S. Hrg. 118–812

YOUTH RESIDENTIAL TREATMENT FACILITIES: EXAMINING FAILURES AND EVALUATING SOLUTIONS

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED EIGHTEENTH CONGRESS

SECOND SESSION

JUNE 12, 2024



Printed for the use of the Committee on Finance

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YOUTH RESIDENTIAL TREATMENT FACILITIES: EXAMINING FAILURES AND EVALUATING SOLUTIONS

WEDNESDAY, JUNE 12, 2024

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:06 a.m., in Room SD–215, Dirksen Senate Office Building, Hon. Ron Wyden (chairman of the committee) presiding.

Present: Senators Stabenow, Casey, Hassan, Cortez Masto, and Crapo.

Also present: Democratic staff: Nicole Brussel Faria, Investigator; Daniel Goshorn, Chief Investigative Counsel; Joshua Sheinkman, Staff Director; and Tiffany Smith, Deputy Staff Director and Chief Counsel. Republican staff: Kellie McConnell, Health Policy Director; Amy Nabozny, Policy Advisor; John O'Hara, Trade Policy Director and Counsel; Gregg Richard, Staff Director; and Charlotte Rock, Senior Health Policy Advisor.

OPENING STATEMENT OF HON. RON WYDEN, A U.S. SENATOR FROM OREGON, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The Finance Committee will come to order.

Today the Finance Committee meets to discuss the horrific abuses and neglect of children at too many residential treatment facilities, places that say they provide behavioral health care to vulnerable kids, but often leave them harmed and more traumatized than they started off.

Just this morning, the committee released a new investigative report, with shocking details about the treatment of kids in these facilities. And these facilities get big dollars from programs under the jurisdiction of this committee, specifically Medicaid and child welfare funds.

There are endless examples of sexual, physical, and verbal abuse, improper restraint and seclusion of young children, unsafe and unsanitary conditions, and even a total lack of provision of behavioral health care. Unfortunately, it seems more often than not, abuse and neglect is the norm at these facilities, and they are set up in a way that makes it happen.

The system is failing, except for the providers running these treatment facilities, who have figured out how to turn big profits off taxpayer-funded child abuse. I don't say that lightly. Our staff spent several years looking at the biggest companies in the indus-

try: Universal Health Services, Acadia Healthcare, Devereux Advanced Behavioral Health, and Vivant Behavioral Healthcare.

Our investigative team reviewed 25,000 pages of company documents, had dozens of conversations with experts, pored over article after article, and saw the problems firsthand when they visited the facilities. Overwhelmingly, it's clear that the operating model for these facilities is to warehouse as many kids as possible while keeping costs low, in order to maximize profit.

That means intentional understaffing, with persons who have zero experience or qualifications to provide the care these children need. As Jay Ripley, the cofounder of Vivant and two other companies once remarked, and I quote now, "You can make money in this business if you control staffing."

It also means facility conditions that are often unsanitary and dangerous, facilities that feel more like a prison than a safe place to help a child get through a difficult time. In these conditions, children cannot get the care they need, like high-quality and individualized treatment.

As if profiting off rampant abuse and neglect of our most vulnerable kids was not bad enough, these facilities rely on enormous amounts of Federal funds. That means that American tax dollars are funding the kind of abuse our investigators found. In some cases, these facilities receive over $1,200 per day per child from the Medicaid program.

The experiences and trauma these kids are left with read like something from a horror novel. A facility routinely restrained children, for example, drugged them, placed them in seclusion, in clear violation of Federal rules. Another facility had a child run away from the program in the middle of the night who was fatally struck by a truck. The staff at the facility tried to cover up the neglect and falsified documents about the child's whereabouts.

Another child was sexually abused by a staffer on an ongoing basis. When the facility caught on to the abuse, instead of firing the staffer, they simply moved them to a different wing of the same facility. Each night the staffer returned to the child's window to say "good night."

There are instances of child fatalities, both at the hands of staff and death by suicide. Unfortunately, the accounts of abuse we hear about today are not outliers. They amount to a systemic culture of mistreating and abusing kids and turning a profit.

We gave the CEO of the Nation's largest provider the opportunity to testify before the committee today so he could defend how the company treats the children in his care. It is disappointing but not surprising that he declined the invitation. His company's conduct and the very business model that we are talking about today is, in my view, indefensible. So the question everybody in this room ought to be asking themselves is, where do we go from here? I want to work in a bipartisan way to shut off the fire hose of Federal funding for these facilities, to put an end to this cycle of abuse.

The buck stops with this committee. In order to get a dime from Medicaid or any other program in our jurisdiction, all these facilities are going to have to start providing actual care. Systemic failures at even a handful of these facilities is an indictment of a flawed model.

It is pretty simple. A facility should not be getting taxpayer money if it cannot prove that it is providing high-quality care.

Finally, none of this matters if there is not oversight and enforcement. These facilities are often located in rural areas and function as black boxes that get left virtually unchecked. As a result, practices that should be used only in rare, extreme cases—like restraint and seclusion—are being used regularly, and being used by staff that is unqualified and poorly trained.

At one Acadia facility in Arkansas, restraint and seclusion were used 110 times in just a month. Without clear nationwide tracking of these facilities, this behavior just slips between the cracks.

There also, as part of our work, is the priority of making sure there are more community-based alternatives for care. We know this based on research, based on this committee's own experience passing the bipartisan Family First law and from doctors and patients themselves. The only people who disagree with this effort to have more community-based alternatives seem to be folks who have a financial interest in protecting the status quo.

In order to reduce our reliance on fraudulent facilities and to reduce the number of kids that end up in them, investing in high-quality community-based care must be a priority. It is simple. If you provide more care and support to kids up front, you reduce the need for residential treatment and the number of kids being subjected to these horrific abuses.

What we found is that too often, kids in foster care are warehoused in these residential facilities for months or years with no planned exit, and no legitimate reason for being there. The Federal Government and American taxpayers have no business funding jail-like settings for foster-care kids.

So, these findings demand bold action. In the coming months, I am going to be working to bring my colleagues together behind legislation in this committee's jurisdiction to raise health and safety standards, require real oversight and enforcement, and investment in community-based services that are proven to actually help kids.

I am just going to wrap up, and we will go to the ranking member, but I just want to acknowledge all the survivors in this room. I met with many last night, again this morning, and I want them to know that your presence and the fact that you have been giving these accounts is what is providing the energy to finally get these long-overdue changes.

So, my thanks to everybody who is with us, who told me about their experiences last night and again this morning. Thank you for your bravery. As chairman of this committee, I am all in, all in to stop the cycle of abuse that has been brought to light today.

Senator Crapo?

[The prepared statement of Chairman Wyden appears in the appendix.]

OPENING STATEMENT OF HON. MIKE CRAPO, A U.S. SENATOR FROM IDAHO

Senator CRAPO. Thank you very much, Mr. Chairman. I appreciate your holding this hearing today.

As Senator Wyden alluded to, just 3 weeks ago the Senate Finance Committee held a hearing to celebrate the child welfare sys-

tem's progress, resulting from the enactment of the Family First Prevention Services Act. We heard from witnesses about the importance of investing in preventive services, and that children are best served when they can receive care within their own homes and communities.

While more work is needed to provide States with a diverse array of evidence-based programs to meet the needs of their communities, the chairman and I are committed to rigorous engagement with the Administration for Children and Families to fulfill our shared commitment of prioritizing familial placement whenever possible.

One of the goals of Family First was to reduce inappropriate placements for children in congregate care settings. To meet that objective, we must ensure that residential treatment interventions are a placement of last resort, with a focus on integrating patients back into the community as soon as is clinically possible.

When home and community-based services fall short of a child's needs, families deserve access to high-quality residential treatment facilities that provide medically necessary treatment in safe, therapeutic environments. Anything less risks causing further harm and escalating an already tragic and difficult situation.

To the victims in the audience and around the country who suffered abuse and neglect in residential treatment, your experience is entirely unacceptable. Facilities entrusted with caring for our most vulnerable youth should be held to the highest standards—and subject to routine and reliable oversight. Chronic patterns of failure must not go unnoticed or unaddressed. The incidents highlighted in Chairman Wyden's investigative report are deeply disturbing. Many of these facilities are reimbursed with Federal Medicaid and title IV–E dollars, as the chairman has said, making these deficiencies even more concerning.

Hardworking taxpayers should not be funding anything less than superior care. Our child welfare and behavioral health systems have made a lot of progress in improving the quality of congregate care settings, but clearly gaps remain. As we consider reforms to remedy inadequacies, we must recognize the different forms of residential treatment facilities, the essential role they play in the care continuum, and the regulations and requirements that are unique to each setting.

For example, Congress established Qualified Residential Treatment Programs, or QRTPs, as a high-quality, clinically informed treatment option for children in the child welfare system with behavioral health needs. Unfortunately, bureaucratic challenges have prevented many States from implementing this model.

Additionally, psychiatric residential treatment facilities are subject to Federal health and safety standards as a condition of participation in the Medicaid program. Congress and the administration should ensure that these requirements are patient-centered, informed by best practices, and promote access for those who require the most intensive services.

I look forward to a productive conversation with our witnesses today about how to improve care quality and increase accountability of youth residential treatment facilities, including by em-

powering States to establish QRTPs and other treatment models that best serve children.

Again, I thank the advocates for being here and Chairman Wyden for his important work on this issue.

Thank you, Mr. Chairman.

[The prepared statement of Senator Crapo appears in the appendix.]

The CHAIRMAN. Thank you, Senator Crapo. And let me just say that in a polarized political environment, it would be so valuable to have a bipartisan solution to the problems that the report has uncovered that we are going to hear about today, and I am going to do everything I can to make that possible.

Senator CRAPO. Yes.

The CHAIRMAN. All right.

With respect to the record, first I will ask unanimous consent to enter into the record the committee's report titled "Warehouses of Neglect: How Taxpayers Are Funding Systemic Abuse in Youth Residential Treatment Facilities." This report contains shocking examples of abuse and neglect at too many facilities.

[The report appears in the appendix beginning on p. 53.]

The CHAIRMAN. Second, I am about to introduce a panel of witnesses that bring the committee valuable expertise from across the spectrum of these facilities. But one perspective that is not represented on the panel is the voices of former patients at these facilities, many of whom are survivors of abuse and neglect.

There are over 100 of these persons in the room today. Many have submitted testimony about their experiences. I ask unanimous consent that these statements be entered into the record. These are some of the statements that we have received from survivors, and we are deeply, deeply appreciative of their giving them to us.

Finally, in addition to the written statements from survivors, Katherine Kubler and 11:11 Media submitted a short video of survivor testimony that they ask be entered into the record. It is quite short. It is extremely powerful to hear these experiences in their own words. I ask unanimous consent to play this video so it can be entered into the record.

Finally, after the video I am going to thank the survivors again and discuss where we go from here. But let us go to this short video.

[Video is played.]

The CHAIRMAN. I thank my colleagues. Does that complete the video? Okay. I thank my colleagues for listening to this, because I think that this has spelled out exactly what our job is all about, which is to end this pattern of abuses. The reason we wanted to show that video is that we felt that even though this was a few minutes of video time, it could make an enormous difference in terms of actually bringing about change.

So I want to thank Senator Crapo and my colleagues who are here, and let's get this message out to the rest of the U.S. Senate. I also want to thank the survivors from the video, and again all of those who have been laying out to me over the last 24 hours the accounts of their abuses that they have unfortunately had to deal with.

Our first witness today was supposed to be Mr. Marc Miller, the president and CEO of Universal Health Services, one of the largest companies. This company is unique in the field. Months ago, when we first decided to hold the hearing, Mr. Miller was the first person we asked to testify.

Instead of engaging the committee's request, the company stonewalled us, ignored repeated requests to even discuss his testimony. Finally a few days ago, his team officially declined to participate in the hearing. So we held a spot for Mr. Miller, in hopes that he might change his mind. But apparently, as of this morning, that is not the case.

So today, the committee released a 130-page report detailing the failings of many of these facilities, many of which are run by Mr. Miller's company. Today is the first step in the committee's legislative process to address abuse and neglect at facilities like the one Mr. Miller's company operates. And the fact that that chair over there is empty speaks a lot to me about this company's commitment to really fixing these very serious problems.

So let us now make sure everyone knows who are guests are who are in attendance.

Ms. Stanford is the abuse and neglect managing attorney at Disability Rights Arkansas, which is a federally mandated legal aid organization that advocates on behalf of all people with disabilities, and has congregate care monitoring services. She has previously worked with victims of domestic violence in shelters and community advocacy organizations. She has a law degree from the Bowen School of Law.

Ms. Manley is faculty and senior advisor for health and behavioral health policy at the University of Connecticut School of Social Work, the Innovation Institute. She has an LSW degree from Rutgers. Her work focuses on systems of care delivery, behavioral health, and children with intellectual and developmental disabilities. Prior to her current role, she served as Assistant Commissioner for New Jersey's Children's System of Care.

Ms. Larin is the Director of the Government Accountability Office's Education, Workforce, and Income Security team. Ms. Kathryn Larin, we welcome you, and we know that your office has done considerable work there at the Government Accountability Office on these issues. We welcome you.

We will start with you, Ms. Stanford.

STATEMENT OF REAGAN STANFORD, JD, ABUSE AND NEGLECT MANAGING ATTORNEY, DISABILITY RIGHTS ARKANSAS, LITTLE ROCK, AR

Ms. STANFORD. Chairman Wyden, Ranking Member Crapo, and members of the Senate Finance Committee, thank you for the opportunity to testify here today. My name is Reagan Stanford. I am the abuse and neglect managing attorney at Disability Rights Arkansas, Arkansas's protection and advocacy agency.

The protection and advocacy, or P&A, system is a federally mandated network of legally based agencies that advocate for and protect the rights of individuals with disabilities, and have authority to access facilities in which individuals with disabilities reside, and all relevant records.

In my role, I oversee a team that uses that access authority to monitor conditions and investigate abuse to ensure that these individuals receive the services they need in a safe and therapeutic environment. Over the past 5 years, we have been focused on the 13 psychiatric residential treatment facilities in Arkansas.

Through our years of spending time inside these facilities, reviewing records, and speaking with children, guardians, and staff members, we have seen firsthand how deeply flawed the overall RTF model is, the pervasive nature of abuse and neglect, lack of active treatment, and failure to provide a therapeutic environment.

The public deserves this and as much information as possible to make informed decisions about care. So, we created the Arkansas PRTF data base. It is spending our limited resources to do what the government could and should be doing.

In facilities across Arkansas, there are countless examples of abuse, violence, and neglect, such as a staff punching a child three times in the face, or a child being held down by peers and sexually assaulted. But it is important not to focus so intensely on cases of extreme abuse that we are lulled into believing that the issue is a few bad actors and not the model.

Far more widespread is the systemic general lack of a therapeutic environment, treatment, and educational services. There is this pervasive assumption that some children need such intensive services that they cannot be served in the community.

Residential treatment is often seen as the pinnacle of treatment, the best and most intensive services a State has to offer. In fact, the most restrictive placements generally offer a level of care that could be replicated or surpassed on an outpatient basis, and that at most comes to approximately 5 hours of therapeutic services a week. The failures of the treatment facilities to provide a safe and therapeutic environment, individualized intensive services, and meaningful discharge planning and follow-through are imputed to the child. The child is often seen as the failure, not the treatment facility.

And because they are viewed as the failure, all too often the child is cycled back into residential placement. Treatment at these facilities is not individualized and is overwhelmingly not specialized. Many of these facilities purport to treat a wide range of conditions, yet the services the children receive are almost indistinguishable from one another.

Interaction with clinicians and mental health professionals is limited. Children attend school at the facilities in classrooms that combine multiple age, grade, and ability levels. Children share bedrooms with peers and spend most of their time idle and in communal spaces under the supervision of entry-level care staff, never alone, but rarely engaged.

Insufficient staffing levels and inadequate staff training lead to reliance on restraint, seclusion, and increasingly law enforcement. The word that most comes to mind when I think of time I have spent monitoring these facilities is “chaos.”

All together, this creates an environment that is incompatible with what children need to learn, grow, and thrive. The added trauma children experience within these facilities follows them

through life, and is compounded by society's refusal to acknowledge the detrimental effects these placements can have.

All of this occurs without meaningful oversight at any level. With limited CMS regulation and oversight, most oversight falls to State agencies assessing compliance with State licensure, even though many providers operate in multiple States.

There is also too heavy a reliance on national accreditation bodies, such as the Joint Commission, which are paid by the providers. What is clear is that often these facilities are operating as placements and not service alternatives. States have bought into and are now reliant on the model of residential treatment, failing to adequately invest in community-based services.

States are so reliant on residential placements that they are hesitant or outright unwilling to hold the facilities accountable, instead considering them partners with the States. You cannot effectively regulate something that you are in partnership with.

Through our work with the P&A network, we know that these problems are not specific to Arkansas. They are well documented in reports from all P&As across the United States. This is a national problem that demands congressional action.

[The prepared statement of Ms. Stanford appears in the appendix.]

The CHAIRMAN. Ms. Manley?

STATEMENT OF ELIZABETH A. MANLEY, LSW, SENIOR ADVISOR FOR HEALTH AND BEHAVIORAL HEALTH POLICY AND ASSISTANT EXTENSION PROFESSOR, INNOVATIONS INSTITUTE, UNIVERSITY OF CONNECTICUT SCHOOL OF SOCIAL WORK, HARTFORD, CT

Ms. MANLEY. Chairman Wyden, Ranking Member Crapo, and members of the committee, thank you for the opportunity to appear before you today to address the youth residential treatment facilities, with a specific focus on failures and the evaluation of solutions.

My name is Elizabeth Manley, and I am a senior advisor for health and behavioral policy at the Innovations Institute at the University of Connecticut's School of Social Work. In this capacity, I serve as a subject matter expert on children's behavioral health systems design, financing, and implementation for State and local leaders.

I currently work with several States and provider organizations on design, implementation, and best practices in mobile crisis response and stabilization services, home and community-based services, and residential interventions for children and youth. I am a former Assistant Commissioner for New Jersey's Children's System of Care, where I was responsible for the oversight of the children's comprehensive continuum of care.

First, I want to state unequivocally that all children, youth, and young adults with complex and intensive behavioral health challenges need and deserve access to the most appropriate and least restrictive, high-quality, and effective treatment and intervention. Our goal must be to support children and families to receive services within their own homes and communities whenever possible

and provide individualized, strengths-based, culturally responsive care as early as possible.

We must respond to their needs with urgency and elevate the voices of youth and families in every step of treatment, planning, and intervention. Residential treatment facilities have an important role in the provision of care for young people with complex behavioral health-care needs, when they have a clinical and behavioral health treatment need that cannot be met in a family or community setting due to the intensity of their treatment and supervision needs.

In those instances, we need the care to be delivered in trauma-responsive environments that embrace parent and caregiver engagement throughout the treatment intervention, and continually focus on best practices. These residential treatment facilities can have a significant benefit to young people and their families.

The challenges are multiple, and include the need for Federal, State, local, and provider changes. States that use a systems approach to address the unique needs of youth with complex needs have demonstrated improvement in their ability to meet the needs of individuals with complex needs and systems involvement.

Some of these challenges for residential facilities include insufficient infrastructure inclusive of oversight, and the technical assistance necessary to meet the unique needs of young people with complex needs. Not all children in residential facilities require the service of their residential, and up-front work around ensuring that the right service is provided at the right time for the right duration is essential to ensuring the proper care.

Our financing incentivizes the wrong door for services and supports. We build beds because it is what we know how to do, when we really need to build home and community-based services inclusive of customized care in the mobile crisis response space.

There are States that are doing this work well. New Jersey is one of those States that has some lessons to be learned for others as well. The best way for Congress to direct Federal resources to impact the issues is to increase accessible, comprehensive family and youth-driven community-based and trauma-responsive behavioral health care.

Thank you for the opportunity to address this very important issue.

[The prepared statement of Ms. Manley appears in the appendix.]

The CHAIRMAN. Thank you very much, Ms. Manley.

Ms. Larin?

STATEMENT OF KATHRYN A. LARIN, DIRECTOR, EDUCATION, WORKFORCE, AND INCOME SECURITY, GOVERNMENT ACCOUNTABILITY OFFICE, WASHINGTON, DC

Ms. LARIN. Good morning, Chairman Wyden, Ranking Member Crapo, and members of the committee. Thank you for inviting me here today to discuss GAO's work on maltreatment of youth in residential facilities.

For over 20 years, GAO has reported on concerns with the physical, emotional, and sexual abuse of youth who have been placed in these facilities. In multiple reports, we have called on the De-

partment of Health and Human Services to enhance its supports to States, which are primarily responsible for oversight of these facilities.

I would like to start by talking about the youth who are placed in residential facilities. Many come through the foster care system as a result of abuse and neglect, and have experienced significant trauma. While some are placed in residential facilities because there are not enough traditional foster homes, others may receive such placements because they have complex mental health, physical, or behavioral needs best addressed in a setting that can provide high-quality, specialized care.

When these youth experience abuse by facilities staff or other residents, it may exacerbate their trauma. In recent years, States have tried to reduce their reliance on residential facilities, and the Family First Prevention Services Act introduced new restrictions on when States can use title IV–E funds for residential facility placements, and the numbers have fallen.

In 2022, 34,000 youths were placed in residential facilities, down from over 100,000 in 2002. With regard to the number of youths who have experienced abuse, however, we do not have good information. This is in part because Federal reporting of instances of abuse is voluntary and not all States do it, and partly because staff and residents may be reluctant to report abuse, for example if they fear retaliation.

We identified several challenges States face in protecting youth in residential facilities from harm—first, monitoring of youth placed in out-of-state facilities. Youth are sometimes placed out of state if there are no available placements in the home State, and this makes monitoring difficult because child welfare officials from the home State can't always visit regularly, and they have to rely on reports from the State where the facility is located.

A second challenge is inappropriate use of psychotropic medications that affect mood, thought, and behavior. Such medications may be warranted in some cases, but inappropriate prescriptions carry health risks. Data on use of such medications among youth in foster care is limited, but historically those in residential facilities have been prescribed these medications at much higher rates. Some States have taken steps to curb inappropriate prescriptions—for example, by developing prescription guidelines.

The use of restraint and seclusion in some residential facilities creates additional challenges to keeping youth safe. Restraint and seclusion should not be used for coercion, discipline, or retaliation, and should not result in harm. But in some instances, staff injure youth while trying to restrain them. Some States have reviewed their use of restraints in response to such concerns.

Regarding oversight, responsibility for overseeing residential facilities for youth and preventing abuse are fragmented. While HHS is the lead agency at the Federal level, responsibility for monitoring facilities and preventing abuse is primarily a State role and can involve State child welfare agencies, law enforcement, and State licensing entities.

We found that some States had taken steps to prevent abuse by requiring better background screenings, conducting training, and improving interagency cooperation. But we also identified areas for

improvement, for example through better training on resolving conflict in trauma-informed care, or by States imposing stiffer penalties for violations.

We also found that HHS could be more proactive, and in 2022 we recommended that HHS facilitate information sharing between States on promising practices for preventing and addressing maltreatment in residential facilities. While HHS agreed with the recommendation, they have not yet implemented it.

In sum, there are longstanding issues related to abuse and neglect in residential facilities. As States and HHS implement the residential facility requirements in FFPSA, there is a new opportunity to further assess the use of these facilities and consider whether additional steps are needed to protect youth from abuse and neglect.

This concludes my statement, and I am happy to answer any questions.

[The prepared statement of Ms. Larin appears in the appendix.]

The CHAIRMAN. Thank you very much. Thank you, all three of you.

And let me start with you, Ms. Stanford. You are the chief facility watchdog, as I understand it, for Arkansas. And obviously, in addition to the lack of care, we found acute harms like physical, sexual, verbal abuse, and unacceptable living conditions. And taxpayers, as I have said, are paying for a significant amount of these harms, sometimes over a $1,000 per day with Medicaid and child welfare dollars.

And to me, these daily sums create an incentive for providers to admit as many kids as they can, and then keep costs low to maximize their profits. So I want to start with you, because you are an expert in the field, so that we can take a look at what American taxpayers are actually paying for.

So my first question to you is, since you have been working in this field for some time, have you seen the kind of abuse and neglect like the type of accounts documented in our report?

Ms. STANFORD. Yes, Senator. We see lots of abuse and neglect. Things are reported to us almost daily, different instances of abuse and neglect. They range in how they can—but kids are being raped. They are being raped by peers and by staff members. There is lots of abuse that is related to restraints, but just other abuse also from people who are untrained and tasked with watching lots of children.

They are failing to learn deescalation techniques to be able to create a safe environment. But I would say it is very widespread, that we see instances of abuse and neglect in the way of failure to prevent violence among peers.

The CHAIRMAN. So would it be fair to say that serious problems at these facilities are not isolated incidents?

Ms. STANFORD. Yes. That would be very fair to say.

The CHAIRMAN. Now, you did some work in prisons, as I understand it. How would you say these facilities compare to jails?

Ms. STANFORD. So, I would say in comparison to jails, they are treated very similar, the kids—very rigid rules. They do not have a lot of access to the outside world, to calls to contact their family. They are cut off. They do not have a lot of personal belongings.

They are very drab facilities that are very comparable to jail settings in many instances.

The CHAIRMAN. Okay.

So, Ms. Larin, over at the GAO—our important agency that looks into these kinds of abuses—you have been looking into these issues for quite some time, I think something like 15 years or some such period. Have you identified similar types of issues in your reports to what we are talking about today?

Ms. LARIN. Yes, absolutely, starting back in 2008 where we identified literally thousands of instances of youth abuse. And up to our most recent report in 2022, we found this is a pervasive issue that continues today.

The CHAIRMAN. All right.

Let me go back to you, Ms. Stanford, and ask you about one facility: the Piney Ridge Treatment Center in Arkansas. We reviewed countless reports from this facility, and as I understand it, you have seen it firsthand. The documents in the public reports that our investigative team reviewed are just horrifying.

One report found the facility conducted 110 restraints and seclusions in a 30-day period. Another found that the facility regularly physically restrained children, injected them with drugs, placed them in seclusion in violation of Federal rules—and the list, based on what we are picking up, goes on and on with failures there.

And as is so often the case, some facilities seem to be doing a decent job. Others are just horrendous. So my question to you is, is the Piney Ridge Treatment Center an outlier? I would like to know your thoughts on this, and can you give us an idea of the scope and prevalence of the kind of violations that I have been discussing.

Ms. STANFORD. I would say that they are not an outlier. Certainly, there are better and worse facilities, and ones that we get more complaints from than others. The conditions at Piney Ridge Treatment Center several years ago were absolutely appalling, and they were operating with full knowledge of Acadia Healthcare.

And now they have improved—they have improved recently, but it took years and years of sustained pressure, and pressure that had to come from outside, that was not going to come inside from Acadia executives, to improve that facility. But we see that at lots of other places.

The CHAIRMAN. I am over my time, and we will have some questions for you in a bit, Ms. Manley.

Senator Crapo?

Senator CRAPO. Thank you, Senator Wyden.

And, Ms. Stanford, I would like to start with you as well. In your testimony, you indicated that we should not just assume that the model is working the way it should, that this is the model that we should be using.

And you indicated that a significant amount of the kind of treatment that is referred to this model could be handled in a home setting, with some number of hours a week of counseling or support outside the home. Could you expand on that notion a little bit?

Ms. STANFORD. Yes. So, I am not a mental health professional, but absolutely from what we have seen, I think there has been this assumption that there are constant services and therapy that are

being provided, or time for self-reflection inside these facilities, and that is not what we see at all.

It is chaos most of the time, and they are not being engaged. They are getting very little therapy. So those—I mean, there are lots of models out there with different types of therapy involving the families, involving just the children with different methods and supports that could be put in place.

I think what kids need is individualized care, and when you put them in these facilities, it necessarily becomes about the efficiency of the facility and not the individual care that can be provided to each kid. They are all being provided the same thing. That is what the model inside that facility is.

And so, just assuming that these places are providing intensive services and relying on that without looking further into what it is they are providing or what additional issues they are creating with the children, is a real disservice to the children.

Senator CRAPO. Well, thank you. And we, and each of you, have already talked about the notion of the need for much more aggressive oversight of these facilities.

Ms. Manley, would you agree that, if I could kind of give a shorthand on what Ms. Stanford was saying, we are overutilizing this model, because we should be focusing on more kids getting their treatment at home with the assistance from outside as needed. Is that something you would agree with?

Ms. MANLEY. Absolutely. Providing good care up front means that many young people can be provided better care in their own homes. There are some young people who benefit from short trauma-responsive, family-engaged residential interventions that are very close to home.

Senator CRAPO. And you emphasized the word "short."

Ms. MANLEY. Yes.

Senator CRAPO. And again, I cannot remember which of you—several of you referenced the fact that when abuse does happen, there is concern about how to get it reported. Ms. Larin, you indicated that the States and local communities are more in charge of the oversight than the Federal Government.

But I think that several of you referenced the fact that whoever is in charge of oversight, the system, the way it works right now, is one in which the fear of retaliation may cause a block to being able to conduct that appropriate oversight. Ms. Larin, would you like to comment about that?

Ms. LARIN. Yes. That is definitely true. When we talked about barriers to getting good information about how often this occurs, a big one is fear of retaliation both by staff, who may observe abuse and not want to report it, and by residents who do not have safe ways to report abuse.

Senator CRAPO. So, I have only got about a minute and a half left. Could each of you take about 30 seconds and tell me how we should improve the oversight in those cases where children do need to be referred to this type of treatment?

Ms. Larin, let's start with you and then move down.

Ms. LARIN. While oversight is primarily a State responsibility, we really believe that HHS could do more to, for example, identify best practices for oversight and share those, facilitate the information

sharing among the States. This is something we have recommended that HHS has not acted on.

Senator CRAPO. Thank you.

Ms. Manley?

Ms. MANLEY. At the State level, State understanding of each of the residential interventions, but more importantly, putting intensive care coordination included for every young person who touches within residential so there is an actual team of individuals who know that young person and spend time with that young person, who can actually report back what it is that is happening.

Senator CRAPO. And, Ms. Stanford, I want to get to you, but I think, Ms. Manley, in your testimony you indicated that you thought that family members should be more involved at the facilities. Is that true?

Ms. MANLEY. Yes. They should have access to young people 24 hours a day, 7 days a week.

Senator CRAPO. I think that would help get to the reporting issue, frankly.

Ms. Stanford?

Ms. STANFORD. I think there could be a lot more of a focus on quality of care. Right now, the minimal Federal regulations that relate to these facilities aren't very specific and do not overall cover that, whether this place is providing a therapeutic environment or the quality of care, or even the level of services that are being provided. So that information needs to be worked out and shared among States in a manner so people can see overall what these providers are providing across the Nation.

Senator CRAPO. Thank you.

The CHAIRMAN. Thank you, Senator Crapo. Senator Stabenow is next. We all saw those pictures of Michigan, and I know my colleague is very, very determined to fix these problems, and we appreciate it.

Senator Stabenow?

Senator STABENOW. Well, thank you very much, Mr. Chairman. And first, welcome. I know we have survivors of Michigan facilities and Michigan advocates here. Welcome. Thank you very much for being here, and I just want to thank the staff that put together this report and all the important effort. So, this is a really significant, really important investigation, and thank you for bringing this out.

And it is true. In 2020, we saw the devastating death of Cornelius Frederick. He was 16 years old living in a residential facility in Kalamazoo, MI. And after simply tossing a sandwich crust at some nearby young people, Cornelius was knocked to the floor and restrained by seven staff members over the course of 10 minutes. Two days later, he passed away.

This is a horrible tragedy. It is horrible what happened, and I know, based on the comments here and the reports and so on, that this is not an isolated incidence, which is why we are here today.

It is wrong, and it is indefensible. The stories of harm to children while in care only highlight the need for strengthening investments in community-based models. And I just want to emphasize again, we actually have good news on this front.

First, let me go back though, to say that President John F. Kennedy, the last bill he ever signed before his own death in 1963 was

the Community Mental Health Act. It had two visions: one, to eliminate what were called asylums at the time, and the other was to provide comprehensive community care, which we have not done until this point.

And we now have, through a model that 20 States are receiving full funding for now through Medicaid, a health-care model called Certified Community Behavioral Health Clinics. We have services being provided by over 500 clinics across the country, but more that needs to be done and certainly more to be understood, because this is a new model, a comprehensive model based on Federally Qualified Health Centers, funding behavioral health care as health care.

But this is a really important model for us to be embracing, I believe. CCBHCs provide comprehensive services, they are equipped to care for children and youth with complex behavioral health needs—everything we are talking about today.

According to the 2020 Department of Health and Human Services report on the first eight States being funded for these clinics, about one-fourth of the patients are children and adolescents. And just last week, the National Council for Mental Wellbeing's latest report on the impact of CCBHCs nationwide said one of the most important ways that services have been expanded through these clinics is for services for young people.

The same report showed that 82 percent of the clinics have established teams that are specifically child- and youth-focused—82 percent, which is good news—and 83 percent of the clinics provide services in one or more school settings.

So we are talking about clinics that require 24-hour psychiatric crisis services, comprehensive services. Anybody who walks in the door can get care based on a health-care model. And I hope, Mr. Chairman, we are going to be embracing and looking more at what is actually happening now to meet some of these issues.

Obviously, we need inpatient that is quality care also. But we are in fact moving forward on comprehensive behavioral care, and I hope we are going to be embracing this more and more.

Ms. Stanford, in your testimony you emphasize that there is a "pervasive assumption that children's complex behavioral health needs cannot be met in community-based settings." You talked about that today, which I appreciate very much. Could you talk more about the strategies you suggest to help counteract that assumption?

Ms. STANFORD. I think the things we are doing here today, getting people to understand what residential treatment is actually providing, is the first step. And it is something that we have been trying to do for 5 years and thought we would be further along in by now.

But if people think that there is an answer, they are not looking for a solution. So, people think that if this is the place where you get that kind of treatment, they are not looking for those community-based treatment options. And a lot more research needs to be done in what could be effective in proving that those models can work, so that they can be implemented for children.

Senator STABENOW. Yes, absolutely. Thank you.

And, Ms. Manley, I know I am out of my time here, but you know, I agree with you. We have to do more to establish clear pathways for community-based care.

You mentioned New Jersey doing good things. I just want to say they are one of the first 8 States to receive full funding for what I just talked about: Certified Community Behavioral Health Clinics. And my guess is that is the services and funding that they are receiving in New Jersey to do what they are doing.

So I would encourage us to really look more at this opportunity that we fully funded, finally, through the Safer Communities Act 18 months ago. The funding is there, the model is there, and I hope we are going to move forward and embrace it more specifically.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Stabenow.

And for those of you who have not followed all of this debate—it is very hard to do so—we understand on this committee that there are several pieces to this puzzle, for example, the behavioral health effort that Senator Stabenow has led. Our whole committee, on a bipartisan basis, worked very hard to get some of those key provisions in other legislation. Chairman Hatch worked with all of us to pass a historic set of reforms called Family First.

So what we are talking about today is essentially building on that progress, recognizing that the abuses that we are looking at, specifically as it relates to these residential treatment facilities, they are a key part of this puzzle. We are not going to fix this unless we address it.

And as we do so, we are going to try to build on matters like Senator Stabenow's legislation, Family First, and other measures.

Senator Casey has been a great advocate for kids and families, and we really appreciate him being here.

Senator Casey?

Senator CASEY. Mr. Chairman, thanks very much, and I want to thank you and the committee staff for this report. The findings in this report are beyond appalling. There are just no words to describe it. As much as there is written in here, I am not sure we have enough words in the dictionary to describe how disturbing this is for the American people.

If it happened in any context, it would be disturbing and appalling, but when you consider that these facilities are using taxpayer dollars—as the title of the report says, "Warehouses of Neglect," and then the subtitle is "How Taxpayers Are Funding Systemic Abuse in Youth Residential Treatment Facilities."

So that goes without saying, but we have to keep saying it, how disturbing it is.

Ms. Stanford, I wanted to speak to, in particular Pennsylvania, my home State, which as of 2023, had the most residential treatment facilities of any other State, 74—far greater than most States.

Many of these facilities are specifically designated for children and youth with disabilities. The four facility operators highlighted in the committee report have been cited for violations for negligence of supervision, assault, sexual and physical abuse, and many other atrocities.

In your written testimony, you state "youth residential facilities cannot provide an adequate therapeutic and educational environ-

ment." We are all concerned about children and youth in these facilities, no matter what their circumstance. But we are especially concerned, of course, for children with disabilities.

In your experience, which I know includes expertise in disabilities, how are residential treatment facilities not meeting the needs of children and youth with disabilities? And then the second part of the question is, what alternatives should be in place to meet their needs?

Ms. STANFORD. So I would say, in every way, they are not meeting the needs of children with disabilities, the psychiatric facilities that I am most familiar with and were most involved in. So, all of the children in those facilities have been deemed at some time to have a disability, and these facilities are not individual.

What people, everyone needs, and particularly children with disabilities, is individualized services that provide tailored supports to them. Instead, they are putting them all in small spaces together with one treatment modality that they are using with all of the children.

But specifically, with educational services, we have seen that these facilities do not understand Federal regulations around special education services for children. So not only are they not getting an adequate education, they are not getting set up for when they are released to have those supports in place, so that they can restart their education.

Senator CASEY. Yes. And also, the committee report mentions multiple instances of restraint and seclusion being used on children and youth in residential facilities. The report references the use of both chemical and physical restraints on children and youth.

The report also details the terrible case of Cornelius Frederick that Senator Stabenow made reference to in her questions. Cornelius was restrained in a prone position until ultimately dying because of the restraint. According to the Department of Education, the vast majority of children restrained and secluded in schools in fact have a disability.

What is the harm that can occur to children, as well as young people with disabilities, who are both restrained and secluded?

Ms. STANFORD. So any time restraint and seclusion are used, that can have a traumatizing effect on children. As you know, restraint involves people physically holding the children, oftentimes on the ground. Prone restraints are still used in these facilities.

So disability or not, but particularly for children with disabilities, that can have a traumatizing effect. They are not taking into account their trauma histories, if these kids have been sexually assaulted, in an event holding them down, with multiple staff members on them on the ground, as well as seclusion.

Senator CASEY. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. I thank my colleague for all his good work for kids.

Senator Hassan is one of our experts on Medicaid and these health-care issues. And I say to our guests, there are probably as many hearings today as I have seen in my time in the Senate, so colleagues are going to be coming in and out. I want you to know that this is part of the challenge of today.

Senator Hassan?

Senator HASSAN. Well, thank you very much, Mr. Chairman and Ranking Member Crapo, for this hearing, and thank you to our witnesses for being here today and for the work that you do.

Ms. Larin, I want to start with you. Last year, while checking on two New Hampshire teenagers who were placed at a facility in Tennessee, a child advocate from New Hampshire uncovered horrific child abuse. These two children returned to New Hampshire after the abuse was uncovered, but it obviously never should have happened in the first place, and they will bear the trauma of that abuse for their lifetimes.

States often have difficulty overseeing out-of-state residential placements for youth, since they cannot regularly monitor conditions at these facilities. How should States increase their oversight of out-of-state placements to help prevent this type of abuse in the future?

Ms. LARIN. Yes, there are definitely steps that States can take to improve their oversight of out-of-state placements. For example, they can require caseworkers to do in-person visits, even if that means traveling out-of-state to do so. One State developed or put together an interagency task force, with the sole purpose of monitoring out-of-state placements.

But really the answer is to reduce or eliminate out-of-state placements. At least one State has stopped placing any children out of state, and others are thinking about that. That really is the answer.

Senator HASSAN. Well, thank you for that.

To Ms. Stanford, we have heard today that residential treatment is common for youth who have complex mental health or behavioral conditions. But evidence suggests that community and home-based care is safer and more effective for children.

Can you talk about the challenges families have getting home and community-based care services for their children?

Ms. STANFORD. Sure. I would say there is a lack of services across the Nation. We have in Arkansas—but also across the Nation—we take a lot of out-of-state kids. So, we are seeing from every State that they are not getting—generally maybe, individual therapy is the only thing that is offered to a family, prior to inpatient care being the next step.

Senator HASSAN. Right.

Ms. STANFORD. So there are a lot of steps in that scale of treatment options that should be available that are being missed.

Senator HASSAN. And how does the current Medicaid reimbursement system incentivize for-profit residential care while further exacerbating challenges to access to home and community-based care?

Ms. STANFORD. I would say that the—as they have talked about the high rates of reimbursement, these facilities are expensive to operate, and the reimbursement rates are very high and leaving a high profit margin.

So anecdotally—I am not a Medicaid reimbursement expert—but we have heard that providers find it not financially sustainable to have services or come up with different treatment models to offer in the community if there is not adequate funding to fund those.

Senator HASSAN. Right; thank you.

To Ms. Manley, many residential treatment programs advertise that they provide addiction treatment for youth, but the services they provide often fall short of the standard of care. In a survey of residential treatment facilities that claim to treat addiction, only one in four facilities offered medication to treat opioid addiction for adolescents, the gold standard for evidence-based treatment.

In your experience, are residential treatment programs offering evidence-based treatments for addiction, and what are the dangers to youth when facilities fail to offer clinically appropriate addiction treatment?

Ms. MANLEY. Sure. It is a great question. So let me just start at the beginning and say that there are some residential interventions that actually do this work and do it incredibly well. But it is generally not just substance use treatment independent of behavioral health treatment.

Senator HASSAN. Right.

Ms. MANLEY. Treating the underlying cause or a worry about trauma and trauma experiences for young people is just really important in substance use. But providing the wrong care at the wrong time for the wrong duration is really not good for any young person.

So, ensuring that we get the right treatment at the right time, and that the organization that is saying that they can do that work—we actually have to know that they are doing that work.

Senator HASSAN. Yes.

Ms. MANLEY. We really need to understand their experiences, their training, how that training is operating. So the oversight part of specialized care is incredibly important in the work of providing residential care.

Senator HASSAN. Thank you very much for that.

And, Mr. Chair, I would just note with regard to the inpatient reimbursement rate—which can be as high as $1,000 a day—and our relative dearth of home and community-based services, if Medicaid incentivized things differently and we could really build up that home and community-based model, we might also reduce the number of young people who are inappropriately placed in these facilities, often out of state.

The CHAIRMAN. You said it much more eloquently than I tried to do about an hour and a half ago. Thank you. That is just—I mean, that is the bottom line.

Senator HASSAN. Yes.

The CHAIRMAN. You know smart, community-based services dollar for dollar give you the best value, and I am going to ask you some questions about your good work in that area shortly, Ms. Manley.

Senator Cortez Masto has also done a lot of work with Medicaid and these key programs.

Senator Cortez Masto?

Senator CORTEZ MASTO. Thank you. First of all, let me thank the chairman and the ranking member. Such an important issue, and I agree: this is a bipartisan issue. It really is not partisan at all, and we should be looking and focusing on the best interests of our children. I thank all my colleagues for being here.

Ms. Manley, let me start with you, and I want to talk a little bit about quality interventions. I am from Nevada. In Nevada, Medicaid is working to improve children's behavioral health by making changes to enhance quality in residential settings. This includes offering bonus payments for shorter stays, increasing oversight of discharge planning admissions, and preventing abrupt terminations and transfer of children. I appreciate you highlighting the need for technical assistance and coaching for residential treatment facilities and oversight organizations.

As the largest health insurer for youth and a major revenue source for the providers at issue in the committee's investigation, Medicaid has a crucial role in facility oversight and accountability. And you touched on that, and I made a note of that, because I do think it is important we hold the health-care providers accountable.

But as so many of you said, there is a partnership here. It is at the State level, it is at the Federal level; it is so much. So let me ask you, what specific technical assistance and coaching do oversight entities like State Medicaid programs need to ensure residential treatment facilities maintain that continuous quality improvement and high-quality interventions?

And then how—because every State obviously is different in how they manage Medicaid—how do we make sure they are doing right here? And there is a lot to it, but I think for purposes of understanding the Medicaid program, making sure we are holding them accountable as well, is just as important.

Ms. MANLEY. Oh, absolutely, and I think one of the challenges for State Medicaid folks is, they have to have expertise in a lot of different areas.

Senator CORTEZ MASTO. Right.

Ms. MANLEY. But the need for expertise, around residential interventions in particular, is a complicated issue because there is a very limited amount of expertise that exists. And so, we really need to make sure that we help our Medicaid partners. As an example, our children's behavioral health folks really understand the impact of what residential interventions are, what they do.

But also, how do you build in the upstream to ensure that young people do not need that intervention, don't need to get it, so that we are really providing the most expertise for children who do need it, for the shortest period of time in the smallest, most family-friendly environment that we can?

In order to do that, we actually have to talk about it; we have to provide resources. We have to work through particular care pathways for States and how young people end up where they do, and help our Medicaid folks understand when things are happening in those residential interventions, what do they need to do to both support the residential intervention in getting better and building a learning environment, but also how to mitigate against any kind of traumatic event that has occurred for that young person. Both of those things are necessary and have to happen.

Senator CORTEZ MASTO. And I agree. And I know everybody knows this, and the challenge—and I see so many people in my State programs, Medicaid programs, who want to do the right thing, but then they are limited by the Federal funds they get because the legislature has not provided enough funds. They are lim-

ited by the continuum of care, what may be available out there and what is not available that we have to grow.

So, there are a lot of challenges. But at the end of the day, for me and I think everybody at this table, it is about doing better and doing more for our kids, and making sure we are looking outside the box in trying to address all of these issues, to do right by them.

Ms. Stanford, let me ask you this. Nevada is prioritizing new investments in community-based services for children with behavioral health needs. The State actually—it proposes using some hospital tax revenue to improve access, to enhance placements at the appropriate level of care.

And Nevada Medicaid plans to match these Federal Medicaid dollars, pending CMS approval—another Federal partner here that is key. I understand, Ms. Stanford, you have worked closely with States on best practices for promoting this community-based care.

In your view, what is driving the overreliance on residential treatment facilities by States, and which option operates as a placement alternative and a service alternative? I'm curious; something that we should be aware of.

And by the way—I know I have limited time. I could be here all day with you. I appreciate the model of best practices highlighting New Jersey, because I think we always should be highlighting, pointing out areas where other States can look to if they are looking for those best practices. But, Ms. Stanford, if you would?

Ms. STANFORD. I think residential treatment is relied on because it's an alluring model, if you do not know what is really going on in there. They are selling this idea that they are specialized providers with expertise and high-quality people in there who are providing something that cannot be provided anywhere, and you have a placement for the child and you've got all the services they need.

So it is a very alluring idea for States. But the reality is not that, and I think that in States, no one knows exactly how to make these places—even the providers—work effectively and be safe and therapeutic environments.

Senator CORTEZ MASTO. And I thank you. I know my time is up, but let me just say this one final thing, Mr. Chair, and I know you know this.

The CHAIRMAN. I would just say to my colleague, she is asking very important questions, and if you want to ask another question or two, go ahead.

Senator CORTEZ MASTO. Oh, thank you. So my concern is, CMS is a crucial partner here. Now, Nevada has Willow Springs. It is in the report, and they are doing everything they can to improve, and literally our legislature, working with our State government, has put in place an improvement plan.

But part of that improvement plan requires CMS to come out with waivers and be a part of the solution. And the challenge I find sometimes is, CMS does not work fast enough or quick enough. I am curious if any of you have any involvement with CMS and information that we need to be aware of, as we are working with that Federal agency as well?

Ms. LARIN. The one thing that I would say is that CMS does have the ability to cancel a contract if a facility, particularly a psychiatric residential facility, is not meeting their health and safety

standards. But when we looked at this in 2020, during that year they had not exercised that authority even once.

Senator CORTEZ MASTO. Well, and I think, Ms. Stanford, you said there is limited CMS oversight and regulation. So, do they have the oversight and regulation or do they not, or they have it and they are not exercising it? I'm curious.

Ms. STANFORD. I think both; both. There have been narrow regulations that are applicable to these facilities. So, they are kind of pigeonholed into these very narrow things. They cannot look at the broader quality of care and what is going on and how services are being provided. But they also, even in our State sometimes—I mean, they are doing a better job at documenting what is going on, but that is it.

There is no progressive discipline that is documented. You can look at the surveys. You can see that they have found things, and that the facilities have come up with these rote plans of correction—that are usually like retraining staff—by the administration that is already in there and was probably part of the problem to begin with, and then that just keeps going on and on.

Every day is a new day. There are no actual sanctions. No matter what happens to kids, no matter what goes on, there are not any actual financial sanctions or any kind of sanctions, at least in Arkansas, to any of the facilities.

Senator CORTEZ MASTO. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. I thank my colleague.

And let me turn to you again, Ms. Manley. This committee has made a special priority of home and community-based services, and the late Senator Hatch worked very closely with all of us on Family First.

I had started—back as a young member of Congress with a full head of hair and rugged good looks—to start thinking about things like kinship care, which we built into Family First, a bigger role for grandparents and the like, helping keep folks at home.

But as we look for promising ideas, you always want to look for ones that have an impressive track record, and it looks like you have another one. You apparently, as the System Commissioner for Children's Care in New Jersey, you came up with a single point of contact system of care, which emphasized home and community-based services and a full continuum of treatment, and I gather this has worked pretty well.

So, I would be interested in your describing this, and then I am going to have a follow-up question on this.

Ms. MANLEY. Sure. One of the big challenges in home and community-based services is, not even just do they exist and are they clinically appropriate, but how do parents access them? And so, when you build a single point of access, one number, a 1–877 number that any parent can call 24 hours a day, 7 days a week and ask for help and we send it—because we believe parents, when they say that they are struggling and we send that help within an hour anywhere in the State of New Jersey—things can change pretty dramatically.

That help is really important, because parents do not call and ask for help from a public system unless they need it. And so, it

is really important that we get there and get there fast. With that, we can actually then do a pretty good assessment that says we are going to look at what is happening for your young person. We are going to look at what is going on for that young person in school. How do we connect the dots and bridge between home and school, and have young people return back to school as quickly as possible?

In that public health approach of really thinking through when and how young people need help, we are trying to decrease the amount of time it takes to get behavioral health care to that place, to that parent, to that caregiver.

Sometimes it is before young people actually really recognize that something is going on, and so we can put in the supports for those young people. So, that single point of access makes a huge difference in terms of accessing care.

The CHAIRMAN. Is this something that we ought to be looking at as we go forward, in a bipartisan way, to create some national incentives for this sort of one point of contact that encourages help for the community health services?

Ms. MANLEY. Yes. I see States really struggling with this idea of, who do they call? Like when they have a really good service delivery system, they still have a struggle of how do parents know when to call and who to call, and in particular if they move across the county line or they go into a different part of the State.

Knowing that the service delivery system is going to look the same no matter where you go within a State is incredibly important as well, so parents and young people can learn to rely on those services.

There is one more point I think is important, which is that, when you can get to young people early, you can change the trajectory of their experience, not only by providing good care, but actually allowing both parents and young people to come to trust the system that may not always be trustful for folks. So just that arriving when they need it is incredibly important. It is a powerful tool.

The CHAIRMAN. That is way too logical for the Federal Government.

Let me ask you about the financial model for the programs that we are discussing. And my concern is that these facilities get paid often with per diem payments that create this almost perverse incentive to drive down care quality and staffing in order to maximize profit.

It is almost like this per diem operation almost bakes in some of the harms that we saw in our report. Do you share that view?

Ms. MANLEY. I think it can. I think one of the challenges in oversight—you know, being an oversight organization was certainly one of my roles—is to ensure that the deliverers of services, those providers who are providing care, are really focused on the quality of care that is delivered at the time they need it for young people, and that we stay very focused on that part of the conversation, making sure that providers do not lose money on this. But also, that there is not a profit margin that puts the service into that place in which we are delivering care that is not necessary.

Just one other point on this. I think the access of making sure that young people need the service right up front, like having a group of people who know that young person, in a teaming process

such as high-fidelity wrap-around, make the decisions around whether or not this residential intervention is necessary in the first place, is really the first point of making sure that the profit on the other end is not incentivized by organizations saying they need this intervention, but by somebody else saying that.

The CHAIRMAN. Okay.

The three of you have been just superb in terms of laying out the challenge, and that is really what we wanted. It seems to me that your comments are very much in line with our investigative report.

You have heard me talk about the importance of dealing with this in a bipartisan way, because that is how you get lasting changes, because it puts everybody together to make an investment in these improvements. I am just going to close with a couple of thoughts. I look out over the room, I see the survivors and the families, and I heard comments last night and I heard comments this morning, and I have read a number of your accounts.

I just want you to know that you have not made this trip thousands of miles to Washington, DC just to hear us talk for a little bit and call it a day. You have laid out a blueprint for the kinds of changes that are necessary, these efforts, for example, for more home and community-based services and the health and safety issues that relate to Medicaid and child welfare rules.

So, I want everybody who is going to be faced with going back thousands of miles home, to know that we are not just talking today. This is the first step of what you need to do to make change.

I am going to do everything I can as chairman of this committee to get a bipartisan approach going—and hopefully we can have it up and running in the fall—that focuses on the issue we are talking about today, which is beefing up health and safety for vulnerable kids and vulnerable families. And you know, taxpayers should not be put in the position to just constantly be writing these enormous checks for the kind of care that we wish kids were getting, but we end up seeing they do not actually get.

So, we are going to be following up very quickly. I am personally going to review the accounts that I put in the Congressional Record that came from all of you around the country. We have also included in the report some tips about where you may be able to get some help now.

I put that out just in the context of, from the time we wrap up today in a minute and I bang this gavel—which is sort of formally closing off today—I want everybody to know we are just getting started, and we will do everything we can to help eliminate the problems this report has discussed and our experts have talked about, that you talk about in your testimonies. And we are going to be back to all of you soon.

And for the members, I want everyone to know that they have 7 days to submit questions for the record. That is June 19th, that is Juneteenth, so that means June 20th by close of business.

But you know, we are here because of the survivors. All of you have told us that the business model today is not doing what is needed to protect vulnerable kids and families. We are going to stay at this, working with all of you until this is fixed.

With that, the Senate Finance Committee is adjourned.

[Whereupon, at 11:27 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF HON. MIKE CRAPO, A U.S. SENATOR FROM IDAHO

Three weeks ago, the Senate Finance Committee held a hearing to celebrate the child welfare system's progress resulting from enactment of the Family First Prevention Services Act. We heard from witnesses about the importance of investing in preventive services, and that children are best served when they receive care within their homes and communities.

While more work is needed to provide States with a diverse array of evidence-based programs to meet the needs of their communities, the chairman and I are committed to rigorous engagement with the Administration for Children and Families to fulfill our shared commitment of prioritizing familial placement whenever possible.

One of the goals of Family First was to reduce inappropriate placements for children in congregate care settings. To meet that objective, we must ensure that residential treatment interventions are a placement of last resort, with a focus on integrating patients back into the community as soon as clinically possible.

When home and community-based services fall short of a child's needs, families deserve access to high-quality residential treatment facilities that provide medically necessary treatment in safe, therapeutic environments. Anything less risks causing further harm, and escalating an already tragic and difficult situation.

To the victims in the audience and around the country who suffered abuse and neglect in a residential treatment facility, your experience is entirely unacceptable. Facilities entrusted with caring for our most vulnerable youth should be held to the highest standards, and subject to routine, reliable oversight. Chronic patterns of failure must not go unnoticed or unaddressed. The incidents highlighted in Chairman Wyden's investigative report are deeply disturbing.

Many of these facilities are reimbursed with Federal Medicaid and title IV–E dollars, making these deficiencies even more concerning. Hardworking taxpayers should not be funding anything less than superior care. Our child welfare and behavioral health systems have made a lot of progress in improving the quality of congregate care settings, but it is clear gaps remain.

As we consider reforms to remedy inadequacies, we must recognize the different forms of residential treatment facilities, the essential role they play in the care continuum, and the regulations and requirements that are unique to each setting. For example, Congress established Qualified Residential Treatment Programs, or QRTPs, as a high-quality, clinically informed treatment option for children in the child welfare system with behavioral health needs. Unfortunately, bureaucratic challenges have prevented many States from implementing this model.

Additionally, psychiatric residential treatment facilities are subject to Federal health and safety standards as a condition of participation in the Medicaid program. Congress and the administration should ensure these requirements are patient-centered, informed by best practices, and promote access for those who require more intensive services.

I look forward to a productive conversation with our witnesses today about how to improve care quality and increase accountability of youth residential treatment

facilities, including by empowering States to establish QRTPs and other treatment models that best serve children.

Again, I thank the advocates for being here and Chairman Wyden for his important work on this issue.

PREPARED STATEMENT OF KATHRYN A. LARIN, DIRECTOR, EDUCATION, WORKFORCE, AND INCOME SECURITY, GOVERNMENT ACCOUNTABILITY OFFICE

Child Welfare: Abuse of Youth Placed in Residential Facilities

Why GAO Did This Study

For over 20 years, GAO has reported on youth in the foster care system who are placed in residential facilities, including concerns with the physical, emotional, and sexual abuse of these youth. In multiple reports, GAO has recommended that HHS enhance the support it provides to States, which are primarily responsible for oversight of residential facilities.

This testimony summarizes findings from prior GAO reports on: (1) youth placed in residential facilities; (2) challenges to preventing harm to these youth; and (3) State and Federal oversight of residential facilities.

This testimony is primarily based on prior GAO reports issued from 2008 to 2022. Each of GAO's prior reports contain a detailed description of the methodology GAO used. Generally, for each report, GAO reviewed relevant documentation and information gathered via interviews or surveys of relevant stakeholders, including officials from State and local child welfare agencies and residential facility administrators.

What GAO Recommends

Most recently, in 2022, GAO recommended that HHS facilitate information sharing among States on promising practices for preventing and addressing maltreatment in residential facilities. HHS agreed with this recommendation but has not yet taken action to address it.

What GAO Found

Prior GAO reports have described allegations of youth being maltreated, and sometimes killed, by staff employed at residential facilities. Many of the youth placed in residential facilities are in foster care. Youth in foster care may be placed in residential facilities for a number of reasons. For example, youth are sometimes placed in residential facilities due to an insufficient number of family foster homes, especially homes that are equipped to provide care for youth with mental or behavioral health needs.

The use of residential facilities as placements for youth in foster care has declined over the course of 20 years, according to data from the Department of Health and Human Services (HHS). Residential facilities were listed as the most recent placement for about 101,000 youth in foster care in 2002. By 2022, the most recent year of available data, that number had dropped to about 34,000 youth.

GAO has previously reported on challenges to preventing harm to youth placed in residential facilities, which include:

- **Monitoring youth in out-of-state placements.** Youth are sometimes placed in out-of-state facilities if there are no available placements in their home State. Stakeholder groups and State agency officials said monitoring youth in out-of-state facilities is difficult because of limited access to the youth or information regarding their care. To address this challenge, one State established an interagency committee that monitored youth placed in out-of-state residential facilities.
- **Inappropriate use of psychotropic medications.** Some youth placed in residential facilities are prescribed psychotropic medications, such as those used to treat depression and anxiety, among other conditions. However, health risks are associated with certain prescribing patterns—such as using multiple psychotropic medications. Some States have taken steps to curb inappropriate use of these medications among youth in foster care, such as re-

quiring physicians to consult a child psychiatrist when prescribing certain medications.

- **Harming youth through use of restraints.** In some instances, staff injure youth while attempting to restrain them, which may result in maltreatment allegations and findings. To address this challenge, one State set up an interagency advisory committee on restraints that meets regularly to analyze restraint data and review feedback from program providers on the use of restraints in their facilities.

Various State agencies are responsible for monitoring residential facilities and working with them to prevent and address abuse or neglect. At the Federal level, HHS is the lead agency for addressing issues related to the safety and well-being of youth, which includes youth in residential facilities. HHS officials reported that they primarily support States' efforts by providing technical assistance and guidance. However, at the time of our 2022 report, some State officials told us they received little to no information from HHS.

Chairman Wyden, Ranking Member Crapo, and members of the committee:

Thank you for the opportunity to discuss our work on residential facilities that are responsible for the care of vulnerable youth in the child welfare system.[1] Residential facilities may be an appropriate part of the continuum of care for some youth. However, for over 20 years, we have reported on youth in the foster care system who are placed in such facilities, including concerns with the physical, emotional, and sexual abuse of these youth.[2] In multiple reports, we have called on the Department of Health and Human Services (HHS) to enhance the support it provides to States, which are primarily responsible for oversight of residential facilities.[3]

My statement today will focus on (1) information about the youth who are placed in residential facilities, (2) potential challenges to preventing harm to youth placed in these facilities, and (3) State and Federal oversight of residential facilities. My statement is based primarily on the findings from our 2022 report on maltreatment of youth in residential facilities, as well as findings from earlier reports.[4]

Each of our prior reports contains a detailed description of the methodology we used. Generally, for these reports, we reviewed agency documents and information gathered via interviews or surveys of relevant experts or stakeholders, including officials from State and local child welfare agencies and residential facility administrators. In addition, for some reports we reviewed selected data from Federal agencies.

The work upon which this statement is based was conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Abuse of youth placed in residential facilities is well documented. As we testified in 2007, we found thousands of allegations of abuse—some of which involved

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[1] There are various types of residential facilities, including treatment programs for youth with behavioral, emotional, mental health, and substance abuse issues; homes for pregnant teens; homes that specialize in supporting and treating youth with severe emotional disorders; group homes; and other institutions. The Department of Health and Human Services refers to residential facilities as congregate care settings.

[2] GAO, *Foster Care: HHS Should Ensure that Juvenile Justice Placements Are Reviewed,* GAO/HEHS–00–42 (Washington, DC: June 9, 2000). GAO, *Residential Treatment Programs: Concerns Regarding Abuse and Death in Certain Programs for Troubled Youth,* GAO–08–146T (Washington, DC: October 10, 2007). GAO, *Residential Programs: Selected Cases of Death, Abuse, and Deceptive Marketing,* GAO–08–713T (Washington, DC: April 24, 2008). GAO, *Residential Facilities: Improved Data and Enhanced Oversight Would Help Safeguard the Well-Being of Youth With Behavioral and Emotional Challenges,* GAO–08–346 (Washington, DC: May 13, 2008). GAO, *Foster Care: HHS Could Do More to Support States' Efforts to Keep Children in Family-Based Care,* GAO–16–85 (Washington, DC: October 9, 2015). GAO, *Child Welfare: HHS Should Facilitate Information Sharing Between States to Help Prevent and Address Maltreatment in Residential Facilities,* GAO–22–104670 (Washington, DC: January 22, 2022). This testimony is primarily based on our reports from 2008 to 2022.

[3] *For example, see* recommendations made in GAO/HEHS–00–42, GAO–08–346, GAO–16–85, and GAO–22–104670.

[4] *See* GAO–08–146T, GAO–08–346, GAO–16–85, and GAO–22–104670.

death—at residential facilities across the country by reviewing claims of abuse in pending and closed civil or criminal proceedings, among other methods.[5] In May 2008, we found that a majority of States reported at least one death of a youth in a residential facility in 2006.[6] More recently, media reports have described instances of youth being maltreated, and in some cases killed, by staff employed at residential facilities.[7]

Maltreatment in residential facilities may include abuse or neglect. Abuse can range from staff members taunting or threatening youth to physical acts such as punching, slapping, or sexual assault. Incidents of neglect can include a lack of supervision by facilities staff, such as failing to respond to suicide attempts or failing to prevent residents from running away.

The number of youth who have been physically, emotionally, or sexually abused or neglected while living in a residential facility is unknown. HHS collects, on a voluntary basis, data from states on allegations of child abuse and neglect through its National Child Abuse and Neglect Data System. However, while some States voluntarily submit such data, we have previously concluded that these data likely undercount instances of abuse and neglect—including those taking place in residential facilities.[8]

There are also many reasons that instances of abuse and neglect in residential facilities may go unreported, according to State agency officials and representatives from stakeholder groups we interviewed for our 2022 report.[9] For example, residential facility staff may not report incidences of abuse that they witness for fear of retaliation from their co-workers or employers. Youth placed in residential facilities may not make reports for fear of prolonging their stay in the facility, being punished, becoming a target for additional abuse, or having privileges taken away.

Youth Placed in Residential Facilities

Many of the youth placed in residential facilities are in foster care.[10] Most youth enter foster care due to abuse or neglect, which is a traumatic experience.[11] When these youth experience abuse or neglect by residential facility staff or other residents, it may exacerbate their trauma.

Youth in foster care may be placed in residential facilities for a number of reasons. For example, youth can be placed in these facilities due to mental or behavioral health needs. As noted in our January 2022 report, according to a study conducted by HHS, a significant proportion of youth in foster care who lived at some point in a residential facility had been diagnosed with a mental health disorder, had behavioral health issues, or had clinical disabilities other than a diagnosed mental health disorder.[12]

Youth are sometimes placed in residential facilities due to an insufficient number of family foster homes, especially homes that are equipped to provide care for youth with mental or behavioral health needs. In 2015, we reported on the barriers to increasing the number of available family foster homes.[13] One barrier was that States had insufficient time and resources to recruit and train additional foster families.

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[5] GAO–08–146T. As we noted in our prior report, allegations alone do not constitute proof of actual abuse.

[6] GAO–08–346.

[7] *See, for example,* CNN, "16-year old boy goes into cardiac arrest and dies after staff at residential facility restrain him, lawsuit says," accessed June 7, 2024, *https://www.cnn.com/2020/06/23/us/16-year-old-restraint-death-michigan-trnd/index.html;* and *The Salt Lake Tribune,* "Utah takes emergency action against youth treatment center after boy's death," accessed June 7, 2024, *https://www.sltrib.com/news/2023/07/21/utah-takes-emergency-action/*.

[8] GAO–08–346.

[9] GAO–22–104670.

[10] Other types of youth who may be placed in residential facilities include: those with disabilities whose special education needs are best met there; those whose parents believe they are at risk of running away or are a danger to themselves or others; and those placed in residential facilities through the juvenile justice system as an alternative to incarceration.

[11] Any frightening, dangerous, or violent event that threatens a child or their loved ones can potentially be traumatic. While not every child who experiences trauma will suffer lasting effects, trauma significantly increases the risk of mental health problems, difficulties with social relationships and behavior, physical illness, and poor school performance. GAO, *Children Affected by Trauma: Selected States Report Various Approaches and Challenges to Supporting Children,* GAO–19–388 (Washington, DC: April 24, 2019).

[12] GAO–22–104670.

[13] GAO–16–85.

Another barrier was a lack of community resources (such as therapy or mental or behavioral health services) needed to support youth in foster care.

Certain youth in foster care are more often placed in a residential facility compared to others. For example, according to a child welfare organization that looked at data from 15 States from 2012 through 2019, older youth and teens are more often placed in residential facilities compared to younger youth.[14] In addition, we reported in 2022 that youth of color and those who identify as lesbian, gay, bisexual, transgender, and queer or questioning, are overrepresented among residential facility placements.[15]

Almost 10 years ago, HHS issued a report stating that child development theory and best practices confirm that youth should be placed in family-like settings that are developmentally appropriate and least restrictive.[16] In addition, a child welfare organization found that youth placed in family foster homes or with kin have better outcomes compared to those placed in residential facilities.[17] Given these findings, State child welfare agencies have undertaken efforts to decrease the use of residential facility placements. For example, in October 2015 we found that States reported increased efforts to find relatives to care for youth removed from their homes, additional recruiting and training for specialized foster families to care for youth with serious emotional, behavioral, or medical problems, and increased supports for families in crisis.[18]

Due to these State efforts, the number of residential facility placements for youth in foster care declined from 2002 through 2022. Among youth in foster care in 2002, nearly 101,000 (about 19 percent) were placed in residential facilities for their most recent foster care placement. According to HHS's most recent data, by 2022, that number had dropped to about 34,000 youth (about 9 percent of placements for youth in foster care).[19]

The Family First Prevention Services Act (FFPSA), enacted in 2018, introduced new restrictions on State use of Federal title IV–E foster care maintenance payments to support youth placed in residential facilities.[20] These restrictions ensure placements in residential facilities are only used in a specific set of limited circumstances. Under FFPSA, title IV–E funding can be used to support youth in residential facilities for 2 weeks. After that time, these funds may only be used to support youth in residential facilities if the setting:

- Is a qualified residential treatment program,[21]
- Specializes in providing prenatal, post-partum, or parenting supports for youth,
- Is a supervised setting in which the child is living independently (for youth 18 years old or older), or
- Provides high-quality residential care and support services for youth who have been or are at risk of becoming sex trafficking victims.

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[14] X. Zhou, J. McClanahan, S. Huhr, and F. Wulczyn. *Using Congregate Care: What the Evidence Tells Us.* Center for State Child Welfare Data, Chapin Hall at the University of Chicago. Chicago, IL (2021). This study used data from 903 counties in 15 States between January 1, 2012 and December 31, 2019.

[15] GAO–22–104670 and GAO. *Foster Care: Further Assistance From HHS Would Be Helpful in Supporting Youth's LGBTQ+ Identities and Religious Beliefs,* GAO–22–104688 (Washington, DC: April 20, 2022).

[16] Department of Health and Human Services. Administration for Children and Families. Children's Bureau. *A National Look at the Use of Congregate Care in Child Welfare.* May 13, 2015.

[17] Casey Family Programs, *What Are the Outcomes for Youth Placed in Group and Institutional Settings?* (updated June 2022).

[18] GAO–16–85.

[19] Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, Adoption and Foster Care Analysis and Reporting System (AFCARS) data.

[20] Title IV–E is the largest source of Federal child welfare funding. In Fiscal Year 2022, title IV–E expenditures totaled about $9 billion.

[21] FFPSA created this new category of residential facility placements and outlines a number of criteria that must be met to be considered a qualified residential treatment program. For example, a program must have a trauma-informed treatment model that is designed to address the needs of youth with serious emotional or behavioral disorders and have registered or licensed nursing staff and other licensed clinical staff available at all times, among other criteria.

Potential Challenges to Preventing Harm to Youth Placed in Residential Facilities

We have previously reported on challenges to preventing harm to youth placed in residential facilities. In addition to the abuse and neglect previously discussed, these challenges include:

- **Monitoring youth in out-of-state placements.** Youth are sometimes placed in out-of-state facilities if there are no available placements in their home State. In 2022, we reported that stakeholder groups and State agency officials we interviewed said monitoring youth in out-of-state facilities is difficult because the home State often must rely on information and reports from the State where the facility is located.[22] In addition, it is difficult for child welfare officials in the home State to know how youth are doing when they cannot visit with them regularly. To address this challenge, one State established an interagency committee dedicated to monitoring the well-being of youth placed in residential facilities out-of-state, including coordinating outreach to providers and State agencies in other States to discuss allegations of maltreatment.
- **Inappropriate use of psychotropic medications.** In 2017, we reported that some youth placed in residential facilities are prescribed psychotropic medications that affect mood, thought, or behavior.[23] These medications may be used to treat conditions such as depression, anxiety, and attention deficit hyperactivity disorder, among others. Information on the number of youth in foster care using psychotropic medications nationwide is limited, according to our 2017 report.[24] However, health risks are associated with certain prescribing patterns—such as simultaneously using multiple psychotropic medications—so it is important to ensure that such treatment is appropriate. We also found in our 2017 report that some States have taken steps to curb inappropriate prescriptions of psychotropic medications among youth in foster care, such as developing prescription guidelines or requiring physicians to consult a child psychiatrist when prescribing certain medications.
- **Harming youth through restraint and seclusion.** Federal regulations governing certain residential facilities State that restraint and seclusion should not be used as coercion, discipline, convenience, or retaliation, and must not result in harm or injury to youth.[25] However, in some instances, staff injure youth while attempting to restrain them, which may result in maltreatment allegations and findings, according to our 2022 report.[26] In addition, seclusion may be traumatic or psychologically damaging to youth, according to HHS. We reported in January 2022 that to address this challenge, one State set up an interagency advisory committee on restraints that meets regularly to analyze restraint data and review feedback from program providers on the use of restraints in their facilities.

State and Federal Oversight of Residential Facilities

States contract with private nonprofit and for-profit providers to operate residential facilities. At the Federal level, HHS is the lead agency for addressing issues related to the safety and well-being of youth, which includes youth in residential fa-

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[22] GAO–22–104670.

[23] GAO, *Foster Care: HHS Has Taken Steps to Support States' Oversight of Psychotropic Medications, but Additional Assistance Could Further Collaboration,* GAO–17–129 (Washington, DC: January 5, 2017). In addition, in December 2012, we reported on the results of the Administration for Children and Families (ACF) surveys of children in contact with the child welfare system conducted during 2008–2011. Eighteen percent of foster-care children were taking a psychotropic medication at the time they were surveyed. Foster children who lived in group homes or residential treatment centers had much higher rates of psychotropic medication use (48 percent) than those living in nonrelative foster homes (14 percent) or formal kin care (12 percent), according to the surveys. The higher utilization rate among children living in group homes or residential treatment centers may be related to these children having higher rates of potential mental health needs. GAO, *Children's Mental Health: Concerns Remain About Appropriate Services for Children in Medicaid and Foster Care,* GAO–13–15 (Washington, DC: December 10, 2012).

[24] GAO–17–129.

[25] These regulations apply to psychiatric residential treatment facilities (PRTF). 42 CFR § 483.356(a)(1), (3). A psychiatric residential treatment facility is any non-hospital facility that provides psychiatric services to individuals under the age of 21 in an inpatient setting (known as the psych under 21 benefit). Restraint means a "personal restraint," "mechanical restraint," or "drug used as a restraint." Seclusion means the involuntary confinement of a resident alone in a room or an area from which the resident is physically prevented from leaving. 42 CFR § 483.352.

[26] GAO–22–104670.

cilities. Federal funding authorized under the title IV–E foster care program, Medicaid, or the Individuals with Disabilities Education Act may be used to support youth in foster care who are placed in residential facilities.

In States, responsibility for monitoring residential facilities and working with facilities to prevent and address abuse or neglect may be spread across multiple agencies. Each agency has different, though sometimes overlapping, responsibilities. For example, among the four States we selected for review in our 2022 report, we found that:

- Suspected incidents of abuse or neglect were reported to the State's child welfare agency or state police.
- Child welfare staff or special police units, together or independently, investigated reports of suspected abuse or neglect to determine if maltreatment occurred.
- State licensing officials sometimes participated in investigations or obtained information from child welfare officials or police and determined if the abuse or neglect resulted from licensing violations. These violations could include inadequate training or staffing ratios, or failure to complete background checks, for example.

We also reported in 2022 that among the four selected States, agencies try to prevent abuse or neglect in residential facilities by requiring background screenings and training for facility staff and increasing interagency coordination, among other things.[27] When abuse or neglect occurs, States may respond in various ways, such as prohibiting a facility from taking in new residents or revoking its license.

Stakeholders we interviewed for our 2022 report suggested additional steps that States could take to further prevent and address abuse or neglect in residential facilities. For example:

- States could provide additional hours of training for residential facility staff and include topics such as conflict deescalation and trauma-informed care.
- States could minimize oversight gaps by making one State agency solely responsible for responding to abuse and neglect in facilities.
- States could impose stiffer financial or other penalties when abuse or neglect occurs in facilities.

Over the years, HHS has emphasized that States are primarily responsible for oversight of residential facilities and efforts to prevent maltreatment.[28] HHS officials reported that they primarily support States' efforts by providing technical assistance and guidance to States. However, at the time of our 2022 report, some State officials told us they received little to no information from HHS. We recommended that HHS facilitate information sharing among States on promising practices for preventing and addressing maltreatment in residential facilities. While HHS agreed with the recommendation, as of June 2024, the agency has not yet implemented it.

In conclusion, there are longstanding issues related to abuse and neglect in residential facilities. As States and HHS implement residential facility requirements in the Family First Prevention Services Act, there is a new opportunity to further assess the use of these facilities and consider whether additional steps will ensure that vulnerable youth placed in these facilities are not victims of abuse and neglect.[29]

Chairman Wyden, Ranking Member Crapo, and members of the committee, this completes my prepared statement. I would be pleased to respond to any questions that you may have at this time.

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[27] GAO–22–104670.

[28] HHS's oversight role includes the authority to cancel state approval of PRTFs that do not meet Federal health or safety requirements. PRTFs, which are one type of residential facility that is funded by Medicaid, could have State approval canceled if, for example, there is a serious occurrence involving the death of a resident. HHS does not have this authority for other types of residential facilities.

[29] FFPSA requires that GAO review the impact of the act's restrictions on Federal reimbursement for residential facility placements. GAO will submit a report to Congress by December 2025.

QUESTIONS SUBMITTED FOR THE RECORD TO KATHRYN A. LARIN

QUESTIONS SUBMITTED BY HON. RON WYDEN

Question. What concerns does the Government Accountability Office have, if any, about educational quality in residential treatment facilities (RTFs)?

Answer. We do not have recent work related to educational quality in residential treatment facilities. However, in 2008 we reported[1] that there were gaps in safeguarding the educational well-being of youth in residential facilities that warranted greater oversight from the Department of Education and States. During that work, we found that not all State agencies required licensed residential facilities to provide evidence of appropriate educational programming. Further, we found inconsistent State monitoring of both the presence and quality of educational programing in government funded residential facilities serving youth. We also found that severe neglect in residential treatment facilities resulted in poor education for some youth. For example, youth in one facility did not receive special education services as required by Federal law.

In the 2008 report, we recommended that to help ensure the Federal regulatory structure protects youth well-being across residential facilities supported by Federal funds, the Departments of Health and Human Services, Justice, and Education should work to enhance their oversight of State accountability for youth well-being in residential facilities. We noted that such efforts could include ensuring that residential facilities are included in Federal oversight reviews and on-site visits to States. The Department of Justice implemented this recommendation by taking several actions to promote interagency and interdepartmental collaboration to enhance Federal agency coordination to address State accountability for youth well-being in residential facilities. However, at the end of fiscal year 2012, the recommendations to Departments of Health and Human Services and Education were closed as unimplemented as neither agency had not taken steps to address them.

Question. What can be done within today's statutory landscape that would improve collaboration across Federal agencies to better oversee youth RTFs?

Answer. While oversight of residential treatment facilities is primarily a State role, the Departments of Health and Human Services and Education told us that they support State's efforts in these areas by providing technical assistance and guidance. However, in our 2022 report,[2] we found that some of the child welfare, education, and licensing officials in our selected States reported receiving little to no information from Federal agencies and had minimal contact with HHS or the Department of Education. We also found that HHS, as the lead agency on addressing issues related to the safety and well-being of youth, had not consulted with or shared its expertise with Education on issues related to preventing and addressing maltreatment in residential schools. We recommended that HHS, in consultation with Education, facilitate information sharing among States on promising practices for preventing and addressing maltreatment in residential facilities for youth. HHS concurred with our recommendation, but has not yet taken steps sufficient to close the recommendation.

Question. If you could make one Federal law change to improve the youth RTF landscape today, what would it be?

Answer. GAO has not recommended changes to Federal law to improve residential treatment facilities. However, in 2022 we reported that HHS documents note that HHS needs timely and reliable data to monitor the extent of child abuse and neglect in residential facilities and evaluate the impact of prevention efforts. Currently, States are not required under law to report incidents of maltreatment in residential facilities to HHS. States voluntarily report such incidents through HHS's National Child Abuse and Neglect Data System (NCANDS), but we have previously reported that these data likely undercount the actual incidents of maltreatment in these facilities.

QUESTION SUBMITTED BY HON. CHUCK GRASSLEY

Question. In 2022, a GAO report recommended that HHS, ACF and Department of Education facilitate information sharing among States on practices to prevent

[1] *https://www.gao.gov/products/gao-08-346.*
[2] *https://www.gao.gov/products/gao-22-104670.*

maltreatment in youth residential facilities. Your testimony shared that HHS has not yet implemented this recommendation.

Can you speak to the barriers that exist to improve information sharing across these agencies and what recommendations there are for HHS to provide more guidance to States?

Answer. While oversight of residential treatment facilities is primarily a State role, the Departments of Health and Human Services and Education told us that they support State's efforts in these areas by providing technical assistance and guidance. However, in our 2022 report,[3] we found that some of the child welfare, education, and licensing officials in our selected States reported receiving little to no information from Federal agencies and had minimal contact with HHS or the Department of Education. We also found that HHS, as the lead agency on addressing issues related to the safety and well-being of youth, had not consulted with or shared its expertise with Education on issues related to preventing and addressing maltreatment in residential schools.

We recommended that HHS, in consultation with Education, facilitate information sharing among States on promising practices for preventing and addressing maltreatment in residential facilities for youth. HHS concurred with our recommendation and reported it, along with Education, would look for further opportunities to promote promising practices for preventing and addressing maltreatment in residential facilities. In March 2022, HHS and Education hosted a technical assistance webinar for State Educational Agency foster care points of contact. The webinar covered a range of topics, including program monitoring activities. However, we have not yet closed this recommendation as we believe HHS should take additional steps to facilitate information sharing among States specifically directed at preventing and addressing maltreatment in residential facilities for youth, particularly foster youth.

QUESTIONS SUBMITTED BY HON. BENJAMIN L. CARDIN

Question. Across our country we see blatant health disparities in so many areas where marginalized groups are not able to get the care they need.

How have you seen health disparities play out in the setting of RTFs, both in on-the-ground experience and in a broader oversight perspective?

Answer. GAO has not conducted work on health disparities in RTF settings. However, we have reported on the use of psychotropic medication for youth in foster care several times. In 2011,[4] for example, we found that youth in foster care in each of the five States we analyzed were prescribed psychotropic drugs at higher rates than youth in Medicaid who were not in foster care. GAO has made several recommendations to the Department of Health and Human Services related to improving guidance to States on monitoring and oversight for children in foster care receiving psychotropic medications and promoting collaboration and information sharing among child welfare, Medicaid, and other stakeholders on psychotropic medication prescribing. HHS has taken action on these recommendations and GAO has closed them.

Question. In April, I held a hearing in the Senate Finance Health Care Subcommittee focused on substance use disorder treatment in the Federal health programs. Since then, the full committee has also highlighted this issue in a hearing. In our subcommittee hearing, we heard from a pediatrician working with young people struggling with substance use who explained how often this struggle coincides with other mental health conditions.

What does substance use treatment look like in RTFs, and how can substance use care be best integrated into a treatment plan for young people with other behavioral health conditions?

Answer. GAO has not reported specifically on substance use treatment for youth in residential treatment facilities. However, in 2020, GAO issued a report that provides information on the continuum of care for individuals with substance use disorder (SUD). We reported that as of May 2020, most counties did not have all levels of SUD treatment available, including outpatient, residential, and hospital inpatient services; nearly one-third of counties had no levels of treatment available. Though

[3] *https://www.gao.gov/products/gao-22-104670.*
[4] *https://www.gao.gov/products/gao-12-201.*

not specific to residential treatment facilities, given the overall capacity constraints, this work suggests that there could be challenges meeting the substance use disorder treatment needs of youth in residential facilities.

QUESTION SUBMITTED BY HON. ELIZABETH WARREN

Question. The staff report refers to many instances where children and young adults are not getting seen or provided services while the facilities claim they are getting these services.

If Federal programs like Medicaid are paying for these services, what could the Department of Health and Human Services do better to ensure that actual services are being provided?

Answer. GAO has not specifically examined the validity of Medicaid claims for services provided to youth in residential treatment facilities.

PREPARED STATEMENT OF ELIZABETH A. MANLEY, LSW, SENIOR ADVISOR FOR HEALTH AND BEHAVIORAL HEALTH POLICY AND ASSISTANT EXTENSION PROFESSOR, INNOVATIONS INSTITUTE, UNIVERSITY OF CONNECTICUT SCHOOL OF SOCIAL WORK, HARTFORD, CT

Chairman Wyden, Ranking Member Crapo, and members of the committee, thank you for the opportunity to appear before you today to address youth residential treatment facilities, with a specific focus on failures and the evaluation of solutions. My name is Elizabeth Manley, and I am a senior advisor for health and behavioral health policy at the Innovations Institute at the University of Connecticut School of Social Work. In this capacity, I serve as a subject matter expert on children's behavioral health systems design, financing and implementation for State and local leaders; I currently work with several States and provider organizations on design, implementation, and best practices in mobile crisis response and stabilization services, home and community-based services, and residential interventions for children and youth. I am the former Assistant Commissioner for New Jersey's Children's System of Care where I was responsible for the oversight of the full children's continuum of care inclusive of all residential treatment interventions.

Context:

First, I want to state, unequivocally, that all children, youth, and young adults with complex and intensive behavioral health challenges, need and deserve access to the most appropriate, least restrictive, high quality, and effective treatment and interventions. Our goal must be to support children and their families to receive services within their own homes and communities whenever possible, and provide individualized, strengths-based, culturally responsive care as early as possible. We must respond to their needs with urgency and elevate the voices of youth and families in every step of treatment planning and intervention.

Residential treatment facilities have an important role in the provision of care for young people with complex behavioral health-care needs when they have a clinical or behavioral health treatment need that cannot be met in a family and community setting due to the intensity of their treatment and supervision needs. In those instances, we need the care to be delivered in trauma-responsive environments that embrace parent and caregiver engagement throughout the treatment intervention and continually focus on best practice. These residential treatment facilities can have a significant benefit to the young person and their family.

Challenges and Opportunities:

Factors that drive treatment failure within a residential treatment facility are not monolithic. The challenges are complex and require multiple strategies at the Federal, State, local, and provider levels. States that use a systems approach to address the unique needs of youth with complex needs have demonstrated improvement in their ability to meet the needs of individuals with complex needs and systems involvement.

(1) **Challenge: Residential facilities are challenged by insufficient infrastructure to support youth receiving care in their facilities.**

Opportunity: Residential treatment facilities need technical assistance and coaching to support internal assessments and ongoing continuous quality improvement related to policy, practice, oversight, and outcomes. This technical assistance is also critically necessary for oversight organizations—

the State, local agencies, and managed care companies responsible for authorizing care, contracts, and, ultimately, for outcomes—to support building and sustaining high quality interventions.

(2) Challenge: Not all children in residential facilities require those services and, across many residential treatment facilities, lengths of stay are often too long. Both factors can cause harm and trauma to youth and families and limit access to residential treatment for those who do need it, resulting in overstays in emergency departments, inpatient psychiatric hospitals, and other settings.

Opportunity: States and communities must create clear care pathways to care and develop and sustain robust home and community-based services and supports that address the developmental and behavioral health needs of children and youth.

(3) Challenge: Our financing incentivizes the wrong services and supports. We build beds because it is what we know how to do, not because it is always what is needed. Our financing is piecemeal and incentivizes States and communities to build and invest in beds, instead of the critical services and supports children and youth need before, during, and after a residential intervention.

Opportunities: New Jersey has sustained the lowest per capita rate of group care utilization [1] by a child welfare system and lowest youth suicide rates,[2] demonstrating that policy solutions that can be employed to support States to improve child and youth well-being, reduce overreliance on child welfare systems as a source of behavioral health care, and reduce group care. The service delivery is outlined in the 2022 Medicaid Federal Policy Guidance.[3] Strategies to address these challenges include:

- Provide an enhanced Medicaid Federal Medical Assistance Percentage.
- Encourage CMS, SAMHSA, and ACF to issue a joint bulletin supporting and providing technical guidance on the use of Medicaid lookalike numbers, single points of access with consistent and trauma-responsive screening and assessment tools, and braided funding.
- Support partnership between SAMHSA and the Center for Medicare and Medicaid Services to develop future system-of-care planning grants that explicitly support States in developing comprehensive systems of care for children's behavioral health alongside Medicaid as a sustainable funding source; and
- Revisit the findings from the PRTF demonstration waiver and explore opportunities to make PRTFs a permanent 1915(c) waiver level of care.

The best way for Congress to direct Federal resources to impact this issue is increased accessible, comprehensive, family- and youth-driven, community-based, trauma-responsive behavioral health care.

Thank you for the opportunity to address you today and for your focus on this important issue.

QUESTIONS SUBMITTED FOR THE RECORD TO ELIZABETH A. MANLEY, LSW

QUESTIONS SUBMITTED BY HON. RON WYDEN

Question. The use of restraint is highly regulated in psychiatric residential treatment facilities (PRTFs). Nevertheless, my report found that restraint is still used frequently and, in many cases, inappropriately, which results in harm and trauma to children.

Do you agree that we need to fundamentally rethink how restraint is used in PRTFs and residential treatment facilities (RTFs) more broadly? If so, how?

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[1] In 2021, New Jersey had a child welfare group/institutional care rate of 8.1 per 100,000 children compared to a U.S. rate of 44.5 per 100,000 children.

[2] From 1999 to 2020, New Jersey had a youth suicide rate of 1.8 per 100,000 youth compared to a U.S. rate of 3.6 per 100,000 youth. Retrieved from *https://www.ojjdp.gov/ojstatbb//victims/qa02704.asp?qaDate=2020&text=yes*.

[3] 2002 Federal Medicaid Policy. Retrieved from: *https://www.medicaid.gov/federal-policy-guidance/downloads/bhccib08182022.pdf*.

Answer. I do agree that we need to fundamentally rethink how restraint is used within all residential interventions.

The use of restraints within varies greatly across the continuum of residential interventions. Although the use of restraints is highly regulated, challenges persist due to several important factors that need attention:

- Coordination of Federal agencies with a focus on inclusion of residential best practices in all Federal regulation, technical assistance for State oversight organizations and standards and quality improvement.
- Cross-reporting on quality standards to prevent residential providers from moving from one Federal funding resource to another when there are concerns about the care that is delivered.
- Oversight organizations need technical expertise to support best practice within a residential organization and recognize organizations who are unwilling or able to meet these expectations.[1]
- Implement staffing ratios and levels essential for good care for youth and families that is consistent with unique needs of youth with complex needs.
- Require training and supervision of all residential staff in trauma responsive care and crisis intervention de-escalation skills.

Support States in moving the front door for behavioral healthcare from the Child Welfare System and Juvenile Justice System to the Children's Behavioral Health System and incentivize States that make this move by providing an enhanced Medicaid Federal Medical Assistance Percentage.

Assist States in building a continuum of care, inclusive of:[2]

- Youth and parent peer support that focuses on navigation, engagement of both youth and families and assistance in building, participating and supporting child family teams.
- Customization of the crisis continuum to meet the unique needs of children, youth, young adults and their families. Mobile Response and Stabilization is a model of crisis care specifically designed to meet the unique needs of children.[3]
- Intensive Care Coordination with High Fidelity Wraparound as the practice model, available for all youth with complex behavioral health needs, including youth within a residential intervention.[4]
- Access to a robust, well-organized service array inclusive of in-home clinical and skill building interventions, outpatient care and community support services.
- Residential interventions within their own State to limit out of state care.

Assist States in building oversight capacity, data collection and workforce capacity building consistent with systems of care:[5]

- Assist States in building their oversight capacity, including care managed through managed care organization. Focus on best practice, continuous quality improvement and reduction of restraint, seclusion and coercive intervention.
- Look to the training and technical assistance to support implementation and transformation for Certified Community Behavioral Health Center (CCBHCs), Building Crisis Capacity and SAMSHA's System of Care Grant Implementation.

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[1] Many States Lack Information to Monitor Maltreatment in Residential Facilities for Children in Foster Care, Office of Inspector General, Government Oversight, U.S. Department of Health and Human Services, *https://oig.hhs.gov/reports/all/2024/many-states-lack-information-to-monitor-maltreatment-in-residential-facilities-for-children-in-foster-care/*.

[2] CIB–05–07–2013, *https://www.medicaid.gov/*.

[3] Mobile Response and Stabilization Services, Innovations Institute, *https://innovations.socialwork.uconn.edu/mrss/*.

[4] Intensive Care Coordination for Children and Youth with Complex Mental and Substance Use Disorders State and Community Profiles, *https://library.samhsa.gov/sites/default/files/intensive-care-youth-coordination-pep19-04-01-001.pdf*.

[5] PRIMER2_A_TofC, *https://gucchd.georgetown.edu/products/PRIMER2ndEd_FullVersion.pdf*.

- Technical Assistance for States would be most beneficial if there is coordination across child welfare, Medicaid and Children's Behavioral Health Directors. The Children's Bureau, SAMHSA and CMS should coordinate to build toolkits that assist States in building oversight capacity with a focus on residential best practice, building trauma responsive care models, and supporting workforce development.
- Assist in building continuous quality improvement strategies that are consistent across States inclusive of data collection and reporting.
- Assist States in building, expanding capacity building centers/centers of excellence with focus on the full continuum of care including residential best practices.
- Ensure that families have ongoing access to their children throughout their experience in residential. CMS and FFPSA can incentivize States that support intensive care coordination with high fidelity wraparound as part of the access, engagement, treatment, and transition process for all youth who access a residential intervention.

Provide oversight support for youth who are receiving residential care in a State that is not their own.

Question. What types of additional regulations need to be put into place to better protect children to ensure that restraint is used appropriately and safely?

Answer. Immediate attention on requiring certifications in crisis deescalation for all individuals who work within a residential intervention.

Immediate attention to increasing the use of intensive care coordination for all youth in and at risk of residential care.

Question. What types of additional oversight measures need to be put into place to ensure that regulations currently on the books are followed?

Answer. Federal oversight for residential interventions sits in multiple organizations that have different roles, responsibilities and understanding of residential best practices. Provide support for Federal oversight organizations to coordinate and embed best practices in rules and regulations to modernize and move to a new vision for restraint and seclusion.

Federal oversight needs to be consistent across all organizations and focused on best practices. It is important to have regulations that are written to support the goal of residential interventions aiming to provide a safe, healing environment.

Question. My investigation found that many providers are moving away from seclusion, which can be a harmful and traumatic intervention.

Should the goal be seclusion-free RTF care?

Answer. Seclusion is both a traumatizing and ineffective intervention for youth who are struggling within a residential intervention. I support seclusion free residential care.

Question. If so, how should the system of care, including staffing, be transformed to realize this goal?

Answer. How to get us there:

Mandate the training in trauma responsive care for all staff within a residential intervention.

Ensure staffing ratios are maintained.

Provide support in the building of Intensive Care Coordination to assist in building external child family teams that step in to support young people when they are struggling within a residential intervention.

Provide support in increasing staffing ratios that support the creation of nurturing environments for youth to heal. Staffing ratios should be set by oversight organizations and based on the population served including, but not limited to age, treatment needs and supervision requirements.

Increase access to allied therapies such as art, music and equine.

Question. RTFs receive per diem payments to care for the children in their custody, which creates the perverse incentive to minimize services and costs in order to maximize margins.

How should the payment structure be shifted to serve the needs of these children?

Answer. The per diem rate structure is not inherently a problem, but it can be improved by adding value-based payment options to reward positive, sustainable outcomes. The rate structure needs to be sufficient to cover high quality, intensive, developmentally appropriate, and trauma and culturally responsive clinical and behavioral services, health care, and normative social activities, along with routine care, supervision, and hygiene. States should have explicit outcome measures that are tracked, in partnership with residential interventions, and all parties should be held accountable to achieving desired outcomes.

Many residential programs have accepted children into their care with a wide range of needs that they may not be best equipped to support. Before any value-based payment measures or outcome measures are implemented tied to payment, incentives, or even punitive measures, States and residential providers must jointly reevaluate their admission, continued stay, and discharge criteria; payment rates; and contractual requirements. Once those are reevaluated and, if needed, reset, then value-based payment approaches can be phased in with the necessary implementation support and quality collaborative processes. Many States lack the expertise and capacity to support residential interventions to improve care and to ensure that the State is clear on its role in setting and overseeing expectations and outcomes—and has the capacity to support the residential to improve care.

Each State must also assess the availability of intensive, clinical and behavioral in-home and community-based services and supports to ensure the necessary array is available and accessible to prevent children and youth from requiring residential care and to enable them to be discharged from the residential intervention as soon as clinically appropriate. These in-home and community-based service providers must receive a living wage and rates that compensate them for the intensity and quality of care as well as for costs associated with place and time of service (in-home, evening and weekends, et cetera). Critically necessary services include mobile response and stabilization services (customized for children and youth), intensive in-home clinical and behavioral services, peer support, and intensive care coordination using Wraparound.

Some residential interventions could provide those services and support continuity of care to children by extending care into the community; rates for the residential intervention could be set for ongoing community-based support. All residential rates should be structured to accommodate and encourage home visits, with behavioral support from the PRTFs provided in the home to support transition.

Question. Many facilities employ an emotionally manipulative incentive-based system wherein a child's privileges are tied to their advancement in treatment and/or behaviors. These systems appear, in many instances, to be manipulative and coercive. Do these practices reflect evidence-based best practices?

Answer. Manipulative and coercive environments do not reflect evidence-based practice. Best practice supports creating safe and healing environments for youth to thrive.[6]

Question. If you could make one Federal law change to improve the youth RTF landscape today, what would it be?

Answer. Require all Qualified Residential Treatment Programs (QRTPs) and PRTFs to determine admission, continued stay, and discharge decisions based on a child and family team (facilitated through intensive care coordination) recommendation (which includes the youth and family) that is based on a combination of standardized clinical assessment tools, input from the youth and family, and recent psychiatric, psychosocial, and health examinations. These determinations should be reviewed and assessed by an individual licensed to provide behavioral health care with expertise in child and adolescent services; for QRTPs, the Qualified Individual must be a licensed behavioral health practitioner with child and adolescent experience who is not directly employed by the child welfare agency.

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[6] Blau, Caldwell, and Lieberman (2014). Residential Intervention for Children, Adolescents, and Families: A Best Practice Guide. Routledge, NY, *https://www.taylorfrancis.com/books/edit/10.4324/9780203743492/residential-interventions-children-adolescents-families-gary-blau-beth-caldwell-robert-lieberman*.

QUESTION SUBMITTED BY HON. CHUCK GRASSLEY

Question. Following the passage of the Family First Prevention Services Act in 2018, a shift is taking place to prioritize family placements over residential settings. Hearing from youth with lived experiences, we know that they have better outcomes when given the opportunity to receive support in their home and remain with their families.

Can you talk about the evidence-based prevention methods that provide therapeutic care for youth in their homes and community?

Answer. Evidence-based preventions methods that provide therapeutic care for youth in their homes and communities are outlined in the 2013 CMS/SAMHSA Bulletin:

- Respite Care.
- Intensive In-Home Services: Combination of therapy, skills training, and behavioral interventions.
- Mobile Response and Stabilization: Customization of the crisis continuum designed to meet the parent/caregiver's sense of urgency regarding their child's behavioral health needs.
- Intensive Care Coordination With High-Fidelity Wraparound as the practice model.
- Youth and Parent Peer Support.
- Flex Funds.
- Trauma-Informed Systems and Evidence-Based Treatments Addressing Trauma.
- Other Home and Community-Based Practices.

Home and community-based services and supports play an important role in engaging parents and youth early in the behavioral health crisis cycle and identifying strategies to provide the right service at the right time for the right duration with a focus of keeping the youth within their own home, school and community.

QUESTIONS SUBMITTED BY HON. BENJAMIN L. CARDIN

Question. Like many others, Marylanders have struggled with accessing care at RTFs due to a limited number of facilities in the State. A lack of licensed facilities in our State means that children end up in emergency departments for extended stays or simply stuck in their own homes without treatment.

As we address the obvious quality-of-care issues in RTFs, how can we also support access-to-care concerns, especially as States try to avoid out-of-state placements?

Answer. Address the challenge for parents in their inability to access home and community-based interventions that would allow youth to remain in their home when in an active crisis. The implementation of a child specific crisis continuum such as Mobile Response and Stabilization has a demonstrated track record of reducing the overreliance on emergency departments by changing the care pathway.

Intensive Care Coordination with High-Fidelity Wraparound is an important component of any strategy to reduce the over reliance on emergency departments, inpatient and residential interventions.

Access to youth and parent peer support is an important part of the service array.

Question. In April, I held a hearing in the Senate Finance Health Care Subcommittee focused on substance use disorder treatment in the Federal health programs. Since then, the full committee has also highlighted this issue in a hearing. In our subcommittee hearing, we heard from a pediatrician working with young people struggling with substance use who explained how often this struggle coincides with other mental health conditions.

What does substance use treatment look like in RTFs, and how can substance use care be best integrated into a treatment plan for young people with other behavioral health conditions?

Answer. The interconnected substance use and mental health needs of youth require a coordinated intervention that connects the impact of the underlying mental health need and substance use. This movement toward a fully integrated model does require training, coaching, and the connection to home and community-based services.

QUESTION SUBMITTED BY HON. MICHAEL F. BENNET

Question. In 2021, Colorado Children's Hospital declared a "pediatric mental health state of emergency."

Since that time, I have repeatedly heard from our pediatric emergency medicine providers about the volume of children coming to the emergency department with a mental health crisis—some who end up staying in the emergency department for weeks, and sometimes even months waiting for an appropriate placement.

This can delay care and be additionally traumatizing to the children and their families, and the health providers caring for them.

In your testimony, you said that all children and youth with complex and intensive behavioral health challenges need and deserve access to the most appropriate, least restrictive, high-quality, and effective treatment and interventions.

What can Congress do to remove barriers and ensure these children have timely access to the appropriate level of behavioral health care they need?

Answer. Support the full implementation of the 2013 CMS/SAMHSA Joint Bulletin.

Customize the crisis response system to meet the unique needs of children. Often mobile crisis systems miss important opportunities to engage with parents/caregivers when crises are manageable within the home, school, and community. These missed opportunities often communicate to parents that the system/professionals know their children better and do not shift the care pathway away from emergency department, but rather parents report have no alternative than to use emergency departments are the first entry to care. Emergency departments are often not equipped to meet the unique needs of children and inadvertently increase the behavioral health needs of the children who seek care. Mobile Response and Stabilization Services are specifically designed to address the needs of youth/families and shift the care pathway away from hospital care by managing crisis within the home school and community.

Increase access to intensive care coordination with high fidelity as the practice model and specific focus on building community support resources.

Increase access to youth and parent peer support.

Increase access to a community-based continuum of care.

Support training and workforce development efforts to include access to trauma-responsive care and developmentally appropriate interventions for children, youth, and families.

Provide an enhanced Medicaid Federal Medical Assistance Percentage to States offering the critical core children's behavioral health services to children and their families through children's behavioral health systems and outside of the child welfare system.

Support partnership between SAMHSA and the Centers for Medicare and Medicaid Services to develop future system-of-care planning grants that explicitly support States in developing comprehensive systems of care for children's behavioral health alongside Medicaid as a sustainable funding source.

Resist calls to support additional title IV–E funding for residential placements. While some of these calls have begun to roll back reforms that limited Federal financial support for group placements within the child welfare system, the best way for Congress to direct Federal resources to impact this issue is increased accessible, comprehensive, community-based, trauma-informed behavioral health care, which will decrease the demand for unnecessary child welfare system involvement and overreliance on harmful and unnecessary use of group and institutional placements. We applaud Chairman Wyden's comments at the outset of the May 22, 2024, hearing, indicating his continued firm support for Family First's efforts to limit the use of congregate care.

Support SAMSHA, Children's Bureau, and CMS in providing technical assistance to coordinate oversight efforts to States.

QUESTIONS SUBMITTED BY HON. ELIZABETH WARREN

Question. Given large multistate operators and corporate entities own residential treatment facilities, should Congress introduce new safety and quality standards as a condition of Medicaid participation?

Answer. In the "Warehouses of Neglect" report, it is not possible to identify the Federal funding source for each youth within the residential facilities, and it is likely that many of the providers are being reimbursed through multiple Federal funding mechanisms like FFSPA and Medicaid. The multistate operators and corporate entities are not limited to Medicaid funding. Safety and quality standards across all the use of Federal dollars would assist States in providing quality care. The challenge in only increasing quality standards within Medicaid is the potential that States will shift to practices such as custody relinquishment and the use of Family First Prevention Services and juvenile justice systems as the primary access to behavioral health care for youth. If all Federal agencies responsible for funding and/or oversight of residential organization should adopt the same quality standards grounded in residential best practices and appropriate staffing ratios.

Quality standards that are infused in all Federal funding would allow States to move to best practice in the provision of residential care for youth.

Coordination across Federal regulators and State oversight organizations in the development of quality standards that support best practice. It is important to build the ability of any process in building quality standards that can adjust to advancement in technologies, best practices, and workforce development strategies.

Question. The Senate Finance staff report says that RTFs often employ unqualified staff, and it quotes one privately held cofounder, Jay Ripley, who founded a firm called Vivant, saying "you can make money in [the RTF] business if you control staffing."

Is there a risk to residents when companies reduce staffing? Do we need minimum staffing ratios in these facilities to ensure that residents are receiving adequate services?

Answer. There is a risk to all youth within the residential facility when organizations reduce staffing.

The quality of care is in direct proportion to staffing ratios, training, supervision, and access to technical assistance. Minimum staffing ratios, qualifications, and training are necessary, in coordination with the oversight organizations at the State level to ensure that safe, consistent, and healing environments are available for youth in need of residential care.

Minimum staffing requirements could ensure best practices are kept around staffing ratios. And this must be considered in the context of the nationwide workforce shortage in this field. Encouraging States to look at reimbursement rates, salaries, and other retention strategies would need to go alongside staffing requirements.

PREPARED STATEMENT OF REAGAN STANFORD, JD, ABUSE AND NEGLECT MANAGING ATTORNEY, DISABILITY RIGHTS ARKANSAS

Chairman Wyden, Ranking Member Crapo, and members of the Senate Finance Committee, thank you for the opportunity to testify here today. My name is Reagan Stanford, I am the abuse and neglect managing attorney at Disability Rights Arkansas (DRA). DRA is the protection and advocacy agency in Arkansas. The protection and advocacy (P&A) system is a federally mandated network of legally based agencies that advocate for and protect the rights of individuals with disabilities. Under Federal law, P&As have authority to access facilities in which individuals with disabilities reside, and access relevant records.

In my role, I oversee a team that uses that access authority to monitor conditions and investigate abuse and neglect at facilities across the State. DRA's goal is to ensure that individuals receive the services they need in a safe and therapeutic environment, wherever that may be. Over the past 5 years, one of the focuses of our work has been the 13 psychiatric residential treatment facilities (PRTFs) in Arkansas.

Through our years of spending time inside these facilities, reviewing records, and speaking with children, guardians, and staff members, we have seen firsthand how

deeply flawed the overall residential treatment model is, the pervasive nature of abuse and neglect, and the low frequency and often low quality of services provided.

DRA's work began to focus on youth behavioral health treatment after receiving complaints about a single PRTF. Our investigation into those complaints revealed widespread concerns that included: repeated substantiated instances of staff physically abusing children, buildings in such disrepair they created safety hazards, a high rate of peer violence, an overall lack of therapy, a lack of activities and engagement, and inadequate educational services. The issues were so pervasive and so obvious that it was difficult to understand how this provider was allowed to continue operating or why children were still being placed there. As we expanded our monitoring to additional PRTFs, we found similar issues at additional facilities. Because of what we observed, were told by residents, and heard from staff, we followed up with numerous investigations. What began as an investigation at a single facility grew into a sustained presence and interaction with all 13 providers.

What we heard directly from children included, "this place is re-traumatizing me," "it feels like they don't really care about us," "we hardly learn skills here to function outside of here," "this place would be more helpful to me if there were more groups," "this place is toxic, unstable, unhygienic, and unfair," "peers are fighting everyday," "it's mentally draining," and "we sit around all day and it feels like no one cares about us." What we observed confirmed what we were hearing.

We began identifying and requesting information from every entity that has any oversight authority or may otherwise interact with these providers. Even with our knowledge and familiarity with the providers and State agencies generally, identifying what existed was a tedious process. Some requests were unfilled because the exact name of a document was not included, some because the facility was operating under one name and registered with Medicaid under another. Documents we did receive were often incomplete or so lacking in detail that it was impossible to make necessary connections between documents.

What this process revealed was that while government agencies had substantial documentation of abuse and neglect existing at these facilities, it would be extremely difficult and time-consuming for anyone who was considering placement at a particular facility to obtain this crucial information. This lack of transparency is even more challenging for out-of-state parents, guardians, and placement agencies. Many of them were contacting our office to inquire about facilities, because they do not have the time or resources to identify the multiple different oversight authorities in every State, their specific roles and the documentation they produce, and the overall licensing structure and level of accountability facilities are being held to. Many more do not reach us and are relying on the representations of the facility, unaware they are sending children to facilities with extensive records of abuse and neglect.

Because every parent, guardian, and child deserves to have as much information as possible in order to make informed decisions about care before admission, we created an Arkansas PRTF database. This database, organized by facility, makes all incidents reported to State licensing, all reports and surveys from oversight agencies, and all police reports for calls related to the facility available to the public. The database can be accessed at *https://disabilityrightsar.org/prtf*. We are expending our limited resources to do what the government could and should be doing.

We later added information about the type and level of services provided at each facility. Provider websites, marketing materials, and recruiters often provide only vague statements about treatment and do not offer specifics on what the child will actually receive, what their day-to-day life will be like, or the level of professionals they will interact with or receive services from on a day-to-day basis.

The results of this ongoing work make clear that youth residential facilities cannot provide an adequate therapeutic and educational environment. Across Arkansas, facilities are rife with countless examples abuse, violence, and neglect. In just the last year examples of physical abuse endured by children include: a staff member struck a child three times in the face with a closed fist leaving the child with bruising and redness to their face and bleeding from their ear; staff drug a child across the ground outside, fracturing his arm; a staff member grabbed a child in a chokehold, pushed them into a bathroom, and remained in the bathroom with the child, with the door closed 5 minutes, where he is alleged to have continued his assault on the child that resulted in a black eye and markings and scratches on his neck; and staff kneed a child in the groin. Additionally, four staff members at a facility showed pornographic images or videos to residents, including one staff

member showing a resident a homemade video of him engaged in oral and sexual intercourse; two staff members made minimal efforts to intervene and allowed a child to be "taunted, punched, and kicked" by peer for over 15 minutes; and a child was held down on a bed by peers and sexually assaulted. These examples are illustrative of what occurs and do not represent the full extent of what is reported or all of the abuse and neglect that goes unreported. Children are being raped, they are being physically assaulted, they are not being protected.

A facility in Arkansas where multiple riots occurred and at least three staff members were found to have sexually assaulted residents was eventually placed on a probationary license status by the State Child Welfare Agency Review Board. This is the first time the Board, which is independent of DHS and statutorily comprised of providers representative of the residential and placement agencies regulated, has ever taken significant action against a facility. During the 10-month probationary period, the facility had unstable leadership, cycled through several CEOs, and received at close to 70 additional citations. Despite this, the board lifted their probationary status. Additionally, they were never required to alert guardians of current or prospective residents of their probationary status or halt or slow admissions. They continued and still continue to receive Medicaid funded placements.

But it is important to not focus so intensely on cases of extreme abuse that we are lulled into believing that the issue is a few bad actors and not the model. Far more common is the systemic, general lack of a therapeutic environment, active treatment, and educational services. The widespread nature of these issues is what makes clear that this model does not work.

What my conversations with guardians, State officials, and providers has revealed is that there is this pervasive assumption that some children need such "intensive services," that they cannot be served in the community. This idea is accepted and repeated even in literature and reports that are critical of residential treatment. It is so ingrained and generally accepted that no further thought is given to what "intensive services" actually means or why such services can only be provided in a residential setting.

Residential treatment is often seen as the pinnacle of treatment, the best and most intensive services a State has to offer. After a child discharges from residential treatment, States are left feeling as though they have little or nothing left to offer. The failures of the treatment facilities to provide a safe and therapeutic environment, individualized intensive services, and meaningful discharge planning and follow through are imputed to the child. The child is often seen as the failure, not the treatment facility. And because they are viewed as the failure, all too often the child gets cycled back into a residential placement.

The restrictiveness of the placement is assumed to positively correlate with the level of services provided. In fact, the most restrictive placements generally offer a level of care that could be replicated or surpassed on an outpatient basis. The "intensive services" that most PRTFs, acute, and subacute programs provide consist primarily of 50 minutes of individual therapy a week, between 1 and 4 hours of group therapy a week, between one and four family therapy sessions a month, and medication management. At most, that comes to approximately 5 hours of therapeutic services per week, which is less than is provided by many community-based models, but at a much higher price. They are reimbursed at the same base rate, regardless of the level of services provided.

Treatment in these facilities is not individualized and is overwhelmingly not specialized. Many of these facilities purport to treat a wide range of conditions, everything from depression to conduct disorders to schizophrenia. Yet the services children receive are almost indistinguishable from each other. Providers often point to treatment plans developed for children as evidence of the individualized nature of treatment. These plans often contain generalized goals and generally prescribe individual or group therapy as the method of achieving the goals. The groups they attend, the behavior management structure they are held to, the point or level system they are subjected to, are all the same.

Interaction with clinicians or mental health professionals is limited. Although these programs are required to be operated "under the direction of a physician," a contracted physician that spends maybe a few hours a week at the facility and is on call to authorize physical restraints, chemical restraints, and the use of seclusion over the phone, is generally fulfilling that requirement. Groups are often run by behavioral health aides and not licensed therapists.

Children cycle through these facilities without receiving required supports or being evaluated for special education services. Even if the child had an individualized educational plan, 504, or behavior plan prior to admission, these plans are rarely implemented in the facility. Instead, they attend "school" at the facility in classrooms that combine multiple age, grade, and ability levels. In most facilities, classroom instruction is minimal and much of a student's education is necessarily self-directed through the completion of packets of worksheets. For older children, classes frequently do not align with graduation requirements and therefore credit is not received when they return to their home school district, particularly if they are returning to another State.

Children share bedrooms with peers and spend most of their time idle in communal spaces under the supervision of entry level care staff, never alone but rarely engaged. Insufficient staffing levels and inadequate staff training lead to a reliance on restraint, seclusion, and increasingly law enforcement. They are not forming healing bonds with adult staff and are often cut off from their families at home. The word that most comes to mind when I think of time spent inside these facilities is chaos. All together this creates an environment that is incompatible with what children need to learn, grow, and thrive.

Not only are these facilities ill-equipped to address the complex trauma of many of the children placed, the added trauma children experience within facilities follows them through life and is compounded by society's refusal to acknowledge the detrimental effects these placements can have. Children that experience added trauma while in congregate care are the norm and not the exception. Far too many children are directly subjected to physical, sexual, and verbal abuse. Even more are impacted by the abuse they witness. We do not believe that a child should ever have to endure or witness abuse in order to access services.

All of this occurs without meaningful oversight at any level. With limited CMS regulation and oversight, most oversight falls to State agencies assessing compliance with State licensure, even though many providers operate in multiple States. The lack of urgency and thoroughness with which incidents are addressed by the providers themselves and by oversight agencies is deeply troubling. One facility in Arkansas broke four children's arms in restraints in a 6-month period. Despite these alarming circumstances they did not engage in any significant self-correction and were not initially subjected to any corrective action by State or Federal oversight authorities. It took pressure and detailed complaints from DRA for corrective action to eventually be put in place. There is also too heavy a reliance on national accreditation bodies such as the Joint Commission. These bodies are paid by the providers, perform onsite inspections only every 3 years, only have the authority to recommend changes, are opaque in their processes and responses to complaints, and have issued blanket accreditations covering facilities they have never visited.

What is clear is that often these facilities are operating as placement alternatives and not service alternatives. States have bought into and are now reliant on the residential treatment model, failing to adequately invest in community-based settings and services necessary to meet the need. States are so reliant on residential placements that they are hesitant or outright unwilling to hold the facilities accountable. In Arkansas, for example, the director of a Department of Human Services division that previously oversaw the licensing of residential treatment facilities joined a recorded technical assistance call specifically to warn providers that DRA had begun publishing additional information about their programs and reassure them that that she considered them to be "partners." You cannot effectively regulate something you are in partnership with. Health inspectors are not in partnership with the restaurants they inspect.

While access to information is absolutely vital and can impact placement decisions, no amount of forced transparency can lead to truly informed choice if there are no other options. As long as residential treatment remains one of the only options available to many families and placement agencies, facilities can rely on desperation placements and will continue to have little motivation to improve.

Through our work with the P&A network, we know that these problems are not specific to Arkansas. The conditions and systemic issues are well documented in countless reports by individual P&As and by the National Disability Rights Network's *Desperation Without Dignity* report. This is a national problem that demands congressional action, which can include:

1. **Increase investment in community-based services and concrete supports that can help prevent the use of congregate care.**

In Arkansas, the Medicaid reimbursement rate for PRTFs is $502/day. Some States have a higher base rate and contract for even higher rates when sending children out of state. This State and Federal funding could be much more appropriately invested in intensive, community-based services.

2. Require meaningful outcome measures and discontinue payments for models that do not provide active treatment and individualized services, including residential treatment.

The role of residential treatment on any continuum of care needs to be critically examined. Although there has been a focus and even insistence on evidence-based treatment in most other areas, there has been heavy investment in residential treatment despite the fact that there is no evidence to support its efficacy.

I have repeatedly asked providers in our State for information on how they are tracking outcomes and measuring the effectiveness of their programs. The most common response is that they have no control over where a child goes when they leave the facility and would not be able to find them to determine their status. So, not only are they not currently making efforts to study the effectiveness of their programs, they do not think it is even possible.

3. Deincentivize out-of-state placements.

When children are sent out of state it makes it (a) more difficult to maintain connections with family, (b) more difficult for out-of-state agencies to monitor the facility and uphold their own State standards (which may be a higher standard than the receiving state), (c) extremely difficult for meaningful discharge planning to occur due to the out-of-state facility not having relationships with providers or even understanding the community that the child is returning to, and (d) it can allow a facility to evade regulation by shifting to court children from another State if one State stops sending children because of subpar conditions.

When States send children in their custody out of state, they are also paying not only the exorbitant daily rates of these facilities, but for caseworkers to fly out and visit, and for teams to travel to facilities to complete, at a minimum, annual inspections of care. This is all money and employee resources that could be going to fund and provide direct services in their home States.

Acadia Healthcare is so invested in the model of sending kids out of state for treatment that they built and are now expanding the capacity of a facility that only accepts out-of-state children. Due to a moratorium on the number of AR Medicaid PRTF beds in place long before the opening of Little Creek Behavioral Health in 2020, they are only licensed to serve out-of-state children.

4. Remedy the failures of oversight that exist at all levels.

The very fact that protection and advocacy agencies are so involved in this arena is evidence of the extent of the problem. P&A's across the country have been monitoring, investigating, writing reports about, and advocating on behalf of clients within facilities. Protection and Advocacy agencies are a backstop. Our involvement is an indication of a failure of the intended government oversight mechanisms.

5. Create an easy to access and navigate system that accurately identifies all youth residential treatment facilities and publishes surveys conducted by state survey agencies, quality of care, and incident data.

While the Quality, Certification and Oversight Reports (QCOR) database contains survey and complaints from PRTFs, the information is inaccurate and incomplete. For example, a 2022 Government Accountability Office report studied PRTFs in Arkansas and Massachusetts despite the QCOR database listing that Massachusetts has no PRTFs dating back to 2010. The information actually contained in the QCOR is opaque, requiring technical knowledge of CMS to access and sort information. And the surveys themselves may not capture the true conditions and incidents at youth residential settings. The QCOR is not a mechanism for public accountability.

6. Invest in research and pilot programs to identify and validate effective treatment options.

QUESTIONS SUBMITTED FOR THE RECORD TO REAGAN STANFORD, JD

QUESTIONS SUBMITTED BY HON. RON WYDEN

Question. The committee reviewed incidents in which oversight actors were able to confirm abuse allegations at residential treatment facilities (RTFs) based on camera footage, but also incidents in which facilities had destroyed footage or failed to collect it altogether. RTFs currently have no standards for footage retention, audio, or internal audits of footage.

At present, is it difficult to get the information, including video evidence, you need to evaluate allegations of abuse and neglect at RTFs?

Answer. Yes. The difficulty varies by facility and has increased over time for most providers. In response to our agency and other protection and advocacy agencies pushing for increased accountability some facilities have focused on blocking access instead of remedying the causes of the investigations. In Arkansas, in the absence of regulations preventing them from doing otherwise, some facilities have recently removed some cameras, shortened video retention periods, and removed audio recording capabilities.

Question. Can you describe the difficulties you encounter?

Answer. Some of the difficulties we frequently encounter include:

- The entire facility or area within the facility where the incident is alleged to have occurred is not covered by video.
- Some entire facilities do not have any cameras. In facilities where cameras do exist, there are often known blind spots that inevitably become common locations of incidents.
- Video does not contain audio or audio is withheld when the video is provided.
- Audio can provide necessary context and clarify intentions, which can assist in determining what actually occurred, particularly when video is grainy or partially obstructed.
- Video no longer exists by the time we are made aware of an incident.
- PRTFs are required to report serious occurrences to the protection and advocacy agency and State Medicaid agency by the close of business the following day. This very narrow situation that currently applies only to PRTFs and only to incidents meeting the definition of "serious occurrence" is generally the quickest way we would be notified about an incident. Even in this scenario video has sometimes already been written over when requested. Two of the Acadia Healthcare facilities in our State claim to only retain footage for 72 hours before it is written over.

Question. What types of standards would improve this?

Answer. Uniform standards that apply to all RTFs or "youth residential programs"[1] that would require:

- Video surveillance with audio in all areas accessible by residents (excluding bathrooms and bedrooms).
- A minimum retention period for all recorded video.
- That video related to any allegation of abuse or neglect be saved outside of the surveillance software for a minimum of 5 years, including footage that substantiates and footage that appears to unsubstantiate an allegation. Saved video should include all available angles and audio, all precipitating events, and conclude only after regular activities have resumed.
- Cooperation with investigative agencies investigating allegations of abuse, neglect, or exploitation of a resident. Standards should clearly define cooperation to include preservation of possible evidence, including video evidence, and require sanctions for failure to cooperate.

Accessing and reviewing video footage from healthcare facilities is a necessary aspect of the protection and advocacy network's purpose, as recently emphasized by the Fifth Circuit in *Disability Rights Texas v. Hollis,* 103 F.4th 1058 (5th Cir. 2024).

[1] S. 1351—118th Congress (2023–2024): Stop Institutional Child Abuse Act (April 27, 2023), *https://www.congress.gov/bill/118th-congress/senate-bill/1351/text.*

Video review is often imperative to the substantiation of abuse. Based on our tracking of data related to PRTFs in Arkansas, so far in 2024 allegations where video was reviewed have been more than two times as likely to be substantiated as those where it was not available. In 2023 video review made allegations almost three times as likely to be substantiated.

Question. RTFs receive per diem payments to care for the children in their custody, which creates the perverse incentive to minimize services and costs in order to maximize margins. How should the payment structure be shifted to serve the needs of these children?

Answer. The payment structure should reflect the varied levels and quality of services within RTFs and require rates to be adjusted based on thoughtfully crafted metrics including the type and frequency of services, the quality of services as determined by youth outcomes, and the number of deficiencies identified or cited by regulatory bodies. This would require data collection and analysis related to youth outcomes and tracking of State and Federal regulation violations that is not currently occurring. The efficacy of models such as value based care and quality adjustment payments should be explored.

Question. Many States send their children out of state for RTF care, including to your home State of Arkansas. In your testimony you raised some concerns related to this practice. Can you expand on why out-of-state placements raise particular care and oversight concerns?

Answer. When children are placed out of state, they are removed entirely from the community they will ostensibly be attempting to reintegrate into, making it nearly impossible for formal or informal connections for discharge supports to be made. The facilities are unfamiliar with the services, service providers, and community dynamics in the sending States and are therefore not equipped to and are not providing any kind of meaningful discharge or aftercare planning.

Children are often subjected to an entirely new and different environment than what they are familiar with. While adjusting to a new placement that regardless of location comes with new rules and expectations, new peers, and new staff, they also may have to adjust to new cultural norms that may be very different from anything they have previously been exposed to. Children from places including Alaska, Hawaii, Maine, and Vermont are sent to Arkansas where things such as the weather, the food, the population demographics, and general cultural norms can be vastly different.

It is more difficult and costly for guardians to visit and therefore more difficult for children to maintain connections with their families. When a guardian's exclusive or primary means of communication with a facility or their child is through phone or video conferencing communication it inhibits the ability of the child to openly report issues to their guardian due to the very limited opportunities for contact at most facilities and the monitoring of communications by staff. The ability of the guardian to independently observe the environment and interactions at the facility or follow up on concerns is also inhibited.

It is more difficult and expensive for out-of-state agencies to monitor the facility and uphold their State standards, which may be higher standards than the receiving State. State agencies rely heavily on the standing of the facility with oversight agencies in the State where it is located, often without a clear understanding of the role of those agencies, the regulations they are enforcing, or the overarching oversight scheme that applies to particular facilities. The direct oversight sending States exercise varies, but should at a minimum, include an annual inspection of care that requires a team to travel to each facility for multiple days. When children in the custody of State child welfare agencies are placed the caseworker may fly out to visit the child monthly.

Out-of-state placements also complicate efforts to address overall issues and generally hold facilities accountable. The more a facility is able to diversify its funding streams through accepting children from additional States, the less impact sanctions from a single State have on their operations and therefore the less receptive they are to investing in meaningful improvements. In addition to limiting out-of-state placements, sharing of information between States coordinated at the Federal level would help address this.

Question. Many programs advertise services for particular subpopulations, such as children with intellectual and developmental disabilities (I/DD) or substance use dis-

order. How are programs and services materially adapted to meet the specialized needs of these groups?

Answer. In our experience, regardless of marketing or assurances made to guardians, programs are not materially adapted to meet the specialized needs of the groups mentioned. The very nature of these facilities is that they are a set program that is not intended to or capable of being responsive to individual needs of children. For example, programs generally have behavior management systems that apply facility wide and are not individually tailored to residents. Due to this a child with an individualized education plan or behavior plan that was being implemented in school prior to admission would have a more individualized experience in public school than inside a residential treatment facility.

Most facilities continue to use universal point and level systems despite research indicating the inappropriateness and ineffectiveness of these methods. The ineffectiveness and even possibly detrimental effects of universal systems are only amplified when applied to youth with intellectual and developmental disabilities.

Question. If you could make one Federal law change to improve the youth RTF landscape today, what would it be?

Answer. Through funding, create incentives for States to expand community-based services; create demonstration projects to identify and validate effective treatment and intervention alternatives to residential treatment; and increase the number of mental health professionals, particularly in underserved regions, through education assistance and work incentives. Although legislative changes to increase standards and oversight of RTFs is desperately needed and may appear more urgent, until viable alternatives to residential care exist, no amount of regulations or oversight will truly address the problem. Creating alternatives allows for a more natural transition to more appropriate services.

QUESTION SUBMITTED BY HON. CHUCK GRASSLEY

Question. In your testimony you shared concerns about youth who are discharged from a residential facility but are at risk of reentering a facility. When I talk to foster youth, they tell me they want permanency.

Can you share from your perspective, how do we prevent youth from moving in and out of residential facilities, and instead find them the permanency and services they need in their communities?

Answer. It is important to recognize that while a large cohort of the children we are referencing are in foster care, there are also a substantial number of children that are placed by their guardians, many of whom are adopted. The way to prevent youth from cycling in and out of facilities is to reduce reliance on residential facilities. This can only be done by increasing funding for and ensuring the existence of comprehensive community-based services, funding supports for foster and adoptive parents such as transportation assistance and respite care that are outside of traditional in-home services, and increasing standards and enforcement of those standards for residential facilities.

Children cycle in and out of residential facilities because they are not provided adequate services pre or post admission and are often negatively impacted by their experiences inside facilities, exacerbating their need for intensive trauma informed services.

QUESTIONS SUBMITTED BY HON. BENJAMIN L. CARDIN

Question. Across our country we see blatant health disparities in so many areas where marginalized groups are not able to get the care they need.

How have you seen health disparities play out in the setting of RTFs, both in on-the-ground experience and in a broader oversight perspective?

Answer. Children in RTFs are more likely to come from economically disadvantaged backgrounds and/or be in the custody of or have had contact with the child welfare system. Racial and ethnic minorities are also overrepresented. These populations being disproportionately represented in residential treatment facilities is evidence of health disparities in access to community based and prevention services.

Question. In April, I held a hearing in the Senate Finance Health Care Subcommittee focused on substance use disorder treatment in the Federal health programs. Since then, the full committee has also highlighted this issue in a hearing. In our subcommittee hearing, we heard from a pediatrician working with young people struggling with substance use who explained how often this struggle coincides with other mental health conditions.

What does substance use treatment look like in RTFs and how can substance use care be best integrated into a treatment plan for young people with other behavioral health conditions?

Answer. In the very few RTFs in Arkansas that are currently advertising substance use management or treatment the "treatment" specific to substance abuse appears to be, at most, intermittent group therapy focused on substance abuse.

I believe someone with more experience with substance use treatment could better speak to best practices in integrating substance use treatment into treatment plans.

QUESTION SUBMITTED BY HON. MICHAEL F. BENNET

Question. Two weeks ago, this committee held a hearing on the Family First Prevention Services Act, which I worked on with Chairman Wyden, Senator Grassley, and former Senator Hatch to introduce in 2016 to help keep children safely with their families and out of the foster care system.

Since Family First became law in 2018, the number of Colorado children living in foster care has decreased by nearly 20 percent.

Unfortunately, for the Colorado children who remain in foster care, 1 in 11 reside in some form of a congregate care facility including the residential treatment facilities we are talking about today.

In 2022, Colorado's Medicaid reimbursement rate was $750 dollars per day for psychiatric residential treatment facilities.

In your testimony you said that this State and Federal funding could be more appropriately invested in intensive, community-based prevention services.

Can you tell us how Congress can more effectively direct these resources to support these children and families?

Answer. What we see over and over again is children in residential treatment facilities that have received minimal community-based services, that often may have consisted solely of individual therapy, prior to admission. In most communities residential treatment is not only the last resort, it is one of the only avenues for the promise of any kind of intensive services.

One way to begin to address the lack of community-based services would be to statutorily define specific, key community-based services including intensive care coordination (high-fidelity wrap), intensive in-home and community services, mobile crisis and stabilization, and therapeutic foster care; increase the Federal medical assistance percentage (FMAP) for these services; and ensure the increased FMAP translates to actual better rates for providers and reinvestment in community-based services. Although these services are already mandated under EPSDT, this could help states build capacity and rebalance the funding toward more community-based services.

For additional information and specific recommendations I would refer you to the statement for the record submitted for this hearing by Jennifer Lav and M. Geron Gadd on behalf of the National Health Law Program. Their statement addresses this question better and more comprehensively than I could, and I am in agreement with everything asserted and recommended, particularly footnote 20.

QUESTIONS SUBMITTED BY HON. ELIZABETH WARREN

Question. Corporate consolidation of health care increases prices and lowers the quality of care, and it creates faceless and multi-state corporations. In your testimony you mentioned that parents contact you for help, because they do not have the time or resources to identify the multiple oversight authorities across numerous States.

How does the patchwork of existing State legislation and regulation make it more difficult for families to find service providers and obtain quality care?

Answer. Residential treatment facilities of different types are not universally defined or referred to on the State level making it sometimes difficult to determine the level of care the facility purports to provide and the applicable regulations. To compare placements families considering out-of-state placement would need to identify the applicable regulations in the States where the facilities are located, determine how they differ from their State, and determine which will be applicable to this placement.

When a State places a child in another State that has different or lesser requirements the placing State can contract with the provider to provide the level of services that would be required in-state. They can also waive those requirements on behalf of the child, which occurs frequently. One example of this is the varying staff to client ratios required in different States. In Arkansas, in PRTFs, the minimum ratio is 1:6 during waking hours and 1:8 during sleeping hours compared to a required minimum ratio of 1:4 in several States that place children in Arkansas.

Regulations and oversight schemes that vary by State also mean that identifying past findings of abuse or neglect or the appropriate entity to report concerns to can be an arduous process. In Arkansas there are six different agencies or independent divisions within agencies that have a role in oversight of PRTFs. To get as complete a picture as possible about a placement it would be necessary to identify and request information from all of these entities.

Question. What role should Federal lawmakers and regulators do to make this easier for families?

Answer. Create a publicly accessible and easily navigable database that includes, at a minimum, all inspection of cares and surveys related to enforcement of the Federal regulations. A State is required to conduct at least an annual Medicaid inspection of care at all facilities where children are placed. That means that some of the facilities that are accepting kids from numerous States should have inspections of care from every placing State. CMS has represented in response to requests that they do not retain copies of these inspections. Therefore, currently, the only way to identify all inspections for a particular facility would be to request them directly from every State.

Require facilities to make publicly available all applicable regulations and contact information for all regulatory agencies with any oversight role in their facility (to include all States from which they receive residents).

Require facilities to publicly post basic but specific information about the services and level of care actually provided (staff to resident ratios, estimated number of hours of therapeutic services with a mental health professional per week, professional staff, family contact policy, facility and unit sizes, et cetera).

Question. You refer to problems you have had identifying the owners of organizations, with some operating under one name and registered with Medicaid under another. Private-equity funds have purchased companies in nearly every sector of the economy; their aggressive deal-making in the health-care sector poses grave risks to patient health and raises questions about potential abuse of taxpayer dollars. I recently introduced the Corporate Crimes Against Health Care Act of 2024, which would fine health-care entities that reported false or incomplete information and make ownership links more transparent.

What techniques do companies use to subvert current reporting requirements?

Answer. Federal oversight of RTFs, particularly PRTFs, functions more as a billing reimbursement program than a meaningful regulatory body. Thus, companies do not flout or subvert existing reporting requirements as much as they take advantage of their absence.

What I referenced in my testimony was a situation that is occurring in Arkansas where several facilities have changed names or are being allowed to operate as a name different than their Medicaid provider name. So, they are generally referred to and their websites and materials reflect one name and that name corresponds with the State licensing entity. The separate State entity that enforces that CMS regulations has a different provider name for the exact same program. There is nothing that publicly links the names or would indicate to someone looking at potential placements that they should be searching for information for more than one name.

For the broader and more nuanced issues related to private equity and overall corporate schemes that negatively impact quality of care and conceal affiliations and ownership my knowledge base as reflected in the response below has been aided immensely by Cory Bernstein, a staff attorney at the National Disability Rights Network.

Existing regulation occurs almost exclusively at the State level. Companies then avoid State reporting requirements by diversifying their programming through geographic and payer diversity. States can only regulate the entities within their jurisdiction, leaving them overmatched against for-profit companies operating nationally or regionally. Understandably, States cannot enforce reporting requirements—including financial mismanagement or outright child abuse—on a for-profit provider's actions in another State. When contracting with out-of-state providers, reporting requirements become particularly difficult to enforce. Within States, RTFs are often regulated by numerous State and municipal-level agencies that have licensure requirements that overlap with—but are distinct from—existing Federal requirements. Thus, companies benefit from information getting siloed both within and between States.

There are few, if any, financial reporting or practice provisions for for-profit RTFs. For private-equity firms, finding even a list of the RTFs they operate may prove impossible. RTFs can exist under various ownership structures, have no care loss ratio requirements, are not required to submit their budgets for review, and can freely contract aspects of facility operations to related third parties for further investor enrichment. In some instances, facilities are owned by nonprofit organizations that then contract with private-equity-owned providers to operate the facility—receiving more than 80 percent of the facility's revenue.[2] The lack of financial practice regulations includes no restrictions on how they use debt to enrich investors at the expense of vulnerable children, all the while claiming they are operating facilities at a loss. Private-equity firms use their signature tactic—leveraged buyouts—to purchase a facility or facility chain with debt, then place the facility as collateral on the transaction. The facilities then reduce costs by reducing staff, treatment options, and sanitary conditions, placing children in greater danger. Moreover, private-equity firms place additional debt on facilities through dividend recapitalizations to pay investors dividends: Sequel Youth and Family Services performed two dividend recapitalizations for at least $94 million in 2017 and 2018. Federal reporting requirements do not bar any of these tactics.

Question. What should State and Federal regulators be doing to tighten these requirements?

Answer. States could improve their reporting and regulatory requirements by streamlining oversight and publicly accessible information about providers in one centralized agency or place. But ultimately, holistic oversight of the national companies offering programming must occur at the Federal level. In addition to the Corporate Crimes Against Health Care Act, regulatory reporting requirements should focus on the ways for-profit RTFs are acquired through and assume debt. Reporting requirements should also greatly improve transparency and set restrictions on the ways that for-profit providers can use Medicaid funds and contract with related parties.

PREPARED STATEMENT OF HON. RON WYDEN,
A U.S. SENATOR FROM OREGON

Today, the Finance Committee meets to discuss the horrific abuse and neglect of children at too many residential treatment facilities, or RTFs—places that say they provide behavioral health care to vulnerable children, but often leave kids harmed and more traumatized than they started off.

Just this morning, the committee released a new report with shocking details about the treatment of kids in these facilities, which get big dollars from programs under the committee's jurisdiction, like Medicaid and the child welfare system. There are endless examples of sexual, physical, and verbal abuse, improper re-

[2] Joaquin Palomino et al., *Far From Home/Far From Safe,* The Imprint (December 11, 2020), *https://imprintnews.org/child-welfare-2/california-ends-out-of-state-placements/50095* ("Though these treatment centers are legally organized as separate nonprofits, they send a combined 83% of revenue back to Sequel to 'manage and operate' the campuses.").

straint and seclusion of young children, unsafe and unsanitary conditions, and even a total lack of provision of behavioral health care.

And unfortunately, it seems that more often than not, abuse and neglect is the norm at these facilities, and they're set up to let this happen. The system is failing, except for the providers running these treatment facilities, who have figured out exactly how to turn a profit off taxpayer-funded child abuse.

I do not say that lightly. My staff has spent 2 years looking into RTFs run by four of the biggest players: Universal Health Services, Acadia Healthcare, Devereux Advanced Behavioral Health, and Vivant Behavioral Healthcare. They've reviewed over 25,000 pages of company documents, had dozens of conversations with experts, pored over article after article, and saw the problems firsthand when they visited facilities themselves.

Overwhelmingly, it's clear that the operating model for these facilities is to warehouse as many kids as possible while keeping costs low, in order to maximize profits. This means intentional understaffing with people who have zero experience or qualifications to provide the care these children need. As Jay Ripley, the cofounder of Vivant and two other previous RTF companies once remarked, "you can make money in [the RTF] business if you control staffing."

It also means facility conditions are often unsanitary and dangerous, and feel more like a prison than a safe place to help a child get through a difficult time. In these conditions, children can't get the care they need, like high-quality and individualized treatment.

As if profiting off rampant abuse and neglect of our country's most vulnerable children wasn't bad enough, these facilities are relying on Federal funding. That means that American tax dollars are funding this abuse. In some cases, RTFs receive over $1,200 per day per child from Medicaid. The experiences and trauma these kids are left with read like something out of a horror novel, and I'll just mention a few.

One facility routinely restrained children, drugged them, and placed them in seclusion, in clear violations of Federal rules.

Another child ran away from his program in the middle of the night and was fatally struck by a truck. The staff at the facility tried to cover up their neglect and falsified documents about the child's whereabouts.

Another child was sexually abused by a staffer on an ongoing basis. When the facility caught on to the abuse, instead of firing the staffer, they simply moved them to a different wing of the same facility, and each night the staffer returned to the child's window to say "goodnight."

These are instances of child fatalities, both at the hands of staff and death by suicide.

Tragically, the accounts of abuse we will hear today are not outliers. They represent a systemic culture of mistreating and abusing kids and turning a profit.

I gave the CEO of the nation's largest RTF provider the opportunity to testify before the committee and defend how the company treats the children in their care. It's disappointing, but not surprising, that he declined the invitation. His company's conduct—and the entire RTF business model—is simply indefensible.

So, the question everyone in this room should be asking themselves is this: where do we go from here? It's time to shut off the fire hose of Federal funding for these facilities to put an end to this cycle of abuse.

The buck stops here. In order to get a dime from Medicaid or any other program in my jurisdiction, all of these facilities are going to have to start providing actual care. Systemic failures at even a handful of these facilities are an indictment of the whole model. It's pretty simple: a facility shouldn't be getting a cent of taxpayer money if it can't prove it's providing high-quality care.

But none of this matters if there is no oversight or enforcement. RTFs are often located in rural places and function as black boxes left completely unchecked.

As a result, practices that should be used only in rare, extreme cases—like restraint and seclusion—are being used regularly and improperly by unqualified and poorly trained staff. At one Acadia facility in Arkansas, restraint and seclusion were used 110 times in 1 month alone. Without clear, nationwide tracking of these facilities, this behavior slips through the cracks.

Finally, there need to be more community-based alternatives for care. We know this based on decades of research, this committee's own experience passing the bipartisan Family First law, and from doctors and patients themselves: children do better being served in their communities. The only people who disagree have a financial interest in keeping these places profitable.

In order to reduce our reliance on fraudulent facilities and to reduce the number of kids that end up in them, investing in high-quality community-based care should be a top priority. It's simple: if you provide more care and support to kids up front, you reduce the need for residential treatment and the number of kids being subjected to these horrific abuses.

My investigation makes clear that too often, kids in the foster care system are warehoused in RTFs for months or years with no plan to exit, and no legitimate reason for being there. The Federal Government and American taxpayers have no business funding jail-like settings for foster-care kids.

These findings demand bold action. In the coming months, I'll be introducing legislation in this committee's jurisdiction to raise health and safety standards, require real oversight and enforcement, and invest in the community-based services that are proven to actually help kids.

I want to acknowledge every survivor in this room. The work of this committee wouldn't have happened without survivors like you coming forward to share your stories. Thank you for your bravery. As chairman, I'm all in to ensure the Finance Committee does everything it can to put a stop to this cycle of abuse.

United States Senate

WAREHOUSES OF NEGLECT: HOW TAXPAYERS ARE FUNDING SYSTEMIC ABUSE IN YOUTH RESIDENTIAL TREATMENT FACILITIES

A SENATE COMMITTEE ON FINANCE STAFF REPORT

I. Executive Summary

In July 2022, the Senate Committee on Finance (the Committee) and Senate Committee on Health, Education, Labor, and Pensions launched an investigation into allegations of abuse and neglect at Residential Treatment Facilities (RTFs) operated by four providers—Universal Health Services (UHS), Acadia Healthcare (Acadia), Devereux Advanced Behavioral Health (Devereux), and Vivant Behavioral Healthcare (Vivant). Since then, the Committee has engaged in a sweeping inquiry, reviewing over 25,000 pages of company productions, holding dozens of conversations with behavioral health stakeholders, and visiting RTFs on the ground.

Children should receive highquality mental health services in the least-restrictive environment that meets their needs. Children are sent to RTFs by private and public actors, including parents and guardians, psychiatrists, child welfare agencies, the juvenile justice systems, and educational systems. The Committee has jurisdiction over many RTF placements funded through the Medicaid program and the Social Security Act's child welfare provisions, through which RTF providers are paid per diems for the children in their care.

The RTF providers optimize per diems by filling large facilities to capacity and maximize profit by concurrently reducing the number and quality of staff in facilities. The Committee's investigation found that children at RTFs suffer harms such as the risk of physical, sexual, and emotional abuse at the hands of staff and peers, improperly executed and overused restraint and seclusion, inadequate treatment and supervision, and non-homelike environments. These harms amount to acute safety concerns and have long-term effects, including suffering, trauma and even death. Taken together, the Committee finds that these harms are endemic to the RTF operating model.

A. Key Findings

The Committee investigation establishes the following key findings:

1. **Congress needs to legislate to improve the conditions in RTFs and the broader behavioral health landscape.** It should focus its attention on the following categories: (i) raising the floor for congregate care standards, (ii) in-

vesting in community-based alternatives for care, and (iii) strengthening the oversight of congregate care facilities.

2. **Children suffer routine harm inside RTFs.** These harms include sexual, physical, and emotional abuse, unsafe and unsanitary conditions, and inadequate provision of behavioral health treatment.
3. **The risk of harm to children in RTFs is endemic to the operating model.** The harms children in RTFs experienced are the direct, causal result of an operating model that incentivizes providers to optimize revenues and operating and profit margin. RTF providers offer minimal therapeutic treatment in deficient physical settings with lean staff composed of non-professionals, which maximizes per diem margins.
4. **Children inside RTFs often do not get the treatment they need for mental and behavioral health needs, despite RTFs being reimbursed to provide intensive services.** Children in crucial developmental years may be placed in RTFs because of serious conditions that require observation and intensive treatment. However, the intensive, specialized treatment advertised by RTF providers often does not occur. RTFs fail to individualize treatment plans and administer the therapeutic behavioral health care described in plans. Further, children spend the majority of their time supervised by general staff who may lack the training, experience, and tools necessary to adequately meet the needs of the children in their care.
5. **Horrific instances of sexual abuse persist unremediated inside RTFs.** At Cedar Ridge Behavioral Hospital (UHS; Oklahoma) a staff member sexually abused a child on an ongoing basis. When this relationship was identified, the facility moved the staffer to another wing, rather than terminating her. The staffer returned to the child's window every night and planned to continue this abuse upon the child's discharge.
6. **The use of restraint and seclusion in RTFs allows for unchecked abuse.** Even though the use of restraint and seclusion are regulated by state and federal entities, these interventions are often used inappropriately and amount to abuse. Restraint and seclusion are utilized by unqualified and improperly trained staff as punishment, are conducted in a manner that injures children, and are used without proper documentation. Oversight authorities rely on facilities' own documentation for monitoring, resulting in few checks on these often problematic and non-compliant interventions.
7. **RTFs have ignored federal restraint and seclusion regulations, resulting in rates of restraint and seclusion that exceed each intervention occurring daily.** At Piney Ridge Treatment Center (Acadia; Arkansas) staff routinely simultaneously chemically restrained and secluded children, in violation of federal regulation. At the same facility, staff conducted 110 restraints and seclusions in a 30-day period. When regulators identified this trend, the facility responded, in part, by administering a 10-question multiple-choice test on restraint and seclusion to staff.
8. **RTFs often employ unqualified or inadequately trained staff and that staff routinely fail to discharge their duties.** As Jay Ripley, the co-founder of Vivant, once remarked, "you can make money in [the RTF] business if you control staffing." Children at RTFs are often supervised by staff who are ill-equipped to address their complex behavioral health needs and, in some cases, children interact with staff who pose a direct threat to their well-being. Poor staffing leads to elopements from facilities, self-harm attempts by children, and child fatalities.
9. **RTF staffing failures have led to tragic incidents, including child fatalities, and children's repeated exposure to risk.** A child eloped from Devereux—Red Hook (Devereux; New York) overnight, enabled by staff who failed to conduct required bed-checks. Staff instead falsified records of the required bed-checks relating to the child's condition and whereabouts. At 6:45 a.m., staff discovered the child had escaped the facility through a window. They contacted the police at 7:10 a.m. Hours earlier, at 4:50 a.m., the child had been fatally struck by a truck 4.5 miles away from the facility. Following this death, the State of New York instituted a week-long, intensive monitoring visit. During this time, monitors observed repeated, additional supervision failures.

10. **RTFs are often non-homelike environments, exposing children to unsafe and unsanitary conditions.** RTFs often fail to provide safe and sanitary conditions to children. Sites contain mold, bedbugs, and spread of communicable disease. Further, they expose children to environmental hazards—such as suicide modalities, improperly administered and monitored medication, and buildings in states of gross disrepair.
11. **RTFs often fail to effectively maintain connections between children and their communities and to plan for children's discharge to the community for ongoing care.** RTFs remove children from their communities and place them in unnatural environments. In the best cases, children are able to maintain connections to their families/guardians and to their community-based care providers, but this is often not the case. Facilities are meant to center a child's connection to their community by maintaining contact with family members and effectively planning for a child's discharge prior to the time of admission. In reality, RTFs often cut off a child from their communities by limiting communication with families/guardians, failing to involve families/guardians in treatment plan development, and keeping children for extended time periods. RTFs also fail to conduct quality discharge planning for children, complicating the child's continuity of care and potential for success.
12. **RTFs often employ carceral technology to monitor children, creating environments that feel more like detention facilities than therapeutic settings.** In an attempt to mitigate harms endemic to RTFs, providers may install more cameras, which are important instruments for effective oversight. Some providers, however, have gone further by implementing corrections monitoring technology and fortifying walls around facilities. The safety enhancements obtained by use of corrections technologies do not outweigh the harms to children in RTF care, and have not demonstrated improved treatment delivery.
13. **State and federal oversight authorities fail to effectively identify and address harm to children in RTFs. When RTFs correct deficiencies, their efforts are remedial rather than company-wide.** There are numerous RTF oversight bodies that include Medicaid agencies, licensing entities, health and human service agencies, child welfare agencies, and monitoring organizations. RTFs often respond to deficiencies by citing facility policy that complies with state and federal rules, by drafting new policy, or retraining/terminating the individuals involved. These actions fail to address the underlying culture of harm at RTFs.
14. **Exploiting corporate structures can enable RTF operators to evade oversight.** In 2017, the CEO of Sequel Youth and Family Services (Sequel), Jay Ripley, sold a majority stake in the company to a private equity firm. In 2021, after being plagued by reporting on abuse and neglect allegations, Sequel sold 13 facilities to a newly-incorporated company, Vivant Behavioral Health (Vivant), also founded by Jay Ripley. Vivant retained many members of Sequel leadership and its footprint has significant overlap with Sequel's.

B. Recommendations

The Committee's recommendations are presented with a recognition of each child's inherent dignity and worth, and with a vested interest in ensuring federal dollars are spent as Congress intended. To improve the current conditions in RTFs, invest in new systems of care, and strengthen the existing oversight landscape, the Committee's recommendations to federal, state, and local governments and facility leadership are threefold.

- First, children who are currently placed at RTFs must be afforded safety, dignity, and homelike conditions and provided with the treatment and support that they need. *Standards inside RTFs must be raised.*
- Second, government funding should *prioritize community-based services and placements* to address children's behavioral health needs.
- Third, *effective oversight mechanisms of RTFs require substantial investment at all levels* of government. Spending on RTF placements and services should be heavily scrutinized by government payers.

In addition, the Committee recommends state and local governments, federal agencies, accrediting bodies, and RTF providers immediately take the following actions:

1. **Congress must legislate to improve the conditions in RTFs and the broader behavioral health landscape.** It should focus its attention on the following categories: (i) raising the floor for congregate care standards (including standards that reflect active treatment and require use of evidence-based treatments), (ii) investing in community-based alternatives for care, and (iii) strengthening the oversight of congregate care facilities.
2. **The companies under investigation in this report must raise standards across facilities.** As this report has shown, abuse, neglect, overuse of restraint and seclusion, and inadequate staffing are direct results of choices RTF companies have made about how to run their businesses, many of which are in violation of long-standing federal rules. At a minimum, RTFs can take the following concrete actions immediately:
    - Require that their facilities comply with long-standing federal rules related to the adequate and appropriate provision of behavioral health services, use of restraint and seclusion, use of emergency safety interventions, serious incident reporting, creation of individualized plans of care, inclusion of an interdisciplinary care team, safe and sanitary environments, and adequate discharge planning, including identifying specific services and formally referring children to external providers.
    - Require cameras in all spaces inside and outside of RTFs, aside from inside bathrooms and children's bedrooms, and ensure that video footage is retained for an appropriate period of time in order to conduct meaningful oversight.
    - Conduct a comprehensive review of their current staffing in their facilities, and invest more in hiring, retraining, training, and supervising staff who can keep children safe and provide them with effective treatment.
    - Require that professionals with advanced training and credentials and supervisors be more involved in overseeing the provision of care in RTFs.
3. **States should use their existing authority to prioritize the availability and utilization of community-based services for children with behavioral health needs.** States have historically inappropriately over used RTF placements as a "solution" for children with complex behavioral health needs or nowhere else to go without investing in robust community-based services or exhausting the available in-community services. This report details that RTFs often do not provide the care that children with complex needs require, resulting in inappropriately long stays, and these stays leave children more traumatized, and without a discharge plan to ensure successful reintegration into the community. States must comply with Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit requirements to provide all medically necessary care to children in Medicaid, including community-based alternatives to RTFs, and should take advantage of federal resources to build additional support for community-based services whenever possible (*e.g.,* intensive care coordination to divert youth from these facilities and family-based services and supports). States should develop and implement strict standards on clinical assessments to ensure children in RTFs truly need that level of care. States should end the practice of placing foster youth without behavioral health needs in RTFs because they have failed to establish viable alternatives.
4. **States should improve RTF oversight activities in order to compel providers to raise the bar on standards within RTFs.** In order to end the practice of medications as a chemical restraint in RTFs, for example, states could create independent, interdisciplinary medical review boards to assess children who are subjected to polypharmacy. States should ramp up their oversight capabilities for youth in both in-state and out-of-state facilities, including by referring all suspected Medicaid fraud related to business models, provision of care, and length of stay data by RTF providers to Medicaid Fraud Control Units. States should also re-evaluate and expand their serious occurrence reporting requirements for RTFs, increase the frequency with which they conduct unannounced site visits, and establish systematic ways to gather uncensored information from staff and residents of RTFs on their experiences and potential abuses and have mechanisms to report timely information to caregivers who request this information.
5. **CMS and ACF should work together to clarify and streamline federal oversight requirements for RTFs.** This could include joint recommenda-

tions or guidance prioritizing or requiring independent state licensure in place of reliance on third-party accreditation, as well as establishing standards for services and supports that must be provided by these facilities. It could also include guidance recommending that RTF companies employ a streamlined review processes of all of their congregate care facilities and require company-wide changes in protocol after a serious adverse event occurs in a single facility. The agencies could also work together to establish a central, public-facing database containing critical information about RTF quality and adverse incidents. The agencies could require more robust data reporting by RTFs to federal entities, including information related to ownership, payment methodologies, serious incident reporting, length of stay, use of seclusion and restraint, out-of-state placements, and demographics of children in RTFs.

6. **CMS and ACF can work collaboratively to center perspectives of youth with lived experience.** This could include establishing an advisory board composed of youth with lived experience in institutional placements who can share their perspective to inform congregate care policy development. The agencies could also promulgate joint guidance to states that focus on policies that protect specific groups of children, such as children identifying as LGBTQIA+, or with a history of child welfare involvement, develop training materials, and disseminate best practices related to placements.

7. **ACF should increase awareness for judges** on the risks of improper placements in RTFs, the full continuum of care, and clinical best practices for treating children with behavioral health needs, particularly for children in foster care. The Committee found that a significant portion of foster children placed at RTFs have no demonstrated behavioral health needs, so family court judges should be dissuaded from placing children in RTFs, particularly if those facilities have a record of abuse, neglect, or overuse of restraint or seclusion. For foster youth with significant behavioral health needs, ACF should train judges on how to assess whether there is appropriate and effective care being provided at RTFs in question.

8. **CMS and ACF can and should do more to prioritize spending on community-based behavioral health services as an alternative to placement in RTFs if possible and safe.** As this report details, both agencies are major payors for RTF placements and have a responsibility to ensure treatment services are actually being provided with the available federal financing. The agencies should issue guidance to states to assist them in understanding what behavioral health services are required to be available as part of the provision of EPSDT services and prioritizing the availability and use of community-based behavioral health care and prevention services for all children, especially those in the child welfare system. This includes robust guidance about adherence to the Family First Prevention Services Act, and EPSDT that goes beyond describing state options and best practices, and instead establishes clear minimum requirements for keeping children safe and ensuring they are receiving medically necessary care.

9. **DOJ should assess RTF placements for potential *Olmstead* violations.** DOJ should require that state and local governments meet their obligation under Title II of the ADA to exhaust least-restrictive, in-community treatment before leveraging congregate care. This report highlights the importance of taking a systematic look at the warehousing of children and youth in RTFs.

10. **Accrediting bodies, such as the Joint Commission, should closely monitor facilities following the discovery of noncompliance with requirements or elements.** In instances where accrediting entities identify areas of noncompliance, they should more actively monitor facilities' implementation of corrective actions, including with revisits. Further, accrediting bodies should consider withholding accreditation when they identify sustained, longitudinal noncompliance. Finally, as one of the singular entities with visibility into the full scope of a given provider's facilities and, thus, any patterns of noncompliance, accrediting bodies should do more to encourage providers to implement changes across facilities, rather than on a remedial facility-by-facility basis.

II. Background

A. Centering Children's Stories

In 2020, 16-year-old Cornelius Frederick was seated in the Lakeside Academy cafeteria (Sequel; Michigan).[1] Cornelius had landed in a series of Residential Treatment Facilities (RTFs) placements in the wake of his mother's death and father's imprisonment.[2] His teachers described him as quiet and brilliant.[3] After Cornelius tossed his sandwich crusts underhand at the children seated at the next table, a staffer knocked him to the floor.[4] More staff piled onto his body; for roughly ten minutes, seven staff members restrained Cornelius.[5] Two staff members—one 6 feet, 5 inches tall and 265 pounds and the other 6 feet, 2 inches tall and 380 pounds—laid atop his torso.[6] Two days later, Cornelius died in the hospital. The medical examiner ruled his death a homicide by asphyxiation, but there were only meager victim fees.[7] Two of the seven staffers involved pleaded no contest to involuntary manslaughter, a third, the former Head Nurse, pleaded no contest to third-degree child abuse.[8]

Another child, 817 miles away at Millcreek Behavioral Health (Acadia; Arkansas), required monitoring for suicidal ideation following multiple suicide attempts.[9] She was regularly strip searched and, at least twice, subjected to a vaginal cavity search.[10] In 2018, the child was restrained by four staffers after she refused a strip search. During the restraint, a staffer touched her breast and made her squat naked in the shower for a forced vaginal cavity search.[11] Even though she endured the indignity of nightly strip searches, staff failed to notice evidence of new self-harm on the child's body (scars and wounds) until Disability Rights Arkansas alerted staff to their existence.[12] Years later, finally out of RTFs, she gave birth to two boys.[13] Following an overdose, she lost custody of her sons and, two months later, died by overdose.[14]

These two children's stories represent the banality of abuse inside RTFs. Children, entrusted to the care of behavioral health providers, are routinely subjected to the risk of abuse. In the best of circumstances, children at RTFs receive care from under-trained and overburdened staff, are given infrequent therapy, sometimes by non-professionals, and are exposed to unsanitary, unsafe, and non-home like envi-

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[1] APM Reports, *Youth Were Abused Here* (Sep. 28, 2020) *https://www.apmreports.org/story/2020/09/28/for-profit-sequel-facilities-children-abused; [https://perma.cc/9NEH-PSW3].*

[2] NBC News, *The brief life of Cornelius Frederick: Warning signs missed before teen's fatal restraint* (July 23, 2020) *https://www.nbcnews.com/news/us-news/brief-life-cornelius-frederick-warning-signs-missed-teen-s-fatal-n1234660; [https://perma.cc/2Q7A-VZZX].*

[3] APM Reports, *Youth Were Abused Here* (Sep. 28, 2020) *https://www.apmreports.org/story/2020/09/28/for-profit-sequel-facilities-children-abused; [https://perma.cc/9NEH-PSW3].*

[4] *Id.*

[5] NBC News, *The brief life of Cornelius Frederick: Warning signs missed before teen's fatal restraint* (July 23, 2020) *https://www.nbcnews.com/news/us-news/brief-life-cornelius-frederick-warning-signs-missed-teen-s-fatal-n1234660; [https://perma.cc/2Q7A-VZZX].*

[6] WWMT, *Former workers enter plea in Lakeside Academy teen's death* (Mar. 16, 2023) *https://wwmt.com/news/local/michael-mosley-zachary-solis-lakeside-academy-cornelius-fredericks-death-2020-sandwich-restraint-manslaughter-homicide-crime-kalamazoo-county-west-michigan; [https://perma.cc/3HH8-VLK9].*

[7] APM Reports, *Youth Were Abused Here* (Sep. 28, 2020) *https://www.apmreports.org/story/2020/09/28/for-profit-sequel-facilities-children-abused; [https://perma.cc/9NEH-PSW3].*

[8] WWMT, *Former Lakeside Academy workers sentenced to probation for teen's restraint death* (Dec. 19, 2023) *https://wwmt.com/news/local/lakeside-academy-student-cornelius-fredericks-michael-mosley-zachary-solis-restraint-homicide-death-probation-sentence-michigan; [https://perma.cc/JSH6-NHEX];* WWMT, *Former workers enter plea in Lakeside Academy teen's death* (Mar. 16, 2023) *https://wwmt.com/news/local/michael-mosley-zachary-solis-lakeside-academy-cornelius-fredericks-death-2020-sandwich-restraint-manslaughter-homicide-crime-kalamazoo-county-west-michigan; [https://perma.cc/3HH8-VLK9].*

[9] Disability Rights Arkansas, *RE: [Redacted] To: [Redacted], Chief Executive Officer* (Jan. 30, 2019) 20190604 Millcreek Alaska HHS Referral Hold at p. 14–16.

[10] *Id.* at p. 15.

[11] Disability Rights Arkansas, *RE: [Redacted] To: [Redacted], Chief Executive Officer* (Jan. 30, 2019) 20190604 Millcreek Alaska HHS Referral Hold at p. 14. Although not specified in the document reviewed by the Committee, Acadia informed the Committee that such searches are performed by physicians or nurses according to doctors' orders based on the specific patient care plan and history. Acadia further stated searches are performed to protect patient safety and with medical staff present at all times.

[12] *Id.* at p. 14.

[13] Seven Days, *The Loss of Grace* (Oct. 25, 2023) *https://www.sevendaysvt.com/news/woodside-investigation-violence-and-isolation-at-vermonts-juvenile-lockup-39222023; [https://perma.cc/HN5L-RQB3].*

[14] *Id.*

ronments. In the worst of circumstances, children at RTFs suffer the above as well as sexual, physical, verbal, or emotional abuse at the hands of staff. Mistreatment is endemic to the conditions at RTFs.

At its core, the RTF model typically optimizes profit over the well-being and safety of children. The rampant civil rights violations that children experience in RTFs are a direct consequence of the industry's model. RTFs employ substandard labor practices and avoid investments in physical maintenance. So long as providers are allowed to proceed with business as usual, children will continue to suffer.

In 2018, a contractor conducted a Medicaid compliance visit at Piney Ridge Treatment Center (Acadia; Arkansas). When the surveyor asked the children to describe their treatment, one child commented: *It's helping me get better, but it is also making me more depressed. Another said: I feel that I can't prepare for the real world if I can't be in the real world.*[15]

Their words implicate everyone. What does it mean to remove a child from the *real world?*

The answer often seems benign. Children are sent to RTFs for many reasons: complex behavioral needs, a lack of in-community resources, or early propensity for criminal behavior. Children arrive in these placements via many channels: judges, parents, guardians, and government agencies who each, for myriad reasons, need somewhere to put children. These are children for whom we have made no place in the *real world.*

The warehousing of these children in RTFs only remedies society's disinterest in addressing their needs. By removing those who are inconvenient from sight, people divest themselves of the responsibility to help them. As Devereux leadership explained to the Committee, it "do[es] not believe [PRTFs] are a natural environment to receive care."[16] By removing children with needs to live in RTFs, their needs are not addressed. Children are suffering as a result. Their lives are ending before they evenbegin—systematically, by design.

It is imperative to imagine, and help create, a *real world* with a place for these children, with the support they need, alongside their communities. With this report, the Committee takes up the work of witnessing and attending to the situation and needs of all children, and imagining that *real world.*

B. History

a. Senate Committee on Finance Jurisdiction and Program Descriptions

The Senate Committee on Finance (the Committee) has jurisdiction over the Social Security Act. Through the Medicaid program and the Act's child welfare provisions, programs in the Committee's jurisdiction pay for a significant portion of youth behavioral health services, including RTF placements.

Medicaid, Title XIX of the Social Security Act, is a joint federal-state program that provides health insurance coverage to low-income individuals, children, and families. Medicaid is the largest health insurer for youth, as well as the primary payer of behavioral health care for all Americans. As such, it has a critical role in caring for youth with complex behavioral health needs. Under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, Medicaid must provide all medically necessary and covered services for all enrollees under age 21.

Most states have elected to provide inpatient psychiatric services for enrollees under age 21, referred to as the "psych under 21" benefit.[17] Psych under 21 services are provided in psychiatric hospitals, psychiatric units in a hospital, or psychiatric facilities called psychiatric residential treatment facilities (PRTFs), which must meet certain requirements on the use of seclusion and restraint, a certification of need for inpatient care, and a plan of care for active treatment, developed by an interdisciplinary team.[18] Aside from certain narrow exceptions, the federal Medicaid program does not reimburse states for the cost of providing care for adults in institutions for mental diseases (IMDs), except for youth who receive this service, and individuals age 65 or older.

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[15] Acadia, *Beacon Health Options—Inspection of Care Report: Piney Ridge Treatment Center* (Apr. 9–12, 2018) 20180409 Piney Ridge AR Beacon Report at p. 4.

[16] Notes from Devereux Advanced Behavioral Health Briefing (May 21, 2024) (on file with Committee).

[17] 42 CFR § 440.160.

[18] 42 CFR § 441.151.

Many states provide psych under 21 services through PRTFs. A PRTF is intended to provide comprehensive mental health treatment to youth who because of severe behavioral health conditions require care that is most appropriately and effectively provided in a residential treatment facility setting. To be able to access care in a PRTF, all other care available in the community must have been identified, and if not accessed, determined to not be appropriate to meet the treatment needs of the child. Among other requirements, PRTFs must comply with annual State Medicaid Agency review,[19] limit restraint and seclusion,[20] report all serious incidents to relevant oversight agencies, and report all deaths to the Centers for Medicare and Medicaid Services (CMS).[21]

PRTFs are intended to provide a brief and intense mental health treatment program in order to facilitate a successful return of the child to the community and the child should be transitioned to a less restrictive setting when treatment in a PRTF is no longer medically necessary. These facilities are required to work with the families of the youth and other services and supports to ensure the care provided in the facility is tailored to meet the youth's individual needs.

The Committee also has jurisdiction over policy and financing of child welfare services through Title IV–B and Title IV–E of the Social Security Act. Title IV–E authorizes funding for states, territories and tribes (states) to administer required child welfare activities, including foster care and adoption assistance. Additionally, IV–E authorizes funding for optional services, including foster care prevention services. Medicaid is the primary payer for health care services for children in the child welfare system.[22] All children who are eligible for IV–E assistance or aging out of foster care are automatically eligible for Medicaid.[23] To receive IV–E funding, state child welfare agencies must submit a plan to the Department of Health and Human Services (HHS), participate in cost sharing, and comply with HHS oversight and regulation.[24]

Additional funding streams within the Finance Committee's jurisdiction used for child welfare services, including foster care, include the Social Services Block Grant (SSBG) and Temporary Assistance for Needy Families (TANF).[25] In 2018, Congress amended Title IV–E by passing The Family First Prevention Services Act (Family First) which sought to prevent the need for foster care placements by investing in prevention services to prevent abuse and neglect. Additionally, Family First created new requirements for specialized residential settings for foster youth with "serious emotional or behavioral health disorders," known as Qualified Residential Treatment Programs (QRTPs).[26] QRTPs must comply with extensive requirements related to licensure, provision of trauma-informed treatment, and community involvement, but are not required to comply with the same rules as PRTFs in regard to the use of seclusion and restraint.[27]

b. Senate Committee on Finance Investigation

On July 21, 2022, Senate Committee on Finance Chairman Wyden and Senate Health, Education, Labor, and Pensions Chair Murray co-launched an investigation into allegations of systemic abuse and neglect of children at RTFs operated by four providers, each owning facilities with a history of public abuse and neglect allegations and a substantial facility footprint:

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[19] 42 CFR § 1864(a); § 1902(a).

[20] 42 CFR § 483.350–483.376.

[21] 42 CFR § 441.151–441.182; § 483.350–483.376.

[22] MACPAC, *Children in the child welfare system* (2017) *https://www.macpac.gov/subtopic/children-in-the-child-welfare-system/#:~:text=Medicaid%20is%20an%20important%20source,are%20automatically%20eligible%20for%20Medicaid; [https://perma.cc/5KJL-F2N3].*

[23] *Id.*

[24] Social Security Act, 42 U.S.C. § 471.

[25] The Child Abuse Prevention and Treatment Act (Public Law 93–247) also funds child welfare services by providing resources to states to support prevention, assessment, and conduct abuse and neglect investigations. This law, and its related programs, are within the jurisdiction of the Senate Committee on Health, Education, Labor and Pensions.

[26] U.S. Dept. of Health and Human Servs. Admin. for Children and Families, ACYF–CB–PI–18–07, *NEW LEGISLATION—Public Law 115–123, the Family First Prevention Services Act: Implementation of Title IV–E Plan Requirements* (July 9, 2018) *https://www.acf.hhs.gov/sites/default/files/documents/cb/pi1807.pdf; [https://perma.cc/W87M-V5PG].*

[27] U.S. Dept. of Health and Human Servs. Admin. for Children and Families, ACYF–CB–IM–18–02, *NEW LEGISLATION*—Public Law 115–123, the Family First Prevention Services Act within Division E, Title VII of the Bipartisan Budget Act of 2018 (Apr. 12, 2018) *https://www.acf.hhs.gov/sites/default/files/documents/cb/im1802.pdf; [https://perma.cc/28DU-BFC7].*

Universal Health Services Inc. (UHS), Acadia Healthcare (Acadia), Devereux Advanced Behavioral Health (Devereux), and Vivant Behavioral Healthcare (Vivant).[28] In the 118th Congress, the investigation continued under Chairman Wyden and Chairman Sanders' leadership.

The two-year investigation establishes that RTFs employ a model that has the potential to expose all children in their custody to harm arising from risk of abuse (physical, sexual, harmful use of restraint and seclusion),[29] inadequate behavioral health treatment, and non-homelike facility conditions. While RTFs secure a steady stream of federal dollars meant to fund placements and intensive services, some RTFs regularly fail to hire adequate numbers of qualified staff, allowing them to maximize operating margin and profit at the expense of children in their care.

This report describes conditions at RTFs that include youth mistreatment and abuse. The Committee reviewed numerous public reports of misconduct as well as more than 25,000 pages of company documents in response to the Committees' inquiry, from restraint and seclusion data to incident reports and corrective action plans (CAPs) to accreditation reports from nongovernmental entities (*e.g.,* The Joint Commission), child welfare agencies, states, Medicaid managed care plans, and protection and advocacy organizations (P&As).[30] The Committee held briefings with senior leadership from each of the four providers, visited RTFs operated by entities unaffiliated with this investigation, and met with dozens of child welfare and behavioral health stakeholders. This report also integrates the voices of youth in the child welfare system using Think of Us' seminal study "Away from Home."

Public reporting over a number of years captures long-standing concerns about the treatment of youth at RTFs. In 2016 and 2017, *Buzzfeed News* published an investigative series detailing accounts of systemic understaffing, physical assaults, improper restraints, and fraudulent admission practices at UHS facilities.[31] In 2020, *The Philadelphia Inquirer* released an exposé alleging numerous incidents of sexual abuse of children with intellectual and developmental disabilities (I/DD) at Devereux facilities, which led to the city of Philadelphia immediately terminating its contract with Devereux.[32] Because of its shared founder and senior leadership, Vivant is linked to one of the highest profile RTF tragedies in recent memory:[33] the

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[28] U.S. Senate Committee on Health, Education, Labor, and Pensions, *Press Release: Murray, Wyden Demand Answers on Mistreatment at Youth Residential Treatment Facilities* (July 22, 2022) *https://www.help.senate.gov/chair/newsroom/press/murray-wyden-demand-answers-on-mistreatment-at-youth-residential-treatment-facilities; [https://perma.cc/SS7S-EZA].*

[29] Per regulation, restraint and seclusion is a permitted emergency safety intervention in many types of RTFs.

[30] Protection and Advocacy agencies (P&As) provide nonprofit legal advocacy services for people with disabilities. They have the authority to enter congregate care facilities, like RTFs, for monitoring and abuse and neglect investigation. They may also pursue litigation or other appropriate remedies under federal, state, and local law.

[31] Buzzfeed News, *"What The Fuck Just Happened?"* (Dec. 7, 2016) *https://www.buzzfeednews.com/article/rosalindadams/intake; [https://perma.cc/S9CG-TYGQ]; A Chain of Private Psychiatric Hospitals Has Been Accused of Failing Vulnerable Young Patients* (Dec. 16, 2017), *https://www.buzzfeed.com/patricksmith/cygnet-health-care; [https://perma.cc/PYT4-HKNA];* Buzzfeed News, *How a Giant Psychiatric Hospital Company Tried to Spin Us—And Silence Its Staff* (Dec. 27, 2017) *https://www.buzzfeednews.com/article/rosalindadams/how-a-giant-psychiatric-hospital-company-tried-to-spin-us; [https://perma.cc/NJH4-E5PX];* Buzzfeed News, *How A 6-Year-Old Got Locked On A Psych Ward* (Dec. 30, 2016) *https://www.buzzfeednews.com/article/rosalindadams/how-a-6-year-old-got-locked-on-a-psych-ward#.fiKjEEvPq; [https://perma.cc/U7E5-6MKF];* Buzzfeed News, *Videos Show the Dark Side of Shadow Mountain Youth Psych Facility* (Apr. 11, 2017) *https://www.buzzfeednews.com/article/rosalindadams/shadow-mountain#.ssL8JJqdl; [https://perma.cc/7DFM-YKSD];* Buzzfeed News, *Videos Show UHS Hospital Staff Assaulting Young Patients* (Nov. 11, 2017) *https://www.buzzfeednews.com/article/rosalindadams/videos-show-uhs-hospital-staff-assaulting-young-patients#.fx3Y771eX; [https://perma.cc/M4QT-XHPQ].*

[32] Philadelphia Inquirer, *Staff abused children for years at the nation's leading behavioral health nonprofit for youth—while red flags were dismissed* (Aug. 11, 2020) *https://www.inquirer.com/news/inq/devereux-advanced-behavioral-health-abuse-children-pennsylvania-20200811.html; [https://perma.cc/ARH2-AHXE];* WHYY, *Philly removes children from Devereux facilities after sex abuse revelations* (Sep. 24, 2020) *https://whyy.org/articles/philly-removes-children-from-devereux-facilities-after-sex-abuse-revelations/#:~:text=The%20Philadelphia%20Department%20of%20Human,of%20abuse%20spanning%2025%20years; [https://perma.cc/NX6H-H5TY].*

[33] The Committee is in possession of records of multiple LinkedIn profiles that support this claim. According to their LinkedIn profiles, the current Vivant Senior Vice President, Strategy and Development worked at Sequel from Dec. 2014 to Sep. 2021 and served as Sequel's Director of Business Development from Sep. 2019 to Sep. 2021. One month following their departure

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death of 16-year-old Cornelius Frederick following a roughly 10-minute restraint by multiple staff after reportedly throwing a sandwich.[34] Ample public reporting documents harm at Acadia facilities, including recently by *ProPublica Illinois* and *The Chicago Tribune.*[35] In one of the stories they co-published, a child referred to Millcreek of Arkansas (Acadia; Arkansas) as "the Misery Mill."[36]

On July 21, 2022 the Committees sent a request for information to the four providers seeking facility demographics and programming, restraint and seclusion practices, abuse and neglect policies, funding streams, records of facility inspections and investigations, and specific considerations regarding the care of youth in the child welfare system, youth with special educational needs, and LGBTQ+ youth.[37] In response to production, on April 7, 2023, the Committees sent follow-up questions to providers. On March 12, 2024, the Committees sent additional questions within the broader framework of the investigation to providers.

c. RTF Federal and State Oversight Efforts

Numerous oversight entities, including federal and state agencies, accrediting bodies, and independent oversight organizations, are involved in regulating and overseeing RTFs. RTFs are subject to, in accordance with both federal and state laws, regulations and monitoring across a host of sectors, such as Medicaid, child welfare, behavioral health agencies, education agencies, long-term care agencies, and the juvenile justice system.[38] Facilities adopt policies and procedures to comply with federal and state regulations. Internally, RTFs regulate themselves by crafting policies to comply with government regulations and company values. Capacity and resources vary widely across these entities and across states.[39] Where RTFs accept out-of-state placements, they may also be subject to laws and regulations from the placing state. When facilities are cited by state entities or third-party accreditors, facilities are typically required to submit a Plan of Correction (POC). In many cases, deficiencies are considered cured when the facility drafts a new policy or reiterates a previous one. Despite this complex set of requirements and oversight entities, noncompliance, harm, and abuse persist in RTFs. The Committee has observed that, in some instances, material underlying issues are not addressed for several months or years.

Government reports have documented mistreatment of youth in congregate care. In 2007, in preparation for a House of Representatives Committee on Education and Labor hearing, the Government Accountability Office (GAO) found that "thousands of allegations of abuse, some of which involved death"[40] had occurred at RTFs and identified systemic issues that allowed for these harms. In 2008 GAO recommended enhancing state oversight.[41] In 2008, GAO released a second report detailing how

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from Sequel, this person assumed the role of SVP at Vivant. A second individual worked at Sequel from Nov. 2019 to Nov. 2021, first as the Lead Clinical Director and then the Chief Clinical Officer. They then began working at Vivant and their tenure as Sequel Chief Clinical Officer and as Vivant Chief Clinical Officer over lapped for a month according to their LinkedIn profile. Thirdly, a current President at Vivant, worked at Sequel from Nov. 2019 to Sep. 2021 as the Vice President of Operations. This person joined Vivant in Oct. 2021. Beyond these three senior leaders, the Committee has identified additional management personnel who worked at both Sequel and Vivant.

[34] NBC News, *Video shows fatal restraint of Cornelius Frederick, 16, in Michigan foster facility* (July 7, 2020) *https://www.nbcnews.com/news/us-news/video-shows-fatal-restraint-cornelius-fredericks-16-michigan-foster-facility-n1233122; [https://perma.cc/FE3K-36CV].*

[35] ProPublica, *Thousands of Foster Children Were Sent Out of State to Mental Health Facilities Where Some Faced Abuse and Neglect* (March 11, 2020) *https://www.propublica.org/article/illinois-dcfs-children-out-of-state-placements; [https://perma.cc/Q8BJ-PWTP].*

[36] ProPublica, *Why a Mental Health Institute for Foster Children Became Known as "The Misery Mill"* (Mar. 11, 2020) *https://www.propublica.org/article/illinois-dcfs-children-out-of-state-millcreek-behavioral-health-arkansas; [https://perma.cc/2P4F-7JDQ].*

[37] U.S. Senate Committee on Health, Education, Labor, and Pensions, *Press Release: Murray, Wyden Demand Answers on Mistreatment at Youth Residential Treatment Facilities* (July 22, 2022) *https://www.help.senate.gov/chair/newsroom/press/murray-wyden-demand-answers-on-mistreatment-at-youth-residential-treatment-facilities; [https://perma.cc/SS7S-EZA].*

[38] U.S. Gov't. Accountability Off., Testimony Before the U.S. House Committee on Education and Labor, *Residential Facilities: State and Federal Oversight Gaps May Increase Risk to Youth Well-Being* at p. 3 (Apr. 24, 2008); *https://www.gao.gov/assets/gao-08-696t.pdf; [https://perma.cc/6LBR-S4KU].* This testimony notes that some facilities are exempt from licensure.

[39] *Id.* at p. 15.

[40] U.S. Gov't. Accountability Off., *GAO–08–146T, Residential Treatment Programs: Concerns Regarding Abuse and Death in Certain Programs for Troubled Youth* p. 2 (Oct. 2007); *https://www.gao.gov/assets/gao-08-146t.pdf; [https://perma.cc/KR2W-4FVY].*

[41] U.S. Gov't. Accountability Off., *GAO–08–346, Residential Facilities: Improved Data and Enhanced Oversight Would Help Safeguard the Well-Being of Youth with Behavioral and Emotional*

"[w]eaknesses in the current federal-state regulatory structure have failed to safeguard the civil rights and well-being of some of the nation's most vulnerable youth."[42] In 2015, GAO reviewed state use of congregate care for children in the child welfare system and found that, while HHS had taken steps to address over reliance on facilities, inappropriate congregate care, including RTF placements, for this population continued.[43] In its fourth publication on the topic in 2022, GAO set out opportunities to improve oversight agencies' *(e.g.,* child welfare system, education system, and facility licensing) information sharing to better prevent abuse and neglect in youth congregate care.[44] Many of GAO's recommendations, across all reports, remain unaddressed by the relevant government entities.

The HHS Office of the Inspector General (OIG) has released numerous reports on regulatory noncompliance at youth RTFs. A 2015 OIG inquiry found that Cedar Ridge Treatment Center (UHS; Oklahoma) did not consistently provide children with Medicaid the proper treatment hours, including finding that the site "provided 199 hours and 25 minutes less than the required weekly minimum service hours for 35 of the 36 acute-care treatment beneficiary-weeks."[45] A 2019 OIG inquiry, stemming from the 9,744 reports of abuse and neglect in congregate care facilities in 2019, outlined six states' congregate care monitoring and response processes, focusing on facilities with multiple incident reports and common ownership structures.[46] In 2022, OIG launched an inquiry into how child welfare and licensing agencies monitor and address reports of maltreatment in RTFs and opportunities for better oversight.[47]

The Department of Justice (DOJ) has sought recoupment and/or fines from RTF providers for misuse of Medicaid funds. In 2020, UHS was subject to a $122 million settlement under the False Claims Act stemming from allegations that the company billed for medically unnecessary behavioral health services, failed to provide treatment, and "pa[id] illegal inducements to federal healthcare beneficiaries."[48] The DOJ alleged that UHS induced patients to seek treatment at the site by providing free transportation, that patients admitted to the UHS facility did not require the level of intensive inpatient care offered, and that the facility did not provide the level of care it advertised.[49] These settlements resulted in a payment of over $117 million to the federal government and an additional $5 million to the federal government and the State of Georgia. Separately, UHS paid an almost $30 million omnibus settlement to resolve 18 cases across numerous jurisdictions.[50]

In 1999, in *Olmstead v. L.C.,* the Supreme Court determined that the segregation of people with disabilities outside the community constituted discrimination under the Americans with Disabilities Act (ADA).[51] In the case, two women with disabil-

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Challenges p. 2 (May 2008); *https://www.gao.gov/assets/gao-08-346.pdf; [https://perma.cc/J36R-69KB].*

[42] *Id.* at p. 12.

[43] U.S. Gov't. Accountability Off., *GAO–16–85, Foster Care: HHS Could Do More to Support States' Efforts to Keep Children in Family-Based Care* (Nov. 2015) *https://www.gao.gov/assets/gao-16-85.pdf; [https://perma.cc/4EEC-TB2G].*

[44] U.S. Gov't. Accountability Off., *GAO–22–104670, Child Welfare: HHS Should Facilitate Information Sharing Between States to Help Prevent and Address Maltreatment in Residential Facilities* (Feb. 2022) *https://www.gao.gov/assets/d22104670.pdf; [https://perma.cc/M6Y7-RDD7].*

[45] U.S. Dept. of Health and Human Servs., Off. of the Inspector Gen., *A–06–14–00029, Cedar Ridge did Not Always Provide the Required Treatment and Therapy Hours for Residential Treatment and Acute Care* at p. 4 (Apr. 2015) *https://oig.hhs.gov/documents/audit/8114/A-06-14-00029-Complete%20Report.pdf; [https://perma.cc/96GA-J7NQ];* Upon this finding, Cedar Ridge Treatment Center remediated and paid back the difference to the State agency.

[46] U.S. Dept. of Health and Human Servs., Off. of the Inspector Gen., *OEI–07–21–00300, Efforts To Improve Response to Reports of Abuse and Neglect of Children Living in Congregate Care Facilities in Six States* (2019) *https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000617.asp; [https://perma.cc/E67X-WNWU].*

[47] U.S. Dept. of Health and Human Servs., Off. of the Inspector Gen., *OEI–07–22–00530, States' Oversight of Residential Facilities To Protect Children From Maltreatment* (Nov. 2022) *https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000739.asp; [https://perma.cc/9EAF-LL5C].*

[48] U.S. Dept. of Just., *Press Release: Universal Health Services, Inc. and Related Entities To Pay $122 Million to Settle False Claims Act Allegations Relating to Medically Unnecessary Inpatient Behavioral Health Services and Illegal Kickbacks* (July 10, 2020) *https://www.justice.gov/opa/pr/universal-health-services-inc-and-related-entities-pay-122-million-settle-false-claims-act; [https://perma.cc/NQ25-QV2K].*

[49] *Id.*

[50] *Id.*

[51] *Olmstead v. L.C.,* 527 U.S. 581 (1999).

ities were admitted to a psychiatric hospital, even though community-based care would have been appropriate for them. The women successfully argued that their placement violated Title II of the ADA, which requires the indiscriminate provision of public services. This decision requires that people with disabilities must be provided treatment that is appropriate, consensual, and can be reasonably accommodated by the state.[52]

In Alabama, the DOJ found that the State's foster care system violated Title II of the ADA pursuant to *Olmstead* because PRTFs delivered substandard education to children with disabilities.[53] In Nevada, the DOJ concluded that there was "reasonable cause to believe that the State of Nevada violates Title II [of the ADA]" because of its practice of placing children in RTFs for long durations which could be avoided if the children received necessary, community-based services.[54] HHS Office of Civil Rights (OCR) investigates allegations of unlawful segregation of people with disabilities under *Olmstead.*

P&As are federally-designated non-profit legal aid organizations that advocate and monitor entities that provide care for people with disabilities in their state or territory of operation.[55] P&As are authorized to conduct unrestricted monitoring of congregate care facilities, like RTFs. Facilities are also required to report "serious incidents" to the relevant P&A. P&As are organized under the National Disability Rights Network (NDRN), a national organization that advocates on behalf of people with disabilities. In 2021, NDRN published a comprehensive indictment of the RTF industry called *Desperation Without Dignity,* highlighting abuse, neglect, and lack of care.[56]

When serious incidents occur at RTFs, facilities are required to report them to oversight actors, including the State Child Protective Services Agency (CPS). Depending on CPS' administrative finding as to whether abuse or neglect occurred, penalties and/or remediation may be required. Substantiation standards vary significantly across states. In particular, a review of state substantiation standards found wide variation in substantiation standards for child abuse and neglect.[57] Thus, even though the results of abuse and neglect investigations are often described as substantiated or unsubstantiated, these may represent dramatically different standards of proof.[58]

Facilities and individual actors at the facility or corporate level may be subject to criminal or civil proceedings for abuse, neglect, or other harms. In one case, a plaintiff was awarded more than $535 million in damages following a peer-to-peer sexual assault incident at Pavillion Behavioral Health System Facility (UHS; Illinois).[59]

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[52] HHS OCR, *Serving People with Disabilities in the Most Integrated Setting: Community Living and Olmstead* (May 13, 2024) *https://www.hhs.gov/civil-rights/for-individuals/special-topics/community-living-and-olmstead/index.html; [https://perma.cc/PC44-RDJ5].*

[53] U.S. Dept. of Just., *Justice Department Finds Alabama's Foster Care System Violates the Americans With Disabilities Act by Discriminating Against Students With Disabilities* (Oct. 12, 2022) *https://www.justice.gov/opa/pr/justice-department-finds-alabama-s-foster-care-system-violates-americans-disabilities-act; [https://perma.cc/5WGE-WYB2].*

[54] U.S. Dept. of Just., Civ. Rights Div., *Investigation of Nevada's Use of Institutions to Serve Children with Behavioral Health Disabilities* at p. 4 (Oct. 4, 2022) *https://www.justice.gov/media/1249731/dl; [https://perma.cc/5T3R-2G7K].*

[55] National Disability Rights Network, *P&A Programs—Overview* (Oct. 19, 2021) *https://www.ndrn.org/wp-content/uploads/2021/10/Protection-and-Advocacy-Programs-Overview.pdf; [https://perma.cc/7WBY-TJYC].*

[56] NRDN, *Desperation Without Dignity* (Oct. 2021) *https://www.ndrn.org/wp-content/uploads/2021/10/NDRN_Desperation_without_Dignity_Final.pdf; [https://perma.cc/MYY9-PLCT].*

[57] Nicholas Kahn, Josh Gupta-Kagan, Mary Eschelbach Hansen, *The Standard of Proof in the Substantiation of Child Abuse and Neglect* 14 J. EMPIRICAL LEGAL STUD. 333,6 (2017) *https://deliverypdf.ssrn.com/delivery.php?ID=334104065093094123020096077124101123039036077022086085028001092070094019120088110026035041039045052104054112125112065004118107102013037042081120074124113020075108034002005090099064064086094084012122112015087094102075087002107005030066024029110099116&EXT=pdf&INDEX=TRUE; [https://perma.cc/UZ3R-TRYH].*

[58] *See e.g.,* Arizona, DCS 09–05 PSRT Policy.

[59] Behavioral Health Business, *UHS Ordered to Pay $535M in Legal Case* (Apr. 1, 2024) *https://bhbusiness.com/2024/04/01/uhs-to-pay-535m-in-sexual-assault-suit/#:~:text=Pavilion%20Behavioral%20Health%20System%2C%20a,went%20to%20trial%20in%20March; [https://perma.cc/C5T2-UDCF].*

Similarly, Acadia was required to pay $405 million in damages to a child who was raped by a foster parent affiliated with the site.[60]

C. RTF Overview

a. Population Served and General Treatment Model

For the purposes of this investigation, RTFs include a variety of types of facilities as discussed above. Each of these types of facilities is intended to provide intensive, short-term inpatient therapeutic services to a diverse group of high-need youth. Congregate care placements are intended to be made on a temporary basis, on the recommendation of a psychiatrist, court, or family members, and are typically made for children who are a danger to themselves and/or others and cannot receive adequate care in outpatient, community-based settings. Children and their families, or the agency that places the child, expect that RTFs offer treatment by licensed, trained professionals to ameliorate children's behavioral health conditions. Ideally, following intensive residential treatment, children would be able to progress to lower acuity settings, like outpatient care in the community, and would only receive intensive residential treatment when all other options in the community have been exhausted. In some cases, though, child welfare agencies place children in state custody without diagnoses in RTFs because they have nowhere else to place them. In 2013, according to the Administration for Children and Families, 28.8 percent of children in congregate care had "No Clinical Indicators."[61]

As Vivant explained to the Committee, "the factors influencing treatment and discharge planning can often be more closely affiliated with permanency rather than clinical recommendations. For example, youth may be discharged from RTFs based on the sudden availability of a foster home or a court order from a judge rather than discharge resulting from completion of clinically assessed treatment goals."[62]

RTFs may advertise that they specialize in serving certain subpopulations and their programming may vary based on this specialization. Facilities may purport to provide mental and behavioral health care (*e.g.,* depression, suicidal ideation, anorexia nervosa, bulimia); SUD treatment; support for children with I/DD, treatment for children with sexually maladaptive behaviors (*e.g.,* a history of inappropriate touching or use of sexual body parts); other psychosocial functional challenges (*e.g.,* withdrawn, reclusive), or other psychiatric or psychological needs.

Regardless of the type of RTF, all children should receive individualized treatment plans with high-quality and frequent individual, group, and family therapy. Facilities should also coordinate medication and case management services. Further, because these are inpatient facilities, many children receive their educational services onsite pursuant to their level of academic achievement or functional performance. Facilities should also support family communication and/or visits and conduct rigorous discharge planning, so that children can sustain their therapeutic improvements following discharge.

b. Programs Operated by the Four Providers

The companies identified in this investigation offer a variety of different programs. Devereux serves children ages four to 22.[63] Across its programs, Devereux offers respite services, clinical services, vocational services, educational services, psychiatric and behavioral services and support, medical services, residential behavioral services and support, and emergency shelter.[64] The organization treats children with I/DD across the 12 specialized programs it operates in Florida, Georgia, Massachusetts, and New York.[65] Two of these programs are hyper-specialized, with Devereux caring for children who are non-verbal and have autism-spectrum disorder (ASD)—Cathy House Group Home and Devon House Group Home—both located in

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[60] Behavioral Health Business, *Acadia Healthcare Faces $405M Judgement in Civil Abuse Case* (July 12, 2023) *https://bhbusiness.com/2023/07/12/acadia-healthcare-faces-405m-judgement-in-civil-abuse-case/; [https://perma.cc/5WZN-7MSN].*

[61] U.S. Dept. of Health and Human Servs. Admin. for Children and Families, Children's Bureau, *A National Look at the Use of Congregate Care in Child Welfare* at p. II (May 13, 2015) *https://www.acf.hhs.gov/sites/default/files/documents/cb/cbcongregatecare_brief.pdf; [https://perma.cc/A2QW-J5DM].*

[62] Vivant, *Senate Inquiry Response* (Aug. 18, 2022) FINAL_ Vivant Senate Inquiry Response (08.18.2022) at p. 30.

[63] Devereux, *Facility Information—Question 1* (Oct. 17, 2022) DEV-S—000356 at 000356–000360.

[64] *Id.*

[65] *Id.*

Massachusetts.[66] Devereux also operates a shelter for "Unaccompanied alien children" in Texas for the Office of Refugee Resettlement (ORR).[67] In reference to its provision of PRTF services, Devereux leadership told Committee staff that the organization's "goal is to work ourselves out of a job."[68]

Acadia operates 10 RTFs that treat behavioral health needs. Standard services include group and individual therapy, medication management, case management, and therapeutic education.[69] Little Creek Behavioral Health (Acadia; Arkansas) specializes in care for deaf and hard of hearing children.[70] Acadia accepts SUD placements at YouthCare (Acadia; Utah) and accepts children exhibiting sexually maladaptive behaviors at Cove PREP (Acadia; Pennsylvania). All other RTFs serve children with depression, anxiety, bipolar disorder, impulse control disorders, attention-deficit/hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), post-traumatic stress disorder (PTSD), reactive attachment disorder, and non-suicidal self-harm.[71]

UHS accepts children with eating disorders, sexual or other trauma, sexually maladaptive behaviors, SUD, a history of trafficking, and I/DD.[72] In a list of UHS facilities provided to the Committee, a log of "specialty services provided" named three facilities: Hermitage Hall (UHS; Tennessee), Newport News Behavioral Health Center (UHS; Virginia), and North Star Behavioral Health System (UHS; Alaska), that offered both "sex offender treatment" and "sexual trauma" treatment.[73]

Vivant provides behavioral health services to children ages 12–20 in four facilities in Arizona, Iowa, and South Dakota.[74] Vivant offers specialized treatment tracks for behavioral health, problem sexual behavior, SUD, transitional services, and General Educational Development (GED) achievement/vocational training.[75] Vivant treats children with mood disorders, conduct disorders, trauma-related disorders, ODD, and SUD.[76] The vast majority of children (98%) in Vivant RTFs are treated in their home state.[77] In July 2022, when the Committee launched this investigation, Vivant operated 13 facilities across Arizona, Iowa, South Dakota, Florida, and Alabama. During the course of the investigation, Vivant divested from the nine facilities across Alabama and Florida. Vivant told the Committee that its decision to divest from its Florida facilities was made in part because it "had not received a high volume of referrals."[78]

In documents submitted to the Committee, Vivant detailed that half of its facilities rely on public dollars for more than 75 percent of their revenue; Devereux leadership told the Committee that 95 percent of its RTF revenue came from Medicaid

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[66] *Id.*

[67] *Id.* at 000360.

[68] Notes from Devereux Advanced Behavioral Health Briefing (May 21, 2024) (on file with Committee).

[69] *See:* Acadia, Acadiana Treatment Center, Disorders Treatment Overview: What Happens in a Mental Health Treatment Center? (accessed June 2,2024) *https://www.acadianatreatmentcenter.com/disorders/; [https://perma.cc/G9KP-5WVW];* Acadia, Resource Treatment Center, Programs Overview: Key Features of Our Residential Programming (accessed June 2,2024) *https://www.resourcetreatmentcenter.com/programs/; [https://perma.cc/8MNQ-3ZL5].*

[70] Acadia, Little Creek Behavioral Health, *Specialized Care for Youth Who Are Deaf or Hard of Hearing* (accessed June 2, 2024) *https://www.littlecreekbehavioral.com/; [https://perma.cc/K4GU-4W66].*

[71] Acadia, *Resource Treatment Center; Little Creek Behavioral Health; Piney Ridge Treatment Center; YouthCare; CovePREP; Village Behavioral Health; Acadiana Treatment Center; Millcreek Behavioral Health; Millcreek Magee; Millcreek Pontotoc; SUWS Carolinas* (Sep. 19, 2022) Request #1.

[72] UHS, *RTF Information Request: Programs* (May 26, 2023) UHS–FINHELP–0000001.

[73] *Id.; see* spread sheet tab two, "programs."

[74] Vivant, *Senate Inquiry Response* (Aug. 18, 2022) FINAL Vivant Senate Inquiry Response (08.18.2022) at p. 8; *Senate Inquiry Response* (Aug. 18, 2022) FINAL_Vivant Follow-Up Responses to the July 21 Letter executed (Oct. 27, 2023) at p. 1.

[75] Vivant, *Senate Inquiry Response* (Aug. 18,2022) FINAL_Vivant Senate Inquiry Response (08.18.2022) at p. 54.

[76] *Id.* at p. 8.

[77] *Id.*

[78] Vivant informed the Committees on October 27, 2023 that to realize its "long-term strategic plan, Vivant has made the business decision to divest from our RTFs in Alabama and Florida, with those RTFs continuing operation under new management." *See: Senate Inquiry Response* (Aug. 18, 2022) FINAL—Vivant Follow-Up Responses to the July 21 Letter executed (Oct. 27, 2023) at p. 1; Notes from Vivant Behavioral Health Briefing (May 22,2024) (on file with Committee).

dollars.[79] Stays in RTFs may be covered out-of-pocket or via private insurance for children placed by families or guardians. Private pay is often less reliable, and approvals are typically for a shorter treatment duration than for patients in Medicaid, so many providers focus on government placements. While children whose stays are covered by private and public funds often overlap in the same programs, including in facilities at-issue in this investigation, this report concerns placements financed by Medicaid and the child welfare system.

c. Lack of Evidence to Support the Efficacy of This Model for Populations Served

RTFs are costly, not as effective as community-based behavioral health treatment options, and often harmful to youth in their care. In 1999, a Surgeon General report found that "there is only weak evidence for [RTFs'] effectiveness," citing concerns such as "criteria for admission; inconsistency of community-based treatment established in the 1980s; the costliness of such services . . . the risks of treatment, including failure to learn behavior needed in the community; the possibility of trauma associated with the separation from the family; difficulty reentering the family or even abandonment . . . victimization by [RTF] staff; and learning of antisocial or bizarre behavior from intensive exposure to other [disabled] children."[80] This report also assessed justifications for residential commitment, such as the safety of the child and the community, as well as the treatment provisioned in RTFs. The Surgeon General noted that most of the evidence in support of RTFs relied on outdated studies (from the 1970s and 1980s) conducted with uncontrolled samples.[81] Further, when sustained improvements were identified, they depended in large part on the strength of community-based care post-discharge.[82] In one large study, conducted longitudinally across six states, it was found that 75 percent of children treated at the RTFs had been readmitted to an RTF or a carceral facility 7 years post-study.[83]

Studies show that home and community-based approaches produce better treatment outcomes than placing children in RTFs, and are more cost-effective than RTF placements.[84] In 2005, Congress directed CMS to conduct a demonstration project comparing behavioral health care provided in home and community-based settings with that provided in PRTFs. The demonstration showed that children who were provided care in the home and community-based settings maintained or improved their functional status, while proving cost-effective, with the participating states reporting an average savings of 68 percent.[85] Where RTFs are determined to be the best option to meet a child's acute needs, the best outcomes are achieved when family involvement is present, reintegration into the community is considered and

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[79] Vivant, *Senate Inquiry Response* (Aug. 18, 2022) FINAL_Vivant Submission of External Reviews (12.15.2023) at p. 4 (note: Vivant lists Public Federal Dollars as "Health coverage provided through Medicaid (including Medicaid Managed Care) and Children's Health Insurance Plan (CHIP) programs."); Devereux Leadership told the Committee that over 95 percent of its RTF revenue came from Medicaid; Notes from Devereux Advanced Behavioral Health Briefing (May 21, 2024) (on file with Committee).

[80] U.S. Dept. of Health and Human Servs. U.S. Public Health Service, *Mental Health: A Report of the Surgeon General* at p. 170 (1999) *https://digirepo.nlm.nih.gov/ext/document/101584932X120/PDF/101584932X120.pdf; [https://perma.cc/UF5Q-T2KP].*

[81] *Id.* at p. 170–171 noting Council for Exceptional Children, *Project Re-Ed Schools for Emotionally Disturbed Children: Effectiveness as Viewed by Referring Agencies, Parents, and Teachers* at p. 703–711 (May 1969) *https://doi.org/10.1177/001440296903500904;* [permalink unavailable]; American Journal of Orthopsychiatry, *The parent-therapist program: Alternate care for emotionally disturbed children* at p. 654–662 (1978) *https://doi.org/10.1111/j.1939-0025.1978.tb02570.x; [https://perma.cc/3NTV-WYGP].*

[82] U.S. Dept. of Health and Human Servs. U.S. Public Health Service, *Mental Health: A Report of the Surgeon General* at p. 170–171 (1999) *https://digirepo.nlm.nih.gov/ext/document/101584932X120/PDF/101584932X120.pdf; [https://perma.cc/UF5Q-T2KP].*

[83] *Id.* at p. 171.

[84] Science Direct, *A systematic review of the effectiveness of children's behavioral health interventions in psychiatric residential treatment facilities* at p. 1 (June 2020) *https://www.sciencedirect.com/science/article/pii/S019074091931326X?via%3Dihub; [https://perma.cc/5UAM-7A47].*

[85] CMS, *Alternatives to Psychiatric Residential Treatment Facilities Demonstration (summary)* (July 2013) *https://www.medicaid.gov/medicaid/long-term-services-supports/alternatives-psychiatric-residential-treatment-facilities; [https://perma.cc/DCZ9-CGDK];* HHS Office of the Secretary, *Report to the President and Congress Medicaid Home and Community-Based Alternatives to Psychiatric Residential Treatment Facilities Demonstration* (July 2013) *https://www.medicaid.gov/sites/default/files/2019-12/prtf-demo-report.pdf; [https://perma.cc/AAF9-M7U9].*

planned for, and where treatment is time-limited.[86] Further, the longer an RTF stay, the longer a child is at-risk of exposure to harms, including the use of restraints and seclusion, physical and sexual abuse, insufficient education, and substandard living conditions. This risk is heightened for children of color, LGBTQIA+ youth, and children with I/DD who are most likely to live in these settings.[87] Any trauma experienced by children in RTFs, in addition to any life experiences a child had prior to entering a facility, will continue to impact them in adulthood.

The Surgeon General's report concluded that "[g]iven the limitations of current research, it is premature to endorse the effectiveness of residential treatment for adolescents."[88] Nevertheless, the model persists.[89] According to the most recent data from the Centers for Disease Control and Prevention, there are 30,600 residential care communities in the US with a total of 1,197,600 licensed beds across the country. 81.9 percent of these facilities have for-profit ownership.[90]

d. The Business of RTFs

RTF industry leaders have an incentive to prioritize operating and profit margins over care, creating the conditions in which the children who are remanded to institutions leave worse off than when they arrived. RTFs receive per diem payments to care for the children in their custody, which creates the perverse incentive to minimize services and costs in order to maximize margins. In multiple cases, provider leadership have explicitly stated their profit-making formula—cut staffing and increase admissions.[91] The following section introduces each of the providers at-issue in this investigation.

Vivant, founded in 2021 by John "Jay" Ripley, is a private, for-profit company which does not have any public-facing corporate presence.[92] Vivant was Ripley's third foray into the youth behavioral health industry, having previously co-founded the private, for-profit RTF provider Sequel Youth and Family Services (Sequel) in 1999, and Youth Services International (YSI) before that. Youth Services International operated a facility in Iowa, which later became the first facility acquired by Sequel after the latter company was founded. In 2017, Ripley sold a majority stake in Sequel to Altamont Capital. Ripley is also the former CEO of Precision Tune Auto Care and co-founder of BGR The Burger Joint.[93]

According to public reporting, after being plagued by media and legal attention following years of abuse and neglect allegations, in 2021, Sequel closed half of its RTFs and sold the remaining facilities to other operators, including selling 13 facilities to

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[86] Magellan Health Services, *Perspectives on Residential and Community-Based Treatment for Youth and Families* at p. 11 (2008) *https://alphacarecms.magellanhealth.com/media/445489/innovativeapproach2.pdf; [https://perma.cc/3R8A-KHSL].*

[87] Children's Rights, *The Harms of Institutionalization* (Jan. 2023) *https://www.childrensrights.org/wp-content/uploads/2023/01/The-Harms-of-Institutionalization-2023-Fact-Sheet.pd; [https://perma.cc/NG4S-QTUS];* Children's Rights, *Families Over Facilities: Ending the Use of Harmful and Unnecessary Institutions and Other Group Facilities in Child Welfare Systems* (Mar. 2, 2021) *https://www.childrensrights.org/wp-content/uploads/imported-files/CR-Families-Over-Facilities-Report.pdf; [https://perma.cc/897G-2WED].*

[88] U.S. Dept. of Health and Human Servs. U.S. Public Health Service, *Mental Health: A Report of the Surgeon General* at p. 170 (1999) *https://ia903202.us.archive.org/12/items/mentalhealthrepo00unit/mentalhealthrepo00unit.pdf; [https://perma.cc/MY9J-434K].*

[89] Taylor & Francis Online, *Implementing Evidence-Based Practice in Residential Care—How Far Have We Come?* (Aug. 9, 2017) *https://doi.org/10.1080/0886571X.2017.1332330; [permalink unavailable].*

[90] CDC, *Residential Care Communities* (Accessed May 15, 2024) *https://www.cdc.gov/nchs/fastats/residential-care-communities.htm; [https://perma.cc/PDD2-4FBN].*

[91] University of Baltimore, *Video Interview at Merrick School of Business with Jay Ripley* (Oct. 2015) (on file with the Committee); Buzzfeed News, *"What the Fuck Just Happened?"* (Dec. 7, 2016) *https://www.buzzfeednews.com/article/rosalindadams/intake; [https://perma.cc/S9CG-TYGQ].*

[92] APM Reports, *Under Scrutiny, Company that Claimed to Help Troubled Youth Closes Many Operations and Sells Others* (Apr. 26, 2022) *https://www.apmreports.org/story/2022/04/26/sequel-closes-sells-youth-treatment-centers; [https://perma.cc/95MN-TXB5];* Vivant leadership confirmed there was no public facing presence for the company, Notes from Vivant Behavioral Health Briefing (May 22, 2024) (on file with Committee).

[93] APM Reports, *Under Scrutiny, Company that Claimed to Help Troubled Youth Closes Many Operations and Sells Others* (Apr. 26, 2022) *https://www.apmreports.org/story/2022/04/26/sequel-closes-sells-youth-treatment-centers; [https://perma.cc/95MN-TXB5];* University of Baltimore, *"Entrepreneurship is Fun!" with Serial Entrepreneur Jay Ripley,* Oct. 1 (Oct. 1, 2015) *https://www.ubalt.edu/news/news-releases.cfm?id=2321; [https://perma.cc/9GKC-XCF6].*

Vivant,[94] meaning Ripley ultimately repurchased several RTFs his company had sold to private equity four years earlier. Vivant leadership told the Committee that the capitalization of Vivant was entirely private and that Ripley used his own capital.[95] Public reporting has alleged that this move to private ownership has allowed providers to escape liability for serious allegations, including the death of a Sequel patient in 2020.[96] Multiple former Sequel executives and staff joined Ripley at Vivant in leadership roles.[97] Vivant and Sequel's facility footprints initially overlapped significantly, and the two companies share leadership and staff, raising questions about whether Vivant is a new, wholly distinct entity.

In an illustrative 2015 interview at the University of Baltimore's Merrick School of Business, Ripley, co-founder and then-principal owner and chairman of Sequel, described his introduction to the RTF industry and his standard operating procedure.[98] Ripley recognized a demand for behavioral health services (at the time, a $135-billion dollar industry) and opened a series of RTFs under YSI. Ripley eventually sold his ownership stake in that company to co-found Sequel, through which he operated many of the same facilities as YSI.[99] When asked how Ripley is able to "create demand," he explained his services "represent a privatization alternative to [behavioral health] programs," and that the company "focus[es] mainly on the public pay side."[100]

Ripley went on to explain that there is precarity in relying solely on private pay placements because parents may be unable to afford programs for their children during economic downturns. Thus, Sequel sought children who are already system-involved or those with public benefits for whom the government will cover the placement cost.[101] Ripley likened the demand for his facilities to "drinking from a firehouse."[102] When asked how his company is able to turn a profit, Ripley said that Sequel is able to get "good margins out of the per diems" states pay for placements. He shared his secret for how to accomplish this: "you can make money in this business if you control staffing."[103] By keeping staffing margins low and placements high, Ripley's RTF business—in all its iterations—is able to profit. As of 2015, Sequel had an operating profit in the $30-million to $32-million range, with revenues of $210-million to $230-million. Sixty-two percent of revenue was spent on staffing, a cost Ripley is mindful of—"you can't have too much staffing to eat that profit."[104] As documented in *Desperation Without Dignity,* cutting corners on staffing and intensive care models results in failures to treat children with evidence-based models.[105]

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[94] APM Reports, *Under Scrutiny, Company that Claimed to Help Troubled Youth Closes Many Operations and Sells Others* (Apr. 26, 2022) *https://www.apmreports.org/story/2022/04/26/sequel-closes-sells-youth-treatment-centers; [https://perma.cc/95MN-TXB5].*

[95] Notes from Vivant Behavioral Health Briefing (May 22, 2024) (on file with Committee).

[96] APM Reports, *Under Scrutiny, Company that Claimed to Help Troubled Youth Closes Many Operations and Sells Others* (Apr. 26, 2022) *https://www.apmreports.org/story/2022/04/26/sequel-closes-sells-youth-treatment-centers; [https://perma.cc/95MN-TXB5];* WBNS, *Sequel Pomegranate closes as advocates, Paris Hilton call for change in "troubled teen industry"* (Oct. 21, 2021) *https://www.10tv.com/article/news/investigations/10-investigates/sequel-pomegranate-closes-advocates-paris-hilton-call-change-troubled-teen-industry/530-540a17cc-22fb-42e7-9227-0d529507b04c; [https://perma.cc/C8SH-UMQM].*

[97] The Committee is in possession of permanent records of multiple LinkedIn profiles that support this claim. According to their LinkedIn profiles, the current Senior Vice President, Strategy & Development at Vivant, worked at Sequel between Dec. 2014 and Sep. 2021, and was the Director of Business Development at Sequel between Sep. 2019 and Sep. 2021; the current Chief Clinical Officer for Vivant, worked at Sequel between Nov. 2019 and Nov. 2021, where they were Lead Clinical Director and later Chief Clinical Officer; a current President at Vivant, worked at Sequel between Nov. 2019 and Sep. 2021 as the Vice President of Operations; all of these profiles indicated the aforementioned individuals joined Vivant in Oct. 2021; APM Reports, *Under scrutiny, company that claimed to help troubled youth closes many operations and sells others* (Apr. 26, 2022); *https://www.apmreports.org/story/2022/04/26/sequel-closes-sells-youth-treatment-centers; [https://perma.cc/95MN-TXB5].*

[98] University of Baltimore, *Video Interview at Merrick School of Business with Jay Ripley* (Oct. 2015) (on file with the Committee).

[99] *Id.* at 10:48.

[100] *Id.* at 10:45–11:52.

[101] *Id.* at 12:14.

[102] *Id.* at 13:05.

[103] *Id.* at 13:41.

[104] *Id.* at 13:48–14:21.

[105] NDRN, *Desperation Without Dignity* at p. 8 (Oct. 2021) *https://www.ndrn.org/wp-content/uploads/2021/10/NDRN_Desperation_without_Dignity_Final.pdf; [https://perma.cc/MYY9-PLCT].*

UHS, headquartered in King of Prussia, Pennsylvania, is a publicly listed holding company of for-profit hospitals and behavioral health care facilities.[106] The company's ticker is the same as the abbreviation—UHS. In 2023, Marc Miller, UHS CEO, received total compensation of nearly $14.5 million.[107] For the year ending December 31, 2023, Medicaid accounted for 27 percent of UHS' total revenue. For the same year, Medicaid represented 39 percent of UHS' revenue in the Behavioral Health category.[108] In 2023, UHS' Behavioral Health segment generated $6.2 billion in total net revenue, comprising roughly 43 percent of the company's total net revenue.[109] In 2023 and 2024 earnings calls, UHS discussed the impact that Medicaid redeterminations have had on the bottom line of their child and adolescent business, including RTFs.[110] In these calls, UHS highlighted its reliance on Medicaid as an important revenue stream.[111] In an October 2023 earnings call, the UHS CFO said, "broadly increasing occupancy [of our behavioral business] is the most significant opportunity we see."[112] Today, UHS is valued at roughly $11.8 billion.[113]

Acadia, headquartered in Franklin, Tennessee, is a publicly-traded chain of for-profit psychiatric and behavioral healthcare facilities.[114] The company's ticker is ACHC. In 2023 Christopher Hunter, Acadia's CEO, received total compensation of nearly $7.5 million.[115] For the year ending December 31, 2023, 53.9 percent of Acadia's revenue came from Medicaid. This was an increase of 3.3 percentage points from 2022 (50.6 percent), or almost seven percent year-over-year growth. 2022 also represented an increase in the percentage of total revenue from Medicaid from the

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[106] UHS, *About* (Accessed, Mar. 28, 2024) *https://uhs.com/about-universal-health-services/; [https://perma.cc/VQ4R-RJQT];* UHS, *Corporate Information* (accessed Mar. 28, 2024) *https://uhs.com/about-universal-health-services/corporate-information/; [https://perma.cc/32B8-XFYL].* The facilities are operated at the subsidiary level.

[107] In 2023, according to a summary compensation table, UHS' CEO had total compensation of $14,407,937 including $78,003 change in pension value and nonqualified deferred compensation earnings; SEC, *2024 Proxy Statement Pursuant to Section 14(a) of the Securities Exchange Act of 1934 (Schedule 14A): Universal Health Services, Inc.* at p. 47 (2024) *https://www.sec.gov/Archives/edgar/data/352915/000119312524086555/d631163ddef14a.htm#TXA631163_96; [https://perma.cc/ZUD8-D8XS].*

[108] SEC, *Fiscal Year 2023 Annual Report Pursuant to Section 13 or 159d0 of the Securities Exchange Act of 1934 (Form 10-K): Universal Health Services, Inc.* at p. 124 (2023); note: UHS disaggregates Medicaid and Managed Medicaid in its 10–K,but the above figure combines the two; *https://www.sec.gov/Archives/edgar/data/352915/000095017024021175/uhs-20231231.htm; [https://perma.cc/DRF3-5MT8].*

[109] *Id. note:* UHS also provided Behavioral Health Care Services-Same Facility Basis in its 10–K.

[110] Behavioral Health Business, *Increasing Occupancy is "Significant" Opportunity for UHS' Behavioral Health Business* (Oct. 26, 2023) *https://bhbusiness.com/2023/10/26/increasing-occupancy-is-significant-opportunity-for-uhss-behavioral-health-business/; [https://perma.cc/4W77-FUEQ];* Behavioral Health Business, *Medicaid Redeterminations Sunk UHS' Child, Teen Behavioral Offerings in 2023* (Feb. 29, 2024) *https://bhbusiness.com/2024/02/29/medicaid-redeterminations-sunk-uhs-child-teen-behavioral-offerings-in-2023/; [https://perma.cc/5MFL-3ADR].*

[111] Behavioral Health Business, *Increasing Occupancy is "Significant" Opportunity for UHS' Behavioral Health Business* (Oct. 26, 2023) *https://bhbusiness.com/2023/10/26/increasing-occupancy-is-significant-opportunity-for-uhss-behavioral-health-business/; [https://perma.cc/4W77-FUEQ];* Behavioral Health Business, *Medicaid Redeterminations Sunk UHS' Child, Teen Behavioral Offerings in 2023* (Feb. 29, 2024) *https://bhbusiness.com/2024/02/29/medicaid-redeterminations-sunk-uhs-child-teen-behavioral-offerings-in-2023/; [https://perma.cc/5MFL-3ADR].*

[112] Behavioral Health Business, *Increasing Occupancy is "Significant" Opportunity for UHS' Behavioral Health Business* (Oct. 26, 2023) *https://bhbusiness.com/2023/10/26/increasing-occupancy-is-significant-opportunity-for-uhss-behavioral-health-business/; [https://perma.cc/4W77-FUEQ].*

[113] Yahoo Finance, *Market Cap for Universal Health Services, Inc.* (UHS) (May 9, 2024) *https://ca.finance.yahoo.com/quote/UHS/; [https://perma.cc/W2F3-JWGL].*

[114] Acadia Healthcare, *About* (accessed Mar. 28, 2024) *https://www.acadiahealthcare.com/about/; [https://perma.cc/3C97-3KMX];* Acadia, *Investors* (accessed June 2, 2024) *https://www.acadiahealthcare.com/investors/;[https://perma.cc/WR5P-LKUD].*

[115] In 2023, according to a summary compensation table, the Acadia CEO had total compensation of $7,404,606; SEC, *2024 Proxy Statement Pursuant to Section 14(a) of the Securities Exchange Act of 1934 (Schedule 14A): Acadia Healthcare Company, Inc.* at p. 41 *https://www.sec.gov/Archives/edgar/data/1520697/000114036124018895/ny20018997x2_def14a.htm#a012; [https://perma.cc/235W-KSSC].*

prior year (49.6 percent in 2021).[116] Today, the company is valued at roughly $6.5 billion.[117]

Acadia has made no secret of its interest in expansion. In an October 2021 earnings call, then-Acadia CEO Debbie Osteen talked of the business opportunities presented by the reduction of stigma surrounding mental health needs.[118] During Acadia's investor day in December 2022, the company announced its plan to double revenue and nearly double profits by the end of 2028, in part by increasing beds by as many as 1,000 or more each year.[119] During a 2023 Wells Fargo Healthcare Conference the Acadia CEO discussed the company's appetite for mergers and acquisitions (M&A): "[w]e're bullish on M&A . . . [o]ur balance sheet is very strong. I think we are the desired partner of choice."[120] Acadia is the only provider that told Committee staff it is actively expanding its RTF business.[121] Since 2012, the company has added 800 beds across its ten facilities.[122] Acadia leadership told Committee staff that they have invested $100 million in quality and technology services, with a new quality team dedicating 100 percent of their time to on-the-ground technical assistance.[123] One technological advancement that Acadia highlighted implementing at RTFs is an "Apple watch-sized item" for monitoring.[124]

Devereux, headquartered in Villanova, Pennsylvania, is a non-profit company with a network of behavioral healthcare facilities.[125] Devereux has a supporting not-for-profit organization, called The Helena Devereux Foundation, that holds and invests assets on its behalf.[126] In 2021, Carl E. Clark, President and CEO of Devereux, received around $800,000 in reportable compensation and estimated other compensation.[127] As of October 2023, according to *Fitch,* "the organization's revenues are highly concentrated with governmental payors" with Devereux receiving half of its total revenue from Medicaid.[128] As of the organization's most recent IRS filing, the organization's total revenue is more than $500 million.[129]

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[116] SEC, *Fiscal Year 2023 Annual Report Pursuant to Section 13 or 159d0 of the Securities Exchange Act of 1934 (Form 10–K): Acadia Healthcare Company, Inc.* at p. 45 (2023) *https://www.sec.gov/Archives/edgar/data/1520697/000095017024022057/achc-20231231.htm; [https://perma.cc/J8CW-45X9].*

[117] Yahoo, *Market Cap for Acadia Healthcare Company, Inc.* (ACHC) (May 9, 2024) *https://finance.yahoo.com/quote/ACHC/?guccounter=1&guce_referrer=aHR0cHM6Ly93d3cuZ29vZ2xlLmNvbS8&guce_referrer_sig=AQAAAILsBTvvFi2oiiqzsLawlmX9DkcwQP-EXoGjRgh4WBE-emzFwGbvx3jahgR2eg_zk3yUjNq9GtsFUsNOcD-_Km5SK6eOrE2grZrVzbCgknpip30TbrRUc-lfC9a6qjdVx2TNpuhF0j5OWWCvQp_DF9mbznj6eYkbqq6TWFWdfWEL.*

[118] Motley Fool, *Acadia Healthcare Company, Inc. (ACHC) Q3 2021 Earnings Call Transcript* (Oct. 29, 2021) *https://www.fool.com/earnings/call-transcripts/2021/10/29/acadia-healthcare-company-inc-achc-q3-2021-earning/; [https://perma.cc/6HB8-2LC3];* Behavioral Health Business, *Acadia Healthcare Sees Opportunity to Consolidate a "Very Fragmented" Behavioral Health Market* (Oct. 29, 2021) *https://bhbusiness.com/2021/10/29/acadia-healthcare-sees-opportunity-to-consolidate-a-very-fragmented-behavioral-health-market/;[https://perma.cc/4H94-PRDL].*

[119] Behavioral Health Business, *How Acadia Healthcare Plans to Double Revenue by 2028* (Dec. 7, 2022) *https://bhbusiness.com/2022/12/07/heres-how-acadia-healthcare-plans-to-double-revenue-by-2028/; [https://perma.cc/KQ6H-CNHL].*

[120] Behavioral Health Business, *Acadia CEO Breaks Down Future Expansion Opportunities* (Sep. 6, 2023) *https://bhbusiness.com/2023/09/06/acadia-ceo-breaks-down-future-expansion-opportunities/; [https://perma.cc/JGE7-JBG5].*

[121] Notes from Acadia Healthcare Briefing (May 17, 2024) (on file with Committee).

[122] *Id.*

[123] *Id.*

[124] *Id.*

[125] Devereux Advanced Behavioral Health, *About* (accessed Mar. 28, 2024) *https://www.devereux.org/site/SPageServer/;jsessionid=00000000.app20118b?NONCE_TOKEN=A5B7AA986524AD5DA25495E6522A332F&pagename=about#:~:text=Founded%20in%201912%20by%20special,and%20their%20families%20%E2%80%93%20every%20year; [https://perma.cc/4V4H-8NH6].*

[126] IRS, *Tax Year 2021 Return of Organization Exempt from Income Tax (Form 990): Devereux Foundation* (2021) *https://apps.irs.gov/pub/epostcard/cor/231390618~202206~990~20230606213841 70.pdf; [https://perma.cc/RGP8-SHUT];* Devereux, *The Helena Devereux Foundation Tax Year 2022 990* (2021) *https://apps.irs.gov/pub/epostcard/cor/300034707~202206~990~20230606213841 43.pdf; [https://perma.cc/QEG5-QC3B].*

[127] IRS, *Tax Year 2021 Return of Organization Exempt from Income Tax (Form 990): Devereux Foundation* (2021) *https://apps.irs.gov/pub/epostcard/cor/231390618_202206_990_20230606213841 70.pdf; [https://perma.cc/RGP8-SHUT].*

[128] Fitch Ratings, *Fitch Affirms Devereux Corporation (PA) Revs at "A-"* (Oct.17, 2023) *https://www.fitchratings.com/research/us-public-finance/fitch-affirms-devereux-corporation-pa-revs-at-a-outlook-stable-17-10-2023; [https://perma.cc/Z292-WDE8].*

[129] IRS, *Tax Year 2021 Return of Organization Exempt from Income Tax (Form 990): Devereux Foundation* (2021) *https://apps.irs.gov/pub/epostcard/cor/231390618_202206_990_20230606213841 70.pdf; [https://perma.cc/RGP8-SHUT].*

RTFs continue to be good business, but there is no evidence that these investments translate to better outcomes for the children in their custody. In one relevant provider case study, Acadia on multiple occasions has invested in the expansion of individual RTFs with questionable improvement in outcomes. According to public reports, in May 2015, Acadia announced that it was expanding its Acadia Montana Treatment Facility (Acadia; Montana). The CEO of the facility said, "[t]his will be our second expansion so again our commitment is to service kids in Montana and our parent corporation Acadia has made that commitment to us to continue to service these kids."[130] But, just 4 years later, Acadia Montana Treatment Facility (Acadia; Montana) closed following reports of a 9-year-old from Oregon being chemically restrained with Benadryl and frequently held in a locked seclusion room.[131] In 2014, Desert Hills (Acadia; New Mexico) reportedly underwent a $20 million expansion, including increasing bed capacity and upgrading the classroom.[132] Desert Hills (Acadia; New Mexico) closed in 2019 after lawsuits alleging physical and sexual abuse and the rampant spread of HIV amongst children.[133] Acadia leadership highlighted their current renovation of Piney Ridge Treatment Center (Acadia; Arkansas) in conversation with Committee staff.[134]

D. Report Focus, Limitations, and Next Steps

This report considers the particular situation of youth at RTFs that receive significant funding from programs within the Committee's jurisdiction. The Committee relied upon company production dating back to 2017, supplemented by public reporting and legal proceedings dating back to approximately the same time. Based upon company productions and the other sources the Committee drew on, the report identifies the array of harms children experience at RTFs and supports each observation with a non-exhaustive, reflective selection of incidents. However, the following report cannot capture every harm suffered by children in RTFs. Many incidents go unreported, are settled privately, or remain sealed. Additionally, the company productions received by the Committee do not include materials related to every facility held by each provider, nor do they represent every incident at the facilities there in named. UHS, for example, produced incident reporting for only 25 of its 59 facilities, as agreed to with the Committee.[135] Further, the Committee surveyed only four providers within a large industry. This report is one piece of a larger, ongoing effort to shed light on the experiences of children in congregate care and seeks to unearth the injustice produced by the lack of service provision in RTFs for children with complex behavioral health conditions. It is the Committee's hope that the evidence presented here can move all readers to action and to tell the stories we haven't.

III. Investigative Findings

A. Many Children in RTFs Are Suffering Abuse During Interactions with Both Staff and Other Youth.

The structure of the RTF model, including financial incentives of the industry to provide as little care as possible, and the vulnerabilities of the children in the care of these facilities, creates conditions which facilitate abuse. The risk of harm looms across the industry. This includes abusive interactions (emotional, verbal, physical, and sexual) by staff and other youth as well as harmful treatment practices, like seclusion and restraint. Children everywhere, and especially those in a medical environment intended to treat complex behavioral health needs, should live free from abuse.

a. Children Are at Risk of Sexual Abuse While at RTFs

Documented instances of sexual abuse against children at RTFs are alarming. When asked how to make facilities better, one survivor responded, "I think the number

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[130] NonStopLocal, *Children's Psychiatric Residential Facility Expands* (Mar. 25, 2015) *https://www.montanarightnow.com/news/childrens-psychiatric-residential-facility-expands/article—403e943f-33e8-54aa-ad1c-680a6f1a26c6.html; [https://perma.cc/HW9R-ULV9].*

[131] AP, *Montana facility closing after chemical restraint flap* (June 18, 2019) *https://apnews.com/general-news-dc4eb3b147d04af3b87c30e6; [https://perma.cc/J9ZM-W27A].*

[132] AP via WBBJ, A*lbuquerque center for troubled youth expanding* (Sep. 29, 2014) *https://www.wbbjtv.com/2014/09/29/albuquerque-center-for-troubled-youth-expanding/; [https://perma.cc/7KRJ-7G57].*

[133] Nashville Post, *Acadia facility closes amid abuse allegations* (Apr. 5, 2019) *https://www.nashvillepost.com/acadia-facility-closes-amid-abuse-allegations/article—707ab44b-adbf-5af8-bf6a-5b48ac61127d.html; [https://perma.cc/XH3C-VZTG].*

[134] Notes from Acadia Healthcare Briefing (May 17, 2024) (on file with Committee).

[135] In correspondence to the Committee (June 5, 2024) (on file with Committee) UHS wrote that it "agreed to prioritize producing documentation for 25 facilities selected by the Committee." However, UHS never produced reporting for the outstanding 34 facilities.

one thing I would change is the amount of sexual assault that happens. . . . In residential facilities, staff are molesting female residents."[136] Another survivor lamented that the children who were treated well were the youth "that were probably sexually abused. . . . The owner [of the facility] ended up getting arrested for rape charges, and two staff got arrested for abuse charges."[137]

The removal of children from their communities to a remote treatment location can create an environment prone to pervasive sexual abuse. While each of the providers investigated has policies and procedures in place to prevent sexual abuse, those practices vary in scope and execution. Further, given a patient population of vulnerable children, RTFs have the potential to attract predatory staff. Leadership at one RTF provider raised this concern to Committee staff—they explained that adults who want to abuse children will find a way to work in the child service industry, in spite of provider hiring screenings.[138] The prevalence of sexual abuse at RTFs undermines their ability to effectively treat children.

i. Staff-on-Youth

Copious evidence from both Committee review and public reporting support the heartbreaking reality of pervasive sexual abuse by staff in these facilities. To quote Devereux Senior Vice President and Chief Strategy Officer Leah Yaw in a *Philadelphia Inquirer* article, pervasive sexual abuse "is an industry-wide problem. . . . From Devereux's perspective we are taking this on."[139]

Public Reporting

Investigative reporters have long highlighted endemic sexual abuse at facilities. An examination of Utah RTF facilities by *The Salt Lake Tribune* explained that larger facilities—similar to those at the center of the Committee's investigation—tend to have "the most out-of-state contracts. And often they have more claims of sexual abuse and violence than Utah's average treatment center."[140] According to the article, Provo Canyon School (UHS; Utah) and Copper Hills (UHS; Utah) have called police to investigate sex crimes at a rate that was over four times higher and 1.6 times higher than the average across facilities in Utah, respectively.[141] Police were called 29 times over 4 years to Provo Canyon School (UHS; Utah) and 21 times over 5½ years to Copper Hills (UHS; Utah).[142]

Sexual abuse at Lighthouse Care Center of Augusta (UHS; Georgia). Lighthouse Care Center of Augusta (UHS; Georgia) operates the same model as other facilities investigated by the Committee and is a clear example of how risk of sexual abuse is endemic to the RTF model. In 2017, a Lighthouse Care Center of Augusta (UHS; Georgia) staffer was arrested and ultimately convicted for child molestation and other charges.[143] The staffer allegedly fondled a child's "breasts, suck[ed] on her nipples, and reach[ed] down inside her pants and digitally penetrat[ed] her vagina [. . . and] performed oral sex on her."[144] The staffer also showed a second child "photos on his phone of a woman masturbating and of himself holding his exposed erect penis."[145] The lawsuit detailed that, "one or both of these female residents [to whom the child disclosed abuse] also disclosed or indicated personal experiences of

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[136] Think of Us, *Away From Home: Youth Experiences of Institutional Placements in Foster Care* at p. 41 (July 2021) *https://assets.website-files.com/60a6942819ce8053cefd0947/60f6b1eba4743625140 93f96_Away%20From%20Home%20-%20Report.pdf; [https://perma.cc/VS6R-ZXYL].*

[137] *Id.*

[138] Notes from Devereux Advanced Behavioral Health (May 21, 2024) (on file with Committee).

[139] Philadelphia Inquirer, *Kids in Need, Preyed Upon At Devereux, the nation's leading behavioral health nonprofit for youth, staff abused children in their care for years, while red flags were dismissed* (Aug. 11, 2020) *https://www.inquirer.com/news/inq/devereux-advanced-behavioral-health-abuse-children-pennsylvania-20200811.html.*

[140] The Salt Lake Tribune, *Inside Utah's troubled teen industry: How it started, why kids are sent here and what happens to them* (Aug. 30, 2020) *https://www.sltrib.com/news/2020/08/30/inside-utahs-troubled/; [https://perma.cc/9WYW-46UC].*

[141] *Id.*

[142] *Id.*

[143] The Augusta Chronicle, *Former Augusta children's hospital employee convicted of child molestation, sentenced* (Dec. 15,2021) *https://www.augustachronicle.com/story/news/2021/12/15/augusta-ga-children-mental-health-facility-child-molestation-timothy-carroll/8907012002/; [https://perma.cc/HK37-ES97].*

[144] Compl. at ¶ 13, *Jane Doe v. Lighthouse Care Center,* Sup. Ct. of Richmond Cnty. State of VA. (July 18, 2020) FILE NO. 2018RCCV00390, *https://hermanlaw.com/wp-content/uploads/2018/07/Lighthouse-complaint.pdf;* [permalink Unavailable].

[145] *Id.* at ¶ 10.

sexual misconduct by the staffer."[146] Two years later, *The Augusta Chronicle* reported two staffers at Lighthouse (UHS; Georgia) both pled guilty to sex crimes and were each sentenced to ten years in prison. Reporting included "video footage show[ing] of the encounter between [the staffer] and the juvenile . . . [with the child performing] oral sex on [the staffer]."[147] Another staffer was accused of taking "a teen girl to his home and [having] sex with her."[148] The two men received 10-year prison sentences.[149]

Public reporting of Devereux facilities in Pennsylvania, Florida, and Georgia, include an investigation detailing more than 40 instances of rape and sexual assault. A 2020 *Philadelphia Inquirer* investigation uncovered widespread sexual violence at Devereux facilities, finding more than 40 children were raped or sexually assaulted over 25 years at Devereux facilities.[150] As reported, a staffer sexually abused a 16-year-old with autism and other developmental disabilities for months at Devereux Brandywine (Devereux; Pennsylvania) utilizing a closet for his abuse because it was not visible from the hallway.[151] The child reportedly came forward only when the staffer began assaulting yet another boy who the child viewed as a brother.[152] At Devereux Mapleton (Devereux; Pennsylvania), a staff member was found to have engaged in institutional sexual assault, unlawful contact with a minor, sexual abuse of children and corruption of minors based on a sexual relationship with a resident in the facility's care.[153] The staffer supplied the child with a cell phone, so they could send each other texts, sexts, and naked photographs.[154] While the child was on therapeutic leave, the staffer reportedly "took her shopping, buying her clothes and sneakers. He then drove the girl to an alley and sexually assaulted her in his car."[155]

In July 2022, a staffer at Devereux Titusville (Devereux; Florida) was arrested on allegations he sexually abused, groomed, and solicited naked photographs from a child in his care.[156] According to *Florida Today* reporting, the child told investigators that "[the staffer] had been molesting him since his arrival at Devereux"[157] on a daily basis. Investigators found "photos and videos from the boy to [the staffer]."[158] The staffer reportedly threatened the boy and said that, if the child failed to send photographs, the staffer would "get other residents to fight him or not allow the boy to have extra food."[159] According to *WXIA* reporting, a staff member at Devereux Advanced Behavioral Health Georgia (Devereux; Georgia) was arrested for possession of child pornography, and further admitted to federal agents that he was "grooming two 16-year-old males at Devereaux [sic] [(Devereux; Georgia)] for the

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[146] *Id.* at ¶ 16.

[147] The August Chronicle, *Lighthouse Care Center staffer charged with sexual assault against person in custody* (Apr. 21, 2017) *https://www.augustachronicle.com/story/news/2017/04/21/lighthouse-care-center-staffer-charged-sexual-assault-against-person-custody/14263048007/; [https://perma.cc/8WJN-Q7ZY].*

[148] The Augusta Press, *Augusta worker accused of sexually assaulting teen patient at children's mental health facility* (May 14, 2022) *https://theaugustapress.com/augusta-worker-accused-of-sexually-assaulting-teen-patient-at-childrens-mental-health-facility/; [https://perma.cc/952N-YNQD].*

[149] The Augusta Chronicle, *Former Lighthouse employee pleads to sexual assault* (June 10, 2019) *https://www.augustachronicle.com/story/news/2019/06/10/former-employee-of-augusta-childrens-mental-health-facility-pleads-to-sexual-assault/4944855007/; [https://perma.cc/F6KT-RWP8].*

[150] Philadelphia Inquirer, *Kids in Need, Preyed Upon At Devereux, the nation's leading behavioral health nonprofit for youth, staff abused children in their care for years, while red flags were dismissed* (Aug. 12, 2020) *https://www.inquirer.com/news/inq/devereux-advanced-behavioral-health-abuse-children-pennsylvania-20200811.html.*

[151] *Id.*

[152] *Id.*

[153] PennLive, *School staffer who had sex with 16-year-old student must stay in prison, Pa. court rules* (July 11, 2018) *https://www.pennlive.com/news/2018/07/school_counselor_who_has_sex_w.html; [https://perma.cc/H6RR-4QJZ].*

[154] *Id.*

[155] Philadelphia Inquirer, *Kids in Need, Preyed Upon at Devereux, the nation's leading behavioral health nonprofit for youth, staff abused children in their care for years, while red flags were dismissed* (Aug. 12, 2020) *https://www.inquirer.com/news/inq/devereux-advanced-behavioral-health-abuse-children-pennsylvania-20200811.html; [https://perma.cc/7KKD-J7GV].*

[156] Florida Today, *Employee at Devereux Facility in Titusville Accused Of Sexual Abuse Against Child* (July 15, 2022) *https://www.floridatoday.com/story/news/local/2022/07/15/employee-devereux-titusville-charged-abuse-against-resident/10067844002/; [https://perma.cc/RZQ9-PYJM].*

[157] *Id.*

[158] *Id.*

[159] *Id.*

purpose of having sexual contact with them when they graduated."[160] The staffer also admitted to federal agents that he was "sexually aroused when restraining juvenile males in his normal course of work at Devereaux [sic] [(Devereux; Georgia)]."[161]

All of these staffers were charged with child abuse-related counts. One was convicted of corruption of minors, unlawful contact/communication with a minor, and institutional sexual assault.[162] A second was convicted on six child abuse-related counts, including institutional sexual assault of a minor.[163] A third was found guilty on three counts, including possession of material depicting sexual conduct by a child and using a computer to solicit, seduce, or lure a child.[164] (The Devereux Advanced Behavioral Health Georgia (Devereux; Georgia) incident appears to be referenced in documents Devereux produced to the Committee.)[165]

Public reporting of sexual abuse at multiple UHS facilities shows instances of staff initiating—and sustaining—sexual contact with children post-discharge. At Cumberland Children's Hospital (UHS; Virginia), a psychotherapist, was charged and indicted on "two counts of object sexual penetration by force."[166] At the McDowell Center for Children (UHS; Tennessee), a staffer "reportedly exchanged more than 8,900 text messages and made 182 phone calls" following the child's discharge. The staffer also "drove to Nashville on two occasions to have sex with [the] teen, who was discharged from the center"[167] 2 months prior. The staffer reportedly used her "position of trust over the teen while in the facility . . . to initiate a sexual relationship with him."[168] The staffer was charged on four counts of statutory rape and convicted on one count of aggravated statutory rape.[169] Similar behavior occurred at Copper Hills Youth Center (UHS; Utah) when a staffer engaged in a sexual relationship with a 17-year-old after her discharge from the facility where he was one of her counselors.[170] The two texted and communicated over social media and, according to reports, "records confirm [the staffer] asked for naked photos/videos of the victim . . . [and he planned to visit the child] to have sex with her."[171] The staffer was convicted for sexual exploitation of a minor and enticing, soliciting, seducing or luring a minor by Internet or text.[172]

Public allegations of sexual abuse by staff at Acadia facilities. According to the *Northwest Arkansas Democrat Gazette,* a staffer was terminated and referred to the authorities for inappropriate contact with a child at Piney Ridge Treatment Center (Acadia; Arkansas). Then, the former staffer "reached out to [a child from the

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[160] WXIA, *Cobb Juvenile Therapist Charged for Allegedly Distributing Child Porn, Grooming Victims* (Nov. 28, 2017) *https://www.11alive.com/article/news/crime/cobb-juvenile-therapist-charged-for-allegedly-distributing-child-porn-grooming-victims/85-495042837; [https://perma.cc/9C8J-N77E].*

[161] *Id.*

[162] PA Megan's Law, *sex offender registry* (accessed May 26, 2024) *https://www.meganslaw.psp.pa.gov/OffenderDetails/Offenses/53283; [https://perma.cc/2Q5R-3XA3].*

[163] *Id.*

[164] *State vs Mitchell Christopher* Case #: 05–2022–CF–036503–AXXX–XX (March 11, 2024) *https://vmatrix1.brevardclerk.us/beca/all_results.cfm?x=4BB88F8C738788AC99BFD224CC0A2DDB79DDE7B88913E70CF906EEDFDFD2C76526FA6ABFEBD34D16D7B733171ED4D4FE; [https://perma.cc/W3HA-FF8F].*

[165] Devereux, *Incident ID: REDACTED Detective Arrived on Campus* (Oct. 25,2017) DEV–S—001163at0001164.

[166] WTVR, *Psychotherapist accused of sex crimes at children's hospital appears in court* (Feb. 10, 2020) *https://www.wtvr.com/news/problem-solvers/problem-solvers-investigations/psychotherapist-accused-of-sex-crimes-at-childrens-hospital-appears-in-court#:~:text=%2D%2D%20A%20psychotherapist%20accused%20of,object%20sexual%20penetration%20by%20force; [https://perma.cc/7AYJ-FL74];* according to public reporting, Harden died by suicide on the day of his court hearing; CBS 19 News, *Guilty plea in case stemming from patient injuries at children's hospital* (Oct. 30, 2019) *https://www.cbs19news.com/story/45090202/guilty-plea-in-case-stemming-from-patient-injuries-at-childrens-hospital; [https://perma.cc/UKP3-MYP5].*

[167] WRKN, *Treatment facility employee accused in rape of Nashville 17-year-old former patient* (Aug. 6, 2021) *https://www.wkrn.com/news/treatment-facility-employee-accused-in-rape-of-nashville-17-year-old-former-patient/; [https://perma.cc/FHY6-PAMB].*

[168] *Id.*

[169] Davidson County, *Tennessee—Criminal Court Clerk* (accessed May 26, 2024) *https://sci.ccc.nashville.gov/Search/CriminalHistory?P_CASE_IDENTIFIER=LINDSAY%5ESHELTON%5E08271991%5E603364; [https://perma.cc/42SR-7XYN].*

[170] KSL, *Counselor had inappropriate relationship with teen girl, charges state* (Nov. 3, 2017) *https://www.ksl.com/article/46192071/counselor-had-inappropriate-relationship-with-teen-girl-charges-state; [https://perma.cc/2MS6-86QJ].*

[171] *Id.*

[172] Kentucky State Police, *Sex Offender Registry* (accessed May 26, 2024) *http://kspsor.state.ky.us/Home/OffenderDetails/gqQiaqn-DO5wifnX4_0wnQ;* [Permalinkunavailable].

facility] via social media and started messaging him and asked for a nude photograph."[173] The staffer pleaded guilty and was sentenced to 10 years probation, required to register as a sex offender, and ordered not to have contact with any minors.[174]

Documents Reviewed by the Committee

In light of numerous public reports of sexual abuse at RTFs, the Committee sought additional records from RTF providers to better understand the scope of such incidents and to understand how providers and facilities respond to such incidents. The Committee's review determined that in many, but not all cases, RTF providers responded quickly and in accordance with company policy to allegations of sexual abuse. This level of responsiveness was greatly aided by the efforts of independent oversight authorities that play a vital role in the review of allegations of misconduct.

The incidents of sexual abuse at RTFs reviewed by the Committee appear similar in character and scope to those reported in the media. Although facilities have policies and practices in place to mitigate these risks, some of these practices, such as use of surveillance cameras and regular checks of children by staff, are unevenly instituted across RTFs. Thoroughness of these policies also varies by provider. For example, Devereux leadership shared with the Committee that it provides all staff and patients with education on how to spot grooming behaviors by staff and peers.[175] Allegations of grooming behavior, such as providing patients with contraband like vape pens or phones, were common in the documents reviewed by the Committee. It should be noted, the behavioral incentive programs, which form the basis of the treatment environment at many RTFs, also include providing candy or other rewards for good behavior.

RTFs treat highly vulnerable populations in isolated settings outside the child's home and, often, far away from their community. As Devereux leadership stated to the Committee, adults who want to abuse children will find a way to work in the child service industry.[176] The Committee's review concludes that incidents of sexual abuse are endemic to RTFs.

Committee review of an incident at Cedar Ridge Treatment Center (UHS; Oklahoma) where a staffer was able to sustain ongoing sexual abuse of a child. Documents indicate that when the relationship was first identified, the staffer was not terminated and, instead, moved to another unit, allowing the relationship to continue. According to an investigative report dated September 21, 2021, Oklahoma Human Services substantiated an allegation of a staffer having an ongoing sexual relationship with a child at Cedar Ridge Treatment Center (UHS; Oklahoma).[177] The child's roommate reported that the staffer would, "come into their bedroom at night and [the child and staffer] would kiss each other and . . . lifted up her shirt (she was not wearing underclothes); [the roommate] was not sure what happened after . . . [because they] made her leave the room."[178] The staffer admitted that she and the child "kissed and touched each other but never had sexual intercourse. [The staff member also] put her mouth on [the child's] breasts."[179] The staffer "admitted she had feelings for [the child] even though [she] knew it was wrong."[180] She also shared her plans of "having a more intimate relationship after [the child] turned 18 and was out of the facility"[181] with one of her coworkers. Cedar Ridge Treatment Center (UHS; Oklahoma) appears to have initially reassigned the staffer to another unit after identifying the "relationship outside the normal staff to patient relationship." However, misconduct by the staffer continued and the staffer returned to stand outside the child's window each night. Cedar Ridge Treatment Center (UHS; Oklahoma) endangered children when it chose not to immediately fire this staffer.

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[173] Northwest Arkansas Democrat Gazette, *Former Piney Ridge employee placed on probation for sex crime* (Feb. 16, 2019) *https://www.nwaonline.com/news/2019/feb/16/former-piney-ridge-employee-placed-on-p/; [https://perma.cc/B7Q6-BJ9M].*

[174] *Id.*

[175] Notes from Devereux Advanced Behavioral Health (May 21, 2024) (on file with Committee).

[176] Notes from Devereux Advanced Behavioral Health (May 21, 2024) (on file with Committee).

[177] UHS, *Oklahoma Department of Human Services—Notification Concerning Finding(s) of Child Abuse/Neglect* (Referred on Sep. 21, 2021) UHS–FINHELP–00011988 at 00011990.

[178] *Id.*

[179] *Id.*

[180] *Id.*

[181] UHS, *Oklahoma Department of Human Services—Notification Concerning Finding(s) of Child Abuse/Neglect* (Referred on Sep. 21, 2021) UHS–FINHELP–00011988 at 00011991.

When Committee staff inquired whether there was any remedial action following this incident, UHS leadership said it was "not normal" for staff to be reassigned following an allegation of misconduct.[182] UHS later followed-up with the Committee to confirm this staffer was later terminated. Further, when asked whether a staffer's failure to report child abuse would result in disciplinary action, UHS leadership said that "it might."[183] Committee staff inquired whether there were conditions that might distinguish Cedar Ridge Treatment Center (UHS; Oklahoma) or its patient population from other sites, but UHS leadership said no.[184] UHS personnel also noted that Oklahoma, where the facility is located, has some of the most stringent Medicaid requirements for congregate care settings.[185]

Committee review of an instance of sexual abuse at an Acadia facility. At Millcreek of Arkansas (Acadia; Arkansas), Disability Rights Arkansas discovered that, when a child with a history of self-harm refused a strip search, she was restrained and forcibly searched.[186] Even though the child's safety plan does not mention "a strip or cavity search of any kind,"[187] a staffer "put her hand inside [the child]'s bra, touched her breasts and visually examined her chest area"[188] during the search. In an interview with the child, Disability Rights Arkansas found that Millcreek of Arkansas (Acadia; Arkansas) routinely performed strip searches on her and had, at least twice, conducted vaginal cavity searches. There are competing narratives surrounding how these strip searches were conducted—facility staff maintained that they were done in a professional manner, alternating the underwear and bra, so that the child was never completely naked, but the child's account disputes this. She stated she was "made to squat in the shower, naked."[189] One of the vaginal cavity searches was documented in the child's record; the child reported that the second, undocumented vaginal cavity search was completed by a supervisor, rather than a nurse.[190] In response to Committee questions regarding this incident, Acadia leadership said "this is a very complex patient." When Committee staff asked Acadia leadership about the company-wide policy on strip and cavity searches, one company executive noted he was not aware of the existence of any corporate policy on the matter.[191]

Committee review of instances of sexual abuse at Devereux facilities. The Committee reviewed documents related to allegations made by a child at Devereux Titusville (Devereux; Florida) of sexual abuse by a staffer.[192] The child reported that a staffer, who had previously been disciplined for "communicating [with children at the facility] on social media and [via] text messages,"[193] had been molesting him since he was admitted to the facility. When another staffer went through the child's phone, they discovered "photos and videos [that] appeared to be sexually explicit."[194] The child detailed how the staffer's sexual advances intensified over many months: the contact started above the clothing and progressed to oral sex, with the staffer telling the child "let me taste it,"[195] and other physical contact.[196] The staffer also solicited videos of the child masturbating in the shower. The staffer bribed the child with gifts (a vape and a new phone) and threatened the child with retaliatory action if he did not comply with the staffer's requests for naked photographs and video.[197] The child said that, on the staffer's phone, there were also "images of another juvenile who previously resided as Devereux."[198] The child said he "did not feel safe at Devereux."[199] The staffer was placed on administrative leave; the next day, a second

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[182] Notes from Universal Health Services Briefing (May 23, 2024) (on file with Committee).
[183] Notes from Universal Health Services Briefing (May 23, 2024) (on file with Committee); UHS later clarified this statement as "the appropriate employee discipline would be dependent on the circumstances" in written correspondence to the Committee.
[184] *Id.*
[185] *Id.*
[186] Disability Rights Arkansas, *RE: [Redacted] To: [Redacted], Chief Executive Officer* (Jan. 30, 2019) 20190604 Millcreek Alaska HHS Referral Hold at p. 14.
[187] *Id.* at p. 15.
[188] *Id.* at p. 14.
[189] *Id.* at p. 15.
[190] *Id.* at p. 15.
[191] Notes from Acadia Healthcare Briefing (May 17, 2024) (on file with Committee).
[192] State of Florida, *Affidavit for Arrest Warrant* (July 13, 2022) DEV–S—001178 at 001178.
[193] *Id.* at 001179.
[194] *Id.* at 001178.
[195] *Id.* at 001179.
[196] *Id.* at 001180.
[197] *Id.* at 001179.
[198] *Id.* at 001180.
[199] *Id.* at 001179.

child reported being sexually abused by the same staffer.[200] These documents appear to substantiate public reporting on a sexual abuse incident at Devereux Titusville (Devereux; Florida).[201] When Committee staff discussed this incident with Devereux leadership, they noted that they did not have records of previous disciplinary action against the staffer related to social media or text communications and immediately terminated the staffer.[202]

The Committee also reviewed company documents related to a publicly reported sexual grooming incident at Georgia Center (Devereux; Georgia).[203] However, the documents provided do not refer to the actual sexual abuse and underlying child harm and, instead, appears to be entirely dedicated to crisis management for the company's public image.[204] The report details Devereux's internal staff communication following both a detective and a reporter coming to the facility. These visitors were relayed up the site's Executive Director's "chain of command"[205] and to the "Corporate Media Relations" team member.[206] The incident report says that Devereux "[s]taff were reminded of social media policies and reminded of Devereux policy on talking to the media."[207] There is no mention of sexual grooming or abuse.[208]

ii. Youth-on-Youth

Conditions inside RTFs expose children to the risk of sexual assault at the hands of peers. This may take the form of physical aggression or sexual violence, often arising out of a lack of supervision and adequate treatment for underlying behavioral health needs, including sexual maladaptive disorders and histories of abuse trauma. Staff may fail to protect children from each other, such as in a February 2018 complaint alleging that Wyoming Behavioral Institute (UHS; Wyoming) consciously placed a child with "known sexual behaviors towards others" in a room with another child.[209] Some facilities offer both "sex offender treatment" and "sexual trauma" treatment, and the overlap of these two high-risk populations in the same facilities has the potential to increase safety risk for both groups.[210]

Public Reporting

Allegations document youth-on-youth sexual assault at Devereux. According to reports, a 13-year-old at Devereux Brandywine (Devereux; Pennsylvania) expressed fear of a 15-year-old, who was stronger than him, and asked to not be placed in the same room as the child. Nevertheless, the staff made them roommates. According to a lawsuit, the older boy forced the younger child to perform oral sex on him on three successive nights in a walk-in closet; the assailant later admitted to his behavior. Other similar closets at the facility had already been "blocked off" so they couldn't be used.[211] Public reporting on this incident is further substantiated by Devereux documents produced to the Committee.[212]

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[200] Devereux Advanced Behavioral Health, *Preliminary Report—Not Final (Level 2 Review—Reviewed)* (July 12, 2022) DEV-S—001190 at 001190.

[201] Florida Today, *Employee At Devereux Facility In Titusville Accused Of Sexual Abuse Against Child* (July 15, 2022) *https://www.floridatoday.com/story/news/local/2022/07/15/employee-devereux-titusville-charged-abuse-against-resident/10067844002/; [https://perma.cc/RZQ9-PYJM].*

[202] Notes from Devereux Advanced Behavioral Health (May 21, 2024) (on file with Committee).

[203] WXIA, *Cobb Juvenile Therapist Charged for Allegedly Distributing Child Porn, Grooming Victims* (Nov. 28, 2017) *https://www.11alive.com/article/news/crime/cobb-juvenile-therapist-charged-for-allegedly-distributing-child-porn-grooming-victims/85-495042837; [https://perma.cc/9C8J-N77E].*

[204] Devereux, *Incident ID: REDACTED Detective Arrived on Campus* (Oct. 25, 2017) DEV–S—001163.

[205] *Id.* at 0001164.

[206] *Id.*

[207] Devereux, *Incident ID: REDACTED Detective Arrived on Campus* (Oct. 25, 2017) DEV–S—001163 at 0001164.

[208] Although the records reviewed by the Committee only reference the company's immediate response to the incident, Devereux officials confirmed to the Committee that after Devereux was informed by police that the staffer was arrested, Devereux terminated his employment and fully cooperated with the police investigation.

[209] UHS, *Allegation of Non-Compliance at Wyoming Behavioral Institute* (Feb. 13, 2019) UHS–FINHELP–00008775 at 00008776.

[210] UHS, *RTF Information Request: Programs* (May 26, 2023) UHS 0000001.

[211] Daily Local News, *Devereux sued over teen sex assault* (May 19, 2019) *https://www.dailylocal.com/2019/05/19/devereux-sued-over-teen-sex-assault/; [https://perma.cc/ZQ7W-NPPB].*

[212] Devereux, *Perform CARE Critical Incident Report* (Oct. 23, 2016) DEV–S—001165; Devereux, *Reportable Incident Investigation—Facility Review* (Oct. 21–23, 2016) DEV–S—001167; Devereux, *Community Care Behavioral Health Organization Unusual Incident Report Form All Counties* (Oct. 23, 2016) DEV–S—001169.

Allegations of youth-on-youth sexual assault at Acadia Millcreek facility. In November 2019, the parents of a seven-year-old filed a lawsuit, alleging their daughter was digitally raped multiple times by her roommate at Millcreek Behavioral Health (Acadia; Arkansas). According to *The Arkansas Democrat Gazette,* Acadia's lawyers denied the allegations and the parties later reached a settlement.[213]

Allegations of both youth-on-youth sexual assault and mishandling of the resulting allegations at multiple UHS facilities.[214] A lawsuit against Laurel Oaks Behavioral Health Center (UHS; Alabama) alleges that numerous incidents of assault involving an 8-year-old were mishandled.[215] The lawsuit said the "wholly defenseless"[216] 56-pound child was assaulted shortly after arriving at the facility. A few days later, the boy "was [again] sexually assaulted [this time] by his [new] roommate,"[217] who had a history of sexual activity. The father said he was notified of the sexual assault, which took place off camera, 12 hours after Laurel Oaks Behavioral Health Center (UHS; Alabama) staff became aware of the incident. Then, he personally drove his son to the hospital, because no Laurel Oaks Behavioral Health Center (UHS; Alabama) staff had. *The Montgomery Advertiser* reported that the alleged abuser admitted to sexually assaulting the boy in his sleep, which aligns with medical records.[218]

Documents Reviewed by the Committee

Company documents reviewed by the Committee contain multiple accounts of youth-on-youth sexual abuse across Acadia, Devereux, and UHS facilities.

Allegations of youth-on-youth sexual abuse at UHS facilities. A November 2022 investigation of Palmetto Summerville Behavioral Health (UHS; South Carolina) conducted by the South Carolina Department of Health and Environmental Control revealed that a 13-year-old with a confirmed history of Child Sexual Abuse sexually assaulted a 10-year-old on two consecutive days. On the first day, the child "showed [the other child] his penis and kissed [the other child] on his lips. [Then, the child] pulled him behind their bedroom door and put his penis in his buttocks."[219] The next day, "the same thing happened again."[220] The assailant "admitted to having sex several times and always behind the door in the room."[221] The Assistant Administrator stated there was no video surveillance of the incident.[222] Policy on room assignments stated that children 13 and older could not room with children 12 and younger, with the policy explicitly stating that someone "identified as having heightened risk status for sexual aggression or victimization should be assigned a room closer to [the] nurses' station or [a] room with video surveillance."[223] This room assignment violated both of these policies.

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[213] Arkansas Democrat Gazette, *Sex assault suit names behavioral health site in Arkansas* (Nov. 17, 2019) *https://www.arkansasonline.com/news/2019/nov/17/sex-assault-suit-names-behavioral-healt/; [https://perma.cc/SN4E-KESA]; Eagles v. Habilitation Center LLC,* CASE NO. 5:19–cv–97–JM (Sep. 11, 2020) *https://www.govinfo.gov/content/pkg/USCOURTS-ared-5_19-cv-00097/pdf/USCOURTS-ared-5_19-cv-00097-0.pdf; [https://perma.cc/QS42-DCCE].*

[214] *See also:* North Carolina Health News, *Durham 11-year-old was sexually assaulted in NC psychiatric hospital, parents allege* (Nov. 30, 2022) *https://www.northcarolinahealthnews.org/2022/11/30/parents-allege-11-year-old-sexually-assaulted-in-nc-psychiatric-hospital/; [https://perma.cc/Q5GQ-6SUV]* (in which an 11 year-old was sexually assaulted by another child at Brynn Marr (UHS; North Carolina)); Al.com, *Abused child suffered scorpion bites, broken bones at Alabama residential treatment, lawsuit claims* (Jan. 25, 2023) *https://www.al.com/news/2023/01/abused-child-suffered-scorpion-bites-broken-bones-in-alabama-residential-treatment-lawsuit-claims.html; [https://perma.cc/249C-U99V]* (in which an 11-year-old at Alabama Clinical Schools (UHS; Alabama) was repeatedly physically abused by staff and other children, resulting in a broken collarbone, face, head, stomach and neck injuries, and scorpion bites).

[215] Montgomery Advertiser, *Lawsuit alleges "deeply troubling" mishandling of 8-year-old's sexual assault in Dothan* (Feb. 10, 2024) *https://www.montgomeryadvertiser.com/story/news/2024/02/10/youth-facility-did-not-protect-residents-from-assault-lawsuit-claims/72540722007/; [https://perma.cc/5R89-MEV8].*

[216] *Id.*

[217] *Id.*

[218] Montgomery Advertiser, *Lawsuit alleges "deeply troubling" mishandling of 8-year-old's sexual assault in Dothan* (Feb. 10, 2024) *https://www.montgomeryadvertiser.com/story/news/2024/02/10/youth-facility-did-not-protect-residents-from-assault-lawsuit-claims/72540722007/; [https://perma.cc/5R89-MEV8].*

[219] UHS, *Summary of Violations (Basis for Imposing Penalties) at Palmetto Pines* (Nov. 8, 2022) UHS–FINHELP–00011436 at 00011447.

[220] *Id.*

[221] *Id.* at 00011449.

[222] *Id.*

[223] *Id.*

An October 2020 investigation at Cedar Ridge Residential Treatment Services (UHS; Oklahoma) concerned an allegation that a child touched a 7-year-old on her "pee pee."[224] Investigators could not review video footage related to the incident due to the 7-year-old's inability to provide a specific time frame for the incident.[225] In March 2018, a child reported being sexually assaulted by another child several times at Wyoming Behavioral Institute (UHS; Wyoming). The investigation conducted by the Wyoming Department of Family Services found the "[a]llegations not supported" but the explanation of findings does not substantively address the allegations and, instead, states staff "took appropriate action" once made aware of the allegation and were "current on training[s]."[226]

Devereux documents substantiate a publicly reported instance of youth-on-youth sexual abuse.[227] The Committee reviewed an incident report produced by Devereux which states that "[u]pon returning from a therapeutic home visit, [a child] noticed some items missing from his side of [the] room."[228] When a staffer asked why the child had not reported that a child was stealing from him, the child explained he was "afraid . . . [because the child] had been forcing him . . . to perform oral sex."[229] The child reported being assaulted by his roommate on three consecutive days.[230]

b. Children Often Experience Physical Abuse in RTFs.

Both staff and peers engage in physical altercations with children inside RTFs. Aside from sexual abuse, children are at risk of physical abuse in interactions with staff, including during instances of restraint and seclusion, and where a lack of supervision allows for peer-on-peer altercations.

i. Staff-on-Youth

Children inside RTFs experience non-sexual physical assault by staff, including instances of improper restraint. Physical abuse at the hands of staff is rampant in RTFs, where staff are permitted to physically restrain children for behavioral health interventions in certain circumstances. Though physical restraint is highly regulated and this intervention typically has to be approved by a physician, documented, and reported to outside agencies, the Committee's review concludes that staff often misuse restraint or harm children during the hold. For example, restraint is often incorrectly documented, and where it is documented, it sometimes goes unreported to required oversight agencies. Apart from the abuse that arises from this permissible physical interaction (physical restraint), staff sometimes physically abuse children without describing the interaction as a restraint—perhaps most viscerally in the case of a child who was burned with scalding water vindictively by a staff member.

Public Reporting

Numerous survivor accounts of physical abuse at the hands of staff at facilities. In Think of Us' study "Away from Home," children at facilities shared accounts of the violence they witnessed and suffered at RTFs at the hands of staff—"I've seen staff members fight a kid, hit a kid," "I was hit. I was punched in the face. One time I was knocked unconscious, one staff grabbed my arm, I was trying to get it out, he full on judo hit me and knocked me out."[231]

A staffer at Cumberland Hospital (UHS; Virginia) poured hot water on a child, leading to second- and third-degree burns. A Cumberland Hospital

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[224] UHS, *Notification Concerning Finding(s) of Child Abuse/Neglect at Cedar Ridge* (Oct. 19, 2020) UHS–FINHELP–00011908 at 00011929.

[225] *Id.*

[226] UHS, *Wyoming Department of Family Services—Notice of Non-Compliance* (Mar. 28, 2018) UHS–FINHELP–00008775 at 00008779.

[227] Devereux, *Perform CARE Critical Incident Report* (Oct. 23, 2016) DEV–S—001165; Devereux, *Reportable Incident Investigation—Facility Review* (Oct. 21–23, 2016) DEV–S—001167; Devereux, *Community Care Behavioral health Organization Unusual Incident Report Form All Counties* (Oct. 23, 2016) Dev–S—001169; Daily Local News, *Devereux sued over teen sex assault* (May 19, 2019) *https://www.dailylocal.com/2019/05/19/devereux-sued-over-teen-sex-assault/; [https://perma.cc/ZQ7W-NPPB].*

[228] Devereux, *Community Care Behavioral Health Organization Unusual Incident Report Form All Counties* (Oct. 23, 2016) DEV–S—001169 at 001169.

[229] *Id.*

[230] Devereux, *Community Care Behavioral Health Organization Unusual Incident Report Form All Counties* (Oct. 23, 2016) DEV–S—001169 at 001169.

[231] Think of Us, *Away From Home: Youth Experiences of Institutional Placements in Foster Care* at p. 40 (July 21, 2021) *https://assets.website-files.com/60a6942819ce8053cefd0947/60f6b1eba474362514093f96_Away%20From%20Home%20-%20Report.pdf; [https://perma.cc/VS6R-ZXYL].*

(UHS; Virginia) staffer, who pled no contest, was sentenced to 1 year in jail for a felony wounding charge based on evidence of a 2019 incident in which she "pour[ed] scalding water on" a non-verbal 16-year-old with developmental disabilities because she had struggled to get him to sleep.[232] According to the Attorney General's office proffer, which detailed the evidence the Commonwealth would have presented had the case gone to trial, the staffer was seen on surveillance video entering the kitchen and later carrying two cups of liquid which she threw on the child.[233] The proffer obtained by *WTVR* details that:

> The staffer initially lied to investigators, telling RTF oversight personnel that she was attempting to shower the victim and believed that the burn must have resulted from a malfunctioning shower. However, interviews with hospital staff determined that the victim has already had his evening shower around approximately 6:30 p.m., and would not normally have another shower after that. In addition, the water system at the hospital has a failsafe safety system that ensures that the water shuts off if it reaches 125 degrees.[234]

In an interview, the child's mother stated she received a phone call that her son "was apparently breaking out with a rash and they had to give him a shot of prednisone and some cream to help with the rash. They thought one of his medicines was going against him."[235] Two days later, the mother learned that the rash was actually a burn; she requested to see what the burns looked like, but was told she was not "allowed to see those pictures," leaving her nothing but a "Zoom call" with her son the next day.[236] The child's mother further described how she learned the details regarding her son's injuries a month later from the facility's Risk Manager:

> He's like we have on video one of our Behavior Techs going into the break room heating up water and pouring it on [the child] intentionally. Going back from the break room into the bathroom numerous times. It wasn't once, it was numerous times. Right then and there, I just broke down crying like how could someone hurt my child that way? He's there to get help.[237]

Other reported incidents of physical abuse at UHS facilities. Celebrity Paris Hilton attested to physical abuse at Provo Canyon School (UHS; Utah) in a *People Magazine* interview. She said, "I think it was their goal to break us down. And they were physically abusive, hitting and strangling us. They wanted to instill fear in the kids so we'd be too scared to disobey them."[238] A nurse at Hermitage Hall (UHS;

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[232] WTVR, *Former hospital worker gets one year in jail for burning a child in her care* (Dec. 20, 2021) *https://www.wtvr.com/news/local-news/stacey-burrell-sentenced; [https://perma.cc/4FD8-D2HQ].*

[233] WTVR, *Worker faces prison time for burning a child at Cumberland Hospital for Children* (Oct. 26, 2021) *https://www.wtvr.com/news/problem-solvers/problem-solvers-investigations/stacey-burrell-conviction; [https://perma.cc/UZC2-NXVN];* WTVR, *Former hospital worker gets one year in jail for burning a child in her care* (Dec. 20, 2021) *https://www.wtvr.com/news/local-news/stacey-burrell-sentenced; [https://perma.cc/4FD8-D2HQ];* WTVR, *Mom learns new details of son's hospital assault: "It killed me"* (Dec. 14, 2021) *https://www.wtvr.com/news/problem-solvers/problem-solvers-investigations/jackson-haddon-details; [https://perma.cc/9L9S-FL2N];* VA Attorney General Proffer, *https://ewscripps.brightspotcdn.com/d1/50/00feabc541bb96523e1cfed97403/burrell-proffer.pdf; [https://perma.cc/6XSM-FGZ5].*

[234] WTVR, *Mom learns new details of son's hospital assault: "It killed me"* (Dec. 14, 2021) *https://www.wtvr.com/news/problem-solvers/problem-solvers-investigations/jackson-haddon-details; [https://perma.cc/9L9S-FL2N];* VA Attorney General Proffer, *https://ewscripps.brightspotcdn.com/d1/50/00feabc541bb96523e1cfed97403/burrell-proffer.pdf; [https://perma.cc/6XSM-FGZ5].*

[235] WTVR, *Mom says son was intentionally burned at hospital: "How could someone hurt my child?"* (Aug. 18, 2020) *https://www.wtvr.com/news/problem-solvers/problem-solvers-investigations/mom-says-son-was-intentionally-burned-at-childrens-hospital-how-could-someone-hurt-my-child; [https://perma.cc/KL8W-RCY7].*

[236] *Id.*

[237] *Id; see also:* Al.com, *Abused child suffered scorpion bites, broken bones at Alabama residential treatment, lawsuit claims* (Jan. 25, 2023) *https://www.al.com/news/2023/01/abused-child-suffered-scorpion-bites-broken-bones-in-alabama-residential-treatment-lawsuit-claims.html; [https://perma.cc/249C-U99V]* (in which an 11-year-old at Alabama Clinical Schools (UHS; Alabama) was repeatedly physically abused by staff and other children, resulting in a broken collarbone, face, head, stomach and neck injuries, and scorpion bites).

[238] People, *Paris Hilton Opens Up About the Secret Terrifying Abuse She Suffered as a Teen* (Aug. 2, 2020) *https://people.com/tv/paris-hilton-opens-up-about-the-secret-terrifying-abuse-she-suffered-as-teen/; [https://perma.cc/69WS-YQVB].*

Tennessee) surrendered her nursing license to the state following allegations she hit a 9-year-old child in the face during a restraint.[239]

A review by *The Washington Post* showed that, in a single year, North Spring Behavioral Healthcare (UHS; Virginia) terminated "employees involved in three physical run-ins with patients, all confirmed by video." In one incident, staffers "pushed a patient into a wall" and in a second incident a staffer "stepped on a patient's head." According to reporting and video footage, "a staffer 'tried to intimidate' a patient 'by putting his foot on the patient's head while he lay on the floor of the time-out room.'" The same month, also confirmed by video footage, another staffer pushed a child into a wall.[240] In the third case, a staffer used restraints unnecessarily.

Incidents at an Acadia facility deemed by reports to be a "misery mill." *ProPublica Illinois* and *The Chicago Tribune* reported on alleged violence by staff against children at the "misery mill"—Millcreek Behavioral Health (Acadia; Arkansas). In one incident, Millcreek of Arkansas (Acadia; Arkansas) reportedly told a mother it was investigating an alleged staff assault of her 11-year-old, but the facility refused to provide details. When she was finally able to speak to her child, she was told, "a female worker had pushed him down, grabbed him by his hair and put her foot in his back." The mother said her child only "got worse" at the facility.[241] The reporting details another child's "horrific" 9 months at Millcreek of Arkansas (Acadia; Arkansas), including being punched in the head by a staffer during a restraint. Her mother filed a police report, saying, "she has reported abuse from an adult at Millcreek and nothing has been done." When her mother saw her child's injuries she removed her from the facility. Further, the child described witnessing children fighting over donated clothes, with one child being beaten while staff watched on, and a staffer allegedly bribing two children to say they did not see the incident.[242] As a child said, "Millcreek was by far the worst, and to this day I would say Millcreek has been my worst life experience. That place beat out losing my family."[243]

Public reporting found multiple instances of physical abuse across Devereux facilities. A jury found a Devereux Brandywine (Devereux; Pennsylvania) staffer guilty of simple assault and endangering the welfare of a child. According to authorities, the staffer punched and kicked a 14-year-old in the head, face, and body until the child was unconscious.[244] According to the *Daily Local News,* a lawsuit alleged a staffer at Devereux Brandywine (Devereux; Pennsylvania) grabbed a child and "shoved him down a hallway, and threw him backwards." The staffer, then, allegedly shoved his face against a wall, and the child fell to the floor. The child went to the hospital after losing consciousness, with welts and bruises on his face. The lawsuit also alleged, "multiple Devereux employees watched," but "not one intervened." According to public reporting, Devereux failed to report the assault until the child's adoptive parents reported it to a tip service.[245]

In another incident, two Devereux Advanced Behavioral Health—Viera Campus (Devereux; Florida) staff were arrested after allegedly grabbing a child's neck and slamming them against the ground. One staffer reportedly assaulted the child while the other, according to public reports, attempted to block the security camera.[246] A

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[239] WZTV, *Tennessee nurse captured on video striking child at behavioral health center in face* (June 16,2021) *https://fox17.com/news/local/tennessee-nurse-captured-on-video-striking-child-at-behavioral-health-center-in-face-nashville-hermitage-hall-mental-health-medicine; [https://perma.cc/9DBA-9JQA].*

[240] The Washington Post, *"He didn't deserve the way he died": Mother of teen restrained at behavioral health facility speaks out* (Jan. 27, 2018) *https://www.washingtonpost.com/local/public-safety/he-didnt-deserve-the-way-he-died-mother-of-teen-restrained-at-behavioral-health-facility-speaks-out/2018/01/26/92428f5e-fd47-11e7-a46b-a3614530bd87_story.html; [https://perma.cc/KTQ8-Q7HK].*

[241] ProPublica, *Why a Mental Health Institute for Foster Children Became Known as "The Misery Mill"* (Mar. 11, 2020) *https://www.propublica.org/article/illinois-dcfs-children-out-of-state-millcreek-behavioral-health-arkansas; [https://perma.cc/2P4F-7JDQ].*

[242] *Id.*

[243] *Id.*

[244] Daily Local News, *Devereux employee guilty of assaulting 14-year-old resident* (June 7, 2022) *https://www.dailylocal.com/2022/06/07/devereux-employee-guilty-of-assaulting-14-year-old-resident/;* [Permalink unavailable].

[245] Daily Local News, *Lawsuit claims teen assaulted by staffer at Devereux* (Feb. 8, 2021) *https://www.dailylocal.com/2021/02/08/lawsuit-claims-teen-assaulted-by-staffer-at-devereux/; [https://perma.cc/2FHF-XPMW].*

[246] Florida Today, *Employee at Behavioral Facility Near Viera Arrested On Charges of Child Abuse, Battery* (Sep. 29, 2021) *https://www.floridatoday.com/story/news/2021/09/29/em-*

separate staffer from Devereux Advanced Behavioral Health—Viera Campus (Devereux; Florida) was arrested after striking a child during a basketball game.[247]

According to court records in Chester County Pennsylvania, over the course of roughly 20 months, "20 Devereux staffers have been charged with assaulting 18 residential patients at the organization's three campuses." Devereux responded that "[e]very provider in the field must deal with the issue of employees who, despite thorough training, support, and supervision, do the wrong thing in complicated situations."[248]

Reports of physical abuse at a Vivant facility in Florida. At St. John's Youth Academy (Sequel/Vivant; Florida) alleged physical abuse by staff caused the Department of Juvenile Justice to end its contract with the facility. According to an October 2022 news report, a staff member got into a fight with a teen at the facility; the incident occurred during a large-scale incident deemed a "riot situation."[249] The teen claimed, "me and [the staffer] ended up getting locked on the wall together . . . Then she proceeded to stab me in the eye with her keys, and she was calling me all types of derogatory comments."[250] The teen was arrested for hitting the staffer, but both he and another member of the staff said the first staffer was having an ongoing relationship with one of the other teens.[251] Following the incident, Florida's Department of Juvenile Justice (DJJ) issued this statement:

> Due to serious concerns for the well-being of the youth at the St. John's Youth Academy and the contracted provider's complete failure to ensure a safe environment at the program, DJJ has taken immediate action to remove all youth at the facility and has closed the St. John's Youth Academy program.[252]

Although the allegations of abuse were not substantiated by the Florida DJJ Office of the Inspector General, DJJ terminated its contract with Vivant following the incident in October 2022.[253]

Committee staff asked Vivant representatives about the incident, who confirmed that Vivant operated the facility at the time of the incident, having assumed contracts the previous year with the State of Florida to operate the multiple facilities then under the Sequel name. When asked by the Committee whether there are special considerations the company employs to prevent these types of large-scale incidents, Sequel/Vivant pointed to its everyday focus on safety and helping youth employ coping mechanisms during crises.[254] Further, Sequel/Vivant insisted that during its takeover of Sequel facilities, it immediately implemented all of its own policies and procedures and reassessed the needs of each of the children in their newfound custody.[255] However, Sequel/Vivant was unable to say "for certain"[256] if all policies had been implemented at St. John's Academy (Sequel/Vivant; Florida) at the

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ployee-devereux-arrested-charged-child-abuse-battery/5896960001/; [https://perma.cc/DAJ4-6R4K].

[247] *Id.*

[248] Daily Local News, *Lawsuit claims teen assaulted by staffer at Devereux* (Feb. 8, 2021) *https://www.dailylocal.com/2021/02/08/lawsuit-claims-teen-assaulted-by-staffer-at-devereux/; [https://perma.cc/2FHF-XPMW].*

[249] WJXT, *Inmate, 18, at St. Johns Youth Academy accused of assaulting staffer; he says he was defending himself* (Oct. 27, 2022) *https://www.news4jax.com/news/local/2022/10/27/18-year-old-inmate-at-st-johns-youth-academy-accused-of-assaulting-staffer/; [https://perma.cc/9T5W-CAGE].*

[250] News4JAX The Local Station, *Inmate, 18, at St. Johns Youth Academy accused of assaulting staffer; he says he was defending himself,* YouTube at 1:43–:52. (Oct. 27, 2022) *https://www.youtube.com/watch?v=IO_iFfmm7XI;* [permalink unavailable].

[251] WJXT, *Inmate, 18, at St. Johns Youth Academy accused of assaulting staffer; he says he was defending himself* (Oct. 27, 2022) *https://www.news4jax.com/news/local/2022/10/27/18-year-old-inmate-at-st-johns-youth-academy-accused-of-assaulting-staffer/; [https://perma.cc/9T5W-CAGE].*

[252] *Id.*

[253] *Id;* News4JAX, *State attorney's office investigating St. Johns Youth Academy after "riot situation"* (Nov. 18, 2022) *https://www.news4jax.com/news/local/2022/11/18/state-attorneys-office-investigating-st-johns-youth-academy-after-riot-situation/; [permalink unavailable];* Physical abuse is documented at other Vivant facilities. *see also:* Tampa Bay Times, *Youth detention staffer accused of beating 16-year-old teen* (Oct. 3, 2018) *https://www.tampabay.com/news/publicsafety/crime/Youth-detention-staffer-accused-of-beating-16-year-old-teen_172314339/; [https://perma.cc/RYN8-F2T8]* (In which staff threw a child to the ground and punched him 11 times).

[254] Notes from Vivant Behavioral Health Briefing (May 22, 2024) (on file with Committee).

[255] *Id.*

[256] *Id.*

time of this incident, over a year after Vivant obtained control of the site.[257] The company was not aware of any changes implemented across other sites as a result of this incident.[258]

Documents Reviewed by the Committee

Company documents reviewed by the Committee substantiate public reporting that RTFs foster a physically abusive environment. Staff may physically abuse children at facilities. In the words of a "tearful and upset"[259] child who eloped and was returned to Cedar Ridge Treatment Center (UHS; Oklahoma) by a police officer, "[y]ou can't leave me here because they hurt me."[260] According to company documents reviewed by the Committee, in two separate instances staff were terminated for abuse allegations. In one allegation, a child reported being thrown across the timeout room by a staffer who was bringing them to the seclusion room. In the other case, a child alleged that a staffer slammed him against a fence "several times" during a restraint, resulting in a lump and abrasion above the child's right temple and a scratch on his back. The staffer was terminated after each incident.[261] When the Committee discussed physical restraint with UHS leadership, they responded that, even when properly trained, staff may respond inappropriately because of human instinct.[262]

Company documents reviewed by the Committee contain numerous accounts of staff physically abusing children by dragging or throwing them. The Virginia Department of Behavioral Health and Developmental Services received allegations of two incidents of physical abuse at Harbor Point Behavioral Health Center (UHS; Virginia) that involved dragging or throwing of children. In one case, an internal investigation found a child had been dragged "across the classroom floor" by a staff member.[263] In a second case, a child was "making noises, cursing" and, after being asked to leave, the child pushed a staffer. Then, the staffer dragged the child out of the dayroom and into the hallway.[264] In one case, a child at Piney Ridge Treatment Center (Acadia; Arkansas) was injured on the way to the seclusion room. While being transported the "child reported that staff threw him across the timeout room."[265]

Company documents reviewed by the Committee contain accounts of staffers frequently placing children in headlocks or chokeholds. Copper Hills Youth Center (UHS; Utah) was investigated by the state after a staffer placed a child in a chokehold during a "physical intervention,"[266] which was supported by video footage. The staffer was terminated.[267] At Palmetto Summerville Behavioral Health (UHS; South Carolina), after a child hit a staffer with a Bible, the staffer "grabb[ed] the [child's] hair and [put] them in [a] chokehold." The incident report detailed how the staffer "allegedly 'grabs [the child's] hair from behind and struggles with her.'. . . [and] then 'puts [the child] in a headlock, still with a hand in her hair.'" Further, the South Carolina Department of Health and Environmental Control (SCDHEC) found that the facility failed to properly notify the SCDHEC of the incident.[268] The investigation concluded the child was not afforded the right "to be free from harm . . . abuse, or neglect."[269] A complaint received by the SCDHEC detailed how video review of a restraint at Palmetto Summerville Behavioral Health (UHS; South Carolina) showed a staffer placing a child in a "choke hold" followed by that staffer "punching [the child] six (6) times once taken down to the ground."[270]

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[257] *Id.*
[258] *Id.*
[259] UHS, *Oklahoma Department of Human Services—Notification Concerning Finding(s) of Child Abuse/Neglect* (Sep. 28, 2022); UHS–FINHELP–00011988 at 00012031.
[260] *Id.*
[261] Acadia, *Corrective Action Plan Recommendation Letter at Piney Ridge* (Nov. 26, 2019) 20191126 Piney Ridge Licensing Corrective Action Plan Recommendations Letter at p. 2.
[262] Notes from Universal Health Services Briefing (May 23, 2024) (on file with Committee).
[263] UHS, *Department of Behavioral Health and Developmental Services—Corrective Action Plan at Harbor Point Behavioral Health* (April 16, 2020) UHS–FINHELP–00010267.
[264] UHS, *Department of Behavioral Health and Development Services—Corrective Action Plan at Harbor Point* (July 1, 2020) UHS–FINHELP–00010312.
[265] Acadia, *Corrective Action Plan Recommendation Letter at Piney Ridge* (Nov. 26, 2019) 20191126 Piney Ridge Licensing Corrective Action Plan Recommendations Letter at p. 2.
[266] UHS, *Copper Hill Action Plan for DHS Violations* (July 8,2022) UHS–FINHELP–00009917.
[267] *Id.*
[268] UHS, *Inspection Results at Palmetto Pines* (Apr. 8, 2021) UHS–FINHELP–00011408 at 000114010–00011411.
[269] *Id.* at 00011408.
[270] UHS, *Inspection Results at Palmetto Pines* (Feb. 23, 2021) UHS–FINHELP–00011386.

Company documents reviewed by the Committee contain accounts of staff physically abusing children by striking them in the head. A South Carolina Department of Health and Environmental Control Plan of Correction for Palmetto Summerville Behavioral Health (UHS; South Carolina) alleged that, while a staffer was redirecting a child, the child threatened the staffer. In response, the staffer told the child he was not "going to do anything fatboy." The child then hit the staffer. In response, the staffer hit the child twice, including punching the child in the head.[271] The South Carolina Department of Health and Environmental Control investigated another complaint of a child "abused by staff" at Palmetto Summerville Behavioral Health (UHS; South Carolina). Camera footage showed the staffer "struck [the child] in the stomach and then several minutes later struck [the child] with a closed fist on the left side of his head/face." The staffer was terminated. The investigator concluded the child "was not free from abuse."[272] A Utah Department of Human Services Provo Canyon School—Springville Campus (UHS; Utah) document detailed multiple staff conduct violations. In one incident, a "school teacher [. . .] hit a student on her head." In another, a staffer "pulled a student's hair for leverage in a restraint."[273]

Numerous cases reviewed by the Committee contain allegations of children physically abused by staff who push them into objects, like fences, walls, and furniture. Video footage substantiated an incident of abuse at Cedar Ridge Behavioral Hospital (UHS; Oklahoma) involving a child being pushed against a wall, punched in the left eye, and punched with a closed fist.[274] An Oklahoma DHS Office of Client Advocacy investigation of Cedar Ridge Behavioral Hospital (UHS; Oklahoma) determined that a staffer held a 12-year-old against a wall, grabbed her by the arm and pulled her to the ground.[275] The staffer's defense for using the improper restraint was that the facility was "short staffed and he could not call for help."[276]

In an instance at Palmetto Summerville Behavioral Health (UHS; South Carolina) a child banged their head against a wall, causing their "lip [to bleed]" and a "small bruise to the nasal bridge of [the] nose area." Then, a staffer placed the child in a "supine restraint in the corner of the wall [while the child] was crying saying [the staffer] had pulled his/hair and pushed his/her face into the wall." Another staffer described the child as "very distraught."[277] SCDHEC representative "requested a copy of the facility's incident report," a staffer told them they could only view it onsite and "refused to provide a copy" because "corporate" prohibited it.[278] Further, when the same government representative requested a copy of video footage, they were told "corporate" disallowed its release.[279] During the incident, the space was determined to be understaffed, with a 1:10 child to staff ratio, rather than the required 1:5 daytime ratio.[280]

Staff fail to properly de-escalate situations, which leads to physical altercations with children and injuries. A Virginia Department of Behavioral Health and Developmental Services Harbor Point Behavioral Health Center (UHS; Virginia) corrective action plan (CAP) described how, rather than de-escalating a situation, a staffer hit the child. This was confirmed by video and eyewitness statements. The staffer was terminated.[281] In a second case at Harbor Point Behavioral Health Center (UHS; Virginia) an internal investigation found a staffer hit a child "across the chest" after the child spat in their face. The staffer was terminated.[282] In another case, at Copper Hills Youth Center (UHS; Utah), a staffer "engaged in a verbal altercation" with a child which escalated into a physical altercation. The fa-

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[271] UHS, *Inspection Report at Palmetto Summerville* (Mar. 15, 2022) UHS–FINHELP–00011327.
[272] UHS, *Plan of Correction Reporting Form at Palmetto Pines* (May 4, 2022) UHS–FINHELP–00011349.
[273] UHS, *State of Utah Department of Human Services Corrective Action Plan for Provo Canyon* (January 13, 2020) UHS–FINHELP–00011508 at00011509.
[274] UHS, *State of Oklahoma Department of Human Services Office of Client Advocacy Investigative Summary for Cedar Ridge Behavioral Hospital* (Feb. 3, 2020) UHS–FINHELP–00011908 at 00011909.
[275] UHS, *Investigation Report Findings at Cedar Ridge* (Feb. 10, 2022) UHS–FINHELP–00011988 at 00012025.
[276] *Id.*
[277] UHS, *Inspection Results at Palmetto Pines* (Mar. 5, 2020) UHS–FINHELP–00011273.
[278] *Id.*
[279] *Id.*
[280] *Id.*
[281] UHS, *Corrective Action Plan at Harbor Point* (Apr. 8, 2021) UHS–FINHELP–00010243.
[282] UHS, *Corrective Action Plan at Harbor Point* (May 20, 2021) UHS–FINHELP–00010309.

cility (UHS; Utah) said the staffer acted inappropriately by not following proper de-escalation techniques.[283]

ii. Youth-on-Youth

Children in RTFs are at risk of physical assault at the hands of other children they live with. The Committee reviewed public reporting and company documents to study incidents of youth-on-youth violence at RTFs.

Public Reporting

In Think of Us' study "Away from Home," a child recounted an incident with their roommate, "yes, my roommate threatened to kill me . . . one girl threw bleach at another girl's face."[284] Another child said, "[f]or those 2 years, I nearly had to physically fight every day, and there was a lot of violent behavior among youth, it was like 'Fight Club'."[285]

Public reporting showed federal investigators found deficiencies related to youth-on-youth assault at North Star Behavioral Health (UHS; Alaska). A former resident reported that fights at North Star (UHS; Alaska) were ubiquitous, stating "you have not gone to North Star unless you've seen a fight."[286] According to reporting, two children at North Star Behavioral Health (UHS; Alaska) were reportedly accidentally locked in a "quiet room" together. One of the children attacked the other and gave them a bloody nose. Separately, a child was reportedly punched, slapped in the eye, and kicked by other children. According to the child's case notes, the "mother stated she is really upset for not being notified."[287]

Public Reporting found LGBTQIA+ children may be seen as targets by their peers at RTFs. According to a report from 2018, a 16-year-old, who had recently come out as gay, was allegedly attacked by two other children at St. John's Youth Academy (Sequel; Florida). According to a police report, the child was attacked from behind and told by his attacker that he "didn't want a fa***t in the pod." The CEO of an LGBTQIA+ advocacy organization said, "[m]ost of [the children in facilities like these] don't come out because they're afraid for their safety, and they're afraid [of] what's going to happen to them, [. . .] LGBT young people, we know, are some of the most at-risk for bullying and harassment in these kinds of facilities."[288]

Public reporting found a child needed emergency care after an alleged assault at Belmont Pines (UHS; Ohio). According to a 2022 report, a child at Belmont Pines Hospital (UHS; Ohio) was taken to the emergency room where he told nurses he had been assaulted by a child at the facility. According to a 911 call, the child was dragged down the hall and hit his head on "a table or like a basket of something."[289] According to reports, the emergency room nurse who made the 911 call told dispatchers that the 9-year-old was covered in bruises, had a laceration, and a large hematoma on his head. Further, the nurse reported she had to ask the staffer accompanying the child multiple times before they admitted they were coming from Belmont Pines (UHS; Ohio).[290]

Documents Reviewed by the Committee

Company documents reviewed by the Committee describe incidents of youth-on-youth violence at RTFs that are similar in scope and severity to those publicly reported.

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[283] UHS, *Copper Hill Action Plan for DHS Violations* (July 8, 2022) UHS–FINHELP–00009917.

[284] Think of Us, *Away From Home: Youth Experiences of Institutional Placements in Foster Care* at p. 45 (July 2021) *https://assets.website-files.com/60a6942819ce8053cefd0947/60f6b1eba4743625140936f96—Away%20From%20Home%20-%20Report.pdf; [https://perma.cc/VS6R-ZXYL].*

[285] *Id.* at p. 36.

[286] Anchorage Daily News, *Federal inspectors fault assaults, escapes, improper use of locked seclusion at North Star youth psychiatric hospital* (Sep. 28, 2022) *https://www.adn.com/alaska-news/2022/09/28/federal-inspectors-fault-assaults-escapes-improper-use-of-locked-seclusion-at-north-star-youth-psychiatric-hospital/; [https://perma.cc/C7WJ-MNQN].*

[287] *Id.*

[288] WJXT, *Deputies: Youth Academy inmate attacked because he's gay* (Sep. 10, 2018) *https://www.news4jax.com/news/2018/09/11/deputies-youth-academy-inmate-attacked-because-hes-gay/; [https://perma.cc/E8EZ-PFSJ].*

[289] WKBN, *Police investigating assault at Belmont Pines hospital* (July 19, 2022) *https://www.wkbn.com/news/local-news/police-investigating-assault-at-belmont-pines-hospital/; [https://perma.cc/NN4U-8L53].*

[290] *Id.*

Multiple incidents of youth-on-youth harm at Harbor Point Behavioral Health Center (UHS; Virginia). Documents reviewed by the Committee show a parent's report that their daughter had been assaulted by multiple children "multiple times" while at Harbor Point Behavioral Health Center (UHS; Virginia), leading to the parents withdrawing their child from care. In one case, the children were "touching and throwing" the child's belongings and, when the child came into her own room, the children "proceeded to attack her," including kicking and punching the child in the face. In another case, the child was assaulted "unprovoked" by another child. In a third case, the child was kicked in the head while seated "quietly." The parents determined that their child's lack of safety required her removal from the program.[291]

Committee found that staff often do not intervene to avoid youth-on-youth harm from occurring. The Arkansas Department of Human Services reviewed video footage from Millcreek Behavioral Health (Acadia; Arkansas) that showed a staffer allowing a child to remove an aerosol can from the table and spray it towards another child. A staffer did not intervene until the child threw the aerosol can at the other child.[292] The report stated that a "clear confrontation was occurring when staff walked away."[293] At Riverpark Hospital (UHS; West Virginia), a child reported that she was repeatedly stabbed by another child.[294] The child said the injuries were not deep enough to necessitate medical attention and that she cried for help, but staff ignored her.[295]

Youth-on-youth assault is often not appropriately reported or provided medical attention. A review by The Joint Commission of North Star Debarr (UHS; Alaska) found that, after a child punched another child, there was no nursing assessment completed. The Nurse Manager acknowledged that was accurate and said that a review should have been completed.[296] In another incident, the South Carolina Department of Health and Environmental Control inspected Palmetto Pines Behavioral Health (UHS; South Carolina) as part of a follow up to a complaint of a child being attacked by other children at the facility, "and this was not the first occurrence."[297]

The Risk Manager recorded that the incident resulted in the child who was attacked "sustaining a knot on his/her head"[298] but this assault was not reported within 24 hours.

c. Children Often Experience Physical Restraint, Seclusion, Chemical Restraint, and Polypharmacy in RTFs, Leading to Harm and Fatalities.

Federal guidelines dictate the limited use of restraint and seclusion in PRTFs, but other facilities that treat children are not required to follow these standards. CMS regulations state that Medicaid dollars are contingent on, "[e]ach [PRTF] resident ha[ving] the right to be free from restraint and seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation."[299] While not all facilities operated by the companies involved in this investigation are PRTFs, the majority of them are. The Committee's investigation shows that these requirements are not working as intended to protect children in these facilities.

There are three types of restraint: chemical, physical, and mechanical. Chemical restraint describes the use of a medication, such as an antipsychotic or benzodiazepine, to sedate a person. Physical restraint refers to a manual hold which restricts a person's normal movement. Mechanical restraint means using equipment or a device to restrict a person's normal movement. Seclusion refers to the practice of putting a child in a separate, contained space on their own.

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[291] UHS, *Incident Report at Harbor Point* (Sep. 26, 2022) UHS–FINHELP–00010355 at 00010358.

[292] Acadia, *Licensing Compliance Record* (Aug. 31, 2021) 20210831 Millcreek AR state licensure-findings at p.1.

[293] *Id.*

[294] UHS, *State of West Virginia Department of Health and Human Services Bureau for Children Families Deputy Commissioner of Programs Division of Children and Audit Services, To: [REDACTED] Program Director, Riverpark Hospital-Barboursville School* (Apr. 20, 2020) UHS–FINHELP–00011728 at 00011729.

[295] *Id.*

[296] UHS, *Final Accreditation Report at Anchorage, AK* (Jan. 18, 2023) UHS–FINHELP–00011215 at 00011221.

[297] UHS, *Inspection Results at Palmetto Pines* (Feb. 23, 2021) UHS–FINHELP–00011332.

[298] *Id.*

[299] 42 U.S.C. § 483.356(a).

While there can be legitimate uses for these practices, such as when a child is actively self-harming, restraint and seclusion are risky measures. Even when employed properly, restraint and seclusion can harm children, including trauma and physical injury. When restraint and seclusion are used improperly, risk increases exponentially—children may be deeply traumatized, seriously injured, or even die.

There are strict guidelines governing the appropriate usage of restraint and seclusion, including technique, appropriate use, documentation protocol, and more. For example, federal PRTF regulations prohibit restraint and seclusion from being used concurrently.[300] But, the Committee's review has determined that restraint and seclusion guidelines and regulations are often ignored.

The following constitutes misuse of restraint and seclusion: its use for discipline, staff convenience, on a child in crisis without staff previously attempting and exhausting other de-escalation measures, on a child who is not in crisis, on a child for longer than regulated "limited duration" timeframes, on a child without the intervention being ordered by a qualified clinician, on a child without following prescribed safety guidelines, on a child that results in injury, its use on a child without documentation thereafter, on a child without being reported to the relevant authorities thereafter, and its use on a child without debriefing the incident thereafter. With respect to a chemical restraint, any non-therapeutic purpose, including as a punishment, as a convenience measure, or as a stand-in for proper staffing, would constitute abuse. Additionally, chemical restraints can be addictive, so regularly exposing anyone to them, especially young children, can cause them to develop a dependence on these medications.

UHS, Acadia, Vivant, and Devereux all use chemical and physical restraints on children. They do not use mechanical restraints. Vivant does not use seclusion as it is "philosophically misaligned and inconsistent with trauma-informed care."[301] In recent years, Acadia has made strides towards eliminating seclusion in its facilities, as well. The company told Committee staff that 7 out of its 10 facilities currently do not use seclusion because it is not therapeutic for a child to be secluded.[302] In those facilities, Acadia has modified seclusion rooms by removing doors from those rooms and adding monitoring cameras.[303] These seven facilities still have Quiet Rooms, Comfort Rooms, and/or De-Sensitization Rooms, which are separate spaces to which a child may choose to remove themselves, but are not required to go.[304]

Chemical restraints and seclusion cannot be used simultaneously, per federal regulation.[305] Nevertheless, in 2018, Piney Ridge Treatment Center (Acadia; Arkansas) was regularly pairing the two interventions. According to documents reviewed by the Committee, as well as an official report cited by *The Arkansas Democrat-Gazette* on restraint overuse at Piney Ridge Treatment Center (Acadia; Arkansas), chemical restraint and seclusion were routinely given concurrently 13 times in a 30-day period.[306] The document cited by *The Arkansas Democrat-Gazette* includes the following quote from a child describing how Piney Ridge Treatment Center (Acadia; Arkansas) staff use both restraint and seclusion, "[t]hey restrain people left and right . . . grab them and take them in the time-out room and give them shots."[307] This is supported by documents produced to the Committee that note Piney Ridge Treatment Center (Acadia; Arkansas) was cited because it "failed to ensure a chemical restraint and seclusion were not used simultaneously."[308] The form names 13 separate instances involving nine separate children for whom staff employed both seclusion and chemical restraint concurrently. The documents show that the facility would routinely place a child in a physical restraint, administer a chemical restraint during the physical restraint, then immediately place the child in seclusion. This

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[300] *Id.*

[301] Vivant, *Response Letter* (Oct. 27, 2023) FINAL-VIVANT Follow-Up Responses to the July 21 Letter executed at p. 6

[302] Acadiana Treatment Center (Acadia; Louisiana), Cove PREP (Acadia; Pennsylvania),and Youth Care Treatment Center (Acadia; Utah) are the three facilities that still utilize seclusion; Notes from Acadia Healthcare Briefing (May 17, 2024) (on file with Committee).

[303] Notes from Acadia Healthcare Briefing (May 17, 2024) (on file with Committee).

[304] *Id.*

[305] 42 CFR § 483.356(a)(4).

[306] Arkansas Democrat Gazette, *Records: Northwest Arkansas child site violated U.S. rules* (Dec. 1, 2019) *https://www.arkansasonline.com/news/2019/dec/01/records-child-site-violated-u-s-rules-2/; [https://perma.cc/62AQ-QZR3].*

[307] *Id.*

[308] Acadia, *Plan of Correction* (Nov. 4, 2019) 20191011 Piney Ridge OLTCPOC RESPONSE-REVISED SIGNED.

same facility conducted 110 restraints and seclusions in a 30-day period.[309] After this prohibited conduct was identified by regulators, Piney Ridge Treatment Center (Acadia; Arkansas) instituted a CAP, which included re-training and a competency test following re-training which consisted of a 10-question multiple choice test. One of the True/False items states "Restraint and seclusion cannot be used simultaneously."[310]

When the Committee raised the above document with Acadia leadership, they said they were aware of this trend of extensive simultaneous restraint and seclusion prior to the public reporting.[311] Initially, to explain this violation of federal regulation, Acadia leadership said that the regulation had just changed and staff were simply following outdated policy which still allowed for concurrent restraint and seclusion.[312] When Committee staff referred Acadia leadership to its own policy which actually disallowed this practice (in alignment with federal rules), Acadia personnel said that, then, the issue was "even more simple" because it meant that staff were not following company policy *or* federal regulation.[313] Later, when asked if a rate of 110 restraints and seclusions in a month would trigger scrutiny through Acadia's standard restraint review processes, Acadia executives said they would need more context and said that some children are "restrained a couple of times a day,"[314] so 110 restraints and seclusions in a single month would not represent every child being restrained or secluded at least once.[315] Further, when asked if this was problematic behavior, Acadia executives objected to the premise of the question.[316]

Committee staff asked UHS leadership whether there are any circumstances when a child might be both chemically restrained and secluded. UHS personnel stated they believed there were circumstances in which it could be necessary and said that there are no rules preventing doubling or tripling up on a restraint and seclusion.[317] In fact, such practice is prohibited by federal regulations.[318]

Committee staff reviewed documents from three of the four providers detailing the rates of incidents and restraint and seclusion at the facilities they operate within the 2017 through 2022 production range. Each provider tracks serious incidents per facility in rates per 1,000 patient days. For all providers except Vivant, which has prohibited the use of seclusion at its facilities, "serious incidents" includes instances of restraint and/or seclusion. UHS provided anonymized data for its facilities related to overall incidents and rates of restraint and seclusion from 2018 through 2022. There were some facility restraint rates that appeared low, but other facility restraint rates that appeared extremely high. However, one cannot say with certainty because the industry lacks established benchmarks and public reporting measures.[319] While 36 of the 59 UHS facilities saw a decrease in the use of restraint between 2018 and 2022, in 2022, 35 UHS facilities had a double digit restraint rate per 1,000 patient days, with the highest being 78.92 restraints per 1,000 patient days.[320] Similarly, while 60 percent of UHS facilities had zero instances of seclusion in 2022, one UHS facility has 12.63 seclusions per 1,000 patient days the same year.[321] In another case, Vivant averaged 5.38 restraints per 1,000 patient days through 2022.[322] Acadia produced multiple incident spreadsheets dating back to February 2017 which cumulatively list thousands of incidents, but the company did

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[309] Arkansas Democrat Gazette, *Records: Northwest Arkansas child site violated U.S. rules* (Dec. 1, 2019) *https://www.arkansasonline.com/news/2019/dec/01/records-child-site-violated-u-s-rules-2/; [https://perma.cc/62AQ-QZR3].*

[310] Acadia, Plan of Correction Response Attachments (Nov. 4, 2019) 20191011 Piney Ridge OLTCPOC RESPONSE ATTACHMENTS; Acadia, *Plan of Correction* (Nov. 4, 2019) 20191011 Piney Ridge OLTC POC RESPONSE-REVISED SIGNED at p. 2.

[311] Notes from Acadia Healthcare Briefing (May 17, 2024) (on file with Committee).

[312] *Id.*

[313] *Id.*

[314] *Id.*

[315] *Id.*

[316] *Id.*

[317] Notes from Universal Health Services Briefing (May 23, 2024) (on file with Committee).

[318] 42 CFR § 483.356(a)(4).

[319] UHS, *Patient Safety Work Product—Incident Rates* (2018) UHS–FINHELP–00012275.

[320] UHS, *Patient Safety Work Product—Restraint & Seclusion Rates* (2018–2022) UHS–FINHELP–000122754.

[321] *Id.*

[322] Vivant, *Senate Inquiry Response* (Aug. 18, 2022) FINAL—Vivant Senate Inquiry Response (08.18.22) at p. 18.

not provide a single rate.[323] Devereux failed to produce any incident or rate and seclusion data to the Committee.

i. Physical Restraint: Misuse and Harm

A 19-year-old with autism died following a restraint at Laurel Heights (UHS; Georgia). According to a 2017 report, a staffer at Laurel Heights (UHS; Georgia) called 911 because there was "a child that's not breathing."[324] According to a Georgia Department of Community Health report reviewed by a member of the press, "the facility used a manual hold in a manner that would potentially impair the patient's ability to breathe resulting in the death of the patient."[325] According to public reporting, during the 8-minute restraint, staff sat on the teen's midsection and back and he "choked on his own vomit"[326] face down.

A child "died of positional asphyxiation"[327] at North Spring Behavioral Healthcare (UHS; Virginia) after being placed in a restraint. According to reports, a child at North Spring Behavioral Healthcare (UHS; Virginia) was placed in a seclusion room where he began punching walls. "After receiving multiple redirections, [the child] did not stop and staff initiated a physical restraint . . . About 2 minutes into the hold nurse observed that [the child] dropped his head down and sounded like he was snoring."[328] The "[n]urse went to get the smelling salts, but [the child] did not respond to it . . . [and noted] scant blood on the end of [the child's] nose."[329] The state medical examiner found that the child "died of positional asphyxiation."[330] According to reports, the child's mother said of her son's death, "[i]t should have never happened. I want my son back."[331]

The State of Alaska stopped sending children to Millcreek of Arkansas (Acadia; Arkansas) due to concerning use of restraints. In a letter dated June 4, 2019, the State of Alaska Department of Health and Human Services notified Millcreek of Arkansas (Acadia; Arkansas) that, due to sustained noncompliance with CMS regulations, Alaska would not approve any new admissions to the facility until further notice. The letter notes that, in March 2018, Alaska conducted an annual review that identified concerns regarding the use of restraint at the facility that warranted corrective action. The following year, an unannounced visit to the RTF identified that use of restraint remained problematic, so Millcreek of Arkansas (Acadia; Arkansas) was placed on a 90-day admissions hold. During that time, the facility was required to address six corrective action items. The same June letter noted that the facility, again, remained out-of-compliance with CMS regulations, prompting Alaska to notify Millcreek of Arkansas (Acadia; Arkansas) that Alaska "will not approve any admissions to the facility until further notice effective immediately."[332]

Restraint should only be used as a last resort, but Committee review determined that in many instances, staff resort to it on a regular basis. According to documents reviewed by the Committee, at Millcreek of Arkansas (Acadia; Arkansas), a child was physically restrained for refusing to consent to a strip search.[333] The documents indicate a staff member attempted to justify the restraint as reasonable given that the child "refused" to follow directions.[334]

At Palmetto Pines Behavioral Health (UHS; South Carolina), a child was acting out and throwing food at a staff member. According to documents reviewed by the Com-

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[323] Acadia, *Incident Report,* ACADIA—00002839; Acadia, *Incident Report,* ACADIA—00002840; Acadia, *Incident Report,* ACADIA—00002841; Acadia, *Incident Report,* ACADIA—00002842; Acadia, *Incident Report,* ACADIA—00002843; Acadia, *Incident Report,* ACADIA—00002844.

[324] 11 Alive, *Family suing over teen son's death in psychiatric hospital* (Dec. 16, 2017) *https://www.11alive.com/article/news/local/holding-powerful-accountable/family-suing-over-teen-sons-death-in-psychiatric-hospital/85-499825458; [https://perma.cc/W775-QRX9].*

[325] *Id.*

[326] *Id.*

[327] The Washington Post, *"He didn't deserve the way he died": Mother of teen restrained at behavioral health facility speaks out* (Jan. 27, 2018) *https://www.washingtonpost.com/local/public-safety/he-didnt-deserve-the-way-he-died-mother-of-teen-restrained-at-behavioral-health-facility-speaks-out/2018/01/26/92428f5e-fd47-11e7-a46b-a3614530bd87—story.html; [https://perma.cc/KTQ8-Q7HK].*

[328] *Id.*

[329] *Id.*

[330] *Id.*

[331] *Id.*

[332] Acadia, *Extended Admission Holds at Millcreek Alaska* (June 4, 2019) 20190604 Millcreek Alaska HHS Referral Hold Letter at p. 1.

[333] Disability Rights Arkansas, *RE: [Redacted] To: [Redacted], Chief Executive Officer* (Jan. 30, 2019) 20190604 Millcreek Alaska HHS Referral Hold at p. 14.

[334] *Id.*

mittee, the staff member stated that they "warned [the child] that if this continued that I was going to deal with [the child] . . . so I chased"[335] the child. In another incident, a nurse who observed a restraint at Cedar Ridge Treatment Facility (UHS: Oklahoma) said "she did not believe a restraint was warranted at the moment it was initiated."[336] The Committee discovered a case at Brynn Marr Hospital (UHS; North Carolina) where a restraint was included in a child's crisis plan. However, restraints are required to be ordered on a case-by-case basis in crisis and, per federal regulation, "must not be written as a standing order or on an as-needed basis."[337]

Facilities use restraint illegally as punishment and on children who are not imminent risks to themselves or others, including when children are sitting calmly. The Committee reviewed a corrective action plan submitted by Piney Ridge Treatment Center (Acadia; Arkansas) to a state oversight agency in which the facility agreed, in response to findings of wrongdoing, that it would "not use physical discipline as a means of correcting a child's behavior."[338]

Foundations for Living (UHS; Ohio) received three citations in August 2019 by the Ohio Mental Health and Addiction Services Bureau of Licensure and Certification for improper use of restraint.[339] A child was placed in a "Handle with Care (HWC) hold for destruction of property and stealing [a] staff radio,"[340] and a second child was restrained because she "refused to give a rod that she had in her pants to the nurses. The documentation stated she was uncooperative but *noncombative,*"[341] and a third child was placed in a hold "for stealing staff keys and running from unit to unit."[342]

At Copper Hills Youth Center (UHS; Utah) a video review found that a "child was sitting down and did not present harm to self, others, or property. The physical restraint used was not justified or necessary."[343] The Committee's review also discovered that Copper Hills Youth Center (UHS; Utah) had language in the admission packet deeming "property damage is cause for restraint,"[344] even though this violates federal rules.

The Committee reviewed many cases of staff using improper restraint techniques. Cedar Ridge Treatment Center (UHS; Oklahoma) was cited for confirmed caretaker misconduct for placing a child in "an improper and unwarranted escort/restraint resulting in an injury"[345] to the child. A staffer at Piney Ridge Treatment Center (Acadia; Arkansas) "reported that questionable restraints are being utilized, such as staff grabbing the beneficiary by the arm and then walking then [sic] back, usually outside and beyond the camera range."[346] Two separate incidents at Provo Canyon School (UHS; Utah) involved staff, "acting outside of their Handle with Care training to restrain a student," including an incident in which a staffer "pulled a student's hair for leverage in a restraint."[347]

At Cedar Ridge Behavioral Hospital (UHS: Oklahoma), the Oklahoma Department of Human Services reported a finding of caretaker misconduct because the restraint used by staff "appeared to be improper technique."[348] During the restraint, the staff

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[335] UHS, *Plan of Corrections Reporting at Palmetto Pines* (Oct. 28, 2020) UHS–FINHELP–00011285 at p. 9.
[336] UHS, *Licensing Complaint Report Summary at Cedar Ridge* (Feb. 26, 2021) UHS–FINHELP–00011933 at 00011938.
[337] CFR § 483.356(a)(2).
[338] Acadia, *Corrective Action Agreement at Piney Ridge* (Nov. 26, 2019) 20191126 Piney Ridge AR DHS Corrective Action Plan Agreement signed at p. 1.
[339] UHS, *Foundations for Living Compliance with Ohio Administrative Code* (Nov. 25, 2019) UHS–FINHELP–00009837 at 00009844–00009845.
[340] *Id.* at 00009843.
[341] *Id.* (italics added).
[342] *Id.* at 00009844.
[343] UHS, *Copper Hills Corrective Action Plan Response* (Dec. 22, 2021) UHS–FINHELP–00009863 at 00009864.
[344] UHS, *Copper Hills Youth Center Alaska Corrective Action Plan* (Feb. 11, 2021) UHS–FINHELP–00009872 at 00009872.
[345] UHS, *Licensing Complaint Report Summary at Cedar Ridge* (Feb. 26, 2021) UHS–FINHELP–00011933 at 00011985.
[346] Acadia, *Inspection of Care Report at Piney Ridge* (Apr. 9, 2018) 20180409 Piney Ridge AR Beacon Report at p. 3.
[347] UHS, *State of Utah Department of Human Services Corrective Action Plan for Provo Canyon* (Jan. 13, 2020) UHS–FINHELP–00011508 at 00011509.
[348] UHS, *Licensing Complaint Report Summary at Cedar Ridge* (Feb. 26, 2021) UHS–FINHELP–00011933 at 00011938.

member "grab[bed the child before] go[ing] to the floor. [The staff] did not take a step back and lower [the child] to the floor per HWC [Handle With Care] guidelines [and] placed his knee in [the child's] side and/or back."[349] Then, the staff escorted the child to the quiet room with one of the child's "arms elevated and one arm underneath [the child's] arm"[350] which is an improper escorting technique. A staffer described the restraint as "almost prone position . . . on his side leaning towards his stomach"[351] but did not intervene.

At Palmetto Pines Behavioral Health (UHS; South Carolina), documents show that a child was restrained with "excessive force"[352] and "there was a danger of suffocation."[353] The child was placed in a restraint while a chemical restraint was prepared and, during this time, the child started to spit. Staff placed a towel over the child's mouth, which is a suffocation risk, even though "facility policy provided for review does not mention actions to be taken or equipment to be used when a resident spits on a staff member during a restraint."[354]

The Committee also reviewed public reporting of incidents of improper restraint. According to *North Carolina Health News,* the state investigated Brynn Marr Hospital (UHS; North Carolina) multiple times and cited deficiencies for failure to properly train staff on restraints and failure to report serious incidents.[355] Eyewitnesses near Desert Hills Hospital (Acadia; New Mexico) raised concerns about the facility's use of restraint; a neighbor of the now-closed facility told local media, "200-hundred to 300-pound men jumping on a little boy that weighs maybe 90 pounds. Come on, man, you're gonna break his back."[356]

Public reporting and documents reviewed by the Committee contain many accounts of restraints resulting in harm to children. According to a 2022 public report concerning Foundations Behavioral Health (UHS; Pennsylvania), a staffer attempted to restrain a nonverbal 18-year-old, but "staff members said they saw [the staffer] block the patient from leaving his room, push him to the ground and then kick the patient in the head, chest and stomach."[357] The child was taken to the hospital where doctors said the child "might have a small radial neck fracture."[358]

In the incident from Palmetto Pines Behavioral Health (UHS; South Carolina) described above, documents reviewed by the Committee showed a child was restrained with "excessive force"[359] and "there was a danger of suffocation"[360] because a towel was placed over their mouth. This improper restraint resulted in the child losing part of a tooth, plus a scratch from staff grabbing the child's neck and bruising and redness on both shoulders.[361]

Oklahoma announced its intention to terminate Cedar Ridge Behavioral Hospital (UHS; Oklahoma) as a Medicaid provider because of the facility's "non-compliance with the requirements of the [corrective action plan], as well as general non-compliance with the applicable rules and regulations."[362] The first example the state cited was the facility's improper use of seclusion and restraint. When Com-

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[349] *Id.* at 00011939.
[350] *Id.*
[351] *Id.* at 00011938.
[352] UHS, *Plan of Correction Reporting at Palmetto Pines* (Oct. 28, 2020) UHS–FINHELP–00011285 at 00011299.
[353] *Id.*
[354] *Id.*
[355] North Carolina Health News, *Durham 11-year-old was sexually assaulted in NC psychiatric hospital, parents allege* (Nov. 30, 2022) *https://www.northcarolinahealthnews.org/2022/11/30/parents-allege-11-year-old-sexually-assaulted-in-nc-psychiatric-hospital/; [https://perma.cc/Q5GQ-6SUV].*
[356] KOAT, *Neighbors who live near Desert Hills Hospital are happy it's closed* (Apr. 1, 2019) *https://www.koat.com/article/neighbors-who-live-near-desert-hills-hospital-are-happy-its-closed/27011248; [https://perma.cc/L2V6-VDQU].*
[357] TAPinto Doylestown, *Foundations Employee Charged with Punching, Kicking Nonverbal Patient* (Aug. 11, 2022) *https://www.tapinto.net/towns/doylestown/sections/police-and-fire/articles/foundations-employee-charged-with-punching-kicking-nonverbal-patient; [https://perma.cc/XG5D-WAZP].*
[358] *Id.*
[359] UHS, *Plan of Correction Reporting at Palmetto Pines* (Oct. 28, 2020) UHS–FINHELP–00011285 at 00011299.
[360] *Id.*
[361] *Id.* at 00011300.
[362] UHS, *Notice of Intent to Terminate Sooner Care Contract at Cedar Ridge* (Apr. 29, 2019) UHS–FINHELP–000011847.

mittee staff inquired about this, UHS leadership highlighted that, in the end, the state never terminated the contract.[363]

At Millcreek of Arkansas (Acadia; Arkansas) a child was sent to the hospital after being "badly bruised"[364] on his shoulder where a staffer held him down during a "three man restraint."[365] The child rated the pain "10/10" and had "no ROM [range of motion]."[366] A staffer said, "I never seen a restraint look like that."[367] Three days later, the child showed a "fading brown, green and yellow bruise, approximately 3 inches in width and 4 to 5 inches in length"[368] to state inspectors who proclaimed, "[t]hat's a pretty good bruise."[369]

In a second incident at Millcreek of Arkansas (Acadia; Arkansas), a child sustained scratches to their hands and neck and a bruise under their eye during a restraint.[370] During this hold, a staff member held the child "against the wall . . . [with their] forearm positioned against the resident's neck and upper chest area, pinning" them.[371] Of the injuries, a nurse said, "the blood was fresh."[372] According to documents reviewed by the Committee, this incident was not initially reported, although the staff member affirmed this was "[i]n a way, yes"[373] a type of abuse.[374]

The Committee reviewed an incident at Cedar Ridge Treatment Center (UHS; Oklahoma) where a staffer "pinched [a child's] hands and feet during a restraint"[375] and reportedly verbally threatened the child.[376] An Oklahoma Office of Client Advocacy investigation confirmed caretaker misconduct and noted that the "body language appeared confrontational, demanding, and intimidating upon review of video footage."[377]

The Committee reviewed another incident of substantiated abuse at Cedar Ridge Treatment Center (UHS; Oklahoma).[378] While the document is heavily redacted, it reads as if the staff member bit, bruised, and spit at a child during a restraint.[379] The state inspector reviewed photographs that "show bruising on the back left shoulder that is consistent with a bite injury and bruising on the inner right bicep consistent with grabbing."[380] The staff member also reportedly "hit the resident" because the resident spat at him.[381]

Failure to properly document use of restraint. Facilities are required to document numerous items related to restraints, including child assessments during restraints and efforts post-restraint to update treatment plans.[382] The Committee reviewed multiple instances where facilities failed to do this. Nevertheless, one company leader described adhering to proper documentation protocol as "onerous but important" to the care of a child, especially when it comes to documenting physicians' orders for use of restraint.[383]

The Committee reviewed a Joint Commission accreditation report which identified an intervention at North Star Palmer Residential Treatment Center (UHS; Alaska) which "may have lasted 13 minutes or over 40 minutes."[384] At Foundations for Living (UHS; Ohio) staff failed to document critical factors, like "vital signs, circulation, range of motion, hydration, hygiene, toileting, need for continued restraint, and

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[363] Notes from Universal Health Services Briefing (May 23, 2024) (on file with Committee).
[364] Acadia, *Statement of Deficiencies and Plan of Correction at Millcreek Arkansas* (June 28, 2019) 20180629 Millcreek 2567 w POC 071119 at p. 2–3.
[365] *Id.* at p. 3.
[366] *Id.*
[367] *Id.* at p. 4.
[368] *Id.*
[369] *Id.*
[370] Acadia, *Statement of Deficiencies and Plan of Correction at Millcreek Arkansas* (May 25, 2018) 20180525 Millcreek CMS 2567 report N Tags POC at p. 5–6.
[371] *Id.* at p. 7.
[372] *Id.* at p. 8.
[373] *Id.*
[374] *Id.* at p. 9.
[375] UHS, *Plan for Immediate Safety at Cedar Ridge* (Apr. 2, 2021) UHS–FINHELP–00011933 at 00011941.
[376] *Id.*
[377] *Id.* at 00011945.
[378] *Id.* at 00011964.
[379] *Id.*
[380] *Id.*
[381] *Id.*
[382] 42 CFR § 483.358(h).
[383] Notes from Universal Health Services Briefing (May 23, 2024) (on file with Committee).
[384] UHS, *The Joint Commission—Final Accreditation Report: Frontline Hospital* (Apr. 25, 2019) UHS–FINHELP–000011252 at 00011266.

other needs as necessary"[385] during a restraint. In another instance, the state's Bureau of Licensure and Certification found multiple children's crisis plans were not developed until well after their admission date.[386] At River Park Hospital (UHS; West Virginia) 60 percent of records reviewed revealed that "the facility failed to ensure the date and time of all restraint or seclusion orders matched the date and time of the restraint or seclusion intervention."[387] The Joint Commission found that, at Pavilion Behavioral Health System (UHS; Illinois), a post-restraint assessment lacked a time denoting the doctor's notification and child-facing debrief, even though both must occur within 24-hours of the intervention.[388] In a Cedar Ridge Behavioral Hospital (UHS; Oklahoma) state review, an assessor looked at 32 restraints and found issues, including lack of physician participation in staff and child debrief post-restraint, improper documentation, and incorrect staff participating in the debrief.[389]

Failure to conduct post-restraint debriefs and assessments. Facilities are required to record and conduct post-restraint debriefs with children, physicians, and staff involved.[390] The Committee reviewed multiple instances where facilities failed to conduct these assessments.

The Joint Commission identified numerous restraint issues at Palmet to Summerville Behavioral Health (UHS; South Carolina). In one case, the physician's post-restraint documentation was "late by over two hours . . . [and] blank in pertinent areas on the restraint form."[391] Further, this same survey found that "required forms were not completed by the same physician over more than 6 months."[392] At Hill Crest Behavioral Health Services (UHS; Alabama) The Joint Commission identified two restraints where there was no evidence a physician was consulted.[393] Cedar Ridge Behavioral Hospital (UHS; Oklahoma) failed to "properly document assessments, specifically several records indicate that the physician had somehow been notified of the post-assessment prior to the assessment taking place."[394] At Brynn Marr Hospital (UHS; North Carolina) multiple restraints had not been reported to the state's P&A, in violation of state law.[395] At Copper Hills Youth Center (UHS; Utah), a review by the Alaska Department of Health and Social Services noted the "majority of reviewed documentation of restraint events were found to be out of compliance with"[396] CMS regulation. At Foundations for Behavioral Health (UHS; Pennsylvania) a restraint "was initiated at 11:45 AM and discontinued at 12:00 PM . . . [but] the 1 hour assessment of the physical and psychological well-being was conducted at 11:30 AM, 15 minutes prior to the start of this restraint."[397] The Joint Commission found that Copper Hills Youth Center (UHS; Utah) failed to authenticate restraint orders in half of the records reviewed.[398] Three records at Hill Crest Behavioral Health Services (UHS; Alabama) did not include "notification of [a restraint to] the recipient's family/legal guardian consistent with organizational policy and the agreement with the family/legal guardian."[399] RTC Resource ACQ

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[385] UHS, *Ohio Mental Health and Addiction Services Survey Report of Foundations for Living* (Sep. 16, 2019) UHS–FINHELP–00009837 at 00009846.
[386] *Id.* at 00009844.
[387] UHS, *Statement of Deficiencies and Plan of Correction at River Park Hospital* (July 4, 2018) UHS–FINHELP–00011745 at 00011747.
[388] UHS, *Final Accreditation Report at The Pavilion Foundation* (Dec. 14, 2022) UHS–FINHELP–00009822 at 00009828.
[389] UHS, *Corrective Action Plan Requested at Cedar Ridge* (Feb. 18, 2021) UHS–FINHELP–00012134 at00012136.
[390] 42 CFR § 483.370.
[391] UHS, *Final Accreditation Report at The Pines* UHS–FINHELP–00011466 at 00011471.
[392] *Id.* at 00011473.
[393] UHS, *Requirements for Improvements* (Jan. 19, 2018) UHS–FINHELP–0009579 at 0009584–0009585.
[394] UHS, *Notice of Intent to Terminate Sooner Care Contract at Cedar Ridge* (Apr. 29, 2019) UHS–FINHELP–000011847 at 000011847–000011848.
[395] UHS, *Statement of Deficiencies and Plan of Correction at Brynn Marr Hospital* (Oct. 20, 2021) UHS–FINHELP–00008911 at 00008917.
[396] UHS, *Alaska Department of Health and Social Services* (Oct. 11, 2019) UHS–FINHELP–00009926 at 00009931.
[397] UHS, *Statement of Deficiencies and Plan of Correction at Foundations Behavioral Health Perseverance* (Mar. 25, 2021) UHS–FINHELP–00010014 at 00010022.
[398] UHS, *Final Accreditation Report at Kids Behavioral Health of Utah* (Jan. 16, 2023) UHS–FINHELP–00009962 at 0000968.
[399] UHS, *Mental Illness Site Visit Report at Hill Crest* (July 25, 2019) UHS–FINHELP–00009384 at 00009390.

Corp (UHS; Indiana) was cited for failing to ensure a face-to-face assessment of a child within an hour of a restraint or seclusion for eight of nine records reviewed.[400]

ii. Seclusion: Misuse and Harm

Committee staff witnessed concerning conditions in multiple seclusion rooms on their visits to a reflective sample of facilities. During Committee staff's visits to RTF sites, Committee staff observed seclusion rooms which had cinder block walls and were no larger than a walk-in closet. At multiple facilities, the small plastic panel on the door, through which staff would be required to observe secluded children, was scratched out. In one RTF, there was a dried black substance on the wall. Staff believe this was dried blood, although it may have been dried feces or some other human substance. When P&A staff inquired about the substance and suggested that it was dried blood, the RTF staffer said, "[i]t's black. Blood isn't black."

Review of public reporting concerning seclusion practices that violate regulations. The Committee reviewed public reporting and testimony on seclusion details practices that violate three federal rules related to seclusion: (i) continuous supervision during seclusion,[401] (ii) not using seclusion as a punishment,[402] and (iii) only placing one child in a seclusion room at a time.[403] According to reports concerning Piney Ridge Treatment Center (Acadia; Arkansas), the "seclusion room has a small, plastic-glass window in the door. The window is often dirty and hard to see through"[404] which would inhibit supervision. *The Salt Lake Tribune* investigative reporting described how, to discipline children for making sexual comments, the staff members at Copper Hills (UHS; Utah) were "putting the boys together in a seclusion room . . . where they were left for hours with little to no supervision."[405] A lawsuit filed by one of the children's guardians claims that, while detained together in the seclusion room, "the boys exposed themselves to one another and engaged in sex acts."[406] At North Star (UHS; Alaska), according to *Anchorage Daily News* coverage of federal investigative reports, two children were "locked in a 'quiet room' together accidentally. One attacked the other, leaving a child's nose bloodied."[407] The article notes that the "hospital didn't investigate how the incident happened."[408] In other reported incidents at North Star (UHS; Alaska),

> The investigators found instances in which children were left in the rooms without any documentation in their records, or were not properly monitored. In one case, a child slept in the room overnight. A patient under the age of 9 spent more than an hour locked in seclusion, against policy, investigators found.

UHS documents reviewed by the Committee show Sandy Pines (UHS; Florida) did not properly document the monitoring of children in seclusion. When The Florida State Agency for Health Care conducted a visit to Sandy Pines (UHS; Florida), the facility was found to be "not in compliance" because it had improper "APPLICATION OF TIME OUT."[409] The facility "failed to document the monitoring of their residents while in 'TIME OUT' for 5 of 14 sampled residents."[410] A nurse at the site told the inspector, "I have worked for this facility for 4 months and I am not familiar with any 'Time Out Logbooks'."[411] Immediately thereafter, "when asked if she could name a resident that she knows has had 'Time Outs,' she states the resident . . . had a 'Time Out' yesterday or the day before that and ac-

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[400] Acadia, *Statement of Deficiencies and Plan of Correction* (Apr. 29, 2021) 20210429 Resource-4-2021 CMS2567 Statement of Deficiencies-final report at p. 2.

[401] 42 CFR § 483.364(a).

[402] 42 CFR § 483.356(a)(1).

[403] 42 CFR § 483.352.

[404] Arkansas Democrat Gazette, *Records: Northwest Arkansas child site violated U.S. rules* (Dec. 1, 2019) *https://www.arkansasonline.com/news/2019/dec/01/records-child-site-violated-u-s-rules-2/; [https://perma.cc/62AQ-QZR3].*

[405] The Salt Lake Tribune, *Utah treatment center sued after boys engaged in sex acts in a seclusion room* (Aug. 27, 2019) *https://www.sltrib.com/news/2019/08/27/utah-treatment-center/; [https://perma.cc/VF6B-TFN6].*

[406] *Id.*

[407] Anchorage Daily News, *Federal inspectors fault assaults, escapes, improper use of locked seclusion at North Star youth psychiatric hospital* (Sep. 28, 2022) *https://www.adn.com/alaska-news/2022/09/28/federal-inspectors-fault-assaults-escapes-improper-use-of-locked-seclusion-at-north-star-youth-psychiatric-hospital/; [https://perma.cc/C7WJ-MNQN].*

[408] *Id.*

[409] UHS, *Statement of Deficiencies and Plan of Correction at Sandy Pines* (Sep. 10, 2021) UHS–FINHELP–00009720 at 00009723.

[410] *Id.*

[411] *Id.* at 00009724.

knowledged that the 'Time Out Log' is 'blank' for this resident."[412] In an interview with a different staffer, the staffer mentioned that another resident had been placed in "Time Out" in September. But, "[r]eview of the September 'Time Out Log' reveals that it is 'blank'."[413] In an interview with a child, the inspector asked "have [you] had any 'Time Outs' for the month of September[?]"[414] The child responded, "Yes, you mean the little room they take me to?"[415] Despite this acknowledgement from the child, the "Time Out Log" corresponding to that child for that month was "blank."[416]

Company documents reviewed by the Committee show issues related to improper documentation of seclusion at additional facilities. The Committee reviewed reports showing documentation issues at a number of RTFs. An assessment from Copper Hills (UHS; Alaska) noted that the "majority of reviewed documentation of seclusion and restraint events were found to be out of compliance with . . . CMS regulations."[417] Piney Ridge Treatment Center (Acadia; Arkansas) also has seclusion practice and documentation issues. In one instance, a seclusion was administered prior to being ordered by a provider. For example, one child was secluded at 12:45 pm, even though the "Restraint Order Received form [sic] MD [. . . is time stamped] 12:48 pm."[418] The Florida Agency for Health Care conducted a visit for Sandy Pines (UHS; Florida) where the facility was found to be "not in compliance"[419] with seclusion documentation requirements. The inspector observed a resident placed in "Time Out" and, upon inspection of the "Time Out Log," there was no corresponding entry.[420] One staffer admitted he "only fills out the 'Time Out Log' if a resident is in 'Time Out' for more than 30 minutes"[421] whereas another staffer explained that "the night staff fills out the 'Time Out Logs' and will only fill it out if the resident is aggressive."[422] The Director of Nursing acknowledged, "I need to re-educate the staff; we have many new staff."[423]

iii. Chemical Restraint & Polypharmacy: Misuse and Harm

A chemical restraint refers to anytime a child is administered a medication outside of their treatment plan as an intervention intended to restrict their normal movement. Chemical restraint is the most restrictive type of restraint and is intended only as an emergency safety intervention, when all other de-escalation methods have failed. The medication administered as a chemical restraint is often a high-dose shot of a sedative or an antipsychotic. Both UHS and Acadia leadership told Committee staff that, in order to safely administer a chemical restraint, they often must concurrently impose a physical restraint or hold on a child. Apart from chemical restraint, which refers to immediate intervention, children in RTFs may also experience polypharmacy, which is often defined as the simultaneous prescription of five or more medications.[424] This practice presents similar risks to children due to potential side-effects and drug interactions.[425]

Chemical Restraint

The Committee reviewed instances where staff used chemical restraints in unjustifiable circumstances, including on children who were calm or without attempting other less restrictive interventions prior. CMS regulations clearly state any type of restraint, including chemical restraint, must be used only

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[412] *Id.*
[413] *Id.* at 00009725.
[414] *Id.*
[415] *Id.*
[416] *Id.*
[417] UHS, *State of Alaska Department of Health and Social Services, Division of Behavioral Health, Site Review Summary of Findings* (Sep. 30, 2019) UHS–FINHELP–00099236 at 00009933.
[418] Acadia, *Statement of Deficiencies and Plan of Correction at Piney Ridge* (Oct. 11, 2019) 20191011 Piney Ridge OLTC POC RESPONSE-REVISED SIGNED at p. 4.
[419] UHS, *Statement of Deficiencies and Plan of Correction at Sandy Pines* (Sep. 10, 2021) UHS–FINHELP–00009720 at 00009721.
[420] *Id.* at 00009724.
[421] *Id.* at 00009725.
[422] *Id.*
[423] *Id.* at 00009726.
[424] Masnoon et al., What is polypharmacy? A systematic review of definitions, BMC GERIATRIC 17, 230 (2017). *https://doi.org/10.1186/s12877-017-0621-2.*
[425] *Desperation Without Dignity,* citing PATIENT-CENTERED OUTCOMES RES. INST., "Research Summary: Ensuring that Youth in Out of Home Care are only Prescribed Psychotropic Medication when it is in their Best Interests," p. 4, *https://www.pcori.org/sites/default/files/2019.07.14-PCORI-research-summary-memo.pdf.*

to ensure the immediate physical safety of the patient.[426] The Committee reviewed incidents that appear to conflict with this regulation. For example, at River Park Hospital (UHS; West Virginia) documents show a chemical restraint used on a child who was "documented as calmly standing in the quiet room"[427] and, then, intramuscularly restrained. In another case, the staff gave an oral chemical restraint to a child who was "cooperative, alert and oriented times four."[428] Another child at River Park (UHS; West Virginia) called a state investigator who overheard a staffer say to the child that "he had two choice [sic] a shot or a pill."[429]

Improper use of chemical restraint practices at Piney Ridge Treatment Center (Acadia; Arkansas) included repeated failures to "document the attempt to allow for time for the client to calm or the use of less restrictive interventions before the administration of a chemical restraint for 10 [children]."[430] In most cases, children received a chemical restraint and another restraint concurrently. In other cases, there are only a few minutes between when a child was placed in an initial restraint and the time that a chemical restraint was ordered.[431] Further, in multiple cases, the child is described as "calm/quiet/willing to talk at the time the chemical restraint was administered."[432]

At Palmetto Pines Behavioral Health (UHS; South Carolina), a child who was physically restrained and given a chemical restraint "started crying and started talking with staff,"[433] but they continued to restrain the child and only "[a]bout 10 minutes after receiving meds we let up."[434]

Public reports document concerns regarding overreliance on chemical restraint and failure to employ proper de-escalation techniques. Independent oversight authorities and first hand accounts document concerns of frequent use of chemical restraints at RTFs. Experts interviewed by the Committee noted that in cases of repeated chemical restraint, children do not develop coping skills. Instead, they become reliant on chemical restraints to "calm . . . down," just as staff rely on chemical restraints for control.[435] As a lawyer at Disability Rights Arkansas explained to *The Arkansas Democrat Gazette,* "[t]he fact that that's kind of [a] pattern [where facilities widely use chemical restraints] shows that they're not effectively de-escalating situations."[436] The reliance on chemical restraint at some facilities is exemplified by Resource Treatment Center (Acadia; Indiana) where The Joint Commission found that the facility had a single month with "97 holds and 50 stat medications"[437] at Piney Ridge Treatment Center (Acadia; Arkansas), where a former nurse said, "[i]t happens every single day that these kids are (restrained), they're re-traumatized at the hands of people who are supposed to be taking care of them."[438]

The Salt Lake Tribune's coverage of a 14-year-old Oregonian's harrowing out-of-state placement at Provo Canyon School (UHS; Utah) sheds light on her experience of being inappropriately and repeatedly chemically restrained. The girl, who had I/DDs, was chemically restrained 17 times over her approximately 3 months at Provo

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[426] 42 CFR 482.13(e)(I)(i)(2); 42 CFR 483.356(a)(3)(i).

[427] UHS, *Virginia Health and Human Resources Plan of Correction* (Jul. 4, 2018) UHS–FINHELP–00011745 at 00011746.

[428] *Id.* at 00011747.

[429] UHS, *Virginia Department of Health and Human Resources IIU Investigation—River Park* (Apr. 5, 2023) UHS–FINHELP–00011734 at 00011735.

[430] Acadia, *Department of Health and Human Services Statement of Deficiencies and Plan of Correction—Piney Ridge* (Oct. 2, 2020) 20201002 Piney Ridge OLTCPOC RESPONSE at p. 2.

[431] *Id.* at p. 25, 26, 27, 30, 31, 34, 36.

[432] *Id.* at p. 6,7, 8, 21, 28, 33, 35, 36.

[433] UHS, *South Carolina Department of Health and Environmental Control—Inspection Results: Palmetto Pines Behavioral Health* (Sep. 28, 2020) UHS–FINHELP–00011285at00011299.

[434] *Id.*

[435] Conversation with Native American Disability Law Center (Apr. 23, 2024) (Notes on file with Committee).

[436] Arkansas Democrat Gazette, *Records: Northwest Arkansas child site violated U.S. rules* (Dec. 1, 2019) *https://www.arkansasonline.com/news/2019/dec/01/records-child-site-violated-u-s-rules-2/; [https://perma.cc/62AQ-QZR3].*

[437] Acadia, *The Joint Commission—Final Accreditation Report: RTC Resource Acquisition Corporation* (June 18, 2021) 20210618 Resource TJC Complaint-Report at p. 7.

[438] KNWA, *KNWA investigation reveals years of licensing issues at children's treatment facility* (Oct. 4, 2021) *https://www.nwahomepage.com/news/knwa-investigation-reveals-years-of-licensing-issues-at-childrens-treatment-facility/; [https://perma.cc/5Z7A-PFNH].*

Canyon School (UHS; Utah).[439] Additionally, there were two dates when the girl was secluded and chemically restrained on the same day; these two instances of same-day chemical restraint and seclusion occurred within a 5-day period.[440] Another child who was repeatedly chemically restrained at Provo Canyon School (UHS; Utah) described it as "a liquid that makes someone fall asleep and calms you down."[441] Desert Hills Hospital (Acadia; New Mexico), which closed in early 2019 following a myriad of safety concerns and the loss of its certification from state regulators, is reported to have overused restraints.[442] According to a neighbor, "I've seen them running down the street after [the children] with those canisters. It's like a bullet, but they shoot them,"[443] while a spokesman for the facility reportedly admitted that Desert Hills Hospital (Acadia; New Mexico) continued to use chemical restraints on children, disregarding requests by state regulators that they stop.[444] State regulators ultimately concluded, "[w]e don't feel like this [is] a treatment center anymore."[445]

Public reporting on Piney Ridge Treatment Center (Acadia; Arkansas) includes an interview with a child who said they received "multiple [chemical restraints] black needle and the red needle"[446] whereas another child noted that "[they s]tart you out wit [sic] 2 shots when you get there . . . can get up to 10 shots at one time."[447] In an inspection report from Piney Ridge Treatment Center (Acadia; Arkansas), a child expressed fear related to chemical restraints. When asked if they felt safe, the child responded, "[n]ot always. I worry about getting shots."[448]

Oversight actors regularly identify problems with how facilities describe chemical restraint policies. The Committee reviewed documents showing that several facilities had policies that did not reflect the appropriate use of chemical restraints. For example, according to a report from the Ohio Department of Mental Health and Addiction Services, Foundations for Living (UHS; Ohio) documents include "an area on the restraint form that identified medication as a less restrictive intervention for restraints." In fact, "[m]edication is a form of chemical restraint, which is prohibited"[449] under applicable Ohio state law.[450] At Cedar Ridge Hospital (UHS; Oklahoma), the Oklahoma Health Care Authority (OHCA) found that "facility policy and procedures regarding chemical restraints were not consistent with OHCA and CMS rules."[451] The facility updated its policies in response to this finding, and while the OHCA accepted the revised policy, it noted that "the definition contained in the policy [still] does not conform to OHCA or CMS regulations."[452] The new policy forbids medication for disciplinary use or convenience, but does not specify that seclusion or restraint, "must be used **only** to ensure the immediate physical safety of the patient/resident or others,"[453] which would be necessary to align the facility's policy with both OHCA and CMS regulations.

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[439] The Salt Lake Tribune, *Utah "troubled-teen" centers have used "booty juice" to sedate kids, a practice outlawed in other states* (Feb. 4, 2021) *https://www.sltrib.com/news/2021/02/04/utah-troubled-teen/; [https://perma.cc/FY7K-7HZN].*

[440] *Id.*

[441] *Id.*

[442] Nashville Post, *Acadia facility closes amid abuse allegations* (Apr. 5, 2019) *https://www.nashvillepost.com/acadia-facility-closes-amid-abuse-allegations/article—707ab44b-adbf-5af8-bf6a-5b48ac61127d.html; [https://perma.cc/XH3C-VZTG].*

[443] KOAT, *Neighbors who live near Desert Hills Hospital are happy it's closed* (Apr. 1, 2019) *https://www.koat.com/article/neighbors-who-live-near-desert-hills-hospital-are-happy-its-closed/27011248; [https://perma.cc/L2V6-VDQU].*

[444] *Id.*

[445] Nashville Post, *Acadia facility closes amid abuse allegations* (Apr. 5, 2019) *https://www.nashvillepost.com/acadia-facility-closes-amid-abuse-allegations/article—707ab44b-adbf-5af8-bf6a-5b48ac61127d.html; [https://perma.cc/XH3C-VZTG].*

[446] Arkansas Democrat Gazette, *Monitors report neglect, sex, dirt at kids facility in Northwest Arkansas* (Nov. 10, 2019) *https://www.nwaonline.com/news/2019/nov/10/monitors-report-neglect-sex-dirt-kids-facility/; [https://perma.cc/HD3L-L9WR].*

[447] Arkansas Democrat Gazette, *Records: Northwest Arkansas child site violated U.S. rules* (Dec. 1, 2019) *https://www.arkansasonline.com/news/2019/dec/01/records-child-site-violated-u-s-rules-2/; [https://perma.cc/62AQ-QZR3].*

[448] Acadia, *Beacon Health Options—Inspection of Care Report: Piney Ridge Treatment Center* (Sep. 4–11, 2018) 20180904 Piney Ridge AR Beacon Report at p. 3.

[449] UHS, *Bureau of Licensure and Certification, Survey Report* (Apr. 20, 2021) UHS–FINHELP–00009322 at 00009325.

[450] Rule 5122–26–16 Ohio Administrative Code 5122 Seclusion, restraint, and time-out (E)(2)(g).

[451] UHS, *Oklahoma Healthcare Authority, Post-CAP Desktop Review Findings* (Mar. 6, 2018) UHS–FINHELP–00012209 at 00012209.

[452] *Id.*

[453] *Id.* at 00012210.

The Committee reviewed evidence of facilities routinely violating their own policies when administering chemical restraints to children. According to a State of Alaska oversight report of Copper Hills Youth Center (UHS; Utah), a nurse "complete[d] the Medication Reconciliation form at the time of admission and obtain[ed] verbal consent from the parent/guardian . . . [however] verbal consent for psychotropic medications . . . does not meet the criteria for Medication Consent and does not contain all elements required by the State of Alaska."[454] The surveyor noted that these "deficiencies were also identified during the previous site reviews in 2016, 2017, and 2018."[455]

Other documents reviewed by the Committee show an incident at Provo Canyon School (UHS; Utah) involving use of chemical restraints on a child without the necessary medical order for a chemical restraint in their record, and the medication is not listed on the child's medication list. An incident report from the same dates says "administered Haldol 5mg/Cogentin 1mg IM × 1 dose."[456] Haldol is an antipsychotic and Cogentin is a brand-name medication that is often administered to treat side effects from Haldol. Here, "IM" refers to intramuscularly, indicating that the child was injected with the chemical restraint. The child's medication list for that day includes another antipsychotic, Olanzapine, which was given orally later in the day. This suggests that the child was chemically restrained twice that day—once in the afternoon with an injection and once in the evening with an oral medication—but there is only one medication order and overall improper documentation.

According to a document from River Park Hospital (UHS; West Virginia), an employee told investigators that, prior to administering a chemical restraint, the facility will contact the doctor and describe the situation, so that the doctor can determine the appropriateness of a chemical restraint, but staff admitted this was not done on every occasion, as required by regulations.[457]

Polypharmacy

Children report taking many medications, which leaves them feeling not like themselves. In many cases, children in facilities are subjected to multiple medications concurrently, known as polypharmacy. According to a 2021 report from Brynn Marr Hospital (UHS; North Carolina), a 16-year-old's medication list was 13 medications long.[458] One former patient told *The Salt Lake Tribune* that he "felt like a zombie"[459] while at Provo Canyon School (UHS; Utah) because he was so overmedicated. An inspection of Piney Ridge Treatment Center (Acadia; Arkansas) found that "(44%) [of children] taking psychotropic medications were not able to name at least 50% of their psychotropic medications."[460] When the same survey was repeated a few months later, there was a similar outcome.[461] Further, only 41 percent of children taking psychotropic medications could state the reason for taking at least 50 percent of their psychotropic medications.[462] At the same facility, 41 of the 43 children whose records were reviewed were on psychotropic medications. At River Park Hospital (UHS; West Virginia) an investigator from the state's Institutional Investigative Unit met with a child who was "not acting like himself. He was very quiet and groggy . . . [and the] reporter could tell he was very heavily medicated."[463]

Committee staff visited facilities to witness their conditions first-hand and interacted with children who appeared overmedicated. While none of the fa-

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[454] UHS, *State of Alaska Department of Health and Social Services Division of Behavioral Health—Site Review Summary of Findings: Copper Hills Youth Center* (Sep. 30–Oct. 3, 2019) UHS–FINHELP–00009926 at 00009931.

[455] *Id.*

[456] UHS, *Utah Department of Human Services, Office of Licensing, UHS of Provo Canyon CAP Request* (Apr. 16, 2020) UHS–FINHELP–00011498 at 00011498.

[457] UHS, *Virginia Department of Health and Human Resources IIU Investigation—River Park* (Apr. 5, 2023) UHS–FINHELP–00011734 at00011735.

[458] UHS, *Division of Health Service Regulation Statement of Deficiencies and Plan of Correction—Brynn Marr Hospital* (Nov. 4, 2021) UHS–FINHELP–00008911 at 00008925–00008926.

[459] The Salt Lake Tribune, *Provo Canyon School's history of abuse accusations spans decades, far beyond Paris Hilton* (Sep. 20, 2020) *https://www.sltrib.com/news/2020/09/20/provo-canyon-schools/; [https://perma.cc/4SSH-GQHD].*

[460] Acadia, *Beacon Health Options—Inspection of Care Report: Piney Ridge Treatment Center* (Apr. 9–12, 2018) 20180409 Piney Ridge AR Beacon Report at p. 4.

[461] Acadia, *Beacon Health Options—Inspection of Care Report: Piney Ridge Treatment Center* (Oct. 5, 2018) 20180904 Piney Ridge AR Beacon Report at p. 3.

[462] Acadia, *Beacon Health Options—Inspection of Care Report: Piney Ridge Treatment Center* (Apr. 9–12, 2018) 20180409 Piney Ridge AR Beacon Report at p. 4.

[463] UHS, *Department of Health and Human Resources IIU Investigation-River Park* (Apr. 5, 2023) UHS–FINHELP–00011734 at 00011735.

cilities Committee staff visited were operated by the four providers at-issue in this investigation, the five sites are a sample of RTFs across the country—for-profit, non-profit, small sites operated by a single provider, large sites operated by chains, rural sites, and more urban sites. In most facilities, the children who Committee staff interacted with appeared dazed. A number of children struggled to maintain eye-contact or hold conversations. At one site, a nurse told Committee staff that many children are on five to eight medications concurrently. He indicated that the majority of children have the number of medications they take increased upon admission. When asked which medications are the most commonly prescribed to children, the nurse named multiple psychotropic medications.

The Committee's review of extensive restraint and seclusion documentation determines that this is a dangerous practice which warrants reconsideration. Restraint and seclusion are behavioral management tools that may only be employed when all other interventions and de-escalation measures have failed. In other words—as a last resort. However, the Committee's review has determined that industry use of restraint and seclusion as a behavioral management tool is ubiquitous despite a robust federal regulatory framework to limit the number of these measures resulting in too many unacceptable outcomes and these practices and the strength of the current oversight of them should be reassessed.

d. Rampant Reports of Children Being Verbally Abused in RTFs.

Children should be free from all forms of abuse, including verbal abuse. In many facilities, children, who are already in a precarious state—due to underlying behavioral health needs, potential system-involvement, and removal from their communities—often report being subjected to verbal abuse by staff and peers. These reports expose a disturbing lack of empathy by some staff employed to treat a highly vulnerable population of children.

Allegations of verbal abuse at facilities are widespread and, in some cases, appear to go unaddressed. Paris Hilton, who spent 11 months at Provo Canyon School (UHS; Utah), told *People Magazine,* "[f]rom the moment I woke up until I went to bed, it was all day screaming in my face, yelling at me, continuous torture."[464] She described how the staff there "were constantly making me feel bad about myself and bully[ing] me."[465] In Think of Us' report "Away From Home" a child described being mocked by a staff member who said, "[t]hat's why your mom didn't want to keep you. That's why you're in foster care."[466] As captured in NDRN's *Desperation Without Dignity,* children reported being "subjected to a near-constant barrage of verbal abuse from staff. Staff curse, yell, make demeaning and derogatory comments, insult and make fun of the children." [. . .] For instance, at a Sequel facility in Alabama, girls reported being called "'f*ng fat,' 'f*ng ugly,' 'bitch,' 'stupid,' and 'ignorant'."[467]

Company documents reviewed by the Committee similarly show numerous allegations of verbal abuse. Records reviewed by the Committee document instances of verbal abuse by staff that align with public reporting. Survey reports from both Copper Hills Youth Center (UHS; Utah) and Palmetto Pines Behavioral Health (UHS; South Carolina) contained allegations of "[s]taff often scream[ing] and curs[ing] at the residents."[468] In an additional Palmetto Pines Behavioral Health (UHS; South Carolina) inspection report, there is a "Consumer Complaint"[469] that a "staff member verbally and physically abused"[470] a child. In a separate, substantiated incident of verbal abuse at Harbor Point Behavioral Health (UHS; Virginia), a child relayed that a staffer said, "by the end of the night he was going to punch

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[464] People, *Paris Hilton Opens Up About the Secret Terrifying Abuse She Suffered as a Teen* (Aug. 2, 2020) *https://people.com/tv/paris-hilton-opens-up-about-the-secret-terrifying-abuse-she-suffered-as-teen/; [https://perma.cc/69WS-YQVB].*

[465] *Id.*; UHS did not own Provo Canyon School when Paris Hilton was a resident.

[466] Think of Us, *Away From Home: Youth Experiences of Institutional Placements in Foster Care* (July 2021) *https://assets.website-files.com/60a6942819ce8053cefd0947/60f6b1eba474362514093f96_Away%20From%20Home%20-%20Report.pdf; [https://perma.cc/VS6R-ZXYL].*

[467] NDRN, *Desperation Without Dignity* at p. 28 (Oct. 2021) *https://www.ndrn.org/wp-content/uploads/2021/10/NDRN_Desperation_without_Dignity_Final.pdf; [https://perma.cc/MYY9-PLCT].*

[468] UHS, *South Carolina Department of Health and Environmental Control Inspection Results* (May 4, 2022) UHS–FINHELP–00011359 at 00011360; UHS, *The Joint Commission—Organization Response to a Safety Event* (Dec. 2, 2021) UHS–FINHELP–00009908 at 00009909.

[469] UHS, *Bureau of Health Facilities Licensing Audit—Palmetto Pines* (Jul. 28, 2021) UHS–FINHELP–00011338 at 00011339.

[470] *Id.*

me in my face."[471] A child at Piney Ridge Treatment Center (Acadia; Arkansas) reported that a staffer "makes fun of me. Calls me a baby for sucking my thumb, also [one staff member] calls me gay."[472] At Provo Canyon School (UHS; Utah) multiple children reported that "staff members curse at students, call students names, such as stupid, and insult students. Some students report that they threaten them."[473] At Harbor Point Behavioral Health (UHS; Virginia) a staff member allegedly said to a child, "I will slap the sh*t out of you, I don't care. I will slap the sh*t out of you if you keep trying to bite me."[474] Although the staff member denied saying this, they did, however, "say to [the child that they] would, 'box'"[475] them. At Devereux Brandywine (Devereux; Pennsylvania) a staffer reportedly said to a child they would show "how they do it in Coatesville"[476] before proceeding to assault them, leaving the child in need of emergency medical care.[477] At Piney Ridge (Acadia; Arkansas), when a *Beacon Health Options* assessor asked a child if they felt treated with respect by staff, they responded, "[m]ost do not. They are mean to me."[478] Other comments in this report related to verbal abuse by staff on children included, "[s]taff calling me names,"; "[s]taff curses—sometimes they curse at residents like say 'you aren't getting shit.'"[479]; and "staff yells."[480] When inspectors discussed this with facility leadership, "[t]here was no response from the provider regarding how they would respond to the identified concerns."[481]

A report by the Oklahoma Department of Human Services Child Care Services documented an allegation of staff using "degrading language"[482] towards children at Cedar Ridge Residential Treatment Facility (UHS; Oklahoma). Other documents from Cedar Ridge Treatment Facility (UHS; Oklahoma) show that a staffer and a child had a "verbal exchange"[483] where the staffer allegedly threatened, "I can make sure they put you back in foster care."[484] In a different case, Piney Ridge Treatment Center entered into a corrective action plan agreeing that "[s]taff will not use racially/culturally inappropriate language with residents or other staff."[485]

e. Children Are Routinely Emotionally Abused in RTFs.

In many facilities, children, who are already in a precarious state—due to underlying behavioral health needs, potential system-involvement, and removal from their communities—are subjected to emotional abuse by staff and peers.

Public reporting contains numerous accounts of staff manipulating the children in their care. In Think of Us' study "Away From Home," a child remarked that, "staff would bet on us (monetarily). They would bet on if we would make it through the program."[486] Another child described staff as, "very much power tripping . . . treat[ing] us like we were nothing."[487] A third child characterized the dynamic similarly: "the staff often seemed to have issues with power and control. Like they were given a supervisor role with no oversight, and they abused

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[471] UHS, *Department of Behavioral Health and Developmental Services Corrective Action Plan—Harbor Point* (May 13, 2019) UHS–FINHELP–00010307 at 00010307.

[472] Acadia, *Beacon Health Options—Inspection of Care Report: Piney Ridge Treatment Center* (Sep. 4–11, 2018) 20180904 Piney Ridge AR Beacon Report at p. 3.

[473] UHS, *Utah Department of Human Services Corrective Action Plan Required—Provo Canyon* (Jan. 13, 2020) UHS–FINHELP–00011508 at 00011509.

[474] UHS, *Department of Behavioral Health and Developmental Services Corrective Action Plan—Harbor Point* (Mar. 17, 2021) UHS–FINHELP–00010232 at 00010232.

[475] *Id.*

[476] Devereux, *Brandywine—Brier Incident Investigation* (incident date Nov. 4, 2019) DEV–S—001175.

[477] *Id.;* Devereux, *Brandywine—Brier RADAR Incident Report* DEV–S—001172 at p. 2.

[478] Acadia, *Beacon Health Options—Inspection of Care Report: Piney Ridge Treatment Center* (Sep. 4–11, 2018) 20180904 Piney Ridge AR Beacon Report at p. 3.

[479] *Id.* at p. 4.

[480] *Id.*

[481] *Id.* at p. 5.

[482] UHS, *Oklahoma Department of Human Services Child Care Services—Licensing Complaint Report Summary* (No date) UHS–FINHELP–00011988 at 00012001.

[483] UHS, *Plan for Immediate Safety at Cedar Ridge* (Apr. 2, 2021) UHS–FINHELP–00011933 at 00011941.

[484] *Id.*

[485] Acadia, *Arkansas Department of Human Services Corrective Action Agreement* (Aug. 6, 2020) 20200806 Piney Ridge ARDHS Corrective Action Plan Agreement at p. 1.

[486] Think of Us, *Away From Home: Youth Experiences of Institutional Placements in Foster Care* at p. 38 (July 2021) *https://assets.website-files.com/60a6942819ce8053cefd0947/60f6b1eba4743625140936f96—Away%20From%20Home%20-%20Report.pdf; [https://perma.cc/VS6R-ZXYL].*

[487] *Id.* at p. 39.

the position of power over us kids."[488] Another child who reflected on their experience at a facility said, "it was kinda more emotionally abusing to a lot of the kids there than it was fixing [. . .] it's kind of like a mental hammer to the head that we are bad people and that's all that we will ever be."[489]

The Committee reviewed substantiated allegations of emotional abuse and neglect. An assessment of Brentwood Behavioral Healthcare (UHS; Mississippi) found "allegations to be substantiated for emotional abuse & neglect on [a child] by facility staff."[490] The verbal abuse of children at Provo Canyon School—Springville Campus (UHS; Utah) met the "definition of emotional mistreatment [. . .] and is not appropriate treatment of vulnerable children."[491]

The Committee reviewed incidents of staff making antagonistic remarks towards children and implementing "group punishment." A staffer at Piney Ridge Treatment Center (Acadia; Arkansas) expressed concerns about staff not treating the children with dignity or making antagonistic remarks towards children whom other staff were attempting to help de-escalate.[492] At Piney Ridge Treatment Center (Acadia; Arkansas) multiple children also report that staff would engage in "group punishment"[493] which undermines children's individual autonomy. Disability Rights Ohio reported that, at Foundations for Living (UHS; Ohio), across multiple units, children reported that the whole unit would get punished for the actions of one peer.[494] During an RTF visit, a child told Committee staff that if a single child acts out, facility staff may impose group punishments, like taking away everyone's pencils and making the children write in crayon, instead. At one facility, Committee staff saw the locker containing candy and personal hygiene products, like deodorant, that children are rewarded with for good behavior.

Many facilities employ an emotionally-manipulative incentive-based system wherein a child's privileges are tied to their advancement in treatment and/or behaviors. Committee staff is concerned by the observed incentive-based systems enacted in many facilities. While it may be appropriate to provide children privileges that align with their individual treatment needs or progress, the process observed at some facilities appears inappropriately designed and coercive. In some cases, children must demonstrate progress in order to access basic coping mechanisms, like music and/or coloring books. This may be counterproductive to an individual child's treatment and limit their ability to learn to self-soothe. A child at Piney Ridge Treatment Center (Acadia; Arkansas) described not knowing how to advance in that facility's system, saying "it is taking me a long time to reach level 3. I don't understand the treatment. I understand what I am supposed to do, but I don't know how to do it."[495] A complaint submitted to the state Department of Health and Human Services by the parents of an 11-year-old against Brynn Marr Hospital (UHS; North Carolina) alleged that, "our daughter was not provided with rules and [then] later disciplined for breaking a rule she wasn't aware of."[496]

A child handbook from Millcreek Behavioral Health (Acadia; Arkansas) describes a non-individualized incentive structure. The document describes a "Phase" approach, where Phase 1 allows a child to "Watch TV on unit; Recreation activities determined by staff" while those on Phase 2 are also permitted to go on "Facility outings to the park, football games, etc." At Phase 2, children earn "Personal Coloring Books" and the right to "Listen to music in room."[497]

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[488] *Id.*

[489] KNWA, *Filthy conditions lead to reprimand for children's treatment facility* (Oct. 6, 2021) *https://www.nwahomepage.com/news/filthy-conditions-lead-to-reprimand-for-childrens-treatment-facility/?ipid=promo-link-block2; [https://perma.cc/GT9G-ZU9L].*

[490] UHS, *Mississippi Department of Child Protection Services Investigation Report—Brentwood Behavioral Healthcare* (Aug. 26, 2022) UHS–FINHELP–00009627 at 0009628.

[491] UHS, *State of Utah Department of Human Services Corrective Action Plan for Provo Canyon* (January 13, 2020) UHS–FINHELP–00011508 at 00011509 to 00011510.

[492] Acadia, *Beacon Health Options—Inspection of Care Report: Piney Ridge Treatment Center* (Apr. 9–12, 2018) 20180409 Piney Ridge AR Beacon Report at p. 3.

[493] *Id.* at p. 5–7.

[494] UHS, *Disability Rights Ohio Monitoring Visit Follow-Up Foundations for Living* (February 27, 2023) UHS–FINHELP–00009317 at UHS–FINHELP–00009318.

[495] Acadia, *Beacon Health Options—Inspection of Care Report: Piney Ridge Treatment Center* (Apr. 9–12, 2018) 20180409 Piney Ridge AR Beacon Report at p. 4.

[496] North Carolina Health News, *Durham 11-year-old was sexually assaulted in NC psychiatric hospital, parents allege* (Nov. 30, 2022) *https://www.northcarolinahealthnews.org/2022/11/30/parents-allege-11-year-old-sexually-assaulted-in-nc-psychiatric-hospital/; [https://perma.cc/Q5GQ-6SUV].*

[497] Acadia, CHAPTER 10 Consumer Rights (07.22) at p. 45.

Documents from Alliance Health Center (The Crossings) (UHS; Mississippi) describe how the facility runs "a level system," where points, as many as four per hour, are earned throughout the day. The facility has five levels, an Alternative Program and four additional levels. The Alternative Program does not allow phone calls, radio or TV; the Entry level only allows children to speak on the phone with a therapist present and does not allow personal music; Level 2 allows one incoming or outgoing call per week and restricts family visitation to 2 hours on campus, and allows a library book; Level 3 increases family visitation to 3 hours on campus and increases call frequency to two incoming or outgoing calls per week; Level 4 increases call frequency to three incoming or outgoing, visitation to 4 hours on or off campus, and allows makeup privileges (girls only).[498]

Similarly, Woodward Academy (Vivant; Iowa) has a "Positive Behavior System that is utilized for all of treatment."[499] Students can use their weekly point earnings on items at the store onsite and, unlike other facilities, points do not appear to be tied to activities and other privileges.

Furthermore, the Committee has concerns about how these incentive-based reward programs interact with the numerous allegations of grooming for sexual abuse by staff at RTFs. The Committee reviewed allegations of grooming which included providing "favorite" children with contraband such as vape pens or cell phones. To a vulnerable child, it may be difficult to distinguish such abusive behavior from "approved" rewards like makeup privileges, or access to radio, TV, or additional phone calls.[500]

B. RTFs Fail to Provide Home-Like Conditions to Children and Expose Them to Unsafe and Unsanitary Environments.

In addition to the risk of abuse and neglect children are exposed to in RTFs, the everyday conditions of the facilities often also impart latent indignity and suffering. RTFs, as therapeutic facilities, should provide home-like environments (safe, welcoming, clean, healthy, and healing) to children. It is clear from children's testimony, public reporting, first-hand accounts to Committee staff, and thousands of pages of documents reviewed by the Committee, that some RTFs trap children in a dehumanizing physical environment and atmosphere.

As a child explained in an oversight report, "[t]he reason I don't feel safe here is because they never clean the unit until the State gets here."[501] Other children echoed similar concerns in Think of Us' study "Away From Home." One survivor said facilities would be better if, "the homes [were] better, not as run down . . . It's bad enough that you're on your own, but then you live somewhere in a crappy neighborhood and a place that you're not proud of." Another survivor sought access to personal hygiene items, saying "the personal hygiene (items) were locked in a cabinet. I wanted to brush my teeth after lunch but I couldn't because it was locked."[502] Two children made the analogy to being treated like animals. One child explained the facility, "really does feel like an animal shelter with the bare minimum," while another child said, "I felt like a dog in a cage.[503]

Committee staff visited five facilities to witness their conditions first-hand. While none of the facilities were operated by the four providers at-issue in this investigation, the five sites are a sample of RTFs across the country—for-profit, nonprofit, small sites operated by a single provider, large sites operated by chains, rural sites, and more urban sites. The conditions at four of the five facilities viewed by Congressional staff reinforce the Committee's findings from document review that many RTFs do not operate home-like conditions. At one facility, children kept their clean clothing in brown paper bags and their dirty clothes in separate brown bags. Committee staff witnessed windows covered in spray paint or obscured by a screen. Chil-

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[498] UHS, *The Crossings Behavioral Health Residential Treatment Center Program Handbook,* UHS-FINHELP-00002463 at 00002466-UHS-FINHELP-00002467; 00002471.

[499] Vivant (Dec. 15, 2023) FINAL—Vivant Submission of External Reviews at p. 189.

[500] When positive behavior support (PBS) systems are designed using evidence-based best practices and effectively implemented, they have proven to be successful across various settings. However, review of the companies' policies reveal that these incentive-based reward programs do not leverage the same evidence-based model and, as such, are ineffective.

[501] Acadia, *Beacon Health Options—Inspection of Care Report: Piney Ridge Treatment Center* (Apr. 9–12, 2018) 20180409 Piney Ridge AR Beacon Report at p. 5.

[502] Think of Us, *Away From Home: Youth Experiences of Institutional Placements in Foster Care* at p. 29, 33 (July 2021) *https://assets.website-files.com/60a6942819ce8053cefd0947/60f6b1eba4743625140 93f96—Away%20From%20Home%20-%20Report.pdf; [https://perma.cc/VS6R-ZXYL].*

[503] *Id.* at p. 29, 62.

dren also told Committee staff that they preferred being placed in juvenile detention (jail) because they were given more food and freedom there. One facility smelled like waste and another facility smelled like gas. At multiple facilities, children's beds were uncovered mattresses, lacking bedding and/or pillows and spaces were in complete disarray. Committee staff also witnessed unpainted plywood boards covering the walls and foam filling-in gaps.

While the non-home-like conditions at some RTF may constitute outright negligence, in other instances the deviations in facility conditions from appropriate standards highlight a risk inherent to the RTF model. Leadership from several RTF providers described to Committee staff the challenges presented by upkeep of facilities often designed to house dozens of children and teens with intense behavioral needs. These leaders described facilities maintenance processes that required constant oversight and large investments of capital. Leaders also described a difficult balance between ensuring RTF environments are safe and capable of withstanding heavy use, without creating an environment that is overly carceral.

In the absence of federal regulation, use of cameras in facilities varies widely across providers. Devereux told Committee staff that it recently made major investments to upgrade its camera system so that it has cameras in all common spaces (including but not limited to activity rooms, hallway intersections, laundry rooms, etc.) and at the threshold of bedrooms and bathrooms at its facilities.[504] UHS, Acadia, and Vivant do not maintain consistent policies.[505] Footage retention, likewise, varies across providers. While some facilities maintain camera footage for weeks or months or following reports of an incident, it is rare that footage is monitored synchronously. Generally, providers retain footage following incidents. Advocates communicated to Committee staff that the lack of camera footage makes it more difficult for them to protect children in RTF custody. Where a facility does have cameras, most do not capture audio. Audio presents potential civil liberties and privacy concerns, but is also championed as the gold standard by advocates because it affords them the fullest picture of the incident. Finally, during visits to RTFs, one facility's Clinical Director told Committee staff that implementing cameras has been a helpful tool in addressing workforce shortages, as they are able to resolve allegations against staff more quickly and with fewer investigative resources.

Millcreek of Arkansas (Acadia; Arkansas) exposed children to unsafe and unsanitary conditions. A government inspection found that Millcreek of Arkansas (Acadia; Arkansas) failed to maintain a "safe, comfortable and home-like environment."[506] These concerns were repeated over multiple years.[507] Bedroom furniture, walls, windows, and paneling were peeling and had holes. Bathrooms had dirty and moldy walls, a "black substance" in seams around the showers, and cracked tiles in the shower stalls. The kitchen had food debris and a "dark substance" on surfaces. Outside, there was trash scattered "in a wide radius around the two dumpsters,"[508] including glass shards, and play equipment had "rotten boards and screws sticking out."[509]

Bedroom conditions in RTFs can be unsafe and unsanitary. RTFs are residential facilities meaning that the facility's bedrooms are, for the duration of a child's treatment, the only place they can call their own. Company production reviewed by the Committee included pervasive accounts of unsanitary and unsafe bedroom conditions. The Joint Commission found that Heartland Behavioral Health

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[504] Notes from Devereux Advanced Behavioral Health Briefing (May 21, 2024) (on file with Committee).

[505] Notes from UHS Briefing (May 23, 2024) (on file with Committee); Notes from Vivant Behavioral Health Briefing (May 22, 2024) (on file with Committee; Notes from Acadia Healthcare Briefing (May 17,2024) (on file with the Committee).

[506] Acadia, *Department of Health and Human Services Statement of Deficiencies and Plan of Correction—Millcreek of Arkansas* (Oct. 25, 2018) 20181025 Millcreek CMS 2567 Annual ICF POC 2018).

[507] *Id.;* Multiple issues with the building condition at Millcreek Behavioral Health, May 27, 2021: Acadia, *Arkansas Department of Human Services Division of Child Care and Early Childhood Education—Licensing Compliance Record—Millcreek* (May 27, 2021) 20210527 Millcreek of Arkansas State Licensure-routine.

[508] Acadia, *Department of Health and Human Services Statement of Deficiencies and Plan of Correction—Millcreek of Arkansas* (Nov. 8, 2018) 20181025 Millcreek CMS 2567 Annual ICF POC 2018; Acadia, *Department of Health and Human Services Statement of Deficiencies and Plan of Correction—Millcreek of Arkansas* (Dec. 18, 2018) 20181218 Millcreek ICF CMS 2567 POC–CMS.

[509] Acadia, *Department of Health and Human Services Statement of Deficiencies and Plan of Correction—Millcreek of Arkansas* (Apr. 1, 2021) 20210401 Millcreek of Arkansas CMS–OLTC) at p. 7.

Services (UHS; Missouri) did not provide a "clean and comfortable environment."[510] A Piney Ridge Treatment Center (Acadia; Arkansas) inspection by Beacon Health Options found numerous reports of recurring bed bugs, which forced a child to sleep on a cot. Multiple children raised infestation issues noting, there are "all sorts of bugs crawling around on our unit like earwigs, ants, and, sometimes, spiders. We've had bed bugs twice."[511] During a Disability Rights Ohio visit to Foundations for Living (UHS; Ohio) in February 2023 a child told observers the heat in their bedroom wasn't working and that it was very cold. This aligned with other reports that the facility was often cold.[512]

Bathroom conditions at RTFs can be unsafe and unsanitary. RTFs are residential facilities meaning that the facility's bathrooms are, for the duration of a child's treatment, the primary place they use to maintain their personal hygiene. Company production reviewed by the Committee included pervasive accounts of unsanitary and unsafe bathroom conditions. For example, at Foundations for Living (UHS; Ohio) a child told Disability Rights Ohio that there were "bloody tampons and feces in the bathroom areas that do not get cleaned for several days."[513] At Millcreek of Arkansas (Acadia; Arkansas) the Arkansas Foundation for Medical Care found bathrooms "excessively dirty and a strong, old urine smell was noted."[514] Disability Rights Arkansas documented that a program at Millcreek of Arkansas (Acadia; Arkansas) with "18 clients [had] only 1 working [bathroom] stall 2 don't work and the [single] working shower is not draining properly [with tiles that are] severely cracked and very sharp."[515] A complaint against Village Behavioral Health (Acadia; Tennessee) detailed cabins that lacked running water. The children used a "port-a-potty at night and have some type of cooler to wash their hands/brush their teeth."[516]

A survey of SandyPines Residential Treatment Center (UHS; Florida) conducted by the Florida Agency for Health Care Administration found eight instances of a "black like substance" in and around showers. When asked about the obvious mold, a maintenance team member said, "I never noticed it, I don't check the bathrooms unless there is a problem," while the housekeeping supervisor admitted the bathrooms were "not in good shape" and said "it [was] mold."[517] An inspection of Harbor Point Behavioral Health (UHS; Virginia) by the Virginia Department of Behavioral Health and Developmental Services identified "Human Rights violations" by the facility, including clogged toilets, mold on shower curtains, unclean bathrooms, soap scum, and vents covered with heavy dust.[518]

Kitchens at RTFs can be unsafe and unsanitary. RTFs are residential facilities meaning that, for the duration of a child's treatment, they consume their meals onsite. In order to ensure adequate food safety, meals must be prepared in sanitary environments and food must be properly stored. Company production reviewed by the Committee included numerous accounts of unsanitary and unsafe kitchen conditions. For example, one child told an assessor that, "[s]ome kids eat out of the trash can and staff treat those particular kids disrespectfully. Staff wonder why kids keep

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[510] UHS, *Joint Commission 60-Day Evidence of Standards Compliance—Great Plains Hospital* (May 13, 2021) UHS–FINHELP–00009366 at 00009379; *see also* in which South Carolina Department of Health and Environmental Control investigation of Palmetto Summerville Behavioral Health Found a "pest control" problem, (UHS, *South Carolina Department of Health and Environmental Control Inspection Results* (May 4, 2022) UHS–FINHELP–00011359 at 00011360).

[511] Acadia, *Beacon Health Options Inspection of Care Report—Piney Ridge Treatment Center* (Apr. 9, 10, 11, 12, 2018) 20180409 Piney Ridge AR Beacon Report) at p. 7.

[512] UHS, *Disability Rights Ohio Monitoring Visit Follow-Up—Foundations for Living* (Feb. 27, 2023) UHS–FINHELP–00009317 at 00009318; *see also* Acadia, *Beacon Health Options Corrective Action Plan for Program Review Inspection of Care—Piney Ridge* (Apr. 13, 2018) 20180304 Piney Ridge Corrective Action Plan for Program Review IOC Piney Ridge Treatment Center at p. 3 in which a "broken out" window is covered in plywood allowing "outside air into the room."

[513] UHS, *Disability Rights Ohio Monitoring Visit Follow-Up—Foundations for Living* (Feb. 27, 2023) UHS–FINHELP–00009317 at 00009317.

[514] Acadia, *Arkansas Department of Human Services Inspection of Care—Habilitation Center* (Apr. 12, 2022) 20220412 Millcreek AR AFMC Licensure Survey Findings at p. 2.

[515] Acadia, *Arkansas Department of Human Services Licensing Compliance Record* (Jul. 8, 2021) 20210709 Millcreek of Arkansas state licensure-findings.pdf at p. 1.

[516] Acadia, *Organization Response for Incident—Village Behavioral Health* (Mar. 31, 2019) 0190331 Village QQPS.

[517] UHS, *Agency for Healthcare Administration Plan of Correction—SandyPines* (Sep. 20, 2021) UHS–FINHELP–00009713 at 00009717–00009718.

[518] UHS, *Office of Human Rights Citation—Harbor Point Behavioral Health Center* (Apr. 14, 2022) UHS–FINHELP–00010213 at 00010213.

trading food, but they don't feed us much."[519] A South Carolina Department of Health and Environmental Control investigation of Palmet to Summerville Behavioral Health (UHS; South Carolina) found "food [was] not being prepared properly and the residents have gotten sick from eating the food."[520] The Joint Commission found River Park Hospital (UHS; West Virginia) refrigerator temperatures were not logged daily. Further, food was open, expired, and inconsistently labeled.[521]

Medication storage and administration at RTFs can be haphazard. RTFs are residential facilities meaning that, for the duration of a child's treatment, they receive their medication onsite. In order to ensure safe medication administration, medication must be stored and administered in sanitary environments by qualified professionals. Company documents reviewed by the Committee included accounts of unsanitary and unsafe medication storage and administration in RTFs. The South Carolina Department of Health and Environmental Control investigated a complaint at Palmetto Pines (Summerville) Behavioral Health (UHS; South Carolina) alleging a child had taken "10–12 Tylenols from a staff bag and ingested them," necessitating emergency room treatment.[522] At both Cedar Ridge Behavioral Hospital (UHS; Oklahoma) and Harbor Point Behavioral Health Care Center (UHS; Virginia) staff gave children incorrect and/or mislabeled medications.[523] The Joint Commission identified that Millcreek Behavioral Health (Acadia; Arkansas) stored urine specimens in the same refrigerator as nasal swab test kits.[524] The Joint Commission found that Hill Crest Behavioral Health Services (UHS; Alabama) policy did not include staff "monitoring the controlled substances (*i.e.,* counting medications at shift change)"[525] to ensure they were the correct amount and a South Carolina Department of Health and Environmental Control inspection of Palmetto Pines (Summerville) Behavioral Health (UHS; South Carolina) identified eight dates without a signature on the "Shift Verification of Controlled Substances Count Sheet."[526] At Brynn Marr Hospital (UHS; North Carolina) the Director of Nursing "could not identify what the MAR [Medication Administration Record] 'NA' stood for."[527] "NA" is a standardized documentation for "Not Administered."[528]

Emergency protocols, hazard communication, and workplace safety at RTFs can be lacking and haphazard.[529] RTFs are residential facilities meaning that, for the duration of a child's treatment, they are in their custody. There are concerns related to the most basic of safety practices at RTFs, like establishing and updating emergency protocols, keeping emergency exits clear, and conducting fire drills. The Joint Commission cited River Park Hospital (UHS; West Virginia) for having cottages that were locked from the inside, "requiring a key . . . [meaning people are not] able to get out of the cottages in the case of an emergency."[530] The

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[519] Acadia, *Beacon Health Options—Inspection of Care Report: Piney Ridge Treatment Center* (Apr. 9–12, 2018) 20180409 Piney Ridge AR Beacon Report at p. 5.

[520] UHS, *South Carolina Department of Health and Environmental Control Inspection Results—Palmetto Pines* (May 4, 2022) UHS–FINHELP–00011359 at 00011360.

[521] UHS, *Joint Commission Final Accreditation Report—River Park Hospital* (May 1, 2018) UHS–FINHELP–00011754 at 00011767.

[522] UHS, *Plan of Correction Reporting Form—Bureau of Health Facilities Licensing—Palmetto Pines* (Jun. 16, 2022) UHS–FINHELP–00011355 at 00011355; 00011357.

[523] UHS, *Oklahoma Department of Human Services Office of Client Advocacy—Investigative Findings—Cedar Ridge* (Feb. 3, 2020) UHS–FINHELP–00011908 at 00011919, 00011921; UHS, *Department of Behavioral Health and Developmental Services Corrective Action Plan—Harbor Point Behavioral Health Center* (Jan. 6, 2020) UHS–FINHELP–00010220; UHS, *Joint Commission Final Accreditation Report—Harbor Point Behavioral Health Center* (Apr. 9, 2021) UHS–FINHELP–00010395 at UHS–FINHELP–00010401.

[524] Acadia, *Joint Commission Preliminary Accreditation Report—Habilitation Centers* (May 14, 2021) 20200514 Little Creek_5142020_Extension-JC-final report at p. 5.

[525] UHS, *Joint Commission Final Accreditation Report—Hill Crest Behavioral Health Services* (May 21, 2021) UHS–FINHELP–00009552 at 00009558.

[526] UHS, *Bureau of Health Facilities Licensing—Inspection Audit—Palmetto Pines* (Apr. 8, 2021) UHS–FINHELP–00011415 at 00011428–00011429.

[527] UHS, *Division of Health Service Regulation Statement of Deficiencies and Plan of Correction—Brynn Marr Hospital* (Oct. 20, 2021) UHS–FINHELP–00008911 at 0008928.

[528] *Id.* at 0008927.

[529] *See also* Acadia, *Indiana Department of Child Services Visit—RTC Resource* (Oct. 15, 2021) 20211015 Resource Licensure Survey at p. 3. in which the Indiana Department of Child Services visited RTC Resource (Acadia, Indiana) where a receptionist discovered a snake inside a box at the front desk.

[530] UHS, *Joint Commission Final Accreditation Survey—River Park* (May 1, 2018) UHS–FINHELP–00011754 at 00011768.

Joint Commission further observed that, at River Park Hospital (UHS; West Virginia), fire extinguishers were locked behind closed doors.[531]

The New York Office of Children and Family Services recommended that Foundations Behavioral Health (UHS; Pennsylvania) install carbon monoxide detectors on all floors.[532] An inspection of North Star Debarr (UHS; Alaska) found that the facility failed to conduct fire evacuation drills during multiple months.[533] An Alaska Department of Labor complaint alleged that North Star Behavioral Health Center—Palmer (UHS; Alaska) violated "general requirements for surface conditions in all places of employment."[534] An Alaska Department of Labor complaint against North Star Behavioral Health Center—Palmer (UHS; Alaska) included allegations of "exposure to airborne chemicals."[535]

Some RTFs have failed to control the spread of infectious diseases. Desert Hills of New Mexico (Acadia; New Mexico) closed amid multiple lawsuits and extensive allegations related to patient safety concerns.[536] Reporting on the site's closure by *The Nashville Post* highlights "the unchecked spread of HIV among patients"[537] as a contributing factor to the facility's closure.

In public reporting regarding The Pines Residential Treatment Center (UHS; Virginia), an eighth-grader allegedly left the facility having contracted herpes.[538] The patient's sister alleged he contracted the incurable, sexually transmitted infection from having sex with other children at the facility or from a suspected sexual relationship with a staffer.[539]

Public reporting described conditions at Willow Springs Center (UHS; Nevada) in April 2020 as "pandemonium."[540] Children had begun to "riot . . . chanting *let us be free.*"[541] When state investigators arrived, a staffer had already died of COVID–19, and 11 staffers and 24 children had COVID–19—this number would later rise to 29 staff and 41 children.[542] Staff were supervising as many as 10 children each (severely out of ratio) and continued working even after testing positive for COVID–19. There was a single housekeeper charged with disinfecting the entire facility. The mother of a 15-year-old in Willow Springs Center (UHS; Nevada) only learned about the extent of the COVID–19 outbreak from a local TV report. When she heard a staffer had died, she had to take unilateral action to bring her son—who tested positive for COVID–19 and had underlying medical conditions—home.[543]

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[531] UHS, *Joint Commission Final Accreditation Survey—River Park* (May 1,2018) UHS–FINHELP–00011754 at 00011767; *see also* UHS, *Joint Commission Final Accreditation Report—Frontline Hospital* (Apr. 25, 2019) UHS–FINHELP–00011252 at p. 00011266 in which doors were locked in the direction of egress from the building.

[532] UHS, *New York Office of Children and Family Services Out-of-State Agency Review—Foundations Behavioral Health* (Jan. 16, 2020) UHS–FINHELP–00010096 at 00010107.

[533] UHS, *Alaska Department of Health Inspection Report North Star Debarr* (Aug. 19, 2022) UHS–FINHELP–00011060 at 00011074; *see also:* UHS, *The Joint Commission Final Accreditation Report—Frontline Hospital* (North Star Palmer) (Apr. 20, 2022) UHS–FINHELP–00011187 at 00011192.

[534] UHS, *Alaska DOL complaint against North Star Residential Treatment Center—Palmer* (Sep. 23, 2021) UHS–FINHELP–00010948 at 0010949–00010950 and 00010954–00010953.

[535] UHS, *Employees allegedly exposed to airborne chemicals; deficient hazard communication at North Star Residential Treatment Center—Palmer* (Apr. 22, 2021) UHS–FINHELP–00010963 at 00010963.

[536] Nashville Post, *Acadia facility closes amid abuse allegations* (Apr. 5, 2019) *https://www.nashvillepost.com/acadia-facility-closes-amid-abuse-allegations/article—707ab44b-adbf-5af8-bf6a-5b48ac61127d.html; [https://perma.cc/XH3C-VZTG].*

[537] *Id.*

[538] HuffPost, *Inside Rick Santorum-Linked Universal Health Services Facility: Herpes, Porn and Drug Dealing* (Jun. 28, 2011) *https://www.huffpost.com/entry/rick-santorum-uhs-facility_n_885010; [https://perma.cc/22YW-BPA3].*

[539] *Id.*

[540] Reno Gazette Journal, *Short-staffed children's hospital fined $17,000 after COVID–19 outbreak led to riots* (May 21, 2020) *https://www.rgj.com/story/news/2020/05/21/covid-19-reno-willow-springs-childrens-hospital-fined-outbreak-riots-coronavirus/5240400002/; [https://perma.cc/MV6V-8E2Z].*

[541] *Id.*

[542] KUNR, *Examining the COVID–19 Outbreak at Willow Springs* (Apr. 6, 2020) *https://www.kunr.org/public-health/2020-04-06/examining-the-covid-19-outbreak-at-willow-springs; [https://perma.cc/ZUK9-HL7R];* Reno Gazette Journal, *Short-staffed children's hospital fined $17,000 after COVID–19 outbreak led to riots* (May 21, 2020) *https://www.rgj.com/story/news/2020/05/21/covid-19-reno-willow-springs-childrens-hospital-fined-outbreak-riots-coronavirus/5240400002/; [https://perma.cc/MV6V-8E2Z].*

[543] Reno Gazette Journal, *Short-staffed children's hospital fined $17,000 after COVID–19 outbreak led to riots* (May 21, 2020) *https://www.rgj.com/story/news/2020/05/21/covid-19-reno-*

Continued

C. Many Children in RTFs Do Not Receive Appropriate Care for Complex Behavioral and Mental Health Conditions.

RTFs are intended and reimbursed to treat and support complex mental and behavioral health needs, but for some patients there is a marked lack of care planning and care provisioned in these facilities. This means that these children are referred to inpatient psychiatric settings for serious diagnosis—which require specific, evidence-based, highly planned, and measurable treatment—but their conditions are going untreated or undertreated and can also be exacerbated by the sexual, physical, verbal, and emotional abuse to which they may be exposed. While at the RTFs, some children are not receiving the high-quality, intensive, evidence-based behavioral healthcare they need and that facilities are reimbursed to provide by the Medicaid and child welfare systems.

a. RTFs Are Intended to Meet the Needs of Children, but Often Fail to Involve the Community.

In many cases, a child's wellness is directly correlated with a connection to their community, whether this is faith-based, kin, parents/guardian(s), or agencies and/or clinical staff, both inside and out of the RTF. These stakeholders should be actively involved in the child's treatment.

Communication breakdowns at RTFs damage children's connections to their family/guardian(s) and impede oversight by relevant entities. For many children, separation from their families and their communities is a traumatic event. RTFs are required to facilitate communication between a child and their family/guardians and to communicate with the child's family/guardian when the child experiences a "serious incident." However, facilities often fail to fulfill this obligation, leaving families and guardians in the dark about their child's care and condition.

Families feel they are not able to adequately communicate with their children or with others about their child's treatment. The Committee reviewed documents which included interviews with parents of children at Piney Ridge Treatment Center (Acadia; Arkansas), which revealed that one of them "did not understand or feel comfortable and satisfied with the frequency with which they can call and visit their child."[544] In a North Star RTC Palmer (UHS; Alaska) survey a parent said she felt "left in the dark" and described the communication as "discombobulated."[545] Another parent said, her son is "on something, but I was not sent any information."[546] Further, at Village Behavioral Health (Acadia; Tennessee) a complaint indicated there was "inconsistent application/interpretation of the visitation"[547] policy which impeded families from visiting their children with the frequency that they wanted.[548]

Facilities sometimes fail to adequately coordinate children's care with other entities, including families and caseworkers. Care coordination is a critical component of treatment for children at RTFs. The Committee reviewed instances of RTFs failing to execute proper coordination, such as at Brynn Marr Hospital (UHS; North Carolina) where a child was transferred from the PRTF unit to the Acute Unit due to an "increase in aggressive behaviors, resistance to de-escalation which resulted in multiple restraints, seclusions, and chemical restraints."[549] The decision to transfer the child from the "PRTF and involuntarily commit her to the [facility's] acute care unit was made with no input from the guardian."[550] The Committee reviewed documents from Foundations Behavioral Health (UHS; Pennsylvania) where a child's family therapy was described as "mostly virtual and were inconsistent"[551] in frequency. The report also highlighted "concern . . . around con-

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willow-springs-childrens-hospital-fined-outbreak-riots-coronavirus/5240400002/; [https://perma.cc/MV6V-8E2Z].

[544] Acadia, *Beacon Health Options—Inspection of Care Report: Piney Ridge Treatment Center* (Apr. 9–12, 2018) 20180904 Piney Ridge AR Beacon Report at p. 4.

[545] UHS, *The State of Alaska Department of Health Division of Behavioral Health RE: Site Review, North Star RTC Palmer—The Summit* (Nov. 14, 2022) UHS–FINHELP–00010975 at 00010993.

[546] *Id.*

[547] Acadia, *Organization Response for Incident #321772: Village Behavioral Health* (Mar. 31, 2019) 20190331 Village QQPS at p. 1.

[548] *Id.*

[549] UHS, *Division of Health Service Regulation—Statement of Deficiencies and Plan of Correction: Brynn Marr Hospital* (May 26, 2023) UHS–FINHEP–00009021 at 00009023.

[550] *Id.* at 00009024.

[551] UHS, *New York State Office of Children and Family Services—Universal Health dba Foundations Behavioral Health* (Nov. 15, 2022) UHS–FINHELP–00010075 at 00010081.

sents for medical care when the target youth went to the hospital"[552] as an area of consistent communication failure. The Joint Commission cited Copper Hills Youth Center (UHS; Utah) because "[p]atient and family rights are not being honored as promised regarding phone calls and communication."[553] SandyPines (UHS; Florida) "failed to provide to ensure [sic] information regarding their residents was communicated amongst departments"[554] in the facility which allowed an alleged sexual relationship between two children to continue.[555]

The Committee observed that out-of-state placements of children in RTFs remove the children from their communities and strain oversight efforts. Many states send children out-of-state if they are unable to find suitable facilities or placements in-state. These placements result in children being removed from their community, materially impacting a child's care. As a P&A described to the Committee, children from out-of-state may face challenges in receiving necessary medical care if their health plans fail to cover out-of-state specialists. Out-of-state placements also pose oversight challenges. Currently, the Interstate Compact on the Placement of Children (ICPC) is meant to govern which oversight entity is responsible for an out-of-state child's well-being; however, in reality this creates a patchwork of agreements which enables loose oversight.[556] At Provo Canyon School (UHS; Utah) a 14-year-old Oregonian with I/DD was physically restrained and chemically sedated over 30 times over 4 months.[557] This prompted Oregon officials to fly to Utah themselves to investigate and ultimately return the child to Oregon. In 2020, Oregon terminated its contract with Sequel, meaning there were "no approved residential treatment placement options outside Oregon"[558] for children in the child welfare system. In 2020, to address some of the oversight gaps related to out-of-state placements, State Senator Sarah Gelser Blouin spearheaded the passage of an Oregon State law that increases standards related to congregate care by requiring out-of-state facilities to meet the same standards as in-state facilities under Oregon monitoring requirements.[559]

Some RTFs strive to meet the children's religious needs, while others do not. Alabama Clinical Schools (UHS; Alabama) has a "non-denominational church service available each week"[560] as part of its program. Management "reported being willing to make religious accommodations if a child observes a different religion [and] mentioned a Muslim child [to] who[m] they once provided special meals, prayer time, and other accommodations."[561] On the other hand, Hill Crest Behavioral Health Services (UHS; Alabama) was cited for having "no true extracurricular activities . . . [or creating] a virtual option for children who wish to attend and participate in a religious service in a denomination of the child's choosing."[562] At North Star Debarr (UHS; Alaska) "[t]wo (2) youth reported a male staff[er] who frequently talks about religion while on the unit . . . ma[king] them uncomfortable."[563] In two instances, The Joint Commission found a Willow Springs Center (UHS; Nevada) treatment plan was missing the child's spiritual and cultural preferences, necessary for a complete picture of the child's needs.[564]

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[552] *Id.* at 00010082.
[553] UHS, *The Joint Commission—Incident: Kids Behavioral Health of Utah Inc.* (Dec. 2, 2021) UHS–FINHELP–00009908 at 00009908.
[554] UHS, *Florida Agency for Health Care—Complaint—SandyPines* (Jan. 3, 2022) UHS–FINHELP–00009744 at 00009747.
[555] *Id.* at 00009749.
[556] APHSA, *ICPC FAQ'S* (Accessed May 22, 2024) *https://aphsa.org/AAICPC/AAICPC/icpc_faq_2.aspx#question1; [https://perma.cc/Z69R-XQLV].*
[557] The Salt Lake Tribune, *Utah "troubled-teen" centers have used "booty juice" to sedate kids, a practice outlawed in other states* (Feb. 4,2021) *https://www.sltrib.com/news/2021/02/04/utah-troubled-teen/; [https://perma.cc/FY7K-7HZN].*
[558] OPB, *Oregon Brings Back All Foster Children Placed Out of State* (June 30, 2020) *https://www.opb.org/news/article/oregon-brings-back-all-foster-children-placed-out-of-state/; [https://perma.cc/9G4M-X9YW].*
[559] SB 1605 (July 7, 2020) *https://olis.oregonlegislature.gov/liz/2020S1/Measures/Overview/SB1605; [https://perma.cc/FB7Q-DRF8].*
[560] UHS, *Alabama Department of Human Resource—Alabama Clinical Schools Review* (Mar. 28–Apr. 8, 2022) UHS–FINHELP–00009111 at 00009117.
[561] *Id.*
[562] UHS, *Alabama Department of Human Resources—Hill Crest Behavioral Health Services Review* (Nov. 27–Dec. 10, 2021) UHS–FINHELP–00009444 at 00009448.
[563] UHS, *The State of Alaska Department of Health, Division of Behavioral Health RE: Site Review ADDENDUM, North Star RTC* (Nov. 25, 2022) UHS–FINHELP–00011003 at 00011017.
[564] UHS, *Joint Commission Final Accreditation Report—Willow Springs Center* (Mar. 12–15) UHS–FINHELP–00010805 at 00010812.

b. RTFs Are Intended and Reimbursed to Offer Intensive Services, but the Committee Observed Instances of Children's Treatment Lacking Measurable Goals.

Children can be referred to RTFs for a variety of complex behavioral health needs, often during critical developmental years, but their treatments are not always well-planned. In some cases, plans are not created whatsoever, despite this being a federal requirement. In cases where plans are created, the Committee observed instances where plans were not calibrated to a child's history or unique needs or only represent a portion of their assessed needs. Further, the Committee observed treatment progress that is poorly measured and infrequently updated, even when children engage in critical safety events, like self-harm. This means that children—whose needs require continuous, specialized therapy—may be held stagnant or even regress during their time at RTFs. Finally, while it may be the case that some children receiving appropriate care merely lack documentation of that care, children at RTFs often receive treatment from a variety of providers across multiple jurisdictions, and such documentation defects could pose a long-term impediment to their care.

Acadia accepted nine unaccompanied, Spanish-speaking children in ORR custody at Millcreek of Arkansas (Acadia; Arkansas), even though it only employed one Spanish-speaking staffer onsite. According to a Disability Rights Arkansas monitoring letter, Millcreek of Arkansas (Acadia; Arkansas) accepted nine children in Office of Refugee Resettlement (ORR) custody who spoke "little to no English."[565] The children only had access to a translator "during the day shift for school hours"[566] and, otherwise, the site relied on "Google Translate [which] is not an effective means of communication."[567] The interpreter service used was remote and children noted that it "feels like talking with a stranger."[568] Company executives explained that they do not presently have any children in ORR custody because such placements now trigger exclusionary criteria on the basis of the company's inability to meet the needs of the child.[569]

Some RTFs routinely fail to create adequate treatment plans for children, with some plans created prior to admission or never created at all. The Committee reviewed an Ohio Department of Mental Health and Addiction Services report from Foundations for Living (UHS; Ohio) which found that children's treatment plans were being developed before their admission assessments were completed.[570] Additionally, at Foundations for Living (UHS; Ohio), documents showed a child was living at the site without ever having completed an intake assessment.[571] At Casa Grande Academy (Sequel/Vivant; Arizona) one child's treatment plan was not documented at time of discharge, one child's treatment plan was created 16 days after their admission, and one child's treatment plan still had not been created upon inspection by the assessors.[572] At Pavillion (UHS; Illinois), the Department of Children and Family Services observed that the facility failed to complete all behavior treatment plans and crisis plans for children at the facility.[573] At North Star Debarr (UHS; Alaska), the Department of Health and Social Services found a child had no plan of care at all.[574]

Records reviewed by the Committee reflect that RTFs sometimes do not provide individualized treatment plans to children based on their assessed

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[565] Acadia, *Disability Rights Arkansas RE: Millcreek Monitoring Report* (Apr. 5, 2019) 20190604 Millcreek Alaska HHS Referral Hold Letter at p. 12.

[566] *Id.* at p. 13.

[567] *Id.*

[568] Acadia, *Disability Rights Arkansas RE: Millcreek Monitoring Report* (Apr. 5, 2019) 20190604 Millcreek Alaska HHS Referral Hold Letter at p. 13.

[569] Notes from Acadia Healthcare Briefing (May 17, 2024) (on file with Committee).

[570] UHS, *Ohio Department of Mental Health and Addiction Services To: [REDACTED] CEO, Keystone Richland Center dba Foundations for Living* (Nov. 26, 2018) UHS–FINHELP–00009230 at 00009233.

[571] UHS, *Ohio Mental Health and Addiction Services Bureau of Licensure and Certification—Survey Report: Keystone Richland Center, LLC DBA Foundations for Living* (Sep. 16, 2019) UHS–FINHELP–00009837 at 00009841.

[572] Vivant, *ADHS Licensing Services—Statement of Deficiencies and Plan of Correction: Casa Grande Academy* (Apr. 4, 2022) FINAL—Vivant Submission External Reviews at p. 319–323.

[573] UHS, *Illinois Department of Children and Family Services To: [REDACTED] Divisional Vice President for Behavioral Health Pavilion* (Jan. 25, 2023) UHS–FINHELP–00009809 at 00009810.

[574] UHS, *State of Alaska Department of Health and Social Services Division of Behavioral Health—Site Review Summary of Findings: North Star Alpine Academy PRTF* (Aug. 8–12, 2022) UHS–FINHELP–00011003 at 00011009.

needs, with some facilities even duplicating goals and plans across children. During an accreditation review at Compass Intervention Center (UHS; Tennessee), The Joint Commission found that in all records reviewed patient treatment plans had identical goals.[575] At Willow Springs Center (UHS; Nevada), The Joint Commission found that the treatment plan in "the patient's record contains the name of another patient that is crossed out and over written with the name of the patient for whom the treatment plan was developed."[576] At Resource Indiana (Acadia; Indiana), the Indiana Department of Child Services Residential Licensing Unit found multiple children lacked treatment plan goals or time schedules for daily activities and in one case, treatment goals for specialized activities.[577] The Alabama Department of Mental Health found that Alabama Clinical Schools (UHS; Alabama) was failing to create individualized services "based on a comprehensive mental health evaluation and assessment of needed treatment and support."[578]

Some children are not being adequately oriented to facilities and their rights upon arrival. At Cedar Ridge Behavioral Hospital (UHS; Oklahoma), an Oklahoma Human Services monitoring visit found a "file with resident rights/policies not signed by the resident."[579] The Colorado Department of Human Services Division of Child Welfare reviewed six children's records at Cedar Springs Hospital (UHS; Colorado) and found "[n]o documentation of the child's orientation to the facility within 24 hours of admission in 2 of the 6 files and 2 other child's [sic] orientations were late."[580]

In some cases, children's treatment plans are not informed by assessments of their histories and diagnoses, often resulting in failures to develop goal-oriented, measurable treatment plans for children. At Brynn Marr Hospital (UHS; North Carolina), a child had "several needs identified in the assessments that were not addressed in their treatment plan. These included marijuana use, depression, suicidal ideation, and lack of a family."[581] The Joint Commission found that Willow Springs Center (UHS; Nevada) did not screen numerous children for neglect or exploitation in the development of their plans.[582] The Joint Commission found that a child admitted to Suncoast Behavioral Health Center (UHS; Florida) presented trauma as measured by a screener and a psychosocial assessment, but the child's "treatment plan goals did not reflect a trauma specific goal during care, treatment, or services."[583] The Joint Commission found that Millcreek of Pontotoc (Acadia; Mississippi) failed to perform a psychosocial assessment for multiple children upon admission.[584] At Cedar Ridge Treatment Center (UHS; Oklahoma), a child's eye was injured when they fell out of bed during a seizure; multiple assessments note a history of seizures, but no precautions were implemented.[585] The Joint Commission's survey of Compass Intervention Center (UHS; Tennessee) revealed that every record reviewed lacked documented goals used to measure progress and, further, no treatment objectives were formulated in terms of progress.[586] At Copper

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[575] UHS, *Joint Commission Health Care Organization: Keystone Memphis LLC* (Jan. 6, 2022) UHS–FINHELP–00008702 at 00008704.

[576] UHS, *Joint Commission Health Care Organization: Keystone Memphis LLC* (Jan. 6, 2022) UHS–FINHELP–00010805 at 00010813.

[577] Acadia, *Indiana Department of Child Services Central Office Residential Licensing Unit—Exit Report and Narrative: RTC Resource* (July 17–20, 2018) 20180717 Resource IN DCS Licensing Survey Report at p. 2.

[578] UHS, *Alabama Department of Mental Health—Certification Site Visit Scoring Summary: Alabama Clinical School* (Jan. 20–21, 2021) UHS–FINHELP–00009210 at 00009213.

[579] UHS, *Oklahoma Human Services—Residential Child Care Facilities Monitoring Summary: Cedar Ridge Residential Treatment Facility* (May 3, 2023) UHS–FINHELP–00012054 at 00012057.

[580] UHS, *Colorado Department of Human Services Division of Child Welfare—Report of Inspection: Cedar Springs Hospital* (Jan. 25, 2023) UHS–FINHELP–00008890 at 00008891.

[581] UHS, *Joint Commission Final Accreditation Report—Brynn Marr Hospital* (Nov. 19, 2020) UHS–FINHELP–00009083 at 00009094.

[582] UHS, *The Joint Commission—Final Accreditation: Willow Springs Center* (Mar. 12–15, 2018) UHS–FINHELP–00010805 at 00010812.

[583] UHS, *The Joint Commission—Final Accreditation Report: Premier Behavioral Health Solutions of FL* (Aug. 4, 2022) UHS–FINHELP–00008660 at 00008671; *see also* Acadia, *State of Mississippi Department of Mental Health—Written Report of Findings: Millcreek of Pontotoc* (May 4–6, 2022) 20220506 Millcreek Pontotoc Licensure-group homes at p. 2.

[584] Acadia, *The Joint Commission—Preliminary Accreditation Report: Millcreek of Pontotoc* (Oct. 5–8, 2021) 20211008 Millcreek of Pontotoc Joint Commission Triennial Report at p. 5.

[585] UHS, *Oklahoma Human Services: Cedar Ridge Residential Treatment Facility* (Aug. 9, 2022) UHS–FINHELP–00011988 at 00011996.

[586] UHS, *The Joint Commission—Final Accreditation Report: Keystone Memphis LLC* (Apr. 9–13, 2018) UHS–FINHELP–00008684 at 00008689.

Hills Youth Center (UHS; Utah) all treatment plans reviewed by The Joint Commission lacked steps by which to measure treatment progress.[587] The Joint Commission found that Millcreek of Pontotoc (Acadia; Mississippi) did not incorporate mental health assessment results into treatment plans.[588] At RTC Resource (Acadia; Indiana), the Office of Long Term Care found that "[t]he goal objectives [in a child's plan] described steps for achieving each goal but the interventions were the same month after month regardless of the youth's progress."[589]

Some RTFs are not adequately assessing the nutritional needs of the children in their custody. In light of numerous complaints by patients of inadequate food at RTFs, the Committee reviewed provider documents related to patient nutrition and found several deficiencies. The Joint Commission found that all records at Compass Intervention Center (UHS; Tennessee) lacked questions regarding weight loss or gain of 10 or more pounds in the previous 3 months, or a decrease in food intake and/or appetite or dental problems.[590] The Joint Commission found that River Park Hospital (UHS; West Virginia) did not complete nutrition screenings for all records reviewed.[591] At Foundations Behavioral Health (UHS; Pennsylvania), the nutrition screen lacked information about weight gain and the assessment for the WRAP program did not include a screen of a child's nutrition status.[592] At Texas San Marcos Treatment Center (UHS; Texas), the facility misapplied their nutrition screening tool to a child with diabetes who required further care. The nutrition screen required a "yes" or "no" answer to trigger a referral, but this question was left blank.[593]

The Committee's review found that children are often unable to understand the treatment they are receiving or articulate treatment goals in their own words. It is critical that RTF patients understand the treatment they are undergoing and are able to articulate it in their own words. The Committee reviewed instances at multiple RTFs where patients were unable to describe their care or such descriptions were not properly recorded. For example, at Piney Ridge Treatment Center (Acadia; Arkansas), 8 of 43 children "could not explain what the help was that they were receiving"[594] and 10 of 43 children "reported the treatment interventions they were receiving not to be helpful in addressing their target psychiatric symptoms."[595] At North Star RTC Palmer (UHS; Alaska) some children "felt that staff determined what was on their respective treatment plans."[596] Both the Department of Mental Health and The Joint Commission found that treatment goals at Millcreek of Pontotoc (Acadia; Mississippi) were not written in the child's words.[597] The Joint Commission found that not a single treatment plan surveyed at Copper Hills Youth Center (UHS; Utah) included children's words or intent regarding their treatment.[598] The Joint Commission cited Foundations Behavioral Health (UHS; Pennsylvania) in two separate years for not writing goals in children's words. The first year, the "care plan goals reviewed [. . .] were written as clinical formulations."[599] The second year, The Joint Commission found that all "patient

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[587] UHS, *The Joint Commission—Final Accreditation Report: Kids Behavioral Health of Utah Inc.* (Jan. 10–13, 2023) UHS–FINHELP–00009962 at 00009967.

[588] Acadia, *The Joint Commission—Preliminary Accreditation Report: Millcreek of Pontotoc* (Oct. 5–8, 2021) 20211008 Millcreek of Pontotoc Joint Commission Triennial Report at p. 8.

[589] Acadia, *DCS Audit Tool: Long Term Care and Emergency Shelter Care—RTC Resource* (Sep. 7–16, 2021) 20210915 Resource DCS-Licensing Review-Report at p. 4.

[590] UHS, *The Joint Commission—Final Accreditation Report: Keystone Memphis LLC* (Nov. 10, 2021) UHS–FINHELP–00008702 at 00008723.

[591] UHS, *The Joint Commission—Final Accreditation: River Park Hospital* (Jan. 22–24, 2018) UHS–FINHELP–00011754 at 00011766.

[592] UHS, *The Joint Commission—Final Accreditation Report: UHS of Doylestown, LLC* (Nov. 20, 2019) UHS–FINHELP–00010185 at 00010197.

[593] UHS, *The Joint Commission—Final Accreditation Report: Texas San Marcos Treatment Center, LP* (Aug. 29, 2018) UHS–FINHELP–00009680 at 00009685.

[594] Acadia, *Beacon Health Options—Inspection of Care Report: Piney Ridge Treatment Center* (Apr. 9–12, 2018) 20180409 Piney Ridge AR Beacon Report at p. 4.

[595] *Id.*

[596] UHS, *State of Alaska Department of Health and Social Services Division of Behavioral Health—Site Review Summary of Findings: North Star RTC Palmer* (Sep. 5–6, 2018) UHS–FINHELP–00010854 at 00010859.

[597] Acadia, *State of Mississippi Department of Mental Health—Written Report of Findings: Millcreek of Pontotoc* (May 4–6, 2022) 20220506 Millcreek Pontotoc Licensure-group homes at p. 2; Acadia, *The Joint Commission—Preliminary Accreditation Report: Millcreek of Pontotoc* (Oct. 5–8, 2021) 20211008 Millcreek of Pontotoc Joint Commission Triennial Report at p. 6.

[598] UHS, *The Joint Commission—Final Accreditation Report: Kids Behavioral Health of Utah Inc.* (Jan. 10–13, 2023) UHS–FINHELP–00009962 at 00009967.

[599] UHS, *The Joint Commission—Final Accreditation Report: UHS of Doylestown, LLC* (Nov. 20, 2019) UHS–FINHELP–00010185 at 00010197.

records reviewed [at Foundations Behavioral Health (UHS; Pennsylvania)] had goals that were not in the patient's own words."[600] At Compass Intervention Center (UHS; Tennessee), The Joint Commission found that two records included "treatment goals [that] were not in the client's own words or in words that represent the client, but in clinical jargon."[601] The Joint Commission identified a similar issue at Cedar Springs Hospital (UHS; Colorado) where a child's treatment goals were written in the third person.[602]

Committee review found that RTFs sometimes exclude families from treatment planning. Under Medicaid, PRTF requirements dictate that an individual plan of care must be developed with input from the "parents, legal guardians, or others in whose care [a child] will be released after discharge."[603] In some instances RTFs appear to skip the family or guardian involvement requirement. At Piney Ridge Treatment Center (Acadia; Arkansas), a 2018 audit found that five beneficiary records "did not document an Individual Plan of Care developed in consultation with . . . his or her parent(s), legal guardian(s), or others in whose care he or she will be released after discharge."[604] In its plan of correction, Piney Ridge Treatment Center (Acadia; Arkansas) explained its commitment to "*verifying* that the Individual Plan of Care was developed in consultation with the recipient and his/her parent/guardian"[605] rather than centering a parent/guardian's meaningful involvement, as intended by the regulation. At Hill Crest Behavioral Health Services (UHS; Alabama), a surveyor noted that "[f]amily members/caregivers need to be more involved in the treatment planning process to be better prepared for the child's discharge."[606] The inspection explained that "[e]fforts to include family in the treatment planning process need to occur more, (*i.e.,* dates/times) and should be made as convenient for the family as possible."[607] The Oklahoma Health Care Authority (OHCA) found that "[c]ollaboration with the guardian was not documented in four (4) of the [plans of care] reviewed, and on multiple plans the signature plan section asking if the guardian participated in plan development was checked 'no.'"[608] Further, in multiple instances, the [plan of care] signature page was simply mailed to the parent/guardian.[609] At North Star Debarr (UHS; Alaska) a parent stated to auditors that while she is informed when the team meeting takes place, they are regularly scheduled when she is at work and unavailable.[610]

The Committee reviewed instances where treatment plans at RTFs were not updated to ensure they are meeting children's changing treatment needs. Children receiving care at RTFs have complex treatment needs requiring ever-evolving treatment plans. The Committee reviewed multiple instances where documented treatment plans failed to account for the patient's evolving needs. For example, Harbor Point Behavioral Health (UHS; Virginia) was cited by the Department of Behavioral Health and Developmental Services for failing to reevaluate treatment plans based on a child's progress along the required timeframe.[611] At Piney Ridge Treatment Center (Acadia; Arkansas), an inspection necessitated a corrective action plan when two children did not have documented plan of care reviews

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[600] UHS, *The Joint Commission—Final Accreditation Report: UHS of Doylestown, LLC* (Aug. 15–17,2022) UHS–FINHELP–00010166 at 00010171.

[601] UHS, *Joint Commission Health Care Organization: Keystone Memphis LLC* (Jan. 6, 2022) UHS–FINHELP–00008702 at 00008708.

[602] UHS, *The Joint Commission—Final Accreditation Report: Cedar Springs Hospital* (Jan. 2, 2020) UHS–FINHELP–00008896 at 00008905.

[603] CMS, *Psychiatric Residential Treatment Facilities (PRTF): General Requirements and Conditions of Participation* (accessed May 30, 2024) *https://www.cms.gov/outreach-and-education/american-indian-alaska-native/aian/prtfgeneralrequirementsandconditionsofparticipation.pdf; [https://perma.cc/DJS9-TDVT].*

[604] Acadia, *Beacon Health Options—Inspection of Care Report: Piney Ridge Treatment Center* (Apr. 9–12, 2018) 20180409 Piney Ridge AR Beacon Report at p. 11.

[605] Acadia, *Beacon Health Options RE: Corrective Action Plan for Inpatient Inspection of Care 4–9–18 to 4–12–18* (May 8, 2018) 20180409 Piney Ridge POC (italics added).

[606] UHS, *Alabama Department of Human Resources—Hill Crest Behavioral Health Services Review* (Nov. 27–Dec. 10, 2021) UHS–FINHELP–00009444 at 00009448.

[607] *Id.* at 00009451.

[608] Acadia, *Oklahoma Health Care Authority—Post-CAP Reassessment Review Findings: Piney Ridge Treatment Center* (Mar. 19, 2021) 20210318 Piney Ridge OHCA Corrective Action Plan Review Findings at p. 1.

[609] *Id.*

[610] UHS, *State of Alaska Department of Health and Social Services Division of Behavioral Health—Site Review Summary of Findings: North Star Alpine Academy PRTF* (Aug. 8–11, 2022) UHS–FINHELP–0011003 at 00011021.

[611] UHS, *Department of Behavioral Health and Developmental Services Corrective Action Plan: Harbor Point Behavioral Health Center* (May 2, 2019) UHS–FINHELP–00010303.

that adjusted for the child's changing conditions.[612] At Palmetto Summerville (UHS; South Carolina), The Joint Commission found that individual assessments were not occurring on the prescribed timeline; in multiple cases, the facility failed to adjust treatment plans based on children's changing conditions.[613] This was also true at First Hospital Panamericano (UHS; Puerto Rico) where treatment plans remained unchanged even as children's behaviors changed.[614] In another case, the Department of Behavioral Health and Developmental Services issued a corrective action plan to Cumberland Hospital (UHS; Virginia) detailing that, even though a child was placed on sexual aggression precautions with a related order from her physician, her service plan was not updated.[615] Further, the Department of Health and Human Services found that Millcreek of Arkansas (Acadia; Arkansas) failed to consult a Qualified Intellectual Disability Professional in the case of three children to ensure that their active treatment plans were up-to-date and responsive to their conditions.[616] Finally, at North Star Debarr (UHS; Alaska), the Department of Health and Social Services found "progress notes seldom detailed a clear picture with correct dates and reasons for the level transition in between units."[617] At Pavilion Behavioral Health System (UHS; Illinois), The Joint Commission observed that the facility was not using its treatment outcome tool to evaluate or modify treatment plans.[618]

The Committee observed instances of RTFs failing to adequately screen for suicide risk and failing to adapt treatment plans for children following self-harm behavior. A report reviewed by the Committee from Disability Rights Arkansas described how a child who was actively engaging in self-harm behavior was only "offered Individual therapy a total of five times from October 12 to November 30, 2018."[619] A report from the South Carolina Department of Health and Environmental Control found that Palmetto Summerville Behavioral Health (UHS; South Carolina) failed to implement its own suicide prevention policies, leaving one child, who subsequently attempted to slit his own neck with a piece of plastic, without a suicide risk screening.[620] In one case at Palmetto Summerville (UHS; South Carolina), a child's treatment plan was not updated to include "suicide as a goal/objective for treatment,"after multiple suicide attempts and statements indicating an intent to kill himself. In a second case at Palmetto Summerville (UHS; South Carolina), a child's treatment plan was not updated to include "goals and objectives addressing suicide," despite her attempt to kill herself by tying clothes around her neck.[621]

In documents from Foundations Behavioral Health (UHS; Pennsylvania) a child had a positive suicide risk screening, but lacked a follow-up suicide risk assessment, even though the child reported both a plan and intent to self-harm.[622] Further, in a second case at Foundations Behavioral Health (UHS; Pennsylvania), a child's suicide risk was not recorded in their suicide screening; the child displayed current suicidal ideation, plan, and intent, but was not placed on 1:1 monitoring.[623] An accreditation visit by The Joint Commission found that First Hospital Panamericano (UHS;

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[612] Acadia, *Beacon Health Options RE: Corrective Action Plan for Inpatient of Care September 4,5,6,7,10 and 11, 2018* (Oct. 5, 2018) 20180904 Piney Ridge AR Beacon Corrective Action Plan at p. 2.

[613] UHS, *The Joint Commission—Final Accreditation: The Pines Residential Treatment Center-Charleston Campus* (May 28–31, 2019) UHS–FINHELP–00011390 at 00011395–00011397.

[614] UHS, *The Joint Commission—Final Accreditation Report: First Hospital Panamericano* (Aug. 21–24, 2018) UHS–FINHELP–00008758 at 00008769.

[615] UHS, *Department of Behavioral Health and Developmental Services Corrective Action Plan: Cumberland Hospital* (Oct. 22, 2020) UHS–FINHELP–00009223 at 00009226.

[616] Acadia, *Department of Health and Human Services Centers for Medicare & Medicaid—Statement of Deficiencies and Plan of Correction: Millcreek of Arkansas* (Apr. 1, 2021) 20210401 Millcreek of Arkansas CMS-OLTC-final report at p. 10.

[617] UHS, *State of Alaska Department Health and Social Services, Division of Behavioral Health—Site Review Summary of Findings: North Star Alpine Academy PRTF* (Aug. 8–11, 2022) UHS–FINHELP–00011037 at 00011041.

[618] UHS, *The Joint Commission Report—Final Accreditation Report: The Pavilion Foundation* (Nov. 29–Dec. 1, 2022 UHS–00009822 at 00009828.

[619] Disability Rights Arkansas, *RE: [Redacted] To: [Redacted], Chief Executive Officer* (Jan. 30, 2019) 20190604 Millcreek Alaska HHS Referral Hold at p. 15.

[620] UHS, *South Carolina Department of Health and Environmental Control Healthcare Quality—Summary of Violations* (Basis for Imposing Penalties) (Nov. 8, 2022) UHS–FINHELP–00011436 at 00011436–00011437.

[621] UHS, *The Joint Commission—Final Accreditation Report: The Pines Residential Treatment Center-Charleston Campus* (May 28–31, 2019) UHS–FINHELP–00011390 at 00011395–00011397.

[622] UHS, *The Joint Commission—Final Accreditation Report: UHS of Doylestown, LLC* (Aug. 15–17, 2022) UHS–FINHELP–00010166 at 00010172.

[623] *Id.*

Puerto Rico) was not fully using their suicide screening tool during intake, and further that a child's treatment objectives were not updated after an instance of self-harm—instead, his privileges were restricted.[624] Other documents from First Hospital Panamericano (UHS; Puerto Rico) show one child's treatment goals remained unchanged following a self-harm attempt.[625]

An accreditation visit by The Joint Commission found that Heartland Behavioral Health Services (UHS; Missouri) was misusing its "Suicide Risk Assessment and Management" tool. In one case, a child attempted suicide the week before admission, but was assessed to be at a "lower" risk of suicide. In another case, a child who had attempted suicide multiple times before admission was assessed as "similarly" at risk.[626] When Committee staff discussed these screening failures with UHS leadership, they pushed back and said that these incidents, instead, likely represent failure to document screenings that may have occurred.[627]

Facilities do not always communicate critical incidents to the required entities within regulated timeframes. According to documents reviewed by the Committee, Harbor Point Behavioral Health Care (UHS; Virginia) was cited for failure to report serious incidents, including child self-harm, to the Virginia Department of Behavioral Health and Developmental Services within the required time frame in each of 2019, 2020, 2021, and 2023.[628] In March 2020, for example, a child at the facility engaged in self-harm by ingesting an item; the child received an x-ray, but the state authorities were not informed until four days later.[629] Documents show that Foundations Behavioral Health (UHS; Pennsylvania) was also deficient due to its "[l]ack of reporting of serious occurrences to both the State Medicaid agency and the state designated protection and advocacy system."[630] At Cumberland Hospital (UHS; Virginia) three serious incidents across 5 months were never reported to the state's licensure authority and, separately, two dozen incident reports were "not reported within the time-frame required by the Human Rights regulations."[631]

c. Treatment Plan Deficiencies Result in Children Not Receiving the Care They Need.

Where RTFs do produce treatment plans for children, listed treatment is often not high-quality or not occurring at therapeutically appropriate and prescribed frequencies. This finding is supported by quotes from children, parents, facility staff, clinical staff, and legislators. As a former patient from Millcreek Behavioral Health (Acadia; Arkansas) described, "There was no hope of ever actually [receiving] any

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[624] UHS, *The Joint Commission—Final Accreditation Report: First Hospital Panamericano* (Aug. 21–24, 2018) UHS–FINHELP–00008758 at 00008769.

[625] *Id.*

[626] UHS, *The Joint Commission—Unannounced Full Event: Great Plains Hospital, Inc.* (Feb. 22–25, 2021) UHS–FINHELP–00009366 at 00009369.

[627] Notes from Universal Health Services Briefing (May 23, 2024) (on file with Committee).

[628] UHS, *Department of Behavioral Health and Developmental Services Corrective Action Plan: Harbor Point Behavioral Health Center* (Mar. 15, 2019) UHS–FINHELP–00010230 at 00010230; UHS, *Department of Behavioral Health and Developmental Services Corrective Action Plan: Harbor Point Behavioral Health* (Mar. 31, 2020) UHS–FINHELP–00010239 at 00010239; UHS, *Department of Behavioral Health and Developmental Services Corrective Action Plan: Harbor Point Behavioral Health Center* (Mar. 31, 2020) UHS–FINHELP–00010237 at 00010237; UHS, *Department of Behavioral Health and Developmental Services Corrective Action Plan: Harbor Point Behavioral Health Center* (Sep. 20, 2021) UHS–FINHELP–00010347 at 00010347–00010348; UHS, *Department of Behavioral Health and Developmental Services Corrective Action Plan: Harbor Point Behavioral Health Center* (Mar. 29, 2023) UHS–FINHELP–00010235 at 00010235; UHS, *Department of Behavioral Health and Developmental Services Corrective Action Plan: Harbor Point Behavioral Health Center* (Feb. 12, 2021) UHS–FINHELP–00010222 at 00010224; UHS, *Department of Behavioral Health and Developmental Services Corrective Action Plan: Harbor Point Behavioral Health Center* (Apr. 26, 2022) UHS–FINHELP–00010271 at 00010271; UHS, *Department of Behavioral Health and Developmental Services Corrective Action Plan: Harbor Point Behavioral Health Center* (Mar. 31, 2020) UHS–FINHELP–00010241 at 00010241.

[629] UHS, *Department of Behavioral Health and Developmental Services Corrective Action Plan: Harbor Point Behavioral Health* (Mar. 31, 2020) UHS–FINHELP–00010239 at 00010239.

[630] UHS, *Foundations Behavioral Health* (Inspections) (modified Feb. 8, 2024) UHS–FINHELP–00010163 at 00010163.

[631] UHS, *Department of Behavioral Health and Developmental Services Corrective Action Plan: Cumberland Hospital* (Oct. 22, 2020) UHS–FINHELP–00009223 at 00009223; UHS, *Department of Behavioral Health and Developmental Services Corrective Action Plan: Cumberland Hospital, LLC* (June 20, 2019) UHS–FINHELP–00009216 at 00009217; *see also:* UHS, *Alabama Department of Human Resources—Hill Crest Behavioral Health Services Review* (Nov. 27–Dec. 10, 2021) UHS–FINHELP–00009444 at 00009447.

kind of psychological treatment, it was psychological mistreatment, and they knew it."[632]

A mother described her child's treatment at Palmetto Summerville Behavioral Health (UHS; South Carolina) to reporters in the following way: "I was hoping that she would be able to get the comprehensive care that she would need [. . .] Boy was I wrong. I was completely wrong. You assume that they go in for their intense treatment, but she came out worse."[633]

These sentiments are echoed by staff. A former staffer at Behavioral Health Treatment Center (Acadia; Tennessee) publicly questioned the efficacy of RTFs' programming saying, "[w]e would watch the kids leave, and to be honest with you, it'd be like, 'Okay, I wonder how long it is before they're in a jail cell somewhere, or they're in another program,' because they weren't getting better with us."[634] A former nurse at Piney Ridge Treatment Center (Acadia; Arkansas) stated a similar position saying, "[t]hese kids, when they leave, they are worse off than when they got there."[635]

Oregon State Senator Sara Gelser Blouin, a champion of improving treatment in congregate care for youth, described a child upon her return from Provo Canyon School (UHS; Utah) in the following way, "The whole idea of sending her to Provo Canyon School [(UHS; Utah)] was supposed to be that her needs were so great, that this was the only place that could help her. And what they sent back to us was a broken, injured, frightened child with more trauma than she went there with."[636]

A child may be receiving appropriate care, even where the facility fails to document treatment and progress. However, this lack of documentation poses a threat to the child's long-term wellness and the continuity of care they receive upon discharge from the facility, which relies upon careful documentation of a child's treatment and condition.

In many cases, facilities are not providing children the care they describe in the children's treatment plans. Both public accounts and provider documents reviewed by the Committee contain accounts of children not receiving adequate care at RTFs, despite per diem reimbursements that are intended to cover a comprehensive set of behavioral health care services. For example, according to public reporting, a child went 40 days without a therapy session at North Star Psychiatric Hospital (UHS; Alaska).[637] A lawsuit filed by the parents of an 11-year-old against Brynn Marr Hospital (UHS; North Carolina) alleged, in addition to assault, that the child did not receive adequate mental health services.[638] The child, who allegedly only saw a psychiatrist twice, despite being billed for more, said, "as someone who's done a lot of group therapy or therapy, there was nothing [at Brynn Marr Hospital Hospital (UHS; North Carolina)] that I would define as therapy."[639]

The Committee's review of company records found that therapy sessions at Casa Grande Academy (Vivant; Arizona) at times do not occur at their scheduled intervals, meaning children do not receive adequate therapy.[640] For example, one child

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[632] THV11, *Some kids have faced violence in Arkansas psychiatric facilities* (Jan. 9, 2023) *https://www.thv11.com/article/news/health/violence-arkansas-psychiatric-facilities/91-082c9941-3132-476e-8aca-c5a2734c04b8; [https://perma.cc/5F5T-RYYC].*

[633] WCSC, *Summerville youth treatment facility facing new accusations, lawsuit* (Jan. 10, 2023) *https://www.live5news.com/2023/01/10/summerville-youth-treatment-facility-facing-new-accusations-lawsuit/; [https://perma.cc/YXT4-KRLV].*

[634] The Daily Times, *What police, private investigations reveal about the Village Behavioral Health* (Apr. 12, 2022) *https://www.thedailytimes.com/news/what-police-private-investigations-reveal-about-the-village-behavioral-health/article_2ae89da8-bad5-5be6-ac87-71ada5cc79fb.html; [https://perma.cc/Z4Y2-F9EM].*

[635] KNWA, *KNWA investigation reveals years of licensing issues at children's treatment facility* (Oct. 4, 2021) *https://www.nwahomepage.com/news/knwa-investigation-reveals-years-of-licensing-issues-at-childrens-treatment-facility/; [https://perma.cc/5Z7A-PFNH].*

[636] The Salt Lake Tribune, *Utah "troubled-teen" centers have used "booty juice" to sedate kids, a practice outlawed in other states* (Feb. 4, 2021) *https://www.sltrib.com/news/2021/02/04/utah-troubled-teen/; [https://perma.cc/FY7K-7HZN].*

[637] Anchorage Daily News, *Federal inspectors fault assaults, escapes, improper use of locked seclusion at North Star youth psychiatric hospital* (Sep. 28, 2022) *https://www.adn.com/alaska-news/2022/09/28/federal-inspectors-fault-assaults-escapes-improper-use-of-locked-seclusion-at-north-star-youth-psychiatric-hospital/; [https://perma.cc/C7WJ-MNQN].*

[638] North Carolina Health News, *Durham 11-year-old was sexually assaulted in NC psychiatric hospital, parents allege* (Nov. 30, 2022) *https://www.northcarolinahealthnews.org/2022/11/30/parents-allege-11-year-old-sexually-assaulted-in-nc-psychiatric-hospital/; [https://perma.cc/Q5GQ-6SUV].*

[639] *Id.*

[640] Vivant, *ADHS Licensing Services—Statement of Deficiencies and Plan of Correction: Casa Grande Academy* (Apr. 4, 2022) FINAL_Vivant Submission External Reviews at p. 309–310.

was supposed to "attend weekly [individual] therapy [and] two group therapy sessions."[641] The child was at Casa Grande Academy for 67 days, but only had individual therapy notes documented on three dates and group therapy notes documented on two dates.[642] Another child at Casa Grande Academy (Vivant; Arizona) "did not have documentation of receiving weekly counseling for 16 out of 21 weeks"[643] at the facility. Further, this same child "did not have documentation for 31 of his/her group therapy sessions from his/her 21-week admission [as well as] no family therapy sessions documented."[644] When Committee staff discussed the lack of therapeutic documentation with Vivant leadership, they noted that they had recently purchased the facility from Sequel at the time of the citation and, further, defended the deficiency saying that simply because a therapy session is not documented as occurring does not mean it did not occur.[645]

According to government reviews of North Star Debarr (UHS; Alaska), the facility had numerous deficiencies related to the provision of therapy. For example, "progress notes seldom detailed a clear picture with correct dates and reasons for the level transition in between units." It is unclear if the required family and individual therapy sessions occurred because children were documented to be in therapy and in other activities at the same time.[646] In another report, the facility also failed, in 6 of 11 records, to keep weeks of therapy notes for individual, group, and family therapy.[647] The inspection cited complaints that most of the information extracted from progress notes "lacked sense, and appeared contradictory."[648] In an interview on the same visit "[o]ne (1) student suggested that the curriculum itself should be different for a '17-year-old versus an 11-year-old,'"[649] while a parent offered that they "[don't] feel like there's any follow through and consistency" related to the treatment diagnosis of their child.[650] Another parent observed that "the [kids] only watch TV every day and watch the same movie."[651]

At Piney Ridge Treatment Center (Acadia; Arkansas), the Oklahoma Health Care Authority found in 4 of 14 weeks of treatment reviewed, the facility had a shortage of treatment hours. One record was completely missing a record of service; a second record had family therapy notes indicating that sessions were only 5 minutes long; and a third record had overlapping therapy session times.[652] At Hill Crest Behavioral Health Services (UHS; Alabama), the Alabama Department of Mental Health found that there was no evidence in files reviewed of the facility providing at least an hour of individual and an hour of group therapy each week to a recipient.[653] The audit found that, "as of 05/22/2019 the last documented individual therapy was on 04/03/2019."[654]

It is often unclear from records whether prescribed medications are given to children. The Committee reviewed an inspection report from Brynn Marr Hospital (UHS; North Carolina) which documented extensive medication administration failures.[655] A child was not given an antipsychotic, two different mood stabilizers, and an antidepressant on multiple occasions.[656] Another child failed to receive a cumulative hundreds of doses of her medications across the 3-months reviewed.[657] The

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[641] *Id.*
[642] *Id.*
[643] *Id.*
[644] *Id.*
[645] Notes from Vivant Behavioral Health Briefing (May 22, 2024) (on file with Committee).
[646] UHS, *State of Alaska Department Health and Social Services, Division of Behavioral Health—Site Review Summary of Findings: North Star Alpine Academy PRTF* (Aug. 8–11, 2022) UHS–FINHELP–00011037 at 00011041–00011042.
[647] UHS, *State of Alaska Department of Health and Social Services Division of Behavioral Health—Site Review Summary of Findings: North Star Alpine Academy PRTF* (Aug. 8–11, 2022) UHS–FINHELP–00011003 at 11009.
[648] *Id.* at 11011.
[649] *Id.* at 11017.
[650] *Id.* at 11021.
[651] *Id.* at 11023.
[652] Acadia, *Oklahoma Health Care Authority—Post-CAP Reassessment Review Findings: Piney Ridge Treatment Center* (Mar. 19, 2021) 20210318 Piney Ridge OHCA Corrective Action Plan Review Findings at p. 2.
[653] UHS, *Alabama Department of Mental Health—Programmatic Findings: Hill Crest Behavioral Health Services* (May 22–23, 2019) UHS–FINHELP–00009384 at 00009388.
[654] *Id.*
[655] UHS, *Division of Health Service Regulation—Statement of Deficiencies and Plan of Correction: Brynn Marr Hospital* (Oct. 20, 2021) UHS–FINHELP–0008911 at 00008924.
[656] *Id.*
[657] *Id.* at 00008926–00008927.

Committee also reviewed documents related to Medication Administration Records at Copper Hills Youth Center (UHS; Utah) which found that 6 of the 14 records lacked initials that indicated the scheduled medication was administered.[658] Further, medications were missing follow-up comments in 12 of the 14 records reviewed.[659] The Committee also reviewed a complaint against Village Behavioral Health (Acadia; Tennessee) which alleged a delay in "administering medications that were prescribed/necessary for [a] patient."[660] A state licensure visit to Millcreek Behavioral Health (Acadia; Arkansas) documented that 60 percent of Medication Administration Records reviewed did not have proof of medication administration.[661] An Alaska Department of Health review of North Star Debarr (UHS; Alaska) found six Medication Administration Records lacked nurses' initials.[662] The Joint Commission found that SandyPines Residential Treatment Center (UHS; Florida) tracked medication administration in a manner that could not be easily understood by a child or their family.[663]

Committee staff visited five facilities to witness their conditions first-hand and saw evidence of improper therapeutic treatment. Committee staff visited five RTFs to better understand facility operations. While none of the facilities were operated by the four providers at-issue in this investigation, the five sites are a sample of RTFs across the country—for-profit, nonprofit, small sites operated by a single provider, large sites operated by chains, rural sites, and more urban sites. Committee staff met many children with I/DD. The chaotic nature of RTFs makes them uniquely inappropriate treatment settings for children with I/DD, yet Committee staff met many children on their visits with these disabilities. There were other concerning indicators observed related to the lack of treatment provisioned at these sites. At one facility, the administrator acknowledged to Committee staff that the facility's previous group therapy curriculum was not informed by clinical standards or children's needs. Instead, staffers, who are only required to have high school diplomas, had been planning and facilitating group therapy sessions. At another facility, an administrator told Committee staff that children only receive a single weekly 30-minute individual therapy session. When asked what could be done to make facilities better, a child told Committee staff they would like to "[s]ee my therapist more."

d. RTFs Are Intended to Offer Brief and Intensive Services, but Children Are Trapped in These Facilities—Sometimes for Years.

Facility length of stay (LOS) data suggests that children remain in facilities for long periods of time, in some cases longer than 18 years.[664] While providers only advertise short to medium duration stays on their websites,[665] these extended facility LOS undermine any facilities' claim that they offer acute, stabilizing mental health services to high-need children.

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[658] UHS, *State of Alaska Department of Health and Social Services Division of Behavioral Health—Site Review Summary of Findings: Copper Hills Youth Center* (Sep. 30–Oct. 3, 2019) UHS–FINHELP–00009926 at 00009933.

[659] *Id.*

[660] Acadia, *Organization Response for Incident #321772* (Mar. 31, 2019) 20190331 Village OQPS.

[661] Acadia, *Licensing Compliance Record* (Aug. 31, 2021) 20210831 Millcreek AR state licensure-findings at p. 3.

[662] UHS, *State of Alaska Department of Health and Social Services Division of Behavioral Health—Site Review Summary of Findings: North Star Alpine Academy PRTF* (Jan. 16–17, 2023) UHS–FINHELP–00011158 at 00011175–00011176.

[663] UHS, *The Joint Commission—Final Accreditation Report: SP Behavioral, LLC* (Jan. 12–15, 2021) UHS–FINHELP–00009784 at 00009790.

[664] UHS, *Sheet ALOS-Last 5 Yrs* (May 26, 2023) UHS–FINHELP–00000001.

[665] UHS, North Spring Behavioral Healthcare, *Welcome to North Spring Behavioral Healthcare:* "We believe that children should not be in residential treatment centers for longer than they need to be. Each individual's treatment should be as short as possible" (accessed June 1, 2024) *https://northspringleesburg.com/about-us/; [https://perma.cc/KUQ2-NJKT];* UHS, *Natchez Trace Youth Academy, Info on Calls, Visits & More:* "Stays are typically 3 to 9 months long" (accessed June 1, 2024) *https://natcheztraceyouthacademy.com/admissions/frequently-asked-questions/; [https://perma.cc/8DR5-SQNR];* Acadia, *Specialized Treatment for Adolescent & Children Ages 5–17:* "Children and adolescents may take part in residential treatment for several weeks or months" *https://www.acadiahealthcare.com/programming-treatment/adolescent/; [https://perma.cc/M5TW-HME7];* Devereux Advanced Behavioral Health, *Residential Treatment Center FAQ's:* "A child's average length of stay is approximately 4 to 6 months" *https://www.devereux.org/site/SPageServer/?NONCE_TOKEN=CC5162714A1ECFAEDAAA578A74807973&pagename=az_rtc_faq; [https://perma.cc/V7QK-BXCE].*

There were 135 Devereux programs between 2017–2022 that had an average LOS longer than a year.[666] There were four programs (Hunter, Brumer Villa, Peekamoose, and Sugarloaf) that had an average LOS in 2021 that was greater than 2,000 days (2,693 days, 2,191 days, 2,183 days, and 2,111 days, respectively). Hunter, Peekamoose, and Sugarloaf are all on the Devereux—Red Hook (Devereux; New York) campus and Brumer Villa is a Pennsylvania facility (Devereux; Pennsylvania), and serve children with Autism Spectrum Disorder, who typically have longer LOS in these settings. Overall, the three longest LOS across all programs for all years were 6,928 days or almost 19 years (2020), 4,104 days or over 11 years (2022), and 3,122 days or 8½ years (2021). The 6,928 day and 4,104 day LOS took place on the Viera Campus (Devereux; Florida). The 3,122 day LOS took place at Brumer Villa (Devereux; Pennsylvania). The shortest LOS reported was one day and this was repeated across a number of facilities.

In 2020, 2021, and 2022, over 40 percent of UHS facilities had an average LOS longer than 6 months (26 facilities, 24 facilities, and 22 facilities, respectively). At a facility level, Havenwyck Hospital (UHS; Michigan) had the longest average LOS in both 2020 (596 days, just over a year and a half) and 2022 (834 days, over 2 years). In 2022, every UHS facility had a max LOS longer than 4 months, with 40 having a max LOS longer than 1 year. Of these 40, eight facilities had a max LOS longer than 3 years. The facilities with the longest max LOS in 2022 were Havenwyck Hospital (UHS; Michigan; 2,220 days, or just over 6 years), Foundations Behavioral Health (UHS; Pennsylvania; 2,115 days, more than 5½), and The Hughes Center (UHS; Virginia; 1,710 days, more than 4½).[667]

Across Acadia facilities, Resource Treatment Center (Acadia; Indiana), Little Creek Behavioral Health (Acadia; Arkansas), and Piney Ridge Treatment Center (Acadia; Arkansas) had the longest average LOS. At Resource Treatment Center (Acadia; Indiana), the average LOS in 2021 was 191.7 days in TGH, 175.3 days in the PRTF, and 215.4 days in RTC. At Little Creek Behavioral Health, the average LOS was 234 days in 2021. At Piney Ridge Treatment Center (Acadia; Arkansas), the average LOS in 2021 was 230.2 days in the PRTF setting and 303.6 days in the TGH. The shortest average LOS was at YouthCare (Acadia; Utah) where the average LOS was 27.1 days in the PHP in 2021.[668] Acadia failed to produce the maximum LOS for 2022 for all of its RTFs.

Vivant has a company-wide average LOS of 162.2 days.[669] The average LOS for each of its four current facilities is as follows: 74.1 days, 97.3 days, 121.7 days, and 79.4 days for Casa Grande Academy (Sequel/Vivant; Arizona), Mingus Mountain Youth Treatment Center (Sequel/Vivant; Arizona), Woodward Academy in (Sequel/Vivant; Iowa), and Brighter Transition Youth Treatment Center (Sequel/Vivant; South Dakota), respectively.[670] Vivant failed to produce the maximum LOS for 2022 for all of its RTFs.

e. RTFs Are Intended and Reimbursed to Offer Intensive Services, But the Committee's Investigation Observed RTFs that were Understaffed or Had Poorly Trained Employees.

The Committee's review uncovered incidents of RTFs being understaffed or having undertrained staff, at times seemingly by design. Further, staff credentials and background checks are haphazardly conducted. Some RTF leaders readily acknowledge staffing issues, and have policies in place to attract qualified staff. Devereux, in particular, had lowered its supervisor to staff ratio from 1:15 to 1:10, so that supervisors can better ensure staff are fulfilling their duties. However, the availability of qualified staff is complicated by RTFs generally being located in remote areas away from population centers containing a qualified workforce. Because children spend so much of their time outside of therapy, and under the supervision of general staff, the importance of having *all staff* be high-quality and well-qualified cannot be

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[666] Devereux, *Agency Spreadsheet* (modified May 25, 2024) DEV–S—000436.

[667] UHS, *Sheet ALOS-Last 5 Yrs* (May 26, 2023) UHS–FINHELP–0000001; UHS, *Addendum to ALOS-Last 5 Yrs* (Jun. 5, 2024) UHS–FINHELP–00012276.

[668] Acadia, *Resource Treatment Center; Little Creek Behavioral Health; Piney Ridge Treatment Center; YouthCare* (Sep. 19, 2022) Request #1.

[669] Vivant, *Average Length of Stay* (Aug. 18, 2022) FINAL-Vivant Senate Inquiry Response (08.18.2022) at p. 29.

[670] *Id. Note:* However, the shorter average LOS at these facilities compared to other operators maybe a statistical anomaly. At the time of production, Vivant had only been in operation for 10 months. Vivant purchased these sites from Sequel and, although the operator changed, children who were in the previous operator's care continued into Vivant's care. It is not clear whether a child's elapsed treatment durations under the custody of the previous provider care was incorporated into the calculation for Vivant's average LOS.

overstated. Children are supervised by staff who are ill-equipped to address their complex behavioral health needs and, in some cases, children interact with staff who actually pose a direct threat to their well-being. Further, in some cases, staff completely abdicated their paid responsibilities and this leads to children engaging in self-harm or child fatalities.

i. Some RTFs Are Routinely Understaffed.

Facilities are required to maintain certain ratios of staff to children, with these ratios often varying by time (daytime and nighttime) or certain units. Further, in some cases, a child might require 1:1 supervision. In many ways, proper staffing is a proxy for patient safety. Nevertheless, in the view of at least one RTF operator, Jay Ripley (Sequel/Vivant Co-founder) understaffing is a cornerstone of the RTF business model because "you can make money in this business if you control staffing."[671] But, as a staffer from Palmetto Summerville (UHS; South Carolina) explained, "when you're understaffed and there's not enough people to properly supervised [,] that little wiggle room of danger is what allow[s] those [elopements] to even happen."[672]

Resource Treatment Center (Acadia; Indiana) routinely faced ratio and understaffing issues—directly leading to harm for children. Documents reviewed by the Committee outlined the following staffing concerns at Resource Treatment Center (Acadia; Indiana) between October 2021 and March 2022. Video showed an unmonitored child on line-of-site precaution injure herself by "cutting her arms under the sleeve of her shirt." This began when the staffer watching them left their position. The unit was operating out of ratio.[673] A visit conducted by the Indiana Department of Child Services found that staff members "did not seem to understand what was meant by being in ratio."[674] The Indiana Department of Child Services found a unit staffed by only one staffer for two shifts.[675] A Notice of Referral Hold was sent due to ongoing issues, including noncompliance with ratios and inadequate supervision.[676] Indiana Department of Child Services reviewed video footage showing a unit had a 1:12 ratio; the required ratio was 1:4.[677] Video showed two unmonitored youth in the Sexually Harmful Behavior (SHB) unit touching each other inappropriately while the unit was operating out of ratio.[678]

The Oklahoma Health Care Authority moved to terminate its contract with Cedar Ridge Behavioral Hospital (UHS; Oklahoma) in part because of endemic understaffing.[679] In April 2019, Cedar Ridge Behavioral Hospital (UHS; Oklahoma) was notified that the Oklahoma Health Care Authority (OHCA) intended to terminate their contract.[680] The OHCA noted that, "20 of the 11–7 shifts and 2 of the 3–11 shifts on one of the PRTF units [. . .] did not meet the 1:8 sleeping/1:6 waking required ratio." OHCA explained that Cedar Ridge Behavioral Hospital (UHS; Oklahoma) had been on a Corrective Action Plan for the previous 3 years for related issues and that the facility was not complying with the terms of a previous

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[671] University of Baltimore, *Video Interview at Merrick School of Business with Jay Ripley* (Oct. 2015) (on file with the Committee) at 13:41. Ripley further notes, later in the interview, "You have to have enough staffing to have an excellent program, but you can't have too much staffing to eat that profit."

[672] WCSC, *Summerville treatment facility has history of escapes, assaults* (Aug. 12, 2019) *https://www.live5news.com/2019/08/12/summerville-treatment-facility-has-history-escapes-assaults/; [https://perma.cc/4GMW-DJYG];* WCSC, *Summerville youth treatment facility facing new accusations, lawsuit* (Jan. 10, 2023) *https://www.live5news.com/2023/01/10/summerville-youth-treatment-facility-facing-new-accusations-lawsuit/; [https://perma.cc/YXT4-KRLV].*

[673] Acadia, *Indiana DCS Resource 30 day notice to comply follow-up on referral hold* (Apr. 8, 2022) 20220329 Resource 30 day notice to comply.

[674] Acadia, *Indiana Department of Child Services To: [REDACTED] CEO, RTC Resource* (Oct. 15, 2021) 20211015 Resource Licensure Survey at p. 3.

[675] Acadia, *Indiana Department of Child Services To: [REDACTED] CEO, RTC Resource* (Mar. 17, 2022) 20220317 Resource-DCS-Licensure-routine Visit.

[676] Acadia, *Indiana Department of Child Services To: [REDACTED] CEO, Resource Treatment Center* (Mar. 29, 2022) 20220329 Resource—Referral hold letter—DCS Licensing.

[677] Acadia, *Indiana Department of Child Services To: [REDACTED] CEO, Resource Treatment Center* (Apr. 8, 2022) 20220329 Resource 30 day notice to comply at p. 2.

[678] *Id.* at p. 3.

[679] Cedar Ridge Behavioral Health (UHS; Oklahoma) ultimately retained its Medicaid contract with OCHA.

[680] UHS, *State of Oklahoma Health Care Authority Notice to Terminate Sooner Care Contract at Cedar Ridge* (Apr. 29, 2019) UHS–FINHELP–00011847.

agreement.[681] A September 2019 OHCA review cited an annual review with "numerous instances of insufficient staffing."[682]

The Committee reviewed documentation of other facilities which were often found to be out-of-ratio, jeopardizing children's safety. In one example of understaffing documented in public reports, state Department of Human Services inspectors found Piney Ridge Treatment Center (Acadia; Arkansas) had only five staff present.[683] A Florida Agency for Healthcare Administration Licensure survey of SandyPines Residential Treatment Center (UHS; Florida) found that multiple units were out of ratio and, when asked what the staffing ratio was, two staff said it was 1:6, even though the facility used a 1:4 ratio.[684] The Utah DHS Office of State Licensing found that Provo Canyon School (UHS; Utah) was "operating well below the required 1:5 staff to student ratio."[685]

The Committee reviewed documentation of riot-like incidents at facilities that appear to have been exacerbated by improper staffing. The Committee reviewed documents related to a riot-like "emergency safety crisis situation"[686] at SandyPines Residential Treatment Center (UHS; Florida) that according to public reporting involved 50 children.[687] During this event, eight children eloped and local emergency personnel injected a child with ketamine, necessitating emergency medical care.[688] Following the incident the Chief Deputy Sheriff told the media, "we would like [SandyPines] to up their staffing, we would like them to up their security measures."[689] After the incident, CMS placed the facility under Immediate Jeopardy due to, "a situation in which the provider's non-compliance with one or more requirements has caused, or is likely to cause serious injury, harm, or death to a resident receiving care in the facility."[690] An inspection of SandyPines (UHS; Florida) found it was understaffed, out-of-ratio, and the facility failed to provide "education, training, and demonstrated knowledge" for their MHTs and nurses.[691]

The Committee reviewed public reports which alleged that a group of girls "rioted" in an attempt to elope from Belmont Pines Hospital (UHS; Ohio). A police report said, "[i]t was clear at that time that the staff of Belmont Pines had lost complete and total control of the facility and the risk of serious physical harm was imminent to the individuals housed there, the staff members and responding officers."[692] According to public reporting, North Star Hospital (UHS; Alaska) experienced a series of events over the course of a weekend, that *Anchorage Daily News* described as "chaotic" and staffers referred to as a "melee."[693]

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[681] *Id.* at 00011847–00011848.

[682] UHS, *State of Oklahoma Health Care Authority, Post-CAP Desktop Review Findings: Cedar Ridge Psychiatric Hospital* (Sep. 20, 2019) UHS–FINHELP–00012223 at 00012223.

[683] KNWA, *KNWA investigation reveals years of licensing issues at children's treatment facility* (Oct. 4, 2021) *https://www.nwahomepage.com/news/knwa-investigation-reveals-years-of-licensing-issues-at-childrens-treatment-facility/; [https://perma.cc/5Z7A-PFNH].*

[684] UHS, *Agency for Health Care Administration—Statement of Deficiencies and Plan of Correction: SandyPines* (Jan. 2, 2020) UHS–FINHELP–00009728 at 00009731–00009734.

[685] UHS, *State of Utah Department of Human Services Office of Licensing RE: UHS of Provo Canyon-Springville Campus License Number: 54140* (Jan. 13, 2020) UHS–FINHELP–00011508 at 00011508.

[686] UHS, *Department of Health and Human Services Centers for Medicare & Medicaid Services—Statement of Deficiencies and Plan of Correction: SandyPines* (Feb. 20, 2023) UHS–FINHELP–00009754 at 00009757–00009758.

[687] WFLA, *50-person riot breaks out at Florida mental health treatment center* (Jan. 22, 2023) *https://www.wfla.com/news/florida/50-person-riot-breaks-out-at-florida-mental-health-treatment-center/; [https://perma.cc/J5QV-NHN5].*

[688] *Id.;* UHS, *Department of Health and Human Services Centers for Medicare & Medicaid Services—Statement of Deficiencies and Plan of Correction: SandyPines* (Feb. 20, 2023) UHS–FINHELP–00009754 at 00009764–00009765.

[689] WPEC, *Sheriff frustrated by frequent calls from SandyPines facility* (Jan. 24, 2023) *https://cbs12.com/news/local/martin-county-sheriffs-office-frustrated-by-frequent-calls-from-sandy-pines-facility-january-24-2023; [https://perma.cc/36ZF-DM9G].*

[690] UHS, *Department of Health and Human Services Centers for Medicare & Medicaid Services—Statement of Deficiencies and Plan of Correction: SandyPines* (Feb. 20, 2023) UHS–FINHELP–00009754 at 00009758; SandyPines (UHS; Florida) was allowed to continue operation during the Immediate Jeopardy period and beyond.

[691] *Id.* at 00009757; 00009760.

[692] WFMJ, *Chaos and mayhem described during riot and escape attempt at Belmont Pines Hospital* (Dec. 15, 2020) *https://www.wfmj.com/story/43062101/chaos-and-mayhem-described-during-riot-and-escape-attempt-at-belmont-pines-hospital; [https://perma.cc/M2RG-KXRY].*

[693] Anchorage Daily News, *Patient escapes and damage reported at North Star youth psychiatric hospital over the weekend* (Oct. 4, 2022) *https://www.adn.com/alaska-news/anchorage/*

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Facilities lacked appropriate leadership capacity. The Committee reviewed instances related to inadequate staff supervision. An Alabama Department of Mental Health site visit to Hill Crest Behavioral Health (UHS; Alabama) found that, "there was no full-time executive director who has overall responsibility for the operation of the agency."[694] A Copper Hills Youth Center (UHS; Utah) Corrective Action Plan moved administrators and program directors to working on-the-ground to comply with staffing ratios, meaning that they were doing direct care work that they did not routinely do.[695] Two programs at Millcreek of Pontotoc (Acadia; Mississippi) failed to include a staffer with a bachelor's degree in every shift while children were awake.[696]

Public reporting by *The Boston Globe* found that Devereux—Rutland (Devereux; Massachusetts), which specializes in serving children with autism, had "many [violations] for negligent supervision." According to the article, Devereux—Rutland (Devereux; Massachusetts) had 301 licensing violations issued by the Massachusetts Department of Early Education and Care, with "many for negligent supervision." It received more citations than any other residential school with an autism specialty. In one case, a child with autism left the facility; in another, the program was found to be operating at a 1:6 ratio, double what was required.[697]

ii. RTF Employees Are Poorly Trained.

Facilities and their staff are entrusted with the treatment and supervision of the children in their custody. Facilities must conduct background checks in a timely and accurate manner, ensure that staff have the appropriate education and credentials to carry-out their responsibilities, and train staff to their job functions (seclusion and restraint, trauma, cultural competency, ethics, abuse and neglect). Staff, at minimum, should be aware of their responsibilities, capable of carrying-out those functions, and prepared to respond to any situation using de-escalation techniques. When non-compliance is identified, it is often addressed by implementing new processes, even in the face of repeat violations or similar issues across facilities. In conversation with the Committee, company leadership indicated that staff training may occur even where they are undocumented. This raises further concerns, however, regarding oversight actors' ability to monitor incidents arising out of staff behavior and remediation following repeat incidents.

Background checks, including state abuse registry checks and licensure checks, are not completed properly. In some cases, criminal history or background checks reveal that staff have histories that may disqualify them from working with children. A state licensure survey noted that the Division of Child Care and Early Childhood Education sent a letter to Millcreek (Acadia; Arkansas) indicating a staffer did not meet the requirements to work with children.[698] A Department of Human Resources site visit to Alabama Clinical Schools (UHS; Alabama) found—from a random sampling of staff—that one staffer did not have an ABI/FBI clearance on file for a criminal history check with finger prints. The staffer had been hired before rules requiring criminal history checks by ABI/FBI were extended to cover all employees, rather than only patient care employees. When the facility (UHS; Alabama) completed the paperwork, they received a letter from the Office of Criminal History requesting additional documentation pertaining to a prior misdemeanor for the staffer.[699] A Notice of Non-Compliance for the McDowell Center for Children (UHS; Tennessee) cited that half of all employee

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2022/10/04/patient-escapes-and-damage-reported-at-north-star-youth-psychiatric-hospital-over-the-weekend/; [https://perma.cc/3QBU-JWJB].

[694] UHS, *Alabama Department of Mental Health—Programmatic Findings: Hill Crest Behavioral Health Services* (May 22–23, 2019) UHS–FINHELP–00009384 at 00009388.

[695] UHS, *Copper Hills Corrective Action Plan Response* (Dec. 22, 2021) UHS–FINHELP–00009863 at 00009865–00009866.

[696] Acadia, *State of Mississippi Department of Mental Health—Written Report of Findings: Millcreek of Pontotoc* (May 4–6, 2022) 20220506 Millcreek Pontotoc Licensure-group homes at p. 3.

[697] The Boston Globe, *There are no words* (Sep. 27, 2023) *https://www.bostonglobe.com/2023/09/27/metro/there-are-no-words/; [https://perma.cc/YN7K-9HBU].*

[698] Acadia, *Arkansas Department of Human Services Division of Provider Services and Quality Assurance—Inspection of Care Summary: Habilitation Center, LLC* (Apr. 12, 2022) 20220412 Millcreek AR AFMC Licensure Survey Findings at p. 2.

[699] UHS informed the Committee that the employee was notified of the need to address the misdemeanor and was later suspended and ultimately terminated. UHS, *Department of Human Resources Division of Resource Management Site Visit Report for Residential Services* (Nov. 23, 2020) UHS–FINHELP–00009148 at00009153; 00009158.

records reviewed had no documentation of a state abuse registry check.[700] Brynn Marr Hospital (UHS; North Carolina) was cited for failing to request a national background check, including fingerprinting, for 75 percent of MHTs who had moved to the state within the last 5 years.[701] A West Virginia Department of Health and Human Resources Bureau of Children and Families inspection of Alabama Clinical Schools (UHS; Alabama) found that "7 of the 12 records reviewed" did not have reference verification.[702]

There are facility staff and leadership on boarding, screening, training, and licensure issues. A West Virginia Department of Health and Human Resources Bureau of Children and Families inspection of Alabama Clinical Schools (UHS; Alabama) noted that seclusion and restraint training for employees was only given once a year.[703] The Joint Commission found that Copper Hills Youth Center (UHS; Utah) had promoted a floor nurse to Assistant Director of Nursing/Infection Control Nurse without having a full initial competency completed for the role of Assistant Director of Nursing.[704] The Joint Commission accreditation report for Resource Treatment Center (Acadia; Indiana) found no documentation of primary source verification for the Psychiatric Director in 2018 and for the Clinical Director in 2019.[705] A Foundations for Living (UHS; Ohio) survey found half of the Qualified Behavioral Health Specialists that were providing Mental Health Day Treatment services were found to not have had the required education in "either mental health or [SUD] competencies."[706] The Joint Commission report for Compass Intervention Center (UHS; Tennessee) found the facility's written suicide risk policy lacked a competence assessment for staff who care for children at risk of suicide.[707] A Department of Mental Health visit to Alabama Clinical Schools (UHS; Alabama) found it did not provide training for all staff on abuse and neglect, and abuse and neglect laws.[708] In a separate visit, the Joint Commission cited Alabama Clinical Schools (UHS; Alabama) for its inability to demonstrate that required health screenings were completed in half of the personnel files reviewed.[709] An inspection of Piney Ridge Treatment Center (Acadia; Arkansas) found the site did not have documentation in HR records that all direct care personnel were CPR certified.[710]

iii. Children Are Harmed When Staff Abdicate Their Responsibilities, in Some Cases Resulting in Patient Deaths.

Inadequate supervision of children permeates RTFs. When describing the supervision at a facility, one child said, "there have been a bunch of times I've sat in my room all day and nobody has checked on me. It kind of makes me feel lonely that nobody checks on me."[711] There is a spectrum of inadequate supervision ranging from inattentiveness, including failing to intervene when witness to ongoing child harm, temporary or complete absences, to failing to discharge the responsibilities of employment. In many cases, inadequate supervision is a causal factor in children

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[700] UHS, *Tennessee Dep. of Mental Health and Substance Abuse Services—Licensure Notice of Non-Compliance Plan of Compliance* (Sep. 28, 2023) UHS–FINHELP–00008735 at00008737.

[701] UHS, *Division of Health Service Regulation—Statement of Deficiencies and Plan of Correction: Brynn Marr Hospital* (Feb. 28, 2023) UHS–FINHELP–00008995 at 00009002.

[702] UHS, *West Virginia Department of Health and Human Services Bureau of Children and Families Office of Children and Audit Services Division of Regulatory Management—Licensure Summary of Findings of Non-Compliance and Plan of Correction: Alabama Clinical School* (Nov. 15–17, 2022) UHS–FINHELP–00009159 at 00009165.

[703] *Id.* at 00009163.

[704] UHS, *The Joint Commission—Final Accreditation Report: Kids Behavioral Health of Utah Unannounced Full Event Jan. 28–31 2020* (Mar. 25, 2020) UHS–FINHELP–00009946 at 00009957.

[705] Acadia, *The Joint Commission—Final Accreditation Report: RTC Resource Acquisition Corporation* (June 18, 2021) 20210618 Resource TJC Complaint-Report at p. 6.

[706] UHS, *Ohio Department of Mental Health and Addiction Services: Foundations for Living Plan of Correction for Day Treatment Certification* (Dec. 11, 2018) UHS–FINHELP–00009230 at 00009242.

[707] UHS, *Joint Commission Health Care Organization: Keystone Memphis LLC* (Jan. 6, 2022) UHS–FINHELP–00008702 at 00008725.

[708] UHS, *State of Alabama Department of Mental Health To: [REDACTED], Executive Director Alabama Clinical Schools* (Oct. 26, 2022) UHS–FINHELP–00009137 at 00009138.

[709] UHS, *The Joint Commission—Final Accreditation Report: Alabama Clinical Schools, Inc.* (Dec. 8–11, 2020) UHS–FINHELP–00009190 at 00009196.

[710] Acadia, *Beacon Health Options—Clinical Record Review: Piney Ridge Treatment Center* (Apr. 9–12, 2018) 20180409 Piney Ridge AR Beacon CAP at p. 6–7.

[711] Think of Us, *Away From Home: Youth Experiences of Institutional Placements in Foster Care* at p. 29, 61 (July 2021) *https://assets.website-files.com/60a6942819ce8053cefd0947/60f6b1eba474362514093f96—Away%20From%20Home%20-%20Report.pdf; [https://perma.cc/VS6R-ZXYL].*

sustaining injuries, including self-inflicted injuries, that require medical attention as well as sexual abuse and even child fatalities. Proper staffing also protects children from staff who might seek to harm or injure them. In conversation with Devereux leadership, Committee staff discussed an incident described in an arrest warrant in which a Devereux staffer attempted to perform oral sex on a child, but was thwarted because other staffers were walking by.[712] Devereux leadership agreed that routine staffing is what is necessary to protect children.

Failure to conduct proper night supervision at Devereux—Red Hook (Devereux, New York) resulted in a child with autism eloping. He was struck and killed by a truck 4.5 miles away from the facility. The Committee examined records related to a disturbing September 2022 incident in which a teenager at Devereux Foundation—Red Hook (Devereux; New York) wandered off campus overnight. The teenager was tragically struck and killed by a pick-up truck while walking alongside the road.[713] According to public reports, the death occurred 4.5 miles away from Devereux Foundation—Red Hook (Devereux; New York). Staff at RTFs are required to document the well-being of children in their care in 15-minute intervals. However, staffers failed to execute overnight observations, falsifying records instead of conducting observations. For example, in facility documentation, the staffers noted that "[a]t 6:30 am, [the child] was in his room sleeping."[714] According to public reports, the child was killed at 4:50 am, over an hour and a half earlier[715] and the child must have left Devereux Foundation—Red Hook (Devereux; New York) even earlier with enough time to walk 4.5 miles away from the facility where he was found.

According to the organization's 15-minute bed-check documents, it was not until "6:45 am, [that] staff [redacted] went to [the child's] bedroom to do the regular 15 minutes bed check and discovered that [the child] was not in his bed and the window was opened."[716] Staff did not contact the police until 7:10 am.[717] An assessment by the New York Justice Center for the Protection of People with Special Needs found that staff had "failed to report in a timely manner that the service recipient was missing,"[718] "failed to conduct proper bed checks,"[719] and "falsified documentation related to the health, safety, and welfare of the service recipient."[720] Devereux leadership acknowledged to Committee staff that the falsified document claim is in connection with bed-checks, but said they have no further information because it is now under state investigation.[721] Devereux informed the Committee they immediately terminated the employees involved and cooperated with the police investigation.

In the wake of this child fatality, the State of New York immediately launched an onsite, extended monitoring visit at Devereux—Red Hook (Devereux; New York). They arrived the same day as the death and stayed for an entire week; while at the facility, they observed additional supervision failures. Inspectors noted that there was one child who required "15-minute checks and arm's length supervision when near roads and parking lots. Review of staff assigned sheets [. . .] revealed that there is no documentation to verify that 15-minute checks were implemented as there are blanks."[722] Another child, who was on 1:1 precaution, was able to

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[712] State of Florida, *Affidavit for Arrest Warrant* (July 13, 2022) DEV–S—001178 at 001179; Notes from Devereux Advanced Behavioral Health Briefing (May 20, 2024) (on file with Committee).

[713] The Daily Catch, *Devereux Teen Killed on Route 9 Wandered Off-Campus Unescorted in Pre-Dawn Hours, State Police Say* (Oct. 8, 2022) *https://www.thedailycatch.org/articles/devereux-teen-killed-on-route-9-wandered-off-campus-unescorted-in-pre-dawn-hours-state-police-say/; [https://perma.cc/B3J7-8Y46].*

[714] Devereux, *Devereux Advanced Behavioral Health Preliminary Report—Not Final (Level 2 Review—Reviewed)* (Sep. 23, 2022) DEV–S—001196 at 001196.

[715] The Daily Catch, *Devereux Teen Killed on Route 9 Wandered Off-Campus Unescorted in Pre-Dawn Hours, State Police Say* (Oct. 8, 2022) *https://www.thedailycatch.org/articles/devereux-teen-killed-on-route-9-wandered-off-campus-unescorted-in-pre-dawn-hours-state-police-say/; [https://perma.cc/B3J7-8Y46].*

[716] Devereux, *Devereux Advanced Behavioral Health Preliminary Report—Not Final (Level 2 Review—Reviewed)* (Sep. 23, 2022) DEV–S—001196 at 001197.

[717] *Id.* at 001198.

[718] Devereux, *New York Justice Center for the Protection of People with Special Needs—Notice to Provider of Investigation Determination RE: VPCR Case Serial Number: 5510139096* (Mar. 24, 2023) DEV–S–001160 at 001160.

[719] *Id.* at 001161.

[720] *Id.*

[721] Notes from Devereux Advanced Behavioral Health Briefing (May 21, 2024) (on file with Committee).

[722] Devereux, *Partial Review* (Sep. 23–20, 2022) DEV–S—001199 at 001212.

"leave the kitchen and go to their bedroom and or dining room area several times and then return to the kitchen"[723] without staff accompanying them. A third child required "prompts/assistance to cut their food to bite size pieces and verbal prompts for pacing"[724] but no staff provided them with assistance or prompts.

In light of these incidents, Devereux leadership told Committee staff it is the first RTF provider to implement Guard1, a technology that comes from the prison industry, across all sites for nighttime use.[725] Staff scan a beacon placed well-inside each child's room every 15 minutes as confirmation that they are completing their required 15-minute checks, minimizing opportunities for document falsification.[726] Since implementing this technology, Devereux has not reported a single nighttime elopement.[727] Devereux is not implementing this technology for daytime use because they received opposition to wrist bands with real-time monitoring from their community due to their carceral association.[728] Additionally, Devereux has expanded and upgraded its use of cameras; it has also achieved accreditation from Praesidium, a specialized certification of best practices in abuse prevention. Devereux has also lowered its supervisor to staff ratio from 1:15 to 1:10, with the intent that supervisors better ensure staff are fulfilling their duties.

A 17-year-old died after staff at Newport News Behavioral Health Center (UHS; Virginia) allegedly failed to get a child who was "throwing up blood" the medical care she needed. According to public reports, a 17-year-old died soon after admission to Newport News Behavioral Health Center (UHS; Virginia). A lawsuit alleged that the nurse who conducted her admission assessment noted symptoms of illness, but failed to notify other staff. The lawsuit alleged the child's condition deteriorated, without care ever being provided; the first call to emergency services was made by a 15-year-old.[729] According to a 911 recording, the child said staff blamed the 17-year-old—"they're telling her she's doing this to herself, and she's faking it."[730] A Virginia Department of Behavioral Health and Developmental Services report cited the facility (UHS; Virginia) for, among other issues, violating standards of care, depriving the child of appropriate services/treatment, and failing to document medical needs.[731] One staffer told a member of the press that the child, "wanted to go to the hospital and they said she's [expletive] faking, there's nothing wrong with her. I said she's saying she's throwing up blood."[732]

Two children overdosed and died at Oak Plains Academy (UHS; Tennessee) after they were able to secure toxic quantities of Benadryl. At Oak Plains Academy (UHS; Tennessee), two 15-year-olds overdosed and died after consuming toxic quantities of Benadryl. According to public reports, the girls were able to access the blister packs of Benadryl and a bottle of Benadryl through the bottom of the nurse's station's "Dutch" style door.[733] The mother of one of the children, who was over 3,000 miles away, was quoted by *Alaska's News Source* as saying, "I don't understand. You send your kids to a place like this you don't think you're never going to see them again . . . I sent her there to be safe, you know, they didn't keep her safe."[734] The mother went on to explain that, "I'll never see her again, I just

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[723] *Id.* at 001199.

[724] Devereux, *Partial Review* (Sep. 23–20, 2022) DEV–S—001199 at 001201.

[725] Notes from Devereux Advanced Behavioral Health Briefing (May 21, 2024) (on file with Committee).

[726] *Id.*

[727] *Id.*

[728] *Id.*

[729] WAVY, *Norfolk behavioral health center didn't follow regulations before fight, state says* (July 30, 2019) *https://www.wavy.com/news/investigative/nurse-reprimanded-put-on-probation-following-teenagers-death-at-newport-news-behavioral-health-center/; [https://perma.cc/3YDZ-52CB].*

[730] *Id.;* initial lawsuit was withdrawn and refiled in 2021, with a court approved settlement in December 2022 (case: #CL2104111B–00).

[731] WAVY, *State report: NN Behavioral Health Center failed to provide adequate care for teen who died* (Sep. 10, 2018) *https://www.wavy.com/news/state-report-nn-behavioral-health-center-failed-to-provide-adequate-care-for-teen-who-died/; [https://perma.cc/6MFV-MJAG].*

[732] *Id.*

[733] WZTV, *Two teens overdose on Benadryl they took from Oak Plains Academy, both have died* (Dec. 2, 2022) *https://fox17.com/news/local/two-juveniles-overdose-on-benadryl-they-took-from-nurses-station-one-has-died-middle-tennessee-nashville-area-local-news; [https://perma.cc/E6Y6-5SKB].*

[734] Alaska's News Source, *"It's just a damn roller coaster. It's a freaking nightmare": Alaskan mother wants justice after daughter's death in treatment center Outside* (Jan. 12, 2023) *https://www.alaskasnewssource.com/2023/01/12/its-just-damn-roller-coaster-its-freaking-nightmare-*

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want justice for her, I just want her story told. And I want—I never want this to happen again to anyone."[735]

Improper staff supervision allowed children to engage in sexual activity that resulted in one child's anal lining tearing, in another instance sex abuse was thwarted by staff supervision. At Willow Springs Center (UHS; Nevada), two children engaged in sexual activities resulting in one child's anal lining tearing.[736] Staff notes documenting the incident did not appear to comport with video footage, suggesting staff were not engaged in proper supervision. Staff documented the locations of the children as follows, Child One: "7:30 PM—Location: Activity Room; Behavior: Programming—7:45 PM Location: Activity Room; Behavior: Programming."[737] Child Two: "7:30 PM—Location: Bathroom—7:45 PM Location: Hallway; Behavior: Programming."[738] While, according to a CMS report, video corresponding to the same times as the staff notes showed both children exit the activity room at 7:33 PM and go into one of the children's rooms.[739] Then, "[b]oth patients remained in the room with the door closed for 20 minutes . . . Both Patient #1 and Patient #2 admitted to engaging in sexual acts during the 20 minutes both patients were in the room."[740]

Staff across facilities abdicate their responsibilities as caregivers by failing to discharge the basic duties expected of them. The Committee reviewed multiple accounts of dereliction of duty by RTF staff. For example, in 2020 the city of Philadelphia removed 53 children from Devereux facilities, stating in part, "[w]e found [staffers] doing nothing. They weren't doing their jobs [. . .] They were not watching the children. And if they were doing it, some of them were doing it sporadically."[741] An 11-year-old girl at Brynn Marr Hospital (UHS; North Carolina) became ill, reporting that she remembered soiling her sheets and clothes in her sleep and waiting for hours for staff to help. "I'm in a situation that I can't control, where I'm locked in my room for hours, and I feel like I'm dying, like vomiting [. . .] and like, just, everything's awful."[742]

In another incident, a 6-year-old with autism was found walking alone on the road after leaving Laurel Heights Hospital (UHS; Georgia) just 3 days after his arrival there. According to public reports, the mother had explained to staff that her child had a tendency to leave facilities, calling him a "runner." Despite this, the child was able to elope. Public reporting indicated that it was the police, not the facility, who notified the mother about the elopement.[743] Public reports quoted the mother as saying, "we sent him there thinking he was going to be safe . . . I mean, that call could have been different. That call could have been 'we just found your son in the middle of the street'."[744]

At Cedar Ridge Treatment Center (UHS; Oklahoma), a staffer "just walked into the door but never went into the room"[745] which allowed a male child to enter "the girls' room [. . . and remain for] 30 minutes before [being discovered by] staff."[746] Staffing concerns persisted into the following year at Cedar Ridge Treatment Center (UHS; Oklahoma). A staffer was found to be "negligent in supervision, allowing stu-

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alaskan-mother-wants-justice-after-daughters-death-treatment-center-outside/; [https://perma.cc/JH8N-KMD7].

[735] *Id.*

[736] UHS, *Department of Health and Human Services Centers for Medicare & Medicaid Services—Statement of Deficiencies and Plan of Correction: Willow Springs Center* (Apr. 1, 2022) UHS–FINHELP–00010425 at 00010431.

[737] *Id.* at 00010430.

[738] *Id.*

[739] *Id.*

[740] *Id.* at 00010430–00010431.

[741] The Philadelphia Inquirer, *City Will Pull 53 Children From Care* (Sep. 25, 2020) *https://www.inquirer.com/news/philadelphia/devereux-philadelphia-abuse-council-remove-children-20200924.html; [https://perma.cc/6CCU-6WBH].*

[742] North Carolina Health News, *Durham 11-year-old was sexually assaulted in NC psychiatric hospital, parents allege* (November 30,2022) *https://www.northcarolinahealthnews.org/2022/11/30/parents-allege-11-year-old-sexually-assaulted-in-nc-psychiatric-hospital/; [https://perma.cc/Q5GQ-6SUV].*

[743] 11Alive, *Mom wants answers from behavioral health hospital after 6-year-old child found alone with scratches* (July 11, 2022) *https://www.11alive.com/article/news/community/6-year-old-atlanta-dfacs-behavioral-health-hospital-scratches/85-41b24b6e-a90e-4761-bd66-e5489e66b759; [https://perma.cc/3LFJ-W92L].*

[744] *Id.*

[745] UHS, *Oklahoma Department of Human Services—Notification Concerning Finding(s) of Child Abuse/Neglect To: [REDACTED], Cedar Ridge Treatment Center* (Apr. 16, 2020) UHS–FINHELP–00011908 at 00011924.

[746] *Id.*

dents in other student's rooms . . . [A]llegations from students were substantiated regarding SAO [sexual acting out] interactions with one another resulting from [the staffer's] negligence."[747] Further, this same staffer shared pornographic material with the children at Cedar Ridge Treatment Center (UHS; Oklahoma).[748] At Copper Hills (UHS; Utah), a staffer "was fired after it was discovered that he reported checking on the youths [who were acting out sexually] every 15 minutes but didn't actually do so."[749]

Staff across some facilities appear to treat logbooks as a box-checking exercise, rather than a legitimate documentation of a child's location and behavioral status. According to *The Philadelphia Inquirer,* in a lawsuit "a program supervisor at the Brandywine campus [(Devereux; Pennsylvania)], said he has caught staff 'prefilling' in logbooks, rather than doing their 15-minute checks."[750] At Palmetto Pines Behavioral Health (UHS; South Carolina), a supervising nurse documented that a patient was "not accounted for in facility. Local Police dept has been notified"[751] while a separate staffer had previously documented that the child "[s]lept through the night. Completed hygiene."[752] At Devereux Foundation (Devereux; New York), following multiple elopements by the same child, an assessor determined, "staff were not consistently documenting [the child's] elopement behavior in RADAR,"[753] the facility's incident tracking system. At North Star Debarr (UHS; Alaska), a random audit of staff notes documenting children's respective locations and activities at 15-minute intervals, called Q15 Minute Checks (Q15min), "reveal[ed] missing Q15min checks and missing staff's initials conducting these checks in four (4) out of eleven (11) charts in association with inaccurate, and contradictory information."[754]

Staff routinely fail to supervise and account for the children in their care. According to documents reviewed by the Committee, a child at Devereux—Rutland (Devereux; Massachusetts) went to the emergency room after stealing a syringe from an unsupervised staff office and injected himself with a foreign substance of potentially Windex and aftershave.[755] The staffer responsible for the child's care was reportedly absorbed in their computer and paperwork, and not paying attention to the child.[756] Devereux leadership acknowledged to Committee staff that this incident was a "lapse" and that the program was out of ratio at the time, citing COVID–19 induced staffing challenges.[757] At Harbor Point Behavioral Health Center (UHS; Virginia), The Joint Commission found a child sleeping alone on the floor outside of a room with their face covered by a blanket. The next day, the child was documented, again, sleeping outside of their room, without staff present.[758] At Millcreek of Arkansas (Acadia; Arkansas), an Arkansas Department of Human Services Division of Child Care and Early Childhood Education inspector "observed a child asleep in room and unattended by staff."[759] *The Boston Globe* found a child

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[747] UHS, *Copper Hills Corrective Action Plan Response* (Dec. 22, 2021) UHS–FINHELP–00009863 at 00009863.

[748] *Id.* at 00009864.

[749] The Salt Lake Tribune, *Utah treatment center sued after boys engaged in sex acts in a seclusion room* (Aug. 27, 2019) *https://www.sltrib.com/news/2019/08/27/utah-treatment-center/; [https://perma.cc/VF6B-TFN6].*

[750] Philadelphia Inquirer, *Staff abused children for years at Devereux facilities* (Aug. 11, 2020) *https://www.inquirer.com/video/staff-abused-children-for-years-at-devereux-facilities-20200813.html;* [permalink unavailable].

[751] UHS, *South Carolina Department of Health and Environmental Control—Inspection Results: Palmetto Pines Behavioral Health* (Sep. 28, 2020) UHS–FINHELP–00011285 at 00011302.

[752] *Id.*

[753] Devereux, *Plan of Correction for Standard 10i–3* (Sep. 23–30, 2023) DEV–S—001199 at 001211.

[754] UHS, *State of Alaska Department of Health and Social Services, Division of Behavioral Health—Site Review Summary of Findings: North Star Alpine PRTF* (Aug 8–11, 2022) UHS–FINHELP–00011003 at 00011013.

[755] Devereux, *Internal Investigation Report Confidential: Rutland* (Dec. 14, 2020) DEV–S—001215 at 001215.

[756] The Boston Globe, *There are no words* (Sep. 27, 2023) *https://www.bostonglobe.com/2023/09/27/metro/there-are-no-words/; [https://perma.cc/YN7K-9HBU].*

[757] Notes from Devereux Advanced Behavioral Health Briefing (May 21, 2024) (on file with Committee).

[758] UHS, *The Joint Commission—Final Accreditation Report: Harbor Point Behavioral Center, Inc.* (Apr. 25, 2018) UHS–FINHELP–00010359 at 0010364.

[759] Acadia, *Arkansas Department of Human Services Division of Child Care and Early Childhood Education Placement and Residential Licensing Unit—Licensing Compliance Record: Millcreek in Arkansas* (May 27, 2021) 20210527 Millcreek of Arkansas State Licensure-routine at p. 3.

with autism ran away from Devereux—Rutland (Devereux; Massachusetts). The child was found barefoot at a gas station. The same child ran away, again, 2 weeks later.[760]

iv. Understaffing and Lack of Supervision Contribute to Elopements, Which Are Critical Safety Events.

Elopements refer to children leaving a facility without permission, including running away. Elopements are critical safety events, with some resulting in child fatalities. Children have been found miles away from facilities in various locations. Upon their discovery, children are sometimes engaging in risky behavior (drinking, armed). Additionally, when children elope, they sometimes injure staff or themselves. Many facilities face repeated elopements. Common facility shortcomings—like understaffing and lack of supervision—contribute to the frequency of elopements.

Elopements present a danger to children. According to public reporting, a patient at North Star Behavioral Health System (UHS; Alaska) hit a fire alarm which unlocked the doors to the facility. Four children eloped. They were found hours later by police. One child was reportedly, "so drunk they had to be taken to a different hospital."[761] In another reported incident, three teens from Foundations for Living (UHS; Ohio) eloped and were found in a library three miles away. Two were taken to a local hospital after making suicidal comments. One reportedly told an officer that he had used a knife to cut his wrists and the other said, "I'm going to get a shotgun and blow my brains out."[762]

Elopements present a risk to staff and the broader community. Some children at RTFs have behavioral health needs that may make them dangerous to themselves or the broader community, if they successfully elope. According to one report, a teen eloped from Newport News Behavioral Health Center (UHS; Virginia) after allegedly strangling a staffer.[763] According to another report, three teens eloped from Natchez Trace Youth Academy (UHS; Tennessee) by jumping a fence and walking 6 miles before taking an unlocked SUV. Later, the three boys allegedly attempted to steal a car from a woman at knife point. Two of the children were arrested. The local Sheriff said, "it's really hard and troublesome because we have to spend time and assets going out [to the facility], and it's just something that's happening and reoccurring way too often."[764] In another incident, two teens eloped from Natchez Trace Youth Academy (UHS; Tennessee), broke into camps, and stole weapons, "including a high-powered rifle, a shotgun, a pistol, and two 22 gauge shotguns" on a Friday. Officials said that they were not notified of the elopements until the next Monday.[765]

The frequency of elopements undermine facilities' claims of providing comprehensive supervision and security to children. The Committee observed frequent elopements at some RTF facilities. According to public reporting, Millcreek of Arkansas (Acadia; Arkansas) saw at least one elopement every month in 2022.[766] In another case at Belmont Pines Hospital (UHS; Ohio), a mother whose child eloped said, "I feel like the facility lacked on their responsibilities to keep her safe

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[760] The Boston Globe, *There are no words* (Sep. 27, 2023) *https://www.bostonglobe.com/2023/09/27/metro/there-are-no-words/; [https://perma.cc/YN7K-9HBU].*

[761] Anchorage Daily News, *Federal inspectors fault assaults, escapes, improper use of locked seclusion at North Star youth psychiatric hospital* (Sep. 20, 2022) *https://www.adn.com/alaska-news/2022/09/28/federal-inspectors-fault-assaults-escapes-improper-use-of-locked-seclusion-at-north-star-youth-psychiatric-hospital/; [https://perma.cc/C7WJ-MNQN].*

[762] Mansfield News Journal, *3 teen runaways from treatment facility found at library* (Jan. 15, 2020) *https://www.mansfieldnewsjournal.com/story/news/2020/01/15/three-runaways-foundations-living-facility-found-library/4476141002/; [https://perma.cc/YT3Y-YCK8].*

[763] Wavy, *Teen assaults staff, escapes Newport News Behavioral Health Center, police say* (Apr. 5, 2019) *https://www.wavy.com/news/teen-assaults-staff-escapes-newport-news-behavioral-health-center-police-say/; [https://perma.cc/3WB2-2JZ3].*

[764] WKRN, *"It's troublesome": Teens escape youth facility, on the run* (Dec. 15, 2023) *https://www.wkrn.com/news/local-news/nashville/its-troublesome-teens-escape-youth-facility-on-the-run/; [https://perma.cc/44SZ-QKSB];* WKRN, *2 minors in custody, another sought after carjacking woman at knifepoint in West Nashville* (Dec. 13, 2023) *https://www.wkrn.com/news/local-news/nashville/3-sought-for-carjacking-woman-at-knifepoint-in-west-nashville/; [https://perma.cc/A5AN-7B92].*

[765] NewsChannel 5, *Armed Teen Runaways Captured in Perry County* (Feb. 23, 2018) *https://www.newschannel5.com/news/armed-teen-runaways-captured-in-perry-county; [https://perma.cc/Y9N4-7269].*

[766] THV11, *Some kids have faced violence in Arkansas psychiatric facilities* (Jan. 9, 2023) *https://www.thv11.com/article/news/health/violence-arkansas-psychiatric-facilities/91-082c9941-3132-476e-8aca-c5a2734c04b8; [https://perma.cc/5F5T-RYYC].*

that they promised me they would do."[767] A police report indicated that this was Belmont Pines Hospital's (UHS; Ohio) second elopement that week.[768]

In another case, three teens eloped from Cedar Ridge Behavioral Hospital (UHS; Oklahoma), two of whom were found in the woods 10 days later. As one child explained, "all three of us just walked out and the staff members were sleeping. When they woke up and seen us [about to leave]. They were just screaming at us. They were like, oh, you know, you're only making it worse for yourself."[769] One mother expressed her frustration saying, "you lost my child. I mean, literally lost a whole person. Three of your children walked away from your facility and you're doing nothing."[770] Another mother said, "it says on the website, 24/7 security. Okay. It it [sic] you know, how does this happen[?]"[771]

Children who elope are sometimes found far from the facility, or even in another state. Public reports document a series of events at North Star Hospital (UHS; Alaska) described as "chaotic." Two children eloped and were found "some 13 hours later and 8.5 miles away" at a local grocery store.[772] Other reports document a child, whose biological mother lived in Wyoming, who eloped from Piney Ridge Treatment Center (Acadia; Arkansas). It was not the facility, but Wyoming officials who told the mother her son had left the facility and it was Arkansas police 5 days later who told the mother her son was found in Missouri. According to the child's mother the Wyoming district attorney "[didn't] want him returning to the treatment center."[773]

Palmetto Pines (UHS; South Carolina) experienced repeat elopements. The Committee reviewed documents related to a South Carolina Department of Health and Environmental Control summary of violations, which said police found a child in a Walmart parking lot with an unknown male. A South Carolina Department of Health and Environmental Control summary of violations for Palmetto Pines (Summerville) Behavioral Health (UHS; South Carolina) found that three children had eloped. All three were later found by law enforcement wet and without footwear.[774] A South Carolina Department of Health and Environmental Control found two children used an emergency release button on an exit door and eloped under a washed out area under a fence. One child's mother ultimately found them hiding in their grandfather's empty house.[775] A South Carolina Department of Health and Environmental Control summary of violations said police found a child from the facility walking along the road.[776] Another South Carolina Department of Health and Environmental Control summary of violations found five children eloped through a hole in the fence, despite it being recently repaired.[777]

f. RTFs Are Intended to Offer Intensive Services and Robust Discharge Planning, but Children Are Routinely Discharged With Subpar Planning.

Children are meant to leave RTFs with a strong basis for long-term wellness. This is effectuated through discharge planning. Discharge planning identifies how children will continue to receive necessary therapies and medications and ensure they receive the right support for their conditions upon their return to the community. In reality, not all facilities adequately plan for a child's discharge. Children leave facilities with insufficient discharge plans in place or without discharge plans whatsoever. Discharge planning failures fundamentally undermine the value of facility

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[767] WCMH, *Police find 4 teens after they escaped from Belmont Pines in Liberty* (June 8, 2021) *https://www.nbc4i.com/news/u-s-world/police-find-4-teens-after-they-escaped-from-belmont-pines-in-liberty/; [https://perma.cc/KJM8-KMKM].*

[768] *Id.*

[769] KFOR, *Teenagers found safe 10 days after leaving Cedar Ridge Behavioral Hospital* (July 21, 2023) *https://kfor.com/news/local/teenagers-found-safe-10-days-after-leaving-cedar-ridge-behavioral-hospital/; [https://perma.cc/2JW6-6HQ8].*

[770] *Id.*

[771] *Id.*

[772] Anchorage Daily News, *Patient escapes and damage reported at North Star youth psychiatric hospital over the weekend* (Oct. 4, 2022) *https://www.adn.com/alaska-news/anchorage/2022/10/04/patient-escapes-and-damage-reported-at-north-star-youth-psychiatric-hospital-over-the-weekend/; [https://perma.cc/3QBU-JWJB].*

[773] KNWA, *2 FOUND: Teen missing from Piney Ridge Treatment Center; mom begs for help in the search* (Sep. 23, 2020) *https://www.nwahomepage.com/news/teen-missing-from-piney-ridge-treatment-center-mom-begs-for-help-in-the-search/; [https://perma.cc/4UUQ-KZVJ].*

[774] UHS, *South Carolina Department of Health and Environmental Control, Healthcare Quality—Summary of Violations (Basis for Imposing Penalties): Palmetto Pines Behavioral Health* (Nov. 8, 2022) UHS–FINHELP–00011436 at 00011441–00011445.

[775] *Id.* at 00011443.

[776] *Id.* at 00011444.

[777] *Id.*

treatment as they fail to create the conditions for children to sustain any treatment improvements after leaving the facility. Children are left with no assurance of their long-term ability to manage their conditions.

Facilities continually fail to fulfill the fundamental discharge planning requirements for the children they treat. Under Medicaid, an individual plan of care includes requirements related to PRTF discharge planning. This written document must include "post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the beneficiary's family, school, and community upon discharge."[778] Like other components of the individual plan of care, discharge planning must be drafted within 14 days of admission to a PRTF. Discharge planning upon admission reinforces the Medicaid program's position that children should only be in an inpatient setting when they have acute needs. From the outset, congregate care providers should be orienting a child's treatment goals towards realizing discharge from this acute setting.

Discharge planning is inadequate at some facilities or not occurring at all. In some cases, discharge plans are not updated to reflect a child's progress. The Committee reviewed documentation of discharge planning failures at several facilities. A review of Millcreek of Arkansas (Acadia; Arkansas) found that beneficiary records lacked discharge planning documentation.[779] At North Star Debarr (UHS; Alaska), a "discharge plan of care was particularly vague and did not specify guardianship's involvement."[780] At Pavilion Behavioral Health System (UHS; Illinois), a reviewer's assessment recommended the facility "[e]nsure . . . Comprehensive Transition Plans (CTP) [another type of discharge plan] are completed for all youth and reviewed per policy/procedures."[781] The Joint Commission found that at North Star Palmer (UHS; Alaska), one child failed to have their condition documented in their discharge summary.[782] At North Star Behavioral Health (UHS; Alaska), a surveyor found that "23 out of 26 charts" had a missing discharge date or specific providers identified in the initial plan of care.[783] In other cases, "some plans were not updated with new dates when the discharge date was changed in other documentation."[784] Copper Hills Youth Center (UHS; Utah) failed to develop treatment plans that identified discharge providers.[785] At Hill Crest Behavioral Health Services (UHS; Alabama), neither the general residential program description nor the SUD residential program description included "[d]ischarge/transfer criteria and procedures."[786]

D. Children in RTFs Are at Risk of Incurring Long-Term Harms, Including Trauma and Death.

The harms children suffer in RTFs are not limited to their time within facilities. Many of the dangers posed by the facilities threaten long-term impacts, including access to self-harm modalities, irreparable separations from community, and lack of education. In some cases, children also die while in RTF custody.

a. Children in RTFs May Be Able to Access Self-Harm Modalities.

Facilities represent that they are able to care for high-risk children experiencing extreme mental health challenges. Many children are admitted to RTFs after expressing suicidal ideation or making attempts. For their safety, self-harm modalities must be removed and the space must be ligature resistant—defined by The Joint Commission as "without points where a cord, rope, bedsheet, or other fabric/material can be looped or tied to create sustainable point of attachment that may result in

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[778] 42 CFR § 441.155.

[779] Acadia, *Beacon Health Options—Clinical Record Review: Millcreek of Arkansas* (July 23–31, 2018) 20180823 Millcreek Beacon POC at p. 4.

[780] UHS, *The State of Alaska Department of Health, Division of Behavioral Health RE: Site Review ADDENDUM, North Star RTC* (Nov. 25, 2022) UHS–FINHELP–00011003 at 00011009.

[781] UHS, *Illinois Department of Children and Family Services To: [REDACTED], Divisional Vice President for Behavioral Health* (Jan. 25, 2023) UHS–FINEHLP–0009809 at 00009810.

[782] UHS, *The Joint Commission—Final Accreditation Report: Frontline Hospital* (Unannounced Full Event Mar. 29, 2022–Apr. 1, 2022) UHS–FINHELP–00011187 at 00011195.

[783] UHS, *State of Alaska Department of Health and Human Services, Division of Behavioral Health—Site Review Summary of Findings* (Sep. 5–9, 2018) UHS–FINHELP–00010854 at 00010856.

[784] *Id.* at 00010857.

[785] UHS, *State of Alaska Department of Health and Social Services, Division of Behavioral Health—Site Review Summary of Findings: Copper Hills Youth Center* (Sep. 30, 2019–Oct. 3, 2019) UHS–FINHELP–00009926 at 00009934.

[786] UHS, *Alabama Department of Mental Health—Programmatic Findings: Hill Crest Behavioral Health Services* (May 22–23, 2019) UHS–FINHELP–00009384 at 00009389.

self-harm or loss of life."[787] Children in facilities are often able to access self-harm modalities (*e.g.,* broken glass, bedsheets, shoelaces) onsite and following elopements. Ligature risks refer to any structure or item that "the patient is able to [use to] create a sustainable point of attachment with another material in order to inflict self-harm or cause loss of life."[788] One facility inspection found multiple ligature points in a room, including a gap between the desk and the corner of the room walls "creating a ligature anchor point" if not sealed properly, additionally a CPAP machine locker had a padlock that created a "loophole anchor point."[789] These issues were remediated while the inspector was onsite.

Multiple children have died by suicide while in RTFs. Despite precautions required by RTF providers, the Committee observed instances of children dying by suicide while in RTF care. According to one 2022 report, a child at Brighter Path Tuskegee (Sequel/Vivant; Alabama) "sustained self-inflicted injuries at the facility . . . [and] died 6 days later"[790] at the hospital.[791] According to another report, an out-of-state child at Willow Springs Hospital (UHS; Nevada) died by suicide in 2023.[792]

There are documented instances of suicide attempts at RTFs. A complaint was lodged against Village Behavioral Health (Acadia; Tennessee) alleging that one night, "a patient tried to jump off the roof to commit suicide and there was only 1 counselor" when there should have been two counselors.[793] A child at Mingus Mountain Estate Resident Center (Sequel/Vivant; Arizona) was placed on heightened supervision protocols by their therapist, requiring the child to be in direct line of sight at all times.[794] During a staffing shift change, the child "was left unsupervised in the dorm for 14 minutes and tied a ripped piece of bedsheet around his/her neck in a suicide attempt."[795]

Facilities must screen for suicide risk for the children in their care, but at times fail to do so. The Joint Commission survey of Foundations Behavioral Health (UHS; Pennsylvania) found that a child with a positive suicide risk screening did not have a suicide risk assessment conducted; however, the child reported having a current plan with intent. In another record, a child was documented as having "increased risk" for suicide, leading the child to be placed on suicide precautions; however, the child wasn't actually placed on a 1:1 with a staffer. Further, the risk policy used for suicide at Foundations Behavioral Health (UHS; Pennsylvania) did not include the "monitoring of patients served who are at high risk for suicide, including placing anyone determined to be at high riskon a 1:1."[796]

The Joint Commission survey of Millcreek of Pontotoc—Willow Springs Group Home (Acadia; Mississippi) found the record of a child, who reported having suicidal ideation and had completed a suicide screening which was positive, did not have a suicide risk assessment completed.[797] The Joint Commission report for Suncoast Behavioral Health Center (UHS; Florida) found the facility did not demonstrate use

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[787] The Joint Commission, *Does The Joint Commission recommend specific ligature-resistant products?* (Jan. 29, 2024) *https://www.jointcommission.org/standards/standard-faqs/behavioral-health/national-patient-safety-goals-npsg/000002224/; [https://perma.cc/TY63-RT4V].*

[788] The Joint Commission, *Is there a height requirement to consider something a "ligature risk"?* (Jan. 29, 2024) *https://www.jointcommission.org/standards/standard-faqs/critical-access-hospital/national-patient-safety-goals-npsg/000002200/#:~:text=Thus%2C%20low%2Dto%2Dthe,to%20inflict%20self%2Dharm%20or; [https://perma.cc/7K4Y-TS68].*

[789] UHS, *The Joint Commission—Final Accreditation Report: Brentwood Behavioral Healthcare of Mississippi, LLC* (May 8, 2020) UHS-FINHELP-00009639at 0009651.

[790] NBC News, *Mom sues Alabama youth facility where son died by suicide to escape "living hell"* (Sep. 1, 2022) *https://www.nbcnews.com/news/us-news/mom-sues-alabama-youth-facilty-sequel-tsi-son-died-suicide-escape-livi-rcna45729; [https://perma.cc/3H8J-9J9J].*

[791] While Vivant owned and operated the Brighter Path Tuskegee (Sequel/Vivant; Alabama) at the time of the child's death, the company has since divested from all Alabama facilities.

[792] This is Reno, *State investigating Willow Springs after suicide* (Apr. 27, 2023) *https://thisisreno.com/2023/04/state-investigating-willow-springs-after-suicide/; [https://perma.cc/4SJS-7SHQ].*

[793] Acadia, *Organization Response for Incident #321772* (Mar. 31, 2019) 20190331 Village QQPS at p. 1–2.

[794] Vivant, *ADHS Licensing Services—Statement of Deficiencies and Plan of Correction: Mingus Mountain Estate Residential CE* (Jan. 28, 2022) FINAL Submission External Reviews at p. 289.

[795] *Id.* at p. 289–290.

[796] UHS, *The Joint Commission—Final Accreditation Report: UHS of Doylestown, LLC* (Aug. 15–17, 2022) UHS–FINHELP–00010166 at 00010172.

[797] Acadia, *The Joint Commission—Preliminary Accreditation Report: Millcreek of Pontotoc* (Oct. 5–8, 2021) 20211008 Millcreek of Pontotoc Joint Commission Triennial Report at p. 16.

of an "evidenced based screening tool" for suicide, homicide, or self-harm behaviors.[798]

The Joint Commission survey of McDowell Center for Children (UHS; Tennessee) found a child's treatment plan did not address history of self-harm, ADHD, or psychosis, all of which were identified as needs upon the child's initial assessment.[799] The Joint Commission visit to First Hospital Panamericano Cidra (UHS; Puerto Rico) found an updated suicide risk screen was not conducted when a child was moved from the inpatient unit to the residential unit, even though the child had a documented heightened risk of suicide.[800] Another survey of First Hospital Panamericano Cidra (UHS; Puerto Rico) found that the "protective factors" section of the suicide screening tool was left blank.[801]

Unkempt facilities present a danger to children. Shoestrings and laces, broken glass, broken furniture, cracked walls, and shower stalls can be used to self-harm. The nature of RTFs subject the facilities to extreme wear and tear, conditions that are at times aggravated by inadequate facilities upkeep. Lack of upkeep can contribute to a dangerous environment for children. For example, at Millcreek of Arkansas (Acadia; Arkansas) a child "was continually accessing items used to self-harm even though she was [on] a 1:1 staff ratio most of the time."[802] The girl consumed batteries from a clock and a remote control and "put glass in her vagina and had elastic placed around her neck on three occasions in a suicide attempt."[803] Disability Rights Arkansas documented that the child "still had access to items to cuther arms. There were numerous new scars over her old scars."[804]

At Palmetto Pines Behavioral Health (UHS; South Carolina), the "facility failed to prevent instances of self-harm."[805] One child "broke [the] toilet and mirror in [the] bathroom and self harmed to [his/her] L wrist then gave piece of porcelain to another [patient] and [he/she] ultimately self-harmed."[806] Then the child, "without permission climbed on top of building regused [sic] to come down."[807] In a Disability Rights Arkansas letter to Millcreek of Arkansas (Acadia; Arkansas), an assessor spoke with "multiple youth" who "spoke of self-harming using objects found in their residence hall." A South Carolina Department of Health and Environmental Control investigation of Palmetto Summerville Behavioral Health (UHS; South Carolina) found multiple allegations were made against the site including that "glass was stored by the dumpster and the residents use glass for self-harm."[808] The Joint Commission report for Suncoast Behavioral Health Center (UHS; Florida) found the facility did not present evidence of "an environmental suicide risk assessment, identifying features in the physical environment to attempt suicide."[809]

Children at Millcreek of Arkansas (Acadia: Arkansas) had multiple ways to access self-harm modalities. The Committee reviewed inspections of Millcreek of Arkansas (Acadia; Arkansas) which note that children have access to self-harm modalities. For example, in one program, across five different halls, children had access to shoestrings and draw strings in their bedrooms.[810] The inspection also identified a "gazebo roof with exposed nails."[811] A separate state inspection found "tennis

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[798] UHS, *The Joint Commission—Final Accreditation Report: Premier Behavioral Health Solutions of FL* (Aug. 4, 2022) UHS–FINHELP–00008660 at 00008673.

[799] UHS, *The Joint Commission—Final Accreditation Report: Keystone Memphis LLC* (Nov. 10, 2021) UHS–FINHELP–00008702 at 00008723.

[800] UHS, *The Joint Commission—Final Accreditation Report: First Hospital Panamericano* (Oct. 26, 2021) UHS–FINHELP–00008742 at 00008747.

[801] UHS, *The Joint Commission—Final Accreditation Report: First Hospital Panamericano* (Aug. 21–24, 2018) UHS–FINHELP–00008758 at 00008769.

[802] Disability Rights Arkansas, *RE: [Redacted] To: [Redacted], Chief Executive Officer* (Jan. 30, 2019) 20190604 Millcreek Alaska HHS Referral Hold at p. 15.

[803] *Id.*

[804] *Id.*

[805] UHS, *South Carolina Department of Health and Environmental Control—Inspection Results: Palmetto Pines Behavioral Health* (Nov. 5, 2020) UHS–FINHELP–00011285 at 00011301.

[806] *Id.*

[807] *Id.*

[808] UHS, *South Carolina Department of Health and Environmental Control—Inspection Results: Palmetto Pines Behavioral Health* (May 4, 2022) UHS–FINHELP–00011359 at 00011360.

[809] UHS, *The Joint Commission—Final Accreditation Report: Premier Behavioral Health Solutions of FL* (Aug. 4, 2022) UHS–FINHELP–00008660 at 00008672.

[810] Acadia, *Arkansas Department of Human Services Division of Child Care and Early Childhood Education Placement and Residential Licensing Unit—Licensing Compliance Record: Millcreek of Arkansas* (May 27, 2021) 20210527 Millcreek of Arkansas state licensure-routine at p. 5.

[811] *Id.* at p. 3.

shoes w/ strings [and] rope on an empty luggage."[812] An inspection at Millcreek of Arkansas (Acadia; Arkansas) also identified play equipment with "rotten boards and screws sticking out."[813] Disability Rights Arkansas, likewise, raised concerns related to self-harm modalities in a letter following-up on multiple monitoring visits.[814] While onsite, "youth spoke of self-harming using objects found in their residential hall . . . [Disability Rights Arkansas] staff observed these same objects freely accessible to the youth."[815] The items at-issue include broken hygiene bins, cracked and sharp shower tiles, torn couch cushions, and a broken mirror.[816] In one instance, a "youth specifically stated she had used the 2nd stall [with the cracked and sharp shower tiles] to self-harm."[817] When Committee staff raised the issue of broken shower tiles with Acadia leadership, they said that children are very tough on the facilities, and the damage documented was normal for facilities.[818] An Alabama Department of Mental Health Rights Protection and Advocacy monitoring report said a child at Hill Crest Behavioral Health Services (UHS; Alabama) observed marks on a child's arms that indicated she had harmed herself within the previous month while at the facility.[819]

Palmetto Pines (UHS; South Carolina) has a history of complaints of self-harm. The Committee reviewed a number of incidents of self-harm at Palmetto Pines Behavioral Health (UHS; South Carolina). One child "barricaded themselves inside of his suicide watch room . . . [and] used the plastics piece to cut his neck in an attempt to kill himself, but it was not sharp enough."[820] A Palmetto Pines Behavioral Health (UHS; South Carolina) report by the South Carolina Department of Health and Environment Control included a complaint alleging, "[r]esidents are able to keep glass and metal objects in their room to use for self harm."[821] In another incident at the same facility, a child with "numerous superficial scratches that [sic] stated they were self-inflicted.[822] Children eloped from Palmetto Summerville Behavioral Health (UHS; South Carolina) and ran to a nearby Dollar General, where an employee said one child "had a piece of glass and cut the top of her arm with it."[823]

Provo Canyon School (UHS; Utah) has seen numerous cases of self-harm. The Committee reviewed records in which Provo Canyon School (UHS; Utah) was cited by the Department of Human Services Office of Licensing for three separate issues concerning self-harm behavior. One child was taken to the emergency department "after tying a piece of her pillowcase around her neck." Another child "caused personal injury during self harm, with wounds that were one and two inches in length."[824] The wounds were so severe that they "were through the fatty tissue."[825] Nine days later, a child eloped from Provo Canyon School (UHS; Utah) and tried "to run into traffic in [an] attempt to end her life."[826] Not one of these incidents related to suicidality and self-harm were reported to the state's Office of Licens-

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[812] Acadia, *Arkansas Department of Human Services Division of Child Care and Early Childhood Education Placement and Residential Licensing Unit—Licensing Compliance Record: Millcreek of Arkansas* (July 8, 2021) 20210709 Millcreek of Arkansas state licensure-findings at p. 1.

[813] Acadia, *Department of Health and Human Services Centers for Medicare & Medicaid—Statement of Deficiencies and Plan of Correction: Millcreek of Arkansas* (Apr. 1, 2021) 20210401 Millcreek of Arkansas CMS–OLTC–final report at p. 7.

[814] Disability Rights Arkansas, *RE: Millcreek Monitoring Report To: [Redacted], Chief Executive Officer* (Apr. 5, 2019) 20190604 Millcreek Alaska HHS Referral Hold at p. 11.

[815] *Id.*

[816] *Id.* at p. 12.

[817] *Id.*

[818] Notes from Acadia Healthcare Briefing (May 17, 2024) (on file with Committee).

[819] UHS, *DMH Rights Protection and Advocacy—Monitoring Report: Hill Crest Behavioral Health Services* (Feb. 11, 2022) UHS–FINHELP–00009396 at 00009412.

[820] UHS, *South Carolina Department of Health and Environmental Control, Healthcare Quality—Summary of Violations* (Basis for Imposing Penalties): Palmetto Pines Behavioral Health (Nov. 8, 2022) UHS–FINHELP–00011436 at 00011440.

[821] UHS, *South Carolina Bureau of Health Facilities Licensing—Audit: Palmetto Pines Behavioral Health* (July 28, 2021) UHS–FINHELP–00011338 at 00011339.

[822] UHS, *South Carolina Department of Health and Environmental Control, Healthcare Quality—Summary of Violations* (Basis for Imposing Penalties): Palmetto Pines Behavioral Health (Sep. 17, 2022) UHS–FINHELP–00011436 at 00011443.

[823] *Id.* at 00011444.

[824] UHS, *State of Utah Department of Human Services Office of Licensing RE: Second Correction Action Plan Required* (Apr. 16, 2020) UHS–FINHELP–00011498 at 00011500.

[825] *Id.*

[826] *Id.*

ing.[827] When asked why they had failed to report the suicide attempt involving the pillowcase, the management at Provo Canyon School (UHS; Utah) explained it was merely a "gesture of suicide."[828]

A child at Palmetto Pines (UHS; South Carolina) made repeated self-harm attempts, but their individual treatment plan was not updated. The Committee reviewed a Joint Commission survey of Palmetto Summerville Behavioral Health (UHS; South Carolina) where a child was assessed with a low risk for suicide upon admittance. Barely a month later, the child engaged in a suicide attempt, "by tying a sheet around his neck." Further, the child later "stated he was going to kill himself," and "placed clothing around his neck." Later, the child stated "he wanted to kill himself," and, following this, stated he was "going to kill himself in the shower and cut himself with a pencil." Despite observation sheets indicating the child was on suicide precautions, the individual treatment plan was not revised "to include suicide as a goal/objective for treatment."[829]

b. Children in RTFs May Receive Substandard Education, Setting Them Up for Future Failure.

Because RTFs are inpatient facilities, most children receive their educational services onsite from online programs charged with providing residents with an adequate education. Studies indicate that youth placed in congregate care settings have worse educational outcomes than their peers, such as lower test scores in English and math, and are more likely to drop out of school.[830] Because children often stay in RTFs for long periods of time, the caliber of the education they receive while in an RTF has a direct bearing on the rest of their lives.

In Alabama, an investigation conducted by the DOJ in 2022 found that the state's Department of Human Resources and Department of Education violated the Americans with Disabilities Act by illegally discriminating against foster care children with disabilities by subjecting them to segregated educational programs.[831] DOJ found that the on-site schools at these RTFs failed to provide residents with "grade-appropriate and adequate instruction, facilities such as libraries, gyms or science labs or extracurricular activities including sports" that are often fundamental to child development.[832] In 2023, a number of federal lawsuits were filed against the State of Alabama for this practice of illegal discrimination. A plaintiff in one of those lawsuits stated that the lack of an education received at the RTF they attended has made it difficult for the plaintiff to "advance academically or interact socially"[833] since leaving the facility. Children may be unable to enroll in a traditional public-school after leaving an RTF because of the gaps and inadequacies in their educational records from their time in RTFs.

Documents produced by UHS indicate that a number of their facilities have woefully neglected the education of their residents, particularly those with disabilities. North Star Debarr (UHS, Alaska) failed to keep on file records of the individualized education programs (IEPs) for multiple residents.[834] An IEP, which is required under the Individuals with Disabilities Education Act (IDEA), is designed and developed to address the specific needs of a student who receives special education and related services. It is unclear how the facility would be able to meet the individualized needs of these residents without maintaining their educational information onsite, including information related to what special education services the child may need, how progress will be measured, current performance, and annual goals. During a 2019 Special Education Quality Assurance Comprehensive Residential Review, New

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[827] *Id.*

[828] *Id.*

[829] UHS, *The Joint Commission—Final Accreditation Report: The Pines Residential Treatment Center-Charleston Campus* (May 28–31, 2019) UHS–FINHELP–00011390 at 11396.

[830] The Annie E. Casey Foundation, *Policy Report: Kids Count* at p. 5 (2013) *https://assets.aecf.org/m/resourcedoc/aecf-EveryKidNeedsAFamily-2015.pdf; [https://perma.cc/YPV4-2L2F],* citing Wiegmann, W., Putnam Hornstein, E., Barrat, V.X., Magruder, J., & Needell, B., *The invisible achievement gap, part 2: How the foster care experiences of California public school students are associated with their education outcomes* (2014).

[831] AL.com, *Alabama foster care children with disabilities given "inferior" care, DOJ says: "It ain't real school"* (Oct. 12, 2022) *https://www.al.com/news/2022/10/alabama-foster-care-children-with-disabilities-given-inferior-care-doj-says-it-aint-real-school.html; [https://perma.cc/2XAT-UCRZ].*

[832] *Id.*

[833] Complaint at ¶ 38, *Cavanaugh v. Buckner* (M.D. Ala. 2023) (2:23–cv–00555) *https://www.alreporter.com/wp-content/uploads/2023/09/Cavanaugh-Fed-Complaint.pdf; [https://perma.cc/N8EA-RJE7].*

[834] UHS, *State of Alaska Department of Health Division of Health Care Services Residential Licensing, North Star Debarr* (Aug. 8–12, 2022) UHS–FINHELP–00011060 at 00011074–75.

York State Education Department officials found that Foundations Behavioral Health (UHS; Pennsylvania) lacked age appropriate instruction for all students on how to protect themselves against reportable incidents.[835]

Committee staff visited five facilities to witness their conditions first-hand. While none of the facilities were operated by the four providers at-issue in this investigation, the five sites are a reflective sample of RTFs across the country—for-profit, nonprofit, small sites operated by a single provider, large sites operated by chains, rural sites, and more urban sites. Committee staff witnessed the lack of appropriate education provisioned in these facilities. At most sites, school consisted of watching a movie. In one classroom, Committee staff observed children completing worksheets from a website called *"EasyTeacherWorksheets.com."* At another site, when Committee staff asked what the unit was, a teacher told staff, "[t]his week we're doing the Jews" and went on to explain that, "[i]t really threw me for a loop what they did to the Jews," insinuating that she had only just learned about the Holocaust's occurrence alongside her elementary and middle-school students. The children, who were as young as 9-years-old, were learning about the Holocaust by watching *The Pianist.*

At one facility, children were seated in silence in rows of plastic chairs, staring at a wall. When Committee staff asked why the children were not in school, an employee explained that, despite it being the middle of the day, "[t]hey go a bit later." In one classroom, the sight words to learn spelling posted on the walls included the word "cut" and placed the words "hurt" and "myself" next to one another, demonstrating a complete lack of awareness related to the needs of the population in their care. Staff at multiple facilities told Committee staff that classroom placement is dictated by program placement, akin to a single-room schoolhouse, rather than by educational-level or other measures that would reflect a child's actual appropriate educational placement.

IV. Conclusion

The conditions and state of affairs outlined in this report did not arise by accident. The harms, abuses, and indignities children in RTFs have experienced and continue to experience today occur inevitably and by design: they are the direct causal result of a business model that has incentive to treat children as payouts and provide less than adequate safety and behavioral health treatment in order to maximize operating and profit margin. Facilities, often filled to capacity with dozens of children with mental health conditions, offer minimal behavioral health care by operating an intentionally lean staffing model with few and inadequately trained clinicians. The harmful and deadly conditions in these facilities are not isolated incidents—they are the result of business decisions by the owners. Despite the egregious failures outlined in this report, these companies are not failing—they are succeeding wildly in securing federal dollars by warehousing children and providing them with inadequate services to meet their needs. Providers will continue to operate this model because it's good business, unless there is some bold intervention.

V. Appendix I: A Historical Summary of the Behavioral Health Landscape in the United States.

In the 1840s, Dorothea Dix, who visited prisons and saw their horrific conditions first-hand, lobbied states to create asylums for people experiencing behavioral health issues who were otherwise likely to be incarcerated.[836] Asylums began as small, locally-populated institutions. But, as their size increased and staffing numbers decreased, they began to look very much like the jails they were intended to replace.[837] Concurrently, in the 1930s and 1940s, asylums and state hospitals developed RTF precursor treatment programs for children who exhibited "delinquent" and "predelinquent" impulses, with the goal of reforming their behaviors to adhere to the social median and then returning children to the community.[838] In the 1950s, as deinstitutionalization began, 50 percent of all hospital beds were psychiatric beds

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[835] UHS, *The State Education Department/The University of the State of New York To: [REDACTED], Chief Executive Officer, Foundations Behavioral Health* (July 5, 2019) UHS–FINHELP–00010088 at 00010093.

[836] The Atlantic, *The Truth About Deinstitutionalization* (May 25, 2021) *https://www.theatlantic.com/health/archive/2021/05/truth-about-deinstitutionalization/618986/; [https://perma.cc/WT35-ZVQQ].*

[837] *Id.*

[838] University of Chicago Press, *Emotionally Disturbed: A History of Caring for America's Troubled Children* at p. 2 (Apr. 26, 2019) ISBN–13 978–0226621432.

for people with mental health needs, the chronically-ill and the elderly.[839] At the time, "there were only 26 U.S. cities whose population exceeded the aggregate population of public psychiatric institutions. The two largest hospitals each had a census that exceeded 16,000."[840]

Following centuries of overreliance on asylums wherein people with behavioral health conditions were routinely admitted for entire lifetimes,[841] President John F. Kennedy signed the landmark Community Mental Health Act (CMHA) into law. The CMHA sought to reduce treatment in institutions and bolster community-based mental healthcare.[842] At its signing, President Kennedy advanced a goal of reducing the number of institutional placements in America by "50 percent or more"[843] and building 1,500 community mental health centers (CMHCs). This vision was never implemented: only half of the CMHCs were ever built. By the 2000s, mental health institutional placements had diminished by 90 percent.[844] This reduction, however, did not realize the full scope of the CMHA's aims. While the clinical community supported deinstitutionalization, especially following the introduction of supposed cure-all psychotropics,[845] and legislators helped facilitate the removal of people from psychiatric hospitals, the necessary, concurrent investment in community-based care never took shape.[846]

Between the 1970s and 1990s, as deinstitutionalization failed to fully materialize due to inadequate community-based mental health infrastructure, states exacerbated the conditions on expensive and highly restrictive treatment institutions for children. RTFs were pushing a "therapeutic rational[e . . .], which called for the temporary separation of a child from her pathological home environment."[847] During the 1980s, states invested in RTFs for children at the expense of community services.[848] In 1982, Jane Knitzer's *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services* noted that "[o]f the 3 million seriously disturbed children in this country, two-thirds are not getting the services they need. Countless others get inappropriate care. These children are 'unclaimed' by the public agencies with responsibility to serve them. The most readily available 'help' for these children remains the most restrictive and costly inpatient hospital care."[849] Since the 1999 Olmstead decision, there has been a drastic reorientation toward in-community placements, but there is still a long road ahead.

VI. Appendix II: Exhibit List

Acadia Company Production

Appendix 1. 20180304 Piney Ridge CAP for Program Review IOC [Redacted]

Appendix 2. 20180409 Piney Ridge AR Beacon CAP [Redacted]

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[839] Psychiatric News, *The Rise and Demise of America's Psychiatric Hospitals: a Tale of Dollars Trumping Sense* (Mar. 2019) *https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2019.3b29; [https://perma.cc/V2E5-422N].*

[840] *Id.*

[841] BMC Psychiatry, *Understanding Psychiatric Institutionalization: A Conceptual Review* (June 18, 2013) DOI: 10.1186/1471–244X–13–169; American Psychiatric Association Publishing, *The Rise and Demise of America's Psychiatric Hospitals: a Tale of Dollars Trumping Sense* (Mar. 14, 2019) *https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2019.3b29; [https://perma.cc/3GJB-BKSB].*

[842] The Community Health Act of 1963, Public Law 88–164; WBUR, *The Last Bill JFK Signed—And The Mental Health Work Still Undone* (Oct. 23,2013) *https://www.wbur.org/news/2013/10/23/community-mental-health-kennedy; [https://perma.cc/3XRB-D7J4].*

[843] The American Presidency Project, *Remarks Upon Signing Bill for the Construction of Mental Retardation Facilities and Community Mental Health Centers* at p. 1 (Oct. 31, 1963) *https://www.presidency.ucsb.edu/documents/remarks-upon-signing-bill-for-the-construction-mental-retardation-facilities-and-community; [https://perma.cc/GK46-CKNU].*

[844] American Journal of Psychiatry Volume 16 Issue 4, *Deinstitutionalization Through Optimism: The Community Mental Health Act of 1963* (June 11, 2021) *https://doi.org/10.1176/appi.ajp-rj.2021.160404; [https://perma.cc/E643-QDSN].*

[845] The Atlantic, *The Truth About Deinstitutionalization* (May 25, 2021) *https://www.theatlantic.com/health/archive/2021/05/truth-about-deinstitutionalization/618986/; [https://perma.cc/WT35-ZVQQ].*

[846] American Journal of Psychiatry Volume 16 Issue 4, *Deinstitutionalization Through Optimism: The Community Mental Health Act of 1963* (June 11, 2021) *https://doi.org/10.1176/appi.ajp-rj.2021.160404; [https://perma.cc/E643-QDSN].*

[847] University of Chicago Press, *Emotionally Disturbed: A History of Caring for America's Troubled Children* at p. 6–7 (Apr. 26, 2019) ISBN–13 978–0226621432.

[848] Children's Defense Fund, *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services* at p. xii (1982) ISBN0938008064, 9780938008064.

[849] *Id.* at p. ix.

Appendix 3. 20180409 Piney Ridge AR Beacon Report [Redacted]

Appendix 4. 20180525 Millcreek CMS 2567 report N Tags POC [Redacted]

Appendix 5. 20180629 Millcreek 2567 w POC 071119 [Redacted]

Appendix 6. 20180717 Resource IN DCS Licensing Survey Report [Redacted]

Appendix 7. 20180823 Millcreek Beacon POC [Redacted]

Appendix 8. 20180904 Piney Ridge AR Beacon Report [Redacted]

Appendix 9. 20181025 Millcreek CMS 2567 ANNUAL ICF POC 2018 (corrected) [Redacted]

Appendix 10. 20181218 Millcreek ICF CMS 2567 POC [Redacted]

Appendix 11. 20190331 Village OQPS [Redacted]

Appendix 12. 20190604 Millcreek Alaska HSS Referral Hold Letter [Redacted]

Appendix 13. 20191011 Piney Ridge OLTC POC RESPONSE ATTACHMENTS [Redacted]

Appendix 14. 20191011 Piney Ridge OLTC POC RESPONSE-REVISED SIGNED [Redacted]

Appendix 15. 20191126 Piney Ridge AR DHS CAP Agreement signed [Redacted]

Appendix 16. 20191126 Piney Ridge Licensing CAP Recommendations Letter [Redacted]

Appendix 17. 20200514 Little Creek—5142020—extension-JC-final report [Redacted]

Appendix 18. 20200806 Piney Ridge AR DHS CAP Agreement signed [Redacted]

Appendix 19. 20201002 Piney Ridge OLTC POC RESPONSE Final [Redacted]

Appendix 20. 20210318 Piney Ridge OHCA CAP Review Findings [Redacted]

Appendix 21. 20210401 Millcreek of Arkansas CMS-OLTC-final report [Redacted]

Appendix 22. 20210527 Millcreek of Arkansas State Licensure-routine [Redacted]

Appendix 23. 20210618 Resource TJC complaint-report [Redacted]

Appendix 24. 20210709 Millcreek of Arkansas state licensure-findings [Redacted]

Appendix 25. 20210915 Resource-DCS-licensing review-report [Redacted]

Appendix 26. 20211008 Millcreek of Pontotoc Joint Commission Triennial Report [Redacted]

Appendix 27. 20211015 Resource licensure survey [Redacted]

Appendix 28. 20220329 Resource—Referral hold letter—DCS licensing [Redacted]

Appendix 29. 20220329 Resource 30 day notice to comply [Redacted]

Appendix 30. 20220412 Millcreek AR AFMC licensure survey findings [Redacted]

Appendix 31. 20220506 Millcreek Pontotoc licensure-group homes [Redacted]

Appendix 32. Acadiana Treatment Center [No Redactions Required]

Appendix 33. Cove PREP [No Redactions Required]

Appendix 34. Little Creek Behavioral Health [No Redactions Required]

Appendix 35. MillCreek Behavioral Health [No Redactions Required]

Appendix 36. MillCreek Magee [No Redactions Required]

Appendix 37. MillCreek Pontotoc [No Redactions Required]

Appendix 38. Piney Ridge Treatment Center [No Redactions Required]

Appendix 39. Resource Treatment Center [No Redactions Required]

Appendix 40. SUWS Carolinas [No Redactions Required]

Appendix 41. Village Behavioral Health [No Redactions Required]
Appendix 42. YouthCare [No Redactions Required]

Devereux Company Production
Appendix 43. DEV–S—000356 [Redacted]
Appendix 44. DEV–S—001160 [Redacted]
Appendix 45. DEV–S—001163 [Redacted]
Appendix 46. DEV–S—001165 [Redacted]
Appendix 47. DEV–S—001167 [Redacted]
Appendix 48. DEV–S—001169 [Redacted]
Appendix 49. DEV–S—001172 [Redacted]
Appendix 50. DEV–S—001175 [Redacted]
Appendix 51. DEV–S—001178 [Redacted]
Appendix 52. DEV–S—001190 [Redacted]
Appendix 53. DEV–S—001196 [Redacted]
Appendix 54. DEV–S—001199 [Redacted]
Appendix 55. DEV–S—001215 [Redacted]

Universal Health Systems Company Production
Appendix 56. UHS–FINHELP–00002463 [Redacted]
Appendix 57. UHS–FINHELP–00008660 [Redacted]
Appendix 58. UHS–FINHELP–00008684 [Redacted]
Appendix 59. UHS–FINHELP–00008702 [Redacted]
Appendix 60. UHS–FINHELP–00008742 [Redacted]
Appendix 61. UHS–FINHELP–00008758 [Redacted]
Appendix 62. UHS–FINHELP–00008775 [Redacted]
Appendix 63. UHS–FINHELP–00008890 [Redacted]
Appendix 64. UHS–FINHELP–00008896 [Redacted]
Appendix 65. UHS–FINHELP–00008911 [Redacted]
Appendix 66. UHS–FINHELP–00008995 [Redacted]
Appendix 67. UHS–FINHELP–00009021 [Redacted]
Appendix 68. UHS–FINHELP–00009148 [Redacted]
Appendix 69. UHS–FINHELP–00009159 [Redacted]
Appendix 70. UHS–FINHELP–00009190 [Redacted]
Appendix 71. UHS–FINHELP–00009210 [Redacted]
Appendix 72. UHS–FINHELP–00009216 [Redacted]
Appendix 73. UHS–FINHELP–00009223 [Redacted]
Appendix 74. UHS–FINHELP–00009230 [Redacted]
Appendix 75. UHS–FINHELP–00009317 [Redacted]
Appendix 76. UHS–FINHELP–00009322 [Redacted]
Appendix 77. UHS–FINHELP–00009366 [Redacted]
Appendix 78. UHS–FINHELP–00009384 [Redacted]
Appendix 79. UHS–FINHELP–00009396 [Redacted]
Appendix 80. UHS–FINHELP–00009444 [Redacted]
Appendix 81. UHS–FINHELP–00009552 [Redacted]
Appendix 82. UHS–FINHELP–00009579 [Redacted]
Appendix 83. UHS–FINHELP–00009627 [Redacted]

Appendix 84. UHS–FINHELP–00009639 [Redacted]
Appendix 85. UHS–FINHELP–00009680 [Redacted]
Appendix 86. UHS–FINHELP–00009713 [Redacted]
Appendix 87. UHS–FINHELP–00009720 [Redacted]
Appendix 88. UHS–FINHELP–00009728 [Redacted]
Appendix 89. UHS–FINHELP–00009744 [Redacted]
Appendix 90. UHS–FINHELP–00009754 [Redacted]
Appendix 91. UHS–FINHELP–00009784 [Redacted]
Appendix 92. UHS–FINHELP–00009809 [Redacted]
Appendix 93. UHS–FINHELP–00009822 [Redacted]
Appendix 94. UHS–FINHELP–00009837 [Redacted]
Appendix 95. UHS–FINHELP–00009863 [Redacted]
Appendix 96. UHS–FINHELP–00009872 [Redacted]
Appendix 97. UHS–FINHELP–00009908 [Redacted]
Appendix 98. UHS–FINHELP–00009917 [Redacted]
Appendix 99. UHS–FINHELP–00009926 [Redacted]
Appendix 100. UHS–FINHELP–00009946 [Redacted]
Appendix 101. UHS–FINHELP–00009962 [Redacted]
Appendix 102. UHS–FINHELP–00010014 [Redacted]
Appendix 103. UHS–FINHELP–00010075 [Redacted]
Appendix 104. UHS–FINHELP–00010088 [Redacted]
Appendix 105. UHS–FINHELP–00010096 [Redacted]
Appendix 106. UHS–FINHELP–00010163 [Redacted]
Appendix 107. UHS–FINHELP–00010166 [Redacted]
Appendix 108. UHS–FINHELP–00010185 [Redacted]
Appendix 109. UHS–FINHELP–00010213 [Redacted]
Appendix 110. UHS–FINHELP–00010220 [Redacted]
Appendix 111. UHS–FINHELP–00010222 [Redacted]
Appendix 112. UHS–FINHELP–00010230 [Redacted]
Appendix 113. UHS–FINHELP–00010232 [Redacted]
Appendix 114. UHS–FINHELP–00010235 [Redacted]
Appendix 115. UHS–FINHELP–00010237 [Redacted]
Appendix 116. UHS–FINHELP–00010239 [Redacted]
Appendix 117. UHS–FINHELP–00010241 [Redacted]
Appendix 118. UHS–FINHELP–00010243 [Redacted]
Appendix 119. UHS–FINHELP–00010267 [Redacted]
Appendix 120. UHS–FINHELP–00010271 [Redacted]
Appendix 121. UHS–FINHELP–00010303 [Redacted]
Appendix 122. UHS–FINHELP–00010307 [Redacted]
Appendix 123. UHS–FINHELP–00010309 [Redacted]
Appendix 124. UHS–FINHELP–00010312 [Redacted]
Appendix 125. UHS–FINHELP–00010347 [Redacted]
Appendix 126. UHS–FINHELP–00010355 [Redacted]
Appendix 127. UHS–FINHELP–00010359 [Redacted]
Appendix 128. UHS–FINHELP–00010395 [Redacted]

Appendix 129. UHS–FINHELP–00010425 [Redacted]
Appendix 130. UHS–FINHELP–00010805 [Redacted]
Appendix 131. UHS–FINHELP–00010854 [Redacted]
Appendix 132. UHS–FINHELP–00010948 [Redacted]
Appendix 133. UHS–FINHELP–00010963 [Redacted]
Appendix 134. UHS–FINHELP–00010975 [Redacted]
Appendix 135. UHS–FINHELP–00011003 [Redacted]
Appendix 136. UHS–FINHELP–00011037 [Redacted]
Appendix 137. UHS–FINHELP–00011060 [Redacted]
Appendix 138. UHS–FINHELP–00011158 [Redacted]
Appendix 139. UHS–FINHELP–00011187 [Redacted]
Appendix 140. UHS–FINHELP–00011252 [Redacted]
Appendix 141. UHS–FINHELP–00011273 [Redacted]
Appendix 142. UHS–FINHELP–00011285 [Redacted]
Appendix 143. UHS–FINHELP–00011327 [Redacted]
Appendix 144. UHS–FINHELP–00011332 [Redacted]
Appendix 145. UHS–FINHELP–00011338 [Redacted]
Appendix 146. UHS–FINHELP–00011349 [Redacted]
Appendix 147. UHS–FINHELP–00011355 [Redacted]
Appendix 148. UHS–FINHELP–00011359 [Redacted]
Appendix 149. UHS–FINHELP–00011386 [Redacted]
Appendix 150. UHS–FINHELP–00011390 [Redacted]
Appendix 151. UHS–FINHELP–00011408 [Redacted]
Appendix 152. UHS–FINHELP–00011415 [Redacted]
Appendix 153. UHS–FINHELP–00011436 [Redacted]
Appendix 154. UHS–FINHELP–00011466 [Redacted]
Appendix 155. UHS–FINHELP–00011498 [Redacted]
Appendix 156. UHS–FINHELP–00011508 [Redacted]
Appendix 157. UHS–FINHELP–00011728 [Redacted]
Appendix 158. UHS–FINHELP–00011734 [Redacted]
Appendix 159. UHS–FINHELP–00011745 [Redacted]
Appendix 160. UHS–FINHELP–00011754 [Redacted]
Appendix 161. UHS–FINHELP–00011847 [Redacted]
Appendix 162. UHS–FINHELP–00011908 [Redacted]
Appendix 163. UHS–FINHELP–00011933 [Redacted]
Appendix 164. UHS–FINHELP–00011988 [Redacted]
Appendix 165. UHS–FINHELP–00012054 [Redacted]
Appendix 166. UHS–FINHELP–00012134 [Redacted]
Appendix 167. UHS–FINHELP–00012209 [Redacted]
Appendix 168. UHS–FINHELP–00012223 [Redacted]

Vivant Company Productions

Appendix 169. FINAL—Vivant Follow-Up Response 21 Letter executed p. 1 [Redacted]

Appendix 170. FINAL—Vivant Senate Inquiry Response (08.18.22) p. 8. [No Redactions Required]

Appendix 171. FINAL—Vivant Senate Inquiry Response (08.18.22) p. 18 [No Redactions Required]

Appendix 172. FINAL—Vivant Senate Inquiry Response (08.18.22) p. 29 [No Redactions Required]

Appendix 173. FINAL—Vivant Senate Inquiry Response (08.18.22) p. 30 [No Redactions Required]

Appendix 174. FINAL—Vivant Senate Inquiry Response (08.18.22) p. 54 [No Redactions Required]

Appendix 175. FINAL—Vivant Submission of External Reviews p. 4 [No Redactions Required]

Appendix 176. FINAL—Vivant Submission of External Reviews p. 189 [No Redactions Required]

Appendix 177. FINAL—Vivant Submission of External Reviews p. 289 [Redacted]

Appendix 178. FINAL—Vivant Submission of External Reviews p. 319 [Redacted]

COMMUNICATIONS

AMERICAN ACADEMY OF PEDIATRICS
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Statement of Benjamin D. Hoffman, M.D., FAAP, President

Chairman Wyden, Ranking Member Crapo, and Honorable Committee Members:

My name is Dr. Benjamin D. Hoffman, and I am the President of the American Academy of Pediatrics, or the AAP, a non-profit professional organization of 67,000 primary care pediatricians, pediatric medical sub-specialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults. I am submitting the following testimony on behalf of the AAP. In addition to my role with the AAP, I also work for Doernbecher Children's Hospital and Oregon Health and Science University, where I serve as a Professor of Pediatrics, Vice-Chair for Community Health and Advocacy, Director of the Oregon Center for Children and Youth with Special Health Care Needs, and Medical Director of the Child Injury Prevention Program.

The AAP appreciates the opportunity to submit testimony for this hearing on youth residential treatment facilities and to share with you our concerns regarding these facilities and why children and youth thrive best in family-based settings. We are grateful to this Committee for its bipartisan oversight of these youth residential treatment facilities and for releasing