" and had been stealing cars and running away. He overcame his problem of lack of honesty.

Raymond Wagner, a professional Social Worker who had been at OCHAMPUS for six and a half years, testified that he had surveyed RTC's, drug and alcohol centers, and was now assistant to Dr. Rodriguez on psychiatric care. He had a BA in social work in 1963, with emphasis on children's problems. His MSW in 1967 was in the supervision of families and children. He was a clinical social worker for three years, specializing in drugs and alcohol abuse. He had been a member of ACSW since 1969 and has a Clinical Social Worker license from California. He was on the 1977 survey of as a part of a national review program regarding the new performance standards. The Appendix A standards were used instead of JCAH standards. Of the five Arizona RTC's surveyed, all took court order placements. One was terminated, was suspended, and three others were required to take corrective action. As to the reasons for which was suspended, he felt they were mostly inconsequential and correctible. His main concern at that time was not the quality of the psychiatrist's care, but that not enough time was being given to each child. Instead, most of the work was done by the family counselors,

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but that was largely administrative. He said was making a genuine effort to upgrade the professional standards of its staff. If there had been qualified clinical therapists at the local level, he would not have been so concerned about the psychiatric coverage. was suspended for 45 days to correct the identified deficiencies in psychiatric services, both as to individual and group therapy. Family counselors were not competent to provide therapy. He spoke with Dr. Lazarus briefly; the problem was the short time the Psychiatrist had available. He said JCAH accreditation is not of primary importance to OCHAMPUS; it is secondary to OCHAMPUS' own standards.

He said Mr. Bair and Dr. Eckhardt did a follow-up to his survey in January 1978 and found that had corrected all deficiencies except II(a)(1), concerning staff qualifications.

George Bair, Chief of the Benefit Services Branch at OCHAMPUS, with a BA in social welfare, two years as a coach and house father at an RTC and two years in the Public Health Service, received his MSW in 1968. In the 1977 survey he was chief of the Survey Branch. He said they had a thousand RTC's in 1974 which in two years later was down to 85, as "Mom and Pop" outfits had dropped out voluntarily. He said the initial survey of was the same as the others, but the difference was initial response. They questioned the integrity of the surveyors and were not responsive to their recommendations. Their tone was legalistic, coming from Mr. Linden. At request, they went back in January '78 to take another look. He took Dr. Eckhardt to help him regarding staff qualifications, and the Dr. did the peer review with Dr. Lazarus. Their findings were that was out of compliance with the standards regarding the sufficiency and qualifications of their professional staff. He said staffing is the most important ingredient in an RTC, and had been a problem since 1974 with . The deficiencies they found were: A nontraditional pattern, in which it was hard to identify who did the treatment. They had 28 primary therapists, according to Dr. Lazarus; these were the Family Counselors. He looked at their qualifications and found very few qualified by education, training and licensure (MSW, PhD in Clinical Psychology). He decided to suspend for 45 days, to give time for them to submit a plan to come into compliance; during that time there were to be no new adminisions. He said there was some doubt whether intended to comply. Later when he received plan and OCHAMPUS accepted it, he expected to fill the family counselor positions with MSW or PhD's. In April 1979 they received a complaint from Fort Huachuca about , plus the Tucson Star articles, and made an immediate investigation regarding the financial and child abuse charges. A team visited Tucson and interviewed children and employees. Dr. Margolis of the Survey team made an onsite investigation which showed that professional people newly hired were not providing

direct psychiatric services, and many had left. This confirmed their original finding, which was that was not in compliance with the staffing requirement; they gave them two options, of which decided on the upgrading of Treatment and Program Directors. In April 1979, OCHAMPUS decided to propose to terminate and they sent the show cause letter. A month later there was a meeting with in OCHAMPUS' office in Denver, and their staff was not satisfied with explanations of the complaints and deficiencies. In June they terminated on his recommendation to Graziano and the Division Chief. He said the Hiliarys provided a tape recording of a confrontation with a CHAMPUS patient, ( ) in a home, with a Family Counselor and another patient. That tape was received as OCHAMPUS Exhibit V, and was documentation considered by OCHAMPUS when it decided to terminate . During his investigation, he interviewed the Peters, the Ruggs, and four or five other staff members. His impression of their veracity was that they were sincere and honest and their stories were consistent. They did not appear to be anxious to hurt nor were they vengeful, but seemed concerned about the kids, and felt they had to tell their stories.

On cross examination he testified that he is not an ACSW certified social worker. Doctor Eckhardt was chosen to review the competence of the staff and whether provided psychiatric services. In CHAMPUS placements, was one of the largest in the country. Dr. Eckhardt reviewed Dr. Lazarus and the services he provided, and Bair reviewed the qualifications of the others, primarily the 28 family therapists. Both reviewed cases and visited several homes and talked with staff and youth. He said all of the 1977 violations were found to have been remedied except one--staffing. The psychologists. PhD's and MSW are critical. The concern was what services they provided. Dr. Eckhardt did not look at the quality of staff other than Dr. Lazarus. His definition of "other professional staff" found at Program Director, Treatment Directors and Family Counselors, all of whom provide psychotherapy. Overall, Dr. Eckhardt was impressed with program, and he also was impressed, except for the staffing issue; he thought there were some good elements in the program. Asked if there were any better programs, he said there was one operated by the San Diego Boys and Girls Society. He said as a social worker he liked but OCHAMPUS requires a medical program, and that is not what provides. He denied that he was "building a case" against .

Asked to describe his opinion as a social worker that had a good program, whereas when he was an OCHAMPUS representative he found them not to meet the standards, he responded "In January of 1978 I thought there was some elements about as far as supervising, taking that kind of kid we just talked about, the delinquent adolescent, there was some good things. I think kids were closely supervised. I think they had a lot of activities for them. The staff seemed to be quite involved with the kids. As someone in San Diego looking for a placement of that kind, if that is all I knew, it would be a placement as I would get it from the medical treatment point of view, because we on the street aren't necessarily looking for medical models for kids, maybe to teach the kids to get along better with parents and not deal with some other kind of dynamics. Now, when I look at it from that point of view, as the role of looking for a medical program,. because that is where I am coming from, then I have to say no, it doesn't meet that model. And if I had a kid

that needed that kind of treatment, a medical model kind of treatment, I would not place him ( )" He disagreed with Dr. Eckhardt's testimony that fit the medical model, and believed he was more qualified than Dr. Eckhardt to make that determination, "based on what we looked at." They were both impressed with Dr. Lazarus' qualifications, but below him was weak with qualified people.

Mr. Bair testified further in June. He said OCHAMPUS' concerns about professional staffing were communicated to at least as early as the beginning of 1977, and on Feb. 9 1978 they defined the requirements they expected to comply. In a conversation with Mr. Burton and Dr. Lazarus on January 30, Mr. Graziano had identified 8 positions which needed to be upgraded to the level of certified therapists if were to be deemed to be in compliance with the Standards; specifically, at a minimum, must upgrade the educational and license requirements for its 6 Family Counselors, its Treatment Directors, and its Program Director. Mr. Graziano pointed out that hiring certified therapists alone would not automatically ensure compliance with standards, and that the 8 positions must not only be upgraded, but the incumbents must have significant direct involvement in the treatment of patients and maintain very strict surveillance over the primary therapy staff.

As to the visit he and Dr. Eckhardt made to in January 1978, he said Dr. Eckhardt's involvement in that survey was limited, as he focused only on the qualifications and services being provided by Dr. Lazarus, and did not look at the qualifications of other staff. Asked if the one Psychiatrist was enough to handle the Arizona program, Dr. Eckhardt said that he did not feel that it was and he said he thought "there could have been more psychiatrists." He believed Dr. Eckhardt agreed with him with respect to the Survey Team's finding on the level of professional staffing as being inadequate. He said Appendix A to the Regulations, Paragraph 2 A1(c), "Other Professional Staff" requires that all primary treatment staff be professionally qualified, and that meant either licensed or certified; he regarded that as an objective standard.

On recross he said that in addition to indicating that there could have been more psychiatrists at Dr. Eckhardt testified that "this is a chronic problem, and was very true in the State Hospitals in Colorado and in Denver." Asked "did he have criticism that was deficient in that it had too few psychiatric contacts with the kids?" He answered "That was part of his concern--and I am fuzzy on that particular issue--but he did express about the size of and that was where he was coming from, that there could be more psychiatrists for this program." He conceded that Dr. Eckhardt testified that the availability of counselors and therapists was better than that found in mental hospitals; he pointed out that the availability of people, of "other staff" including house parents, was not the issue; instead, it was a qualified staff that OCHAMPUS was concerned about. The noncredentialed people were available, and there was no problem there; what they were concerned about was the qualified (certified) people, and those people did not exist. He conceded that Dr. Eckhardt said that he had a very favorable impression of the program; asked about Dr. Eckhardt's impression that adhered to a medical model, he said "That is just wrong, he did not look at the rest of the staff. He only looked at one person and their background. He did not look at the qualifications." He said not many of the

Family Counselors with whom he had visited had Master's degrees. He said Dr. Eckhardt could not have come to a conclusion that the program adequately served the group of kids, as he did not look at the qualifications of' primary therapists. He talked to a lot of people, but they were not qualified people. He emphasized that the primary therapists in the program were not credentialed to do what they were doing, in terms of the OCHAMPUS standards which require "professional staff shall meet licensing or certification requirements of that state." Asked "If there was some MSW's, if there was some PhD's psychologists; how did know that it didn't comply with the terms of that as far as numbers of persons as compared to numbers of kids?" He answered "It is degreed people that you did have were not in the position that they had the responsibility for direct treatment." Asked if later selected one of the options given it, and believed it had complied with that option by April of 1979, was it true that the direct treatment staff needed to be these types of persons (meaning credentialed or certified persons), he said "Yes, however, you have left out the other part of that option. I think we also said at that time, 'While the second option would require the upgrading of fewer positions than could possibly accomplish with the present staff, it would require substantial reorganizational changes. The primary psychotherapy and case management would have to be shifted from the Family Counselors to the Treatment Directors. The Treatment Directors could then delegate specific therapeutic tasks to the Family Counselors."

Asked why, if hadn't complied with OCHAMPUS' demands by the April 1979 deadline, wouldn't that be listed in the 5 show cause charges, he said he could only assume that OCHAMPUS believed that was still in the process of upgrading the positions and recruiting new staff for the professional jobs, and inasmuch as it was still a continuing problem, he did not himself address it. Further, the five issues were those which were raised by the April fact finding mission which were dealing with the 5 specific complaints at the time: cost sharing, overcharging, duplicate billing, record keeping, failure to engage proper supervision, physical abuse issues;

On redirect he emphasized that the fact there may have been a chronic problem with respect to the availability of psychiatrists is not an excuse for the deficiency in that area that they found at .

Richard Rubb testified that he has a BS degree in Sociology. He and his wife worked for from May 15 to June 25, 1978. They had previously worked at a private non-profit RTC in Albuquerque, New Mexico. His wife did not have a degree but she had had some experience. They were both house parents and family counselors at two different houses in Tucson. He did not feel they could properly perform both functions. The contacts they observed between the Staff Psychiatrist and the youth were "very little;" sometimes the kids had not seen him at all even though they had been in the house for several months; this conclusion was based on their observation of the patients' records, which they were required to bring up to date. He actually observed only one therapy session when he took one of the boys to Dr. Schorsch; he and his wife talked with the Psychiatrist about five minutes, and then they brought the boy in and they talked with him for five to ten minutes; then the boy left and they talked to Dr. Schorsch for another five minutes. He believed it was an initial psychiatric review, which was supposed to have taken place soon after the boy got to the house, but he had been there five months at the time.

He and his wife were asked by Mary Harper, the Treatment Director, to back-date records of treatment of children under their care. They observed a confrontation, where a counselor goaded a patient into getting angry, literally backed him into a corner by walking towards him, because he did not take off his hat. After the patient tried to push the counselor away, he was grabbed and they wrestled and landed on the floor. He remembered the counselor spitting in the patient's face, which made him angrier and he was kicking and screaming, then Bob Burton came in and took over, holding the counselor down. He said a counselor was not considered to be doing his job unless he did a lot of yelling and screaming and swearing at the kids, and he thought this was verbal abuse. This also went on all the time, and that's one of the reasons he and his wife left. He said they felt that this kind of therapy accomplished nothing, and did not help the kids work through their anger. He said "I think there's a certain amount of validity in that type of therapy, if its administered by someone who knows what they're doing, who is well trained, who knows the kids well and knows what that kid needs as far as treatment; but at it was administered by untrained people, by house parents who a lot of whom had very little training as far as child care work. Everybody got yelled at, its just what happened there. It was the 'therapy' that went on. We felt it was very senseless." They did not feel qualified to administer that kind of therapy; he said if a girl misbehaved or ran away, it was always said to have been for a sexual reason, and the girls were usually referred to as "whores and sluts." They left because they were very disappointed in the program, but he was not disgruntled. He said the house parenting in Albuquerque was one of the best jobs he ever had. He and his wife enjoyed the work greatly, but both were very disappointed in what they found at .

On cross examination he testified that in the 40 days he worked at he would had a limited knowledge of contacts between the Psychiatrist and the kids, but said they were in contact with 20 kids in three different houses, and were required to review the records of those 20 kids. Although he and his wife dealt with the kids on a personal level, on the basis of mutual respect; viewed his wife's behavior as being seductive, which was so silly that it didn't deserve the dignity of response. After they heard that charge, they left. If had characterized his own performance as lackluster, that was not communicated to him; he was not surprised, however, because he and his wife did not yell and scream at the kids and could not fit into the organization.

On redirect he said the charge by Mary Harper that his wife was seductive was that his wife wasn't yelling at the kids, and when she talked softly to them, that was seductive. He observed his wife's behavior with respect to the males in the house, and did not consider her behavior seductive, and believed that he would have noticed if she had acted in a seductive manner toward another male.

Charles Gallegos testified that he had been employed in various positions at OCHAMPUS since November, 1976, had a BS degree in biology and psychology followed by six years experience with Medicare, where he was responsible for onsite reviews of acute care hospitals and nursing homes; and then 31/2 years as a fraud investigator. For several years after joining OCHAMPUS, he was involved in the certification of Residential Treatment Centers, and they had just hired a team of surveyors, all of whom were qualified as either MSW's or Psychiatric Nurses, to conduct onsite reviews to determine compliance with the

standards in Appendix A. At that time Mr. Graziano was Chief of the Health Services Directory, and was responsible for all provider certification. After the survey made in the Fall of 1977, he and Mr. Graziano discussed the results and determined to make an initial 45-day suspension; following that there was a series of negotiations and letters with through January 1978, when the resurvey resulted in the determination that the suspension could be lifted because of the information provided by regarding their willingness and intention to come into compliance with the deficiencies that were noted. A year later another survey uncovered a lot of the deficiencies concerning the medical staff, and professional involvement and treatment program were again brought to light. At that time the Arizona Daily Star articles were being printed, and they had received telephone calls from Fort Huachuca and some individuals, so in April 1979 he went to Tucson and made contacts with some former employees. This was primarily the result of complaints received from Sgt. about the treatment of her daughter, . Also, the DAS audit was going on at that time, and the draft of their report indicated problems in the areas of cost sharing, so they felt it was necessary to follow up on these matters. As the DAS audit, at least 5 RTC's were being audited, including . One team member initially talked with Don Mathis of DES to see what they were doing at that time, while the others were checking other sources, and then they came to Tucson for a day, to talk with former employees and parents of ; they met with officials on the third day, and these included at least Michael Cracovaner, Dr. Schorsch, and Mr. Linden. They also met with two new staff members, Dr. Robert Sawicki, who was involved in the street program, which was not a CHAMPUS activity, and a newly hired psychologist named Julie Williams. They discussed their involvement in the program, and he received the impression that "they really didn't have much direct involvement in the things like the hiring of employees and the direct treatment of any of the children. In fact, Julie Williams told me that she had not been involved in any of the direct treatment at that point. She had only been there, I believe, a month or so. Dr. Sawicki was involved with the street program, which CHAMPUS never really had a great deal of involvement with. He felt that he had some input into that program. Again, he didn't have any control over, essentially, his own destiny, meaning he had no say as to who was hired or fired or which direction the program went in." Shortly after their return to Denver they discussed the matter with OCHAMPUS officials and thereafter issued the letter suspending future admissions. In May, he visited Tucson again, to recontact some of the individuals he had talked with on the earlier visit and to obtain written statements from them concerning their involvement with the program. He described his contacts with Bob Lowe of the Arizona Daily Star, starting with Mr. Lowe's initial contact about the DTS audit, on which he was unable to furnish any findings; later he talked with Mr. Lowe about individuals that he had taken statements from concerning the program including Mr. Carillo, Mr. and Mrs. Peters, and Wayne Burg. The rest of the names he obtained were through contacts with Peters, Carillo and those folks. He had asked Lowe if he would send him copies of anything that he wrote, but that became unnecessary because the JAG office of Fort Huachuca was furnishing him the newspaper articles,

On cross examination he said he did not have professional credentials in psychiatry or psychology, and did not consider himself qualified to review that aspect of any organization or program. He was responsible administratively for the certification-and determination of CHAMPUS standards for RTCs, and they had a team of surveyors who were professionally qualified. He said by April, 1979 not the only unresolved issue, but the primary issue, was the issue of staff composition

and this was the only unresolved issue that was still being addressed and still of concern following the resurvey; there may have been other minor issues, but the real issue was "whether or not the program was in fact medically based, whether or not the staff was professionally qualified to render the services." He said the OCHAMPUS standards are the guidelines, and these do not indicate any ratio of therapist patients. Asked "What exactly did you do during the 1979 survey-to-determine whether had complied with the OCHAMPUS composition standards?" he answered "During that visit I talked with Dr. Schorsch, and I think I already mentioned I interviewed Dr. Sawicki and Dr. Williams." Asked what facts he found which disputed contention that it had upgraded all Treatment Director positions to meet the OCHAMPUS mandates by the April deadline, and he said "I guess all I am contending is that the contacts I made at that time and the questions I asked concerning staff yielded the fact that there has been essentially two people hired, Dr. Sawicki and Julie Williams. Dr. Sawicki being limited to the street program and Dr. Williams really not having been involved in any kind of treatment at that point. There was also another name mentioned at that time, Sally Saen, who had not yet arrived at the time of our visit." Asked if he was also aware that William Scott, MSW was also on the staff at that time, he said he was aware that Mr. Scott was the Program Director or Treatment Director for another southern county in Arizona. Asked if he didn't find that had made good faith efforts to comply with OCHAMPUS staff composition mandates by this time, he said he found that had undergone a recruitment effort, the success of which was rather limited based on the number of people who had been hired. He said there were some credentialed people that he knew about, already employed by , including Bill Scott and a psychologist named Duda. Asked if he would agree that good faith efforts were being made by to comply with the mandates set for it by Graziano, he said "Certainly efforts were being made. This was not an issue which had arose in April 1979. It was an issue that came out of November 1977. So we're talking 17, 18 months of effort and 18 months later we still have not found full compliance with what was mandated 18 months previous to that." He said an attorney from the DES called him in June about CHAMPUS payments, and told him that Sally Saen and Dr. Sawicki had left . Asked about back-to-back two-year accreditations from JCAH, he said "JCAH is the starting point for participation in CHAMPUS. Without JCAH accreditation there is no way anybody, regardless of the program, can be a CHAMPUS-approved Residential Treatment Center."

On recross he was asked why the text of the June 11, 1979 letter from Graziano to appeared in the Arizona Daily Star, two days before that letter was received by VisionQuest, he said he did not provide it and was not sure how that happened, but if it did happen that was not appropriate. He later said "I guess that did happen" but concluded that it was inappropriate to provide it prior to the time it was provided to .

Clare Burton, wife of the Executive Director and public relations person for , testified about the making of a film on the Wagon Train which was prepared by CBS News. She said the confrontation that was depicted was typical of what goes on in a Wagon Train, but it was condensed, in that they took about 50 hours of film, but used only 1 hour, so the episodes appeared to be much closer together than they actually-happened. had no way of controlling what CBS finally showed, and nothing on the film was staged. The film was shown at the hearing, and a copy was received into evidence.

The Hearing Officer inquired as to the confrontations shown in the film, where Mr. Burton, another man and a woman talked to the youth in a very direct and strong tones, and asked how those tones compared with the "yelling and screaming" that had been described by the witnesses as being characteristic of confrontations. She said that confrontation means "basic issues" and at times it gets loud, but there are other times when it is not so loud. She said the volume would be about as loud as you can get for a time, but after a minute or two or a few minutes would taper down and would end with the kid and the staff talking at a normal level. Asked her opinion of the loudness of the language on the confrontation tape, she said "we will have some yelling and screaming on that."

Esther Rosen testified that she is a Staff Analyst for the Office of Appeals and Hearings of OCHAMPUS, and handled the administration of the appeal. In the course of doing that, she compiled a series of files which were identified as patient case record files, concerning the statements made by regarding claims submissions; all but two of these files were selected by her at random from a group of 40 or 50 files which had been brought to OCHAMPUS' attention as a part of the charge of improper payments; the other two were the youth about which there were charges of abuse, and . There was objection, at least initially, by Counsel that these files should not be received as evidence, inasmuch as they had not been furnished to him along with all the other appellate files prior to the first hearing, implying there was surprise on his part. After inquiry by the Hearing Officer, it developed that those files had been made available to Mr. Linden at the first hearing in late April; the Hearing Officer then found there was no basis for to have been surprised by the offer of that evidence, inasmuch as it had had 60 days to review the matter and prepare to meet any evidence contained therein during the second session of the hearing which was held the last three days of June. Thereafter Mr. Linden withdrew the objection, and the files were received into evidence.

Dr. Alexander Rodriguez, a Commander in the Navy, testified that he is assigned to the Office of Secretary of Defense and detailed to OCHAMPUS as medical director. He had been in that position for about 9 months. He has a B.S. and an M.D. followed by completion of a residency in adult and general psychiatry. He was Director of the Navy's Neuropsychiatric training program and Chief of Psychiatry at the U.S.. Naval Hospital, Guantanamo Bay, Cuba; this was followed by the completion of a two-year fellowship in child and adolescent psychiatry at the University of California, San Francisco. He is a member of a large number of professional associations, including the American Psychiatric Association, the American Academy of Child Psychiatry, the Colorado Psychiatric Society and Colorado Academy of Child and Adolescent Society, and many others. He is board-eligible in adult and general psychiatry, child psychiatry and utilization and review, has completed Part 1 of his American Board of Psychiatry and Neurology, and is due to complete the second part in November, 1982. He had received numerous awards from psychiatric organizations, and had served as clinical instructor in psychiatry at the University of California and the University of Colorado, teaching psychiatric residents and supervising psychology and interns and social workers, plus maintaining an active clinical practice at Fitzimmons, where he sees patients. His professional and administrative career has been involved in hospital base practice and with very disturbed children and adolescents and at one time while detailed to the Department of Health and Human Services, he was responsible for oversight of all the children's programs in the Department.

Dr. Rodriguez testified that before he was assigned to OCHAMPUS, DOD had published a notice of proposed rule making, proposed termination of Residential Treatment care as a CHAMPUS benefit; he believed that residential treatment care "is an absolute essential component of the spectrum of psychiatric services that we would consider as acceptable benefits," so he became involved in staff work on that proposal; thereafter, the Assistant Secretary of Defense for Health Affairs retracted the notice of rule making, but required OCHAMPUS to develop a major plan of action to make residential treatment "high quality care that was accountable, financially and in terms of quality of care and utilization review." Thereafter, OCHAMPUS sponsored a national workshop, including professionals in the field of psychiatric care for children and adolescents, to review the CHAMPUS standards and revise them so that they will be "the state of the art" for residential treatment care. Appendix A of the OCHAMPUS regulations continues to be the cornerstone of those standards. One of the principal participants was the President of the American Society of Psychiatric Services for Children. In addition, Dr. Rodriguez is actively involved in the area of Military Families and Community Psychiatry, or troubled families where there is child abuse, rape, sexual assault or other kinds of chaotic family life. He said "One of my reasons for coming to OCHAMPUS was because of the opportunity to continue my work as a military psychiatrist for military families in an area I thought I could broaden myself and also perhaps offer some of my skills and my interests." He considered himself qualified to comment on the psychiatric treatment needs of children and adolescents of military families.

He said he first heard of in 1979 at San Diego from Dr. Perry Bock, whom he considers an outstanding professional in child psychiatry and also an outstanding administrator. He said Dr. Bock expressed some concern and questions about program, primarily in relation to the "danger of confrontation therapy." When he arrived at OCHAMPUS, he learned that had been terminated. Thereafter, in preparation for the hearing, he was asked to review the available records. A Navy Research Medical Corps Captain, Dr. Jannsen, who is head of the Children's Division of the Meninger Foundation Clinical Hospital, was on duty in his office as a two-week reservist. He and Dr. Jannsen reviewed appeal records, including correspondence, case files, and other documents concerning the appeal.

He is also acquainted with L. George Horne, one of the outstanding authorities in the country on child residential care, in his opinion, and President of OCHAMPUS RTC Providers Organization. He had asked Mr. Horne what to do about , and was informed that Mr. Horne was not favorably disposed toward , because he had major questions about the nature of confrontation therapy. Further, his real concerns were about allegations that had been raised in the past about child abuse in the program. Mr. Horne told him that he had been asked by for some assistance in becoming a part of the San Diego treatment community. "He indicated to me that he communicated back to and to us, his phraseology, he told them to get their act together and then he would feel disposed to recognize them." He also said Mr. Horne told him there were top people in the child residential business who felt very favorably about . An objection was made to this hearsay testimony, and the witness stated that he recognized the double hearsay nature of the information, but that was a part of the information that he received from Mr. Horne, for whom he had great respect.

Asked if Dr. Jannsen expressed any opinion with respect to the review he conducted of records, he said "He had reservations about confrontation therapy. It was largely due to the potential explosiveness of it. He and I talked about the difficulties of working in this particular population of kids, particularly older, latency-aged children and young--older adolescents, particularly those who are tough, street-wise, angry children, who have been neglected and abused and who perhaps have been abusers themselves, who have been in and out of the penal system. We talked about that, I think, with a great sense of sharing opinions because that's something we have a lot of feeling about as professionals, how really difficult it is to treat these kids; that has bitten off a big bite to try and commit themselves to doing this. But, in review of the records, review of the peer review assessments, it was our conclusion that we both had serious concerns about confrontation therapy, and by the very nature of its potential explosiveness, that these are difficult kids to work with under any circumstances, they can--it can be extremely difficult under certain circumstances when they are being confronted in a very aggressive way. We had other concerns, just in terms of long-term consequences, which has to do with a psychological defense mechanism called "identification with the aggressor," that even where, through a very powerful, strong, loving and caring relationship with somebody, there is the communication of something else through physical striking, beating, pushing, intimidation, that something might suffer in a certain number of children with that kind of exchange. But, what gets integrated, incorporated into the psychology of that person is the use of aggression as a way of resolving conflict in the future." Their conclusion was the same as that of the 3 psychiatrists who conducted the peer review, Drs. Clark, Sams and Burkquist, all of whom were child and adolescent psychiatrists who reviewed the CHAMPUS records concerning cases in depth. Further, they agreed they would have difficulty in admitting a patient to the program as it was up to the point of termination by CHAMPUS. "I would have to say that I would not be able to admit a patient to that facility. I could not do that." He said that after hearing all the things that were presented at the hearing, he could not ignore the good, nor could he ignore the bad. He concluded, "I will say this: I really respect the people at . I really respect what they have undertaken. I can't come out of this without really seeing a commitment of that staff to children, to very troubled children. I think that tape today very poignantly demonstrated that, the last magazine article did. They're doing something very, very important in terms of trying to provide a service for many children, some of whom are certainly emotionally disturbed, and many, many more who are emotionally disturbed, but not of a very severe psychiatric nature. But they are certainly troubled, no doubt about that. So, I come out of this with a clear sense of feeling good things about , yet I still have many concerns about . One of those is the fact that operations are spread out over such a wide geographical area, and one psychiatrist would have difficulty in providing the direct supervision and immediate attention to patients which is typical of the classic mental health institutions, where they use psychiatric technicians and psychologists, both of whom are under immediate supervision of a psychiatrist; however, with the one psychiatrist is at such a distance from the patients, that he "doubted the ability of a psychiatrist to be able to provide the intensity and comprehensiveness of necessary professional services."

He testified further that OCHAMPUS has a Congressional mandate to establish care that is based on the BlueCross/Blue Shield high option plan, which is a very

traditional medical program, and CHAMPUS has someone looking over its shoulder to make sure that its program matches this medical model, which is intensive and comprehensive in its services. If not, they would not be able to pay for the services rendered. As to the relationship with JCAH, he indicated that CHAMPUS could not fully rely on JCAH as the only basis for its determination of compliance with the OCHAMPUS standards, but had to rely on its own inspection and follow-up system. He said after he was assigned to OCHAMPUS 9 months before, he had never observed any biases in OCHAMPUS' staff against CHAMPUS beneficiaries, and the people were committed to military families; neither had he perceived any biases by OCHAMPUS staff against Residential Treatment Centers. He said those staff members worked very hard to put together position papers that convinced the Assistant Secretary that he should reconsider his decision to propose elimination of RTC's as CHAMPUS providers, and thus that benefit was saved.

Asked about his familiarity with the confrontation therapy as a psychopeutic modality, he said "Confrontation therapy grew out of a form of psychotherapy called 'Gestalt' which encourages patients to express their feelings, and sometimes get their anger up in order to express themselves. And the therapist also expresses his feelings, so that there is communication between the two." He has used confrontation therapy in his practice, but it did not include pushing, shoving, kicking, bumping, yelling, screaming, cursing or name calling, hair pulling or any other kind of physical or verbal aggression, which in his estimation is not confrontation therapy, but "flirts with being assault and battery." He said "confrontation therapy has not been adequately evaluated in the literature." What he saw and heard in the tapes was not what he called confrontation therapy, but maybe simply confrontation, which came very close to abuse, if not outright abuse. He said some of the consequences of confrontational therapy, if improperly conducted by unqualified persons, could result in accidents occurring and people getting hurt during physicals. That was his greatest concern. The other concern was the latent kind of negative outcome that Dr. Jannsen spoke about, the identification of the aggressor, which had somewhat later in life causes the patient to resort to confrontation, and doing a physical on someone else, where something could get out of control. Asked what, in his opinion, would be required for a professional to be qualified to provide adequate confrontation therapy, and he said "It would take a very lengthy period of time to learn the techniques and to face their own feeling states about what was occurring to them and their patients, and is a very indepth process which takes great skill and great insight by the person providing the therapy in terms of his own psychological makeup." He felt it would take a minimum of six months to a year of highly skilled supervision and utilization of the confrontation technique to be able to be minimally skilled, and even then a kind of backup by a colleague or a peer would be required, to whom the therapist could turn to if he felt his powerful feelings would get him out of control. Even though he himself had practiced confrontation therapy earlier in his professional career, he said he would be unable to practice again without a refresher course with somebody who was doing it more regularly.

The thirty-minute cassette tape of the confrontation between patient and unidentified staff members and others was played at the hearing. Both counsel agreed that the intensity level of the tape tended to decrease as the tape was played, indicating that there was some movement towards final resolution of the problem. Asked to express his reaction to and assessment of what he had heard from the tape, he said he had previously heard

two minutes of the tape, but at the hearing had for the first time heard the whole tape. He said hearing the tape was a very emotional experience, and it appeared to be a real confrontation involving real people. He said "I was extremely uncomfortable with it, not withstanding we could not see, I think, a blind person could feel what was happening and could certainly hear the nature of this confrontation which greatly disturbed me. The older voice (a staff member) as well as the younger voices (perhaps patients) were mocking. They were disparaging and that was sadistic, calling her names, mocking in a mocking, taunting fashion. I have a really hard time accepting any person in a position of responsibility of any person who is charged to them for care on--under any circumstances calling this young woman the names that this older voice called her and making the kinds of statements that she did, and the tone of voice that she did. It was a gang rape in my view. It was an assault. I wrote down two comments that I identified as : "I am mad because you are hurting me, my f. ...g side is killing me. I heard those very clearly. This makes me very angry. That's my reason."

Asked if he had reviewed any case files of patients who had a need for medication, and should they have been given them as a matter of right, he said that he and Dr. Jannsen reviewed the file on , and believed that he needed a level of care of a higher level of intensity and comprehensiveness than could provide, and "certainly needed a higher level of psychopharmacologic care than he received; he felt that response was not timely and not appropriate in his case, and OCHAMPUS should have raised questions about reimbursing for that care.

Asked about the system of using nonprofessional personnel in psychotherapy, he said that for professions that are traditionally recognized as professional psychotherapists, any nonprofessional personnel would not be allowed to accept responsibility in a medical care system unless there was high level of proximity, immediacy, and expectancy of professional staff who could train them and directly and indirectly supervise them and their charting. Asked if he believed, from the evidence he had heard and the evidence in the record of the hearing, that the non professional staff at received adequate training and supervision to make this program adequacy accountable for patient quality of care, he said "On the basis of what I have heard and read I would say provided a very uneven level of supervision and training, that certainly, appeared to aim at adequacy, but very frequently fell below that." As a result of that, some undocumented numbers of staff are not qualified to do the things that they are doing because they are not adequately supervised and not adequately trained. This situation could result in a lack of adequate treatment or psychotherapy as only professionals are capable of doing primary psychotherapy. Spending time with patients and talking with them, following guidelines and goals established in the treatment plan, is not professional psychotherapy, even though it could lead, in combination with the efforts of many other people, to behavior change. He said "You have to differentiate between therapy and counseling. Nonprofessional people can do counseling and they're an essential part of the treatment program."

He said as to the staff which was required to be on outings, "Professional staff had to be along, as those things cannot be entrusted to nonprofessional staff no matter how well they are supervised." He believed there was a possibility of significant problems that could lead to the encroachment on patients' rights.

He said that "In general, ordinary living experienced people, you have, as I was when I first came into mental health as a psychiatric technician, can't provide very much more than caring, sharing, helping. Maybe a wish to do something good, but that has to be channeled and has to be given skills. And that's why we need a level of training and supervision that is continuous, and intense, and professional." Asked if he thought that could justify that it operates on a medical model, he said "No, I take opposition to Dr. Eckhardt's view that this facility operated on a medical model. I don't see in any way how one psychiatrist and a limited number of credentialed and noncredentialed mental health persons and a group of other persons who have variable kinds of experiences who are providing the primary contacts with the patients can be called a medical model. There seems to be a view here that there is a kind of peculiar 'trickle down effect' emanating down from the Medical Director, that as long as that individual accepted some general legal responsibility, that there was professional medical psychiatric care. And its very clear that was not being provided in a significant number of cases that we looked at. Dr. Jannsen and I, as well as Dr. Clark, Dr. Sams, and Dr. Burquist were certainly in agreement that did not have a medical model." He added, "being a juvenile delinquent in and of itself does not mean one has a psychiatric condition." He said he had never known a CHAMPUS policy or bias against providing access to emotionally disturbed children to psychiatric treatment because they were involved in juvenile justice system.

On cross examination he was asked if his testimony indicated some ambivalence about the program and what OCHAMPUS rules are, he said "If I'm ambivalent at all in my view of the program, I am not ambivalent about CHAMPUS rules or the action that we took. If the decision had to be made today, I would agree with the decision to terminate and I would do that reluctantly. Again, I stated why, I think it--I have problems with the program, with all the good things that are happening, there are some fairly major things, in my opinion, that I think really do not square with CHAMPUS standards. That's why it is difficult for us." He stated that he is not Board certified as a child psychiatrist, but practices and teaches child psychiatry, and supervises psychologists, social workers, psychiatric residents and medical students. His present practice is limited to military families seen in a military child guidance clinic, which amounts to about 5 hours per week;. thus he is more of an administrator than a clinician at this time. At previous times, he was a fulltime clinician in pediatrics and adult and child psychiatry.

He said OCHAMPUS considers RTC's to be absolutely essential, and that has been its view at least for the 9 months that he has been there, during which he had seen no such bias existed. There was some speculation from child mental health and social service organizations that such was the case, but it was incorrect, in his view. There were people from the Department of Defense who had questions about how OCHAMPUS was spending its dollars, but to say that resulted in a CHAMPUS bias is without foundation.

As to the two options given to in Mr. Graziano's January 12, 1979 letter, he was asked if he agreed with Graziano as whether that would have brought into compliance. He said "That would have addressed one of the issues upon which we terminated . That did not address a number of others which surfaced after that date; he said he could not agree that the only issue was staff composition. Asked more specifically "Were these things complied with and were these the issues that were being surveyed by your April team? Would you personally agree that brought VisionQuest into compliance on

the staff composition issue?" He answered "Structurally, yes. Process wise I am not sure. We would have to continue and evaluate that." He added that he wanted greater detail about the credentials of each of the specific individuals mentioned in the pertinent section of OCHAMPUS regulations whose credentials and licenses were required for an RTC. Asked if he considered Dr. Eckhardt to be an expert in the field of child psychiatry, he said "I have no understanding of what his clinical skills are so I can't comment on that. I know that he was on the faculty of the University of Colorado. . . I really don't know enough about Dr. Eckhardt to be able to say whether he is skilled and a qualified person. . . the best knowledge I have of him, again having spoken to no one about him, is simply that he is a Board-certified child psychiatrist who practices in the State of Colorado and that he lives in my community." He pointed out that the report Dr. Eckhardt signed clearly states that there is some question about staff composition, but he remembered testimony from Dr. Eckhardt earlier that seemed to contradict the statement, and he did not understand why his recollection would be different than his review during the time he was doing the survey. Asked if Dr. Eckhardt said that he believes that had adhered to a medical model, he said that was correct. Asked if he disagreed with that, he said "Yes, I do disagree with that." As to Dr. Eckhardt's statement about the availability of counselors and therapists at being better than that found in mental hospitals, he said he would agree on the basis of level of dedication and skills of some of staff, but it's all put into a relative frame, and Dr. Eckhardt is talking about one of the worst hospitals, in which he now works; after working in that hospital he would have been impressed, as with the witness.

As to Dr. Eckhardt's comment that some of the staff often perform more effective treatment than highly credentialed professionals, Dr. Rodriguez told of an outstanding American psychiatrist who had a severe emotional illness of his own, and wrote in his memoirs that he always turned to an elderly black man who worked as an orderly in the hospital whenever he went into one of his rages, because that man had learned how to approach people in a calming, caring, empathetic, sensitive way that allowed him to feel he could have someone to talk to that would be non-threatening that he could communicate with.

Further, as Dr. Eckhardt's mention of encountering patients who knew they could turn to someone on the staff, he said OCHAMPUS never had any contention about the caring of staff; the "questions have been about their professional credentials, and caring in and of itself is not enough, like professional credentials in and of themselves are not enough." As to the wilderness adventures being a "camping" experience, Dr. Rodriguez expressed the opinion that it is no adventure and it is no lark, and to many of the patients it was one of the special events of their stay. One of the things that psychiatrists are realizing is that change can take place outside the walls of the institution. He cited Discovery Land in Texas, which has a similar program to and Outward Bound. He added "Discovery Land, I think would be more unique than in the sense that there are professional therapists in close proximity to everything that occurs at every level on that outing." He said he would feel more comfortable with outings if there was an intensive level of professional level of psychotherapeutic staff available after the outing, inasmuch as psychiatrists and psychologists do not go.

Asked about his opinion of the confrontation technique, he said "I would just like to emphasize that I am not comfortable with confrontation techniques as I

understand it being applied at the time we were talking about, at , and I am really not comfortable with the low level of credentials of professional staff."

As to history, he was not. aware that at age 10 she spent in-patient time at Palo Verde Mental Hospital at Tucson and at 11 she spent patient time at the Arizona Mental Health Hospital; asked about the input of the staff members, and his use of the word "sadistic" and whether it could have been a way of giving out feelings from , he responded, "As I alluded to before in other references, it depends upon what you want to call something. But I have perceived people at who seem to believe that this particular form of confrontation, using physical confrontation, aggressive, vociferous or other kinds of aggression, that that is reaching out, breaking through resistence, wherever the phrase may be used, it is a nice, calm, cool and collected way that that's presented. I don't feel that calm and cool about that kind of confrontation."

As to the case of , where there was a difference of opinion between himself and the psychiatrist, regarding the need for medication. He said he found no other indications wherein a child needed drugs but medication was withheld by . He fully agreed with position and it would not use drugs to restrain children, however.

With respect to the training program for staff, and concerning his earlier testimony that there was a therapeutic part and counseling part, and whether might have thought it was complying in good faith, he said, "I can understand how might have thought it felt that it was complying in good faith. I remember now, listening to John Peters' testimony regards to how he, and as I remember his saying Bill Scott sat down to go over the check list and his competency in certain areas, and I was disturbed a little bit by the sense of frustration he had, that there was not a kind of mutual checking off of that in a sense of both of them acknowledging that in fact he really was competent. He was checking it off."

He said he was aware that conducted and still conducts extensive family counseling and conceded that there were some approved RTC's who did not include family therapy in their programs, but pointed out that such would no longer be acceptable to CHAMPUS in the future, under the new regulations to be effective in August, 1982.

Regarding his testimony that he had not seen any bias at OCHAMPUS with respect to court-ordered or court-placed children, he said he did not believe there was any validity to the ORBASKA News Letter charging such a bias on the part of OCHAMPUS. However, he was not at OCHAMPUS in 1979 and could not testify concerning their position at that time.

Asked further about his testimony regarding Discovery Land, he said that program was more than an adventure program, and is heavily oriented toward psychotherapy elements. Asked "Is not also?" He responded "In this respect I think we may say that Discovery Land might be somewhat closer to , and vice versa, and I also spelled out to you that my concern in comparing those two programs, and Discovery Land, but I felt much more comfortable with Discovery Land's utilization with the psychiatric staff going out on the outings. I do not feel comfortable with not including a high level of professional staffing on those outings. That would have made it much

more of a therapeutic experience." He conceded that the 1979 outings could have been different from the 1982 outings with which he was familiar; also, he did not know how many MSW's, PhD's and psychologists and so-called medical health specialists are or were engaged in Wagon Train activities or the outdoor activities at . Asked if he knew that psychiatrists had gone out to Wagon Train at times, he answered in the affirmative, and said he knew that children were removed from the Wagon Train at times, when psychiatric intervention was needed.

As to the ultimate question, whether the program was medical in nature, he was asked if he knew that Dr. Edward Greenwood of Menninger's had found in 1976 for JCAH that adhered to a medical model, he said "All that Dr. Greenwood said was was in substantial compliance with JCAH accreditation standards." "And its true that JCAH requires a medical model?" He answered "That is debatable, and that's subsequently been reviewed incidentally by JCAH." Asked if in 1979 JCAH required a medical model at the time the OCHAMPUS termination, he said "I think JCAH could have said to have striven for a medical model in all of its facilities that it surveyed."

Evaluation of the Evidence

The evidence in this case comes from a wide variety of sources. It includes factual testimony and expressions of opinion, some from "skilled" witnesses and others from "expert" witnesses in the medical and psychiatric field. In the following section, the Hearing Officer will discuss the weight which should be given to the testimony to each of these persons, based on: his/her professional qualifications; the nature and extent of the information which he/she had about the medical nature of the program at the time he/she expressed an opinion; and the extent, if any, of interest in the outcome of this proceeding which might affect his/her testimony.

The witnesses have been arranged in the ascending order of professional qualifications, beginning with the ones least qualified to express an opinion as to the psychiatric nature of the program, and ending with the medical doctors who specialize in child psychiatry.

1. Former Employees and Resident

John Peters had no degree and a few psychology courses in college. He and his wife served as house parents for 7 months during which they tried to get the kids to the Psychiatrist once a month, but some had not seen him for 3 months; the periods in which they saw the Psychiatrist was from 15 to 20 minutes and they were present. They themselves received no training but had received two demonstrations on the technique of confrontation.

Richard Rubb had a BS degree; he and his wife worked at VisionQuest for about six weeks in 1978; his wife had no degree but some experience. The contacts they observed between the Psychiatrist and the youth were very infrequent, sometimes not in several months. He observed one therapy session which lasted from 5 to 10 minutes with the boy, the other 10 minutes they were with the Psychiatrist; this was an initial psychiatric interview, and the boy had been at for 5 months. His observation of the confrontation technique was that counselors goaded patients into getting angry, and when the patient became physical he was "put on the floor;" there was also spitting in the faces of patients and much kicking and screaming, which apparently was expected of house parents. The reason he and his wife left VisionQuest was they thought it was "very senseless" and did not feel qualified to administer that kind of therapy.

_____, a former resident for one year, said he did not see a medical doctor before going to and saw a Psychiatrist one week after he entered; the "psychotherapy" consisted of weekly group meetings with house parents and family counselor, with a lot of screaming, abusive language and cursing by the staff. In a year he saw Dr. Lazarus twice, each for an hour; they both yelled and screamed. He also attended two family counseling sessions, and there was yelling at him and his parents, so his parents dropped out.

The Hearing Officer finds that the testimony of these three witnesses was credible and indicates that unqualified staff were providing therapy, and that the Psychiatrist saw each patient very infrequently and then for a very short period of time, which was insufficient to provide an adequate quality of psychotherapy, as required of an OCHAMPUS provider.

2. Professional but Non-Medical Personnel

Judge Collins appeared to be a sincere and dedicated jurist who did his best to provide rehabilitation, treatment and opportunities for the youth who came under his jurisdiction. However, he was extremely vague in his understanding of medical matters, and his judgment in the medical field was not adequate. His opinion that 99% of delinquent children needed psychiatric care was not based on medical evidence nor experience. Thus his opinion as to the medical and psychiatric nature of the program can be given little weight.

Judge Adams was another impressive legal figure who was determined to improve treatment of troubled youth. He was in frequent contact with mental health professionals, and was dissatisfied with the mental health facilities provided by the State of California and many other states, and was sincerely seeking better methods of rehabilitating youth who had committed criminal acts. His understanding of and interest in psychiatric treatment was of less importance to him than his interest in helping the children improve their lives, in order to avoid further incarceration. He was uninformed as to the need for medical qualifications for people to perform psychotherapy. It must be concluded that his opinion as to whether the program was a psychiatric treatment program was comparable to that of Judge Collins, and can be given little weight.

Charles Gallegos had a BS degree in biology and psychology, and was employed by OCHAMPUS primarily in the investigation of the complaints which were received by OCHAMPUS about in early 1979. His principal testimony relevant to professional qualifications of staff concerned the employment of two PhD psychologists, one of whom was not involved in the CHAMPUS program; the other had been on the job only a month and had performed no direct treatment of any child. Two months later, the two PhD's had left.

The Hearing Officer finds that the testimony of these three witnesses does not support contentions, but instead shows that the primary need of patients was for rehabilitation in the correctional sense, rather than for medical/psychiatric treatment, as required for OCHAMPUS cost-sharing.

3. Psychologists and Social Workers

David Fiegenbaum had an MS in Counseling and Communications when he worked for ; this was before July '77, when the staffing issue arose. He was first a Family Counselor and later was Director of Schools. He expressed the opinion that upward to 90% of the kids he worked with had some emotional difficulties in functioning in the community and in the home; some of the kids had been through psychologists, clinical social workers and had run the gamut of therapy before they came to . He did not mention psychiatrists. As a Family Counselor he worked with the Psychiatrist on treatment guidelines and treatment plans, and was responsible for individual and family counseling. The children, he believed, "could or could not have" emotional problems which carried a medical diagnosis, and 95% of the time no diagnosis was made by the staff. Although the Hearing Officer was impressed with Mr. Fiegenbaum's experience, it clearly had no relationship with the determination of the need for psychiatric treatment, or the techniques of psychotherapy provided by psychiatrists or by qualified paraprofessionals operating under the supervision and direction of a psychiatrist. His opinion can be given little weight in reaching a conclusion in this case.

William C. Scott had been employed by for five years, and had an MSW. He had been a Youth Counselor, Family Counselor and Treatment Director. He provided some individual counseling and therapy to youth, and did supervisory work as Program Director for one of the Arizona counties. His opinion was that a medical model consists of having a psychiatrist in charge of all treatment and overseeing all. treatment by making the original diagnosis and assessment, followed by all treatment decisions and evaluations being subject to his approval. He had no problem with direct patient care being provided by staff who were not degreed mental health professionals, and felt you can train competent people to do that so long as they are supervised by professionals. He also thought it was proper for non-degreed staff to utilize the techniques of confrontation; it did not take a lot of training to confront a person over simple work chore failures, as long as major confrontation were not approached by the line staff without the knowledge of himself or the Treatment Directors. He believed had complied with the OCHAMPUS deadline to upgrade all Treatment Director positions to MSW or PhD. He said the Medical Director was in charge of initial psychiatric evaluations, usually during the first three or four weeks; following that patients were seen by the Psychiatrist briefly at intervals of three to six weeks, depending on the Psychiatrist's assessment of the patient's need for treatment. He said you didn't have to have weekly treatment to make it a medical model. Asked to describe the confrontational therapy techniques, he discussed the setting of limits and the applying of disciplinary measures, but said he was not familiar with the medical literature with respect to confrontational therapy.

The Hearing Officer was not persuaded by Mr. Scott's testimony that the level of therapy and the confrontation technique practiced by the non-degreed staff members on the patients was "psychotherapy," as a part of a medical treatment program, even though the overall program was supervised and under the professional responsibility of a qualified psychiatrist.

Ronald C. Payette. BA, MSW, ACSW and Treatment Director at another RTC in Tucson, was a very impressive witness. The difference in the nature of the children taken by and McCaffrey is his agency did not take delinquent children, but took only children who had a psychiatric label, but were not necessarily involved in the criminal justice system nor had they been declared delinquent. However, he felt that most children who were labeled delinquent were emotionally disturbed as well. His school had a psychiatrist review each child's record upon entrance for validation of diagnosis and development of an ongoing treatment plan. In his professional opinion, a great majority of adolescents who commit delinquent acts have underlying emotional problems.

The Hearing Officer has a high regard for Mr. Payette's opinion. It provides general support for position that its patients needed psychiatric care. It does not, however, relate to the nature of the care provided, nor the qualifications of the primary therapists, which are the principal questions to be resolved in this-proceeding.

Frank A. Petroni, with a PhD in Psychology, had worked in behavioral research, including studies of troubled adolescents at the Menninger Clinic. His firm had done several research studies financed by to evaluate program and to measure its effect on the lives of the former patients. He said most of the people he saw at had ego strength difficulties, poor

self-images, lack of confidence and a great deal of psychological variables, but he made no reference to their need for psychiatric treatment. His firm did not measure the results of confrontation techniques, but he expressed his personal opinion that it was "just as effective" as any other therapeutic strategy. He believed that the program was effective, especially with OCHAMPUS families because of the way the families participated, and learning of new ways to deal with their problems and their own kids.

The Hearing Officer concludes that little information was provided by Dr. Petroni as to the critical question in this case. His discussion of the milieu approach and the confrontational technique, and his finding of merit in both, was placed in terms of "everything that would do the trick" to help these troubled youth improve their conduct. However, no information as to medical or psychiatric treatment of any nature was provided. Moreover, he was not an entirely disinterested witness, as he had been under contract with for a number of years to evaluate the accomplishments of its programs.

Lu Kruger, MSW, who had worked for seven years as Treatment Director and Guidance Counselor at the school, appeared to be a highly motivated and sincere paraprofessional who was very much interested in the children she served. As "child advocate," she handled the complaints of children in the homes in Pima County. She believed that the children she served were emotionally disturbed; and believed that confrontation was necessary with those children, as they had been provided with many types of therapy which didn't work and were really at the end of their rope. techniques required them to face issues before there was confusion and a buildup of anger, resulting in a secure feeling on the part of the child, knowing that he/she was not going to be allowed to get out of control and hurt themselves or do anything harmful. The Psychiatrist met with the youth and some staff, and wrote diagnoses and "suggestions" for treatment, in appointments which usually lasted an hour, usually in the first two weeks and not more than a month. She believed that a large majority of the children who came to had already seen psychiatrists.

The Hearing Officer was very favorably impressed with Mrs. Kruger and her interest in helping delinquent children. Her testimony did not strengthen the case, but rather tended to weaken it, particularly with respect to her opinion that not all of the children received by had been referred by a psychiatrist, as is required by the regulations. Further, she apparently approved the use of non-degreed staff to conduct confrontations, usually on the spur of the moment and without any input from a Psychiatrist or Psychologist. This also weakens the argument that the "psychotherapy" under OCHAMPUS regulations, must be-provided under the guidance and supervision of a qualified Psychiatrist.

The Delta Institute report of Evan A. McKenzie, MA, JD, spent some time in discussing labels, but concluded that "the therapeutic label does not really fit ." It referred to the youth as being hard core delinquents or other court referrals for fairly serious offenses, and refers to the confrontation technique as an "emotional catharsis" on the part of the youth. He said he thought the philosophy combined psychotherapeutic principles, parenting skills and common sense plus some Plains Indian mysticism.

The Hearing Officer considers Mr. McKenzie's report highly favorable to , but lacking in support for argument that "psychotherapy" is being carried on with the youth, by non-degreed house parents under the general supervision of the child psychiatrist.

John R. Harden, a JCAH surveyor with a Masters in Public Health who was working on a Doctorate in Forensic Psychology, stated in an affidavit that he had participated in the study in Tucson in February 1978, and found that "had achieved substantial compliance with JCAH standards" as a result of which Tucson was awarded a two-year accreditation as a residential psychiatric facility. In the itemized list of 32 areas which evaluated , the category "Clinical care and evaluation and utilization of youth studies" was marked "complied with with certain exceptions." He believed that was providing appropriate and necessary care to disturbed youngsters.

Based on the nature of Mr. Harden's report, and his discussion in the affidavit, plus Dr. Rodriguez' testimony with respect to the problems OCHAMPUS had experienced with respect to JCAH certifications, the Hearing Officer is not impressed with the conclusions reached by Mr. Harden, nor with the fact that JCAH had accredited as a Residential Treatment Center, based on its psychiatric treatment program for emotionally disturbed youth.

Raymond Wagner, a member of ACSW and a licensed clinical social worker in California, has been employed by CHAMPUS for 61/2 years, serving RTC's and drug and alcohol centers. He participated in the 1977 VisionQuest survey, utilizing Appendix A standards instead of JCAH standards. At that time his main concern was not the quality of the Psychiatrist's care, but that not enough time was being given to each child, and therefore most of the work was being done by family counselors. If qualified clinical therapists had been available at the local level, he would not have been so concerned about psychiatric coverage, but family counselors were not competent to provide therapy.

The Hearing Officer believes that Mr. Wagner was correctly concerned about the very small amount of time the Psychiatrist had to spend with each child in the VisionQuest program, and that he was justified in being concerned about the quality of psychiatric treatment that could be provided by non-degreed staff, without sufficient paraprofessional supervision available.

George Bair, with a BA in Social Welfare and MSW, had worked for OCHAMPUS for more than five years. He described the course of contacts between OCHAMPUS and officials concerning the nature of therapy program.

In January, 1978, they took a second look at what they regarded as shortcomings, and took Dr. Eckhardt with him regarding staff qualifications, with the Doctor doing the peer review of Dr. Lazarus, the psychiatrist. Their findings were that was out of compliance with the OCHAMPUS standards regarding the sufficiency and qualifications of its professional staff. They could not identify who did the psychiatric treatment; of the 28 Family Counselors, who Dr. Lazarus said did the treatment, very few were qualified by education, training and licensure.

He said Dr. Eckhardt reviewed Dr. Lazarus and his services; but he himself reviewed the qualifications of all other therapists, including the Family Counselors.

He was still concerned that they did not have enough PhD's and MSW's to provide professional counseling for the children and concluded that had not complied with its commitment to upgrade the quality of staff. He said did not comply with the medical model required by OCHAMPUS standards, and he would not place a child needing that kind of treatment in .

As to Dr. Eckhardt's testimony that it was his impression that adhered to a medical model, he said that Dr. Eckhardt was just wrong, as he did not look at the rest of the staff, but only looked at Dr. Lazarus and his background, and did not look at the qualifications of any of the other employees, which contended were the ones who did the primary therapy. He himself had interviewed these people and found that they were not credentialed and not qualified to perform that type of medical treatment. The degreed people that they did have, he said, were not in positions where they did direct treatment, but instead were doing paper work. The fact that there was a shortage of psychiatrists nationally was not an excuse for the deficiency in that area that they found at .

The Hearing Officer believes that Mr. Bair had a sincere and justifiable concern about the nature of the "psychotherapy" being provided to children at . He was concerned, as was Dr, Eckhardt, that one psychiatrist would have difficulty in serving a large number of children on an adequate basis. Considerable weight is given to his testimony that Dr. Eckhardt only looked at Dr. Lazarus' qualifications and performance, but never looked at the qualifications of the so-called primary therapists, which was his responsibility. His opinion tends to offset that of Dr. Eckhardt with respect to the qualifications of the persons serving under Dr. Lazarus, who were represented as being the staff members who performed primary therapy.

Donald B. Mathis, Deputy Director of Arizona DES, has been a counselor at the Brown Schools in Texas and a consultant at Day Top Village, and was a member of a number of organizations working with youth delinquency. His professional qualifications, however, are unknown. He said in his opinion, provided quality of professional services which was better than those provided by state mental hospitals; further, that program was psychiatrically oriented. DES licensed as a residential treatment facility for children with psychological problems which prevented their being placed in foster homes. Many of them were "multiple losers" who had been placed in other treatment facilities without success, but had a good success rate with these losers because of its intensive treatment programs. He distinguished between a psychiatric facility and a psychological facility based on whether the treatment program was under the direction and control of a psychiatrist; inasmuch as treatment was under the control of a psychiatrist, it was a psychiatric facility, in his opinion. He recognized that relied heavily on non-professionals to carry out the therapy, but the kind of program they operated did not require professionals and as long as they were supervised by professionals, it met the professional test.

When he was pinned down by OCHAMPUS counsel on the use of the word "therapeutic" he said he was talking about collective experiences, not necessarily carried out in the traditional manner on a one-to-one basis by a psychotherapist. Asked

what he considered to be professionals, he referred to MSW's and Bachelors in social work and psychology; he did not refer to PhD's in psychology, as required by OCHAMPUS regulations. He expressed the belief that meets the standard of care generally practiced in the United States for psychiatric residential centers, and he believed there were more psychiatric controls at than at some of the licensed hospitals, Asked if he were professionally qualified to make a judgment on the standards of medical practice in the United States, he answered in the negative.

The Hearing Officer was tremendously impressed with Mr. Mathis and his testimony with respect to his investigation and his findings concerning the charges against made by former staff members. However, his testimony concerning his equally favorable evaluation of the psychotherapy program was not impressive; instead, it developed that his concern was more in the field of social rehabilitation than in medical psychiatric treatment of youth. This is perfectly understandable for a person with Mr. Mathis' responsibilities for the child welfare program for the State of Arizona. However, it does not provide strong support for claims that it had adequate qualified stuff. members to provide psychotherapy in the medical sense for all the OCHAMPUS youth which were in its program.

4. Expert Opinions from Psychiatrists

Dr. Lloyd Eckhardt, a Certified Psychiatrist and a disinterested witness, was employed by OCHAMPUS to accompany Mr. Bair to perform a survey of in January 1978. Their report is found in the Facility File, Exhibit 48. On the relevant issue of "Staff Composition and Organization," the team found "There is a deficiency in the number of qualified treatment stuff to provide psychiatric services. The current structure and composition of the treatment stuff does not support a medical/psychiatric facility wherein individual psychotherapeutic approaches are integrated." In his narrative report which accompanied his team report, Dr. Eckhardt reported that the team made a three-day visit to , and areas he reviewed were: "Chart Review, Youth Conference with the Medical Director, Client interview, House Parent and Family Counselors; and visitation to the facilities residential homes and school." As to Chart Reviews, he found complete compliance with the record system, and all entries signed by the psychiatrist. He observed a conference between the Psychiatrist, the House Parent, and Family Counselor, and a youth who had previously been in a psychiatric hospital; he found that the "psychiatrist made many sensitive and pertinent observations about the youth's behavior." As to the visit to the group home, he talked with house parents and one of the youths; he found the house parents to be well informed concerning the youth's problems and the interactions between the youth in that home, and considered the opportunity for immediate intervention and confrontation to be one of the most useful therapeutic tools employed. In his final comments, he found the Medical Director "eminently qualified for his position" and "all the members of the stuff I met seemed deeply concerned and committed to the program and each child's progress in the program." He concluded, "I sincerely feel that the RTC is meeting the therapeutic needs of its youth. This facility provides treatment to a segment of our youth that would otherwise, undoubtedly, be incarcerated or placed in a psychiatric institution."

The Hearing Officer believes that the team's report and Dr. Eckhardt's comments in his narrative report tend to support Mr. Bair's testimony that Dr. Eckhardt dealt exclusively with the qualifications of the Medical Director at , and did not look at the qualifications of the remainder of the staff, who performed the vast majority of the "psychotherapy"; as to those people, he was impressed with their commitment to the program but expressed no opinion as to their qualifications. In his concluding sentence, quoted above, he placed first emphasis on those youth who would otherwise have been incarcerated, before he mentioned those who would have been placed in psychiatric institutions. This tends to support further the OCHAMPUS view that rehabilitation, rather than medical treatment, was the principal need of the youth at , and the principal emphasis of the program.

Dr. Eckhardt's testimony at the hearing is summarized on pages 21-24. He said he found the clinical aspects of the program to be of extremely high quality and appeared to have been completely satisfied with the performance of the Medical Director; he believed the system of having a Psychiatrist with Treatment Directors and treatment teams under him, seemed workable. He said his opinion that "there could have been more psychiatrists" was typical of the chronic problem of finding psychiatrists for this sort of institution. He concluded that was adhering to a medical model because it had medical input from the top, and that use of a Treatment Director as a primary therapist did not undercut the medical model concept. He said he thought the program was of very high quality, and provided an alternative to incarceration; the program was dealing with emotional problems, "so I think it is psychiatric." He said the Medical Director was responsible for about 130 patients but he didn't think that each of the children would be in crisis at the same time, and he could respond to crises as they arose, and the staff could handle other problems.

The Hearing Officer believes the nature of Dr. Eckhardt's involvement in the inspection was limited to his opinion of Dr. Lazarus' qualifications and performance; it is clear that he did not review the qualifications of the "primary therapists" who conducted the day-to-day "therapy" of the patients. His belief that one psychiatrist could handle the psychotherapeutic needs of 130 children was based on his belief that the psychiatrist would be used primarily for crises, a medical conclusion which is not shared by the other physicians whose opinions are described later in this section.

Dr. David Ruben was the second psychiatrist to support the opinion in this appeal. Dr. Ruben did not appear at the first hearing; an affidavit was submitted, because of his unavailability at. that time. He did not testify at the second session two months later, and no explanation was offered. His affidavit indicated that he was no longer an employee of , but continued to serve in a part-time consultant capacity until could obtain the services of a full-time psychiatrist. The Hearing Officer notes that continued expansion of activities must have resulted in a considerable increase in the number of children to be provided psychiatric treatment, which resulted in a part-time psychiatrist's time being spread even thinner than in the 1978-79 period when Dr. Lazarus had only 130 children to serve. Dr. Ruben's opinion was based on the review of the clinical records of patients he saw, beginning two months after the termination. He believed Dr. Schorsch had been intensely involved in providing individual treatment, and believed that

followed a medical model, inasmuch as the Psychiatrist "directed and was the final authority concerning all treatment "provided to the patients. As to the lack of credentials of other treatment staff, he believed that the ability to provide effective treatment was the credential that was most critical. He believed the youth accepted by , even though they had come to it through the juvenile court system in most cases, almost always had an indication of serious underlying emotional problems, or disorders. He expressed the view as a practicing psychiatrist who was totally familiar with the program, that the program provided "highly effective treatment and care to deal with the serious and emotional problems of the youth placed in its program." He believed that the grounds used by OCHAMPUS to terminate were "totally without substance."

The Hearing Officer recognizes the close connection between Dr. Ruben and the organization, for which he worked for several years and for which he was serving as a consultant at the time his affidavit was given; further, although Dr. Ruben was practicing in Tucson at the time of the hearing, he did not testify and thus was not subject to cross examination. His opinion, based entirely on records and hearsay, strongly supports position in this appeal.

Dr. Alexander Rodriguez, the Medical Director for OCHAMPUS, testified at considerable length concerning his review of the records concerning the program prior to its termination, and his discussion of that program, insofar as its psychiatric nature was concerned, with Dr. Jannsen, a psychiatrist from the Menninger Clinic, who reviewed the same records. Dr. Rodriguez said he and Dr. Jannsen had reservations about confrontation therapy, because of the potential explosiveness of the situation in which it was employed. Other concerns were that "identification with the aggressor" might cause these children to themselves become confrontation-oriented in dealing with others in the future. They reached the same conclusion as the three Peer Review psychiatrists, who had reviewed the case files in depth, that they would not admit their patients to the Program.

Part of his concern was based on having heard the tape recorded confrontation withwhich he regarded as a kind of "emotional gang rape" with some physical injury to the child; further, with only one psychiatrist at such a distance from the patients, it was doubtful that he was able to provide the intensity and comprehensiveness of necessary professional services. As to use of non-professional personnel in psychotherapy, he expressed the opinion that those non-credentialed persons were not provided adequate training and professional supervision which was required under the, circumstances, and thus they were not qualified to do the things they were doing. He found a difference between therapy and counseling, the latter of which could be done by non-professional people. He said Drs. Jannsen, Clark, Sams and Burquist agreed with him that did not have a medical model. As to the 1976 findings by JCAH, he said their findings were that was in "substantial compliance" with its accreditation standards; as to the question of whether JCAH required a medical model, he said this was debatable, and the subject had subsequently been reviewed by JCAH. He pointed out that JCAH certification was only the first step toward acceptance as an OCHAMPUS provider, and that the more important standards were those found in Appendix -A to the OCHAMPUS regulations.

The Three Peer Reviewers, Drs. Clark, Sams and Burquist were Board certified child psychiatrists who were employed by OCHAMPUS to review the records concerning program, and provide an expert opinion as to whether that program met the OCHAMPUS standards for Residential Treatment Centers. Their unanimous opinion was that it did not. Among their findings was that a psychiatrist did not provide individual psychotherapy to each patient on a frequent, regular basis, and even in quarterly reports, the psychiatrist was not reported as being present; the records did not document that individual psychotherapy was provided by a psychologist nor a Treatment Director, or any qualified professional therapist; that the family counselors, youth counselors and house parents, in general, were not professionally qualified to provide psychiatric services; and there were insufficient qualified staff; that there was no evidence that distinguished between Psychotherapy and counseling; that the techniques used by treatment staff to manage patients were not medically appropriate and were not recommended by acceptable treatment interventions; that they could not assess "confrontation therapy" due to lack of description in the records; that the records lacked signed progress notes documenting the provision of psychotherapy by qualified professional staff, as required by CHAMPUS standards; that primary therapy responsibility did not rest in the hands of a trained mental health professional possessing MSW, PhD or MD degree; instead, these people appeared to serve exclusively as treatment supervisors and coordinators; that the in-service training program was not sufficient to meet the CHAMPUS requirements for professional staff involvement in primary therapy and family therapy; that there was a serious deficiency in the failure to document interdisciplinary quarterly review and treatment planning conferences; that the records do not comply with the requirements for documentation of treatment, evaluation, and therapy sessions. In answer to the final question, as to whether the program would be recommended to their patients, two of the peer reviewers said they would have to be more intimately familiar with the program to recommend it, and the third said he would recommend the program for the management of "certain acting-out character-disorder cases, but not under the assumption that a specific psychiatric program would be provided."

Review of CBS News Videotape

This one-hour film is an excellent presentation of the highlights of a Wagon Train adventure. It clearly shows the confrontation technique in action, performed by the Executive Director, who makes a powerful argument for its effectiveness in changing the lives of troubled and delinquent youth. Other confrontations conducted by Mary Harper and a man called Pete are similarly impressive, and demonstrate the helpful impact of the "aggressive love" and "touching" philosophy. It must be concluded that the film makes a strong case for the program as a better way to change the lives of delinquent youth than by incarcerating them in traditional institutions.

However, it does not reflect any degree of psychiatric or psychological treatment by professional personnel at any level, as envisoned by the OCHAMPUS standards for RTC's. Moreover, it establishes clearly the OCHAMPUS charge that uses nonprofessional staff (who may have had much experience with troubled youth) to carry on a quasi-psychiatric kind of treatment, This may and undoubtedly does, work with many youth, but it cannot properly be called psychotherapy, which is the essential element of the medical program which is required of an OCHAMPUS-approved residential treatment center.

Review of Confrontation Tape

and Treatment File

After the introduction by OCHAMPUS of a tape recording of about 30 minutes of a confrontation between staff and , introduced entire treatment file, so that the incident can be placed in perspective, and also to emphasize that had considerably improved when she left .

The Hearing Officer has listened to the tape 3 times and makes the following observations: Apparently the tape recorder was accidently left on, as it had no starting or stopping point which was identifiable in the "confrontation." From the conversation, which consisted largely of loud crying and screaming by , plus very loud talk from an adult, presumably the counselor, and from one other person, probably another youth.

would scream and cry out and the counselor would say "Let it out - - get that s . . . out of your system. . . Tell us you hate it ( ). Come on tell us that you hate it." The adult person used many obscene words and much language of the street. She said "I'll tell your Mom, little girl," and frequently raised her voice to the shouting level. Although the counselor at times would make a helpful suggestion or would occasionally demonstrate some empathy toward the patient, it was apparent that she did not retain control of her own emotions throughout the confrontation. The intensity of the confrontation varied from time to time, subsiding and then being reopened and renewed. At times the counselor would say "Come on - hit this pillowl Get these feelings out--that's what poisons your system--get them out." Toward the end, the counselor appeared to be trying to end the confrontation on a more positive note; in talking about the requirements on her own time, she said, "I've got 5 girls in this house, and sometimes one of them will tap me on the shoulder and say "I haven't had my hug today."

The Hearing Officer can find no basis for concluding that anything constructive or positive was accomplished during the confrontation. Instead, it appeared that the counselor was unable to accomplish what she was trying to do, and it was clear that had not benefitted from the incident. Her tone was as tearful, harried and distraught ate the end of the confrontation as it was at the beginning.

It should be noted that Mrs. Burton mentioned that the cassette would have "yelling and screaming" on it, but did not indicate that there was anything positive about the tape itself, nor did she attempt to explain it any further than that. Mr. Linden, in his objection to the admissibility of the tape without admitting 's entire treatment file, also did not indicate that there was anything unusual about the tape, nor did he attempt to explain what had occurred. Instead, he offered the entire file to show that had improved, and presumably that the result of the confrontation which was accidentally taped was helpful, or at least not harmful, to her progress.

A review of the Treatment File indicates that on October 20, 1977, was accepted into Day Care program. She was a twelve year old child with problems of getting along with her parents, who were divorced, and neither of whom had paid much attention to her. Seven days later she was caught

in possession of rolling papers and observed trying to get two other youths to use her home in which to stay if they ran away from . It was the staff's belief that she was lieing about her activities and attempting to run away. She had previously been incorrigible and truant from junior high school, with several short-term runaways, numerous petty burglaries, and defiance of authority. doubted that successful treatment could take place in the Day program because her mother's having to work at night leaving little supervision in the home. It was understood that residential treatment would most likely result when space was available.

On October 31 she was transferred to the Residential program, and on November 1, the "admission psychiatric screening" report was prepared by Dr. Lazarus who gave her a diagnosis of "hysterical neurosis with symptoms of anxiety, depression, sexual confusion, and delinquent behavior. 300.1"

There were two Physical Incident Reports, one dated November 11 and the second dated November 12, concerning incidents in which the Youth Counselor and another youth restrained until she could calm down and promise not to hit anyone. The first lasted 15 minutes, according to the report signed by Dianne Cox, the Youth Counselor; the second did not give any amount of time involved, and was signed by the same Youth Counselor. Since there is no other report in the treatment file of a similar incident, it is presumed that the tape recording described above was made on one of those two dates, November 11 or November 12. It is interesting to note that Dr. Lazarus signed both forms "read and approved" on December 2, 1977, some three weeks later.

The Hearing Officer considers it important to recognize that the nature of the confrontation (if it were a typical confrontation involving a serious problem, and it seemed that such was the case) made it desirable for the staff to have brought the matter to Dr. Lazarus' attention promptly thereafter, in order that steps could have been taken to resolve the matter. The three-week delay was not explained, and is considered as reflecting adversely on the quality of psychiatric care provided by .

The "Plan for Service" for was dated November 18, 1977; it identifies problems and strengths, and describes the treatment plan which was to consist of individual counseling twice a week conducted by the family counselor "under the supervision of the Medical Director--Staff Psychiatrist." Further, the family counselor was to conduct individual counseling sessions on a weekly basis, to encourage her parents to become more involved with and to recognize and confront their daughter's manipulation. Also, was to participate in group counseling at the group home, conducted twice a week by the Family Counselor; to encourage her to adopt a value system more closely aligned with those of society in general. "and that any misbehavior would be immediately confronted by staff, with dysfunctional aspects highlighted acceptable alternatives suggested, and appropriate consequences set." Daily confrontation with house staff was to encourage to verbalize her feelings rather than act them out. "Any physical incident with either staff or peers will meet with immediate confrontation and will be considered an extremely serious infraction for . The house parent will attempt to extinguish her fighting and assaultive behavior within 90 days. This type of physical-acting out will be met with serious and far reaching consequences and will receive the consistent message, that acting out is unacceptable behavior

and will not be tolerated." She was to participate in the Wilderness Survival program, to provide her with a rite of passage from childhood to adulthood, to encourage her to relinquish much of her 'baby' act."

The Psychiatric Evaluation Report was dated November 23 1977 and signed by Dr. Lazarus. It said was previously interviewed at a Mental Health Center. Their impression of was that she "is an emotionally disturbed little girl who appears to be acting out unresolvable family problems." Psychological tests were recommended, but the family did not follow through. Dr. Lazarus reported that he interviewed the child and gave a diagnosis of "Hysterical Neurosis, symptoms of anxiety, depression, sexual confusion, and delinquent behavior." His plan for treatment was milieu therapy, individual therapy, group therapy, family therapy, special education, and recreational therapy.

On November 25, returned to the House after spending the afternoon at her mother's, and brought some marijuana and some unknown pills back to the home. She attempted to get other girls to use the marijuana and pills, but they reported the matter to staff instead. There was a great deal of discussion, during which was caught in several lies.

The initial monthly progress report for the month of November, 1977, states "During one of ‘s temper tantrums, a tape recorder was accidentally left on, and her entire tantrum was recorded. The tape was later played back for and she realized how childish she had been acting. She has since promised to try to control her temper in the future." This form is dated September December 5, the date that it was signed by Dr. Lazarus. It does not indicate any treatment was given by the psychiatrist, a PhD psychologist or an MSW social worker.

The monthly progress report for December, 1977 indicated that mother had developed a more positive attitude about the program and was cooperating more. had participated in one conjoint family session, two counseling sessions with her mother, and two group counseling sessions, all conducted by the family counselor. had not been involved in any physical incidents during the month, but had been able to verbalize her feelings rather than act them out, through daily confrontation and staff support. She had participated in the wilderness survival program, and had benefitted from it. Individual counseling had been conducted daily by the house mother under the direct supervision of the family counsel; neither name was provided.

The utilization review report dated January 3,1978, indicated that had made considerable progress during the past few months and had begun to establish good relationships with the other girls. Individual counseling had been conducted by the house mother "under the supervision of the family counselor" on a daily basis to allow to verbalize the anger and frustration of the day so that there would be a safe forum for her to expose and discuss these feelings."

In a psychiatric review dated January 25, 1978, Dr. Lazarus found that had been making significant progress, showing more responsibility in the group home and indulging in less regressive and irritative and manipulative attention seeking behavior. In the February, 1978, monthly progress report, the psychiatrist

recommended that begin extended visits as a part of her transition to the partial day care program, since she was improving generally. It is noted that the heading, "Additional Comments" states that was seen by Dr. Lazarus on January 25, 1978. This is the first time an entry of this kind was noted.

On March 2, 1978, at a group home meeting, it was reported that was sent home from school for stealing and lying, which said was from additional problems she was having with her family and particularly with her brother.

On March 8 it was reported that had spent four days at home that week and things were apparently doing well. On March 16, they had a meeting in connection with 's leaving the residential treatment program and they were impressed with ‘s eloquence in expressing herself, and her demonstrated growth in wisdom and maturity. She was to be transferred to the street program on March 31.

On April 1, the discharge summary shows that she made great strides in her last few months in the residential program and her attitude toward her mother had improved greatly. There were a few lieing incidents and acting out incidents in school, but these took a marked turn toward the positive.

In the street program, a new plan for service was prepared by Dr. Lazarus. The diagnosis was changed from hysterical neurosis to apprehension, and he saw no evidence of any pathological anxiety or depression. In a meeting on May 22, 1978, became obnoxious and resisted when confronted by staff and peers about emotionally closing out both peers and staff. Her behavior in school was also confronted, which prompted an outburst of tears. She felt lonely and had received no support from her mother who was currently working on two jobs and had little-time for . She agreed to be more open and honest with the staff and peers, and youth and staff agreed to "approach her daily to reenforce their caring."

The discharge summary is dated June 13 and shows that was discharged on June 8, after she had maintained the progress she had made while in the residential program, but little or no progress on any of the areas that remain unresolved. The focus of treatment was on her family interaction, with her mother being away from home the majority of time, doing two jobs; resented her mother's absence, was jealous of her siblings, refused to talk to her father, and manipulated her mother's fiance. Her school performance was inconsistent, and she acted out her frustrations and insecurities in the school environment, often creating physical disruptions. After father refused to sign additional billing forms, and her mother being undecided concerning her commitment to , the mother decided that would "hate me even more" if she were not withdrawn from the program. believed she was ready for discharge even though she recognized that she had resolved none of her remaining difficulties and threatened to have herself returned to residential treatment if she was not discharged. Forty-five minutes after the meeting closed, the mother called and said she was withdrawing from the program because she could not fight the rest of her family about it any longer. She called the Arizona Director and demanded 's immediate-discharge.

Psychiatrist John L. Schorsch concluded that chances of successful reintegration into her family or the community are poor."

The Hearing Officer's impression of all this information about is that she did improve in her relationships with her peers and with members of the staff during the several months she was in the residential treatment program and also while in the street program. The biggest problem was her relationship with her mother and her mother's relationship with the rest of her family, and this did not seem to improve much. The important question is, however, whether needed psychiatric care in the first place. The evidence of treatment by Dr. Lazarus and Dr. Schorsch consists of one visit after the initial evaluation in a period of six months. As previously indicated, the Hearing Officer does not believe that the family counselors and youth counselors were sufficiently qualified from a professional standpoint to provide adequate psychiatric care. Moreover, the contents of the "confrontation" tape discussed above do not provide any basis for optimism about the nature of the confrontation program employed by , conducted by untrained and undegreed staff members. Instead, the whole affair was entirely unprofessional, and sounded more like a cat fight than a professional encounter between two individuals.

In sum, the Hearing Officer does not believe that the case, which has been discussed at great length herein, lends substantial support to contention that it was performing a "psychotherapeutic" program for . It does indicate that she had problems which were primarily associated with her relationship with her mother and the other members of her family and as those relationships improved, her behavior improved. There is no independent evidence, other than supplied by Dr. Lazarus' initial psychiatric diagnosis, that she had been referred to by a psychiatrist on the basis of a need for psychiatric treatment. It is thus concluded that the file does not provide support for position in this appeal.

SECTION II - ANCILLARY ISSUES

Twelve specific issues are set forth in the Formal Review Determination letter dated June 30, 1980 signed by the Acting Deputy Director of OCHAMPUS. Prior to the hearing, raised a "13th issue," that OCHAMPUS had an arbitrary and capricious antagonism towards funding the care of the kinds of delinquent children accepted by . The evidence in the record with respect to each of these 13 issues will be discussed very briefly, followed by a Finding concerning each.

I. Most Favorable Rate

The evidence shows, and admitted, that for a period of time early in the - OCHAMPUS relationship, DES of Arizona was not adequately funded to pay the full cost of handling their children; although made a sincere effort to get the State to budget for an adequate level of payment, it was not possible to do so, and they subsequently sued the State. There was a substantial difference between the monthly amount charged OCHAMPUS and the amount charged the State. This was explained, at least in part, on the ground that the OCHAMPUS rate was an all-inclusive rate, whereas DES paid only for major items, and health insurance carriers were billed separately for items such as medical care. It is clear that did charge OCHAMPUS more per child per month than they charged the Arizona DES, in violation of the OCHAMPUS regulation which requires an RTC to give OCHAMPUS the same rate as the lowest rate which is charged to any of its other clients.

The evidence also indicates that another RTC in Tucson, which apparently is very highly regarded by OCHAMPUS as a facility for treatment of similar children, has also charged different rates for several years to the State of Arizona and OCHAMPUS. The Treatment Director of Jay McCaffrey School testified that this had been the case for as long as he could remember, for exactly the same reasons as given by . Absent any evidence of effort by OCHAMPUS to determine that such was the case, and to take any action to enforce its regulations as to the McCaffrey School for doing the same thing as had done, it must be found that these two institutions were not treated consistently.

Moreover, the report of the Defense Audit Service indicates that OCHAMPUS had not established sufficient controls to ensure that the rates charged by RTC's were reasonable and were based on the actual costs of the care, and thus OCHAMPUS was paying more than its statutory share of the total cost of care. DAS recommended that a system be established to obtain effective rate controls, to have audits of the rate proposals before new rates were negotiated, to rescind the interim instruction that permits RTC's to bill a combined charge, and to request contract audit assistance for reviews of provider rates and billing procedures.

Finding: On the basis of (1) OCHAMPUS the system then in effect, which system had shortcomings found in the DAS audit report, and (2) the similar activities of an approved RTC with which OCHAMPUS was unaware, or if it had known, had taken no action, it would be inappropriate to take action against because of its rate structure, and the fact that paid a higher monthly fixed fee than did DES of Arizona.

A second element of this issue is OCHAMPUS' allegation that frequently adopted a policy of waiving beneficiary cost shares, resulting in an escalation of program costs because increased the amounts billed to CHAMPUS.

OCHAMPUS stated that it cannot tolerate such a practice, irrespective of any alleged philanthropic motives, in view of the legal requirement that beneficiaries pay a cost share for all medical services rendered.

The report of audit of the Defense Audit Service concludes, among other things, that eleven million dollars a year could be saved by changing and enforcing the beneficiary--CHAMPUS cost sharing requirement by enforcing the regulatory provisions, violation of which are very general throughout the country. It also recommends a change in the cost-sharing formula to permit CHAMPUS to bear a greater burden of long-term psychiatric care; and also recommended that a system be established to require providers to submit documentary evidence that the beneficiary cost share had been collected before CHAMPUS payments were made, and if the member does not pay his share, that should be withheld from military pay allotments.

Finding: Inasmuch as the cost share collection violation is a wide-spread failure in RTC's, which has not been the subject of action to amend the Regulations to provide a more equitable system, it would be inappropriate to penalize for its failure to collect cost share from beneficiaries. This Issue should be dismissed.

II. Camping

It first should be pointed out that the Wagon Train experience, although discussed throughout the hearing, is not one of the subjects of dispute as to this particular issue, as no OCHAMPUS-funded youth went on a Wagon Train. However, the "Wilderness-experience" was regarded by OCHAMPUS as "camping" and thus not subject to cost-sharing. contended that it is a highly therapeutic and essential part of their treatment program for troubled youth, and had been very successful in contributing to overall rehabilitation of these youth and adolescents.

Evidence in the record demonstrates that the time spent on a Wilderness experience is no summer camp or vacation experience. If anything, it is probably the most severe and demanding portion of the youth's stay at . Moreover, for those who can complete it successfully, it may be the most significant event in proving to a child that he or she can be successful at something, or that he or she has personal strength that was never previously known.

The opinion of Dr. Rodriguez appears to support the Hearing Officer's conclusion that the "camping" exclusion in the OCHAMPUS regulation did not properly apply to the Wilderness Experience.

Finding: No action should be taken against as to Issue 2, and this Issue should be dismissed.

3. Erroneous Payments and Overpayments

The evidence shows that the situation with respect to the payment of bills presented to three different Fiscal Intermediaries by during the relevant period, was, to say the least, highly disorganized. One Fiscal Intermediary was replaced by another, which lasted only six months before OCHAMPUS had to rescind its contract for inadequate performance, and assign the responsibility to a third Fiscal Intermediary. Most of the complaints concerning overpayments and erroneous payments occurred during the period of these two changeovers, which was a period of chaos for the Fiscal Intermediaries and for , and possibly for OCHAMPUS.

OCHAMPUS contended that had deliberately submitted duplicate billings for children who had been placed by Arizona DES, and who were also eligible for OCHAMPUS benefits; on the theory that because OCHAMPUS was slow to approve children and adolescents for entry into their program, they would be billed to DES until such time as OCHAMPUS picked them up financially, and then DES would be reimbursed.

The evidence produced by consisted of testimony from one of the bookkeepers, who denied that that happened, but instead that the bookkeeping had been done accurately and honestly It was also the testimony of the CPA employed by ; he was a professional auditor, and expressed his opinion that honestly reported and recorded their various financial transactions, and also that its reputation with their former CPA was of high order. Finally, there was the very impressive testimony of the Deputy Director of Arizona DES, Mr. Don Mathis that he had carefully looked into these allegations of billing duplications, and found no basis whatsoever for such a charge; rather he had concluded that the bookkeeping system was accurate and honest.

There was also testimony of the Treatment Director at Jay McCaffrey School that the same condition that existed with respect to the payment of their CHAMPUS bills for many months, and at one time the financial situation at their school became so critical, due to the slow payment by OCHAMPUS Fiscal Intermediaries, that all the staff, including himself, had to take two weeks off without pay.

Considering the chaotic condition which existed at the time, which was certainly not attributable in any way to but was entirely the responsibility of OCHAMPUS, it cannot be concluded that was guilty of any deliberate attempts to procure overpayments or duplicate payments. Instead, the evidence supports the general conclusion that was doing like any other business would do when it had large amounts of money tied up waiting for a government agency to pay its bills and had insufficient cash flow.

Finding: The evidence does not support this charge, and this Issue should be dismissed.

4. Emergency Reports and Records

At the outset, it must be recognized that the operation demanded a great deal of dedication from its employees, while the salaries paid were

relatively modest. Thus the turnover for house parents and other lower level treatment staff was very high, particularly during the first year of the employees' tenure. This accounts for many of the difficulties that were experienced in dealing with the reports and records prepared by and maintained by . The evidence does show that "report writing sessions" were held, at which house parents and other staff personnel sat down and "created" clinical records, generally to fill a need for a continuous record which had not been timely prepared by the house parents and counselors who should have done so. In other words, they had to fill in the gaps after the fact. Thus it is clear that many of the reports were "manufactured" and may have had no relation to actual facts with respect to particular patients.

The Hearing Officer was favorably impressed with the several former employees of who were called to testify at the hearing by OCHAMPUS, and who described their part in such report writing sessions. No offsetting evidence was produced by .

Finding: The charge that failed to comply with the OCHAMPUS regulations regarding emergency reports and adequate clinical records was established by competent evidence; and this Issue should be sustained.

5. Staff Composition and Organization

This is the principal issue in this entire proceeding, and has been previously discussed at great length, with a recommendation for action thereon. It need not be discussed further here.

6. Staff Development

Much of the discussion of staff composition also relates to staff development. However, it should be added that the constant turnover, plus the gradual and steady growth of homes and the increased number of patients, made the subject of staff development a difficult problem. Former employees who testified at the hearing indicated, without dispute by witnesses, that there was little training provided for these staff members. Instead, there were monthly sessions which they were urged to attend, but if they had some reason not to attend, they were excused. Moreover, the participation of the Staff Psychiatrist appears to have been minimal, and the subject matter discussed at these staff development sessions appeared to have been more administrative in nature than the conduct of "clinical training" aimed at improving the house parents and counselors' capacity to render psychotherapeutic services to the youth who were under their care.

Finding: The evidence establishes that staff development was not adequately carried on by , particularly when it is the Agency's contention that the vast majority of its psychotherapy was carried on by non-degreed, non-credentialed employees who had high school or Bachelor's degrees in a non-medical discipline. This Issue should be sustained.

7. Patient's Rights

Most of the charges of the denial of patients' rights resulted from "physicals" as a part of the confrontation "therapy" discussed above. They usually appeared to have occurred in connection with an attempt by the staff member to talk directly to the youth, followed by a violent action taken by the youth, to which the staff member responded. Often there was more than one staff member present, and such instances tended to get "out of hand" occasionally. There is also a very fine line between aggressive confrontation and patient abuse, one which is easily overstepped by untrained or minimally qualified staff members who are not aware of the things that can be expected to happen to them, and particularly those who cannot control their own emotions and tempers when physically or verbally assaulted by a patient. Further, many of the staff were former athletes, husky outdoor types who are used to physical contact, and could have physically abused the patients without fully intending to do so. made it clear to these employees that it would not tolerate patient abuse and denial of patient rights, and did take action in a number of cases to reprimand or terminate employees who engaged in those activities. One is inclined to think that this occurred primarily with respect to the junior staff members such as house parents, rather than to members of the "circle" who could initiate "touching."

The confrontation and physical, discussed herein, can only be regarded as a denial of 's rights. Dr. Rodriguez referred to the episode as "gang rape" in an emotional sense, and the Hearing Officer agrees with that opinion.

As to the shaving of 's head, it appears that he had agreed with the staff members that if he were found lying in a particular matter regarding a stolen car, they could cut his hair; when staff thought he had lied, and he did not deny it, the Director instructed someone to cut his hair, in accordance with their understanding. While this may be an undesirable course of action, it cannot be considered as a denial of 's rights as a patient, inasmuch as he had brought the matter upon himself and had agreed to the haircutting.

The examples cited by OCHAMPUS in its "statement of position" relate in many instances to activities at the Colorado Springs and New Mexico establishments which are not relevant to the charges in this proceeding.

As to calling female patients by obscene names, the record is in conflict. staffers would say "You don't want to act like a slut or whore, do you?" and then the patient would think they had been called such a name. This is another fine line, wherein it is difficult to determine whether the offensive appellation was actually used with reference to the individual patient.

Finding: On balance, the evidence tends to show there was a significant amount of denial of patients' rights, primarily orally but occasionally physically, and that Management was either unaware of many of these incidents or condoned or encouraged them. This Issue should be sustained.

8. Admission, Referral and Discharge Policies

As in most other activities, its philosophy of assigning responsibilities for making professional determinations to unprofessional persons led to assign the responsibility for making the admission assessment to the Program Director. Because the Program Director positions were not regularly filled with credentialed or certified psychotherapists, determined that it would accomplish the requirements of the Regulations by having its Psychiatrist perform a complete evaluation within two weeks of the child's entrance into the program. As a practical matter, the records indicate that the two week expectation was rarely accomplished; instead, it was often from four to six weeks and sometimes as much as three months before a child would first be evaluated by the Psychiatrist.

Finding: The policy of with respect to admission of patients does not comply with the requirement of the regulation that "professional staff of the residential center, to include the psychiatrists, shall review the admission assessment and determine whether admission is (not was) appropriate." This requirement applies to the initial intake of patients prior to their acceptance. This Issue should be sustained.

9. Assessment and Treatment Planning

The case files indicate that there were individual written treatment plans for each patient, approved by the Psychiatrist, in virtually all cases, and these generally met the requirements of Section 11 F.2. "Treatment Planning:" As OCHAMPUS contends in its position paper; they are primarily plans for future treatment, rather than a record of the treatment each patient actually received. This is consistent with the philosophy that treatment goes on twenty-four hours a day by anyone on the staff, and that writing all those contacts down would be impractical and nonproductive. It appears that the rather infrequent (average three months) contacts with the Psychiatrist, and the limited duration (10 to 15 minutes) of those contacts with each patient, were recorded in many instances, but the contents of such treatments were rarely recorded. Moreover, OCHAMPUS is correct in contending that Family Counselors who prepared the treatment plans do not have professional qualifications; specifically two Family Counselors who had only undergraduate degrees.

There appears to be some misunderstanding by OCHAMPUS personnel of the one-year commitment question. says the child is expected to make a commitment for treatment for one year, but that such commitment is not a therapeutic requirement, which would be routinely enforced as to all patients; instead, the length of time of treatment would vary according to the needs of the patient.

Finding: The evidence establishes that did not comply with the requirements of OCHAMPUS regulations in this respect, and this Issue should be sustained.

10. Patient Clinical Records

Former employees of testified that they had been instructed to falsify clinical records and to bring them up to date where other staff personnel had left the program. Two current employees at , Donald Barnes and Mary Harper, who made statements to OCHAMPUS that such was not the case, did not testify. The Hearing Officer concludes that the sworn testimony of OCHAMPUS witnesses is deserving of greater weight than the written statements of those who denied such a practice but did not testify and finds that updating and backdating of clinical records by personnel who did not perform the services, and thus created fictional entries, was carried on by . Moreover, the specific examples of backdating in the file show that they were signed by the Psychiatrist some time after they were prepared, rather than at the time of the treatment or review activity. As previously indicated, the lack of scheduled and identified therapy session made it impossible for to enter therapy notes showing the date, type, duration and frequency of therapy sessions.

Finding: The evidence supports the OCHAMPUS position on this Issue, which should be sustained.

11. Dietetic Services

OCHAMPUS charged that did not comply with its standard requiring it to provide "properly planned, nutritious and appealing food which meets national standards." Affidavits were obtained from ex-employees of , stating that the quality of food and the amounts provided were not always satisfactory and that storage of fresh meats was not always adequate.

rebutted the charges with statement from a Registered Dietitician to the effect that they had a new meat distribution system which was expected to improve the situation; moreover, contended that it met or exceeded all federal dietary standards.

The only evidence produced at the hearing was the testimony of former staff members that from time to time they had difficulty in getting enough food, clothing, toothpaste and other necessities for children under their care.

Finding: On the basis of minimal testimony and small evidence in the record of this appeal, the Issue is considered de minimus. It should be dismissed.

12. Physical Plant

The thrust of this charge is that , from time to time had more children in some of the group homes than the maximum for which they were licensed. The testimony of the only witness who discussed this matter at the hearing indicated that one time they had one boy above their licensed maximum for a few days, until another boy left. The statements in the appeals file indicate that the group home occasionally had more children than they were authorized. However, testimony of the Assistant Director of DES indicated

no problem in that area, and it was his agency that conducted the licensing.

Finding: This Issue, too, is considered de minimus, and is not proved by the evidence. It should be dismissed.

13. Alleged OCHAMPUS Antagonism Toward Treatment of Children Placed in RTC's With Involvement of Courts

contended that OCHAMPUS officials had such a prejudice, which has no legal foundation, and that this prejudice subverts the very purpose of the OCHAMPUS program, the provision of treatment for the dependents of active and military personnel. Further, since OCHAMPUS adopted its policy regarding court-involved placements, it attempted to usurp the authority of the Congress to determine the purposes of the OCHAMPUS program. It contended that DOD regulation excluding in-patient stays directed by or agreed to by a court, as an alternative to incarceration for a criminal act, and providing that inpatient stays paid by CHAMPUS be directed only by authorized physician provider, was improper. It also pointed out that the DAS audit report recognized that OCHAMPUS knew it was having problems in enforcing that policy, and "as of February-15, 1979 a workable policy had not been established". OCHAMPUS also contended that the action of the DOD in issuing a Notice of Proposed Rule Making to eliminate RTC coverage demonstrated the Department's bias.

OCHAMPUS maintains that its officials had no bias against RTC or the kinds of children served by those facilities, and that its officials went to bat with the Department to attempt to retain the benefits. It also argued that DOD officials had no such bias, either, inasmuch as they withdrew the Notice and continued the program. It pointed out that Congress had given the Department a mandate to tighten up on its policies relating to Residential Treatment Centers providing psychiatric services, in view of the extended hospitalization required for many of the patients and the increasingly high costs encountered in paying for that program.

The Hearing Officer has carefully considered the arguments of the Parties, and concludes that the action taken by OCHAMPUS, with the approval of the Department of Defense, did not demonstrate any bias against emotionally disturbed youth who get in trouble with the law. Instead, their efforts appear to have been justified by the fundamental nature of the CHAMPUS program as a health benefit program for medical (psychiatric, in this case) treatment. If a youth were referred to an RTC by a court as an alternative to incarceration for a criminal act, there was no necessary correlation between that reason for placement in an RTC and any identified medical (psychiatric) problems that the youth had. On the other hand, where a youth was referred to an RTC by a psychiatrist or other psychiatric, professional, as required by the Regulation, the need for psychiatric (medical) treatment was clearly established. Thus it is clear that the insistence by OCHAMPUS on medical treatment for troubled youth in need of medical treatment was not arbitrary, prejudiced nor biased against ; instead, it is a logical position for OCHAMPUS to take, in view of its responsibility for ensuring that federal funds were spent only for purposes authorized by applicable Statutes and Regulations.

Finding: No evidence has been adduced to establish VisionQuest's charges of any bias by OCHAMPUS. This Issue should be dismissed.

CONCLUSIONS

Careful analysis of the evidence in the record of this proceeding leads the Hearing Officer to the following conclusions:

(1) The most significant evidence was the opinions expressed by the Psychiatrists. Dr. Ruben's opinion, based on records and conversation with the staff, favored the position of . Dr. Eckhardt's opinion was inconclusive and incomplete and did not provide strength to the position. Five Psychiatrists expressed opinions which supported the OCHAMPUS position; each had reached his conclusion from reviewing records, most of which had been prepared by , and by talking with other psychiatrists. The expert opinions of the three Peer Reviewers, plus Drs. Rodriguez and Jannsen, are considered_ to outweigh those of Dr. Rubens and Dr. Eckhardt, not merely on numbers alone, but on the nature of the information considered by each psychiatrist, and any possible bias that each might have.

(2) The testimony of Psychologists and Social Workers as to the nature of the program was about equally divided as to whether the "psychotherapy" furnished by met the OCHAMPUS standards. Their factual testimony however, generally supported the OCHAMPUS position that the "therapy" was being provided by unqualified persons, who did not meet the requirements for an RTC found in the DoD Regulation.

(3) The testimony of the two former employees and one former resident, as to the events they observed while they were in the program, strongly supports the OCHAMPUS position.

(4) In sum, a substantial preponderance of the probative and credible evidence in the record of this proceeding shows that OCHAMPUS, as the moving party in this matter, has met its burden of proving its charge that did not in June, 1979, provide an acceptable medical/psychiatric program for youth, so as to qualify for continuation as an OCHAMPUS-approved Residential Treatment Center for children and adolescents. Thus, OCHAMPUS's action to terminate as an authorized provider was warranted and proper. The General Issue is answered in the AFFIRMATIVE.

(5) Inasmuch as it is found that did not provide the requisite psychiatric treatment program, it is of much less importance whether the evidence proves the Twelve Issues alleged by OCHAMPUS in its Formal Review decision in June, 1980. However, the Hearing Officer prepared very brief findings on each of these issues. It is entirely possible that the ultimate decision on this Appeal could be made without reference to these twelve issues; they are relatively much less important than the basic issue of psychiatric care, but apparently are of considerable importance to the reputation of as a treatment program for troubled youth.

(6) The Thirteenth Issue was not supported by any convincing evidence from .

From participating in this proceeding for almost two years, reading masses of information and listening to the many witnesses who testified, the Hearing Officer is convinced that the program has been very effective in providing a means for rehabilitating troubled and

delinquent youth who have not been helped by the "traditional" institutions. Very possibly the program is a real breakthrough, and can become one of the best programs for helping delinquent young people in the United States. It has an appealing approach to youngsters with its outdoor life, Indian mysticism and gradual building of personal responsibility on the part of its residents. Further, it has a dedicated group of employees who, with only minor exceptions which are promptly corrected, literally give their lives to helping these kids. The touching, nurturing and confrontation techniques appear to be powerful ways to reach adolescents who have never had anyone to care about them or what they do, and to set and enforce reasonable limits on their conduct in everyday life. The Hearing Officer joins Dr. Rodriguez and many others in expressing admiration for many of the elements of the program, and hopes that it will continue to grow and spread to other parts of the United States.

But that does not mean that the program is a medical/psychiatric treatment program, under any interpretation of the OCHAMPUS Regulations. As a practical matter, no single psychiatrist would be physically able to provide quality psychotherapy to hundreds of youth in several counties, and indeed, in several states. Nor is there convincing evidence that all, or even most, of residents were in need of psychiatric treatment, as required by DoD Regulations.

The Hearing Officer believes very strongly that this Recommended Decision to confirm the termination of by OCHAMPUS should not be regarded as a finding that 's program is not important and necessary for troubled youth in these troubled times. It very clearly is highly desirable and much to be encouraged. Unfortunately for , however, the basic concept of the OCHAMPUS health program for military families is, and probably will continue to be, concentrated on the need for and the providing of psychotherapy by degreed and licensed professionals as required in the DoD Regulations.

Since had not brought its treatment program into compliance with the OCHAMPUS requirements, its termination in June, 1979, as an authorized OCHAMPUS provider was proper, under the DoD Regulations.

RECOMMENDED DECISION

It is the recommendation of the Hearing Officer that OCHAMPUS' Formal Review Determination dated June 30, 1980, sustaining the termination of as an authorized OCHAMPUS provider on June 11, 1979, be AFFIRMED.

January 13, 1983

Harold H. Leeper
Hearing Officer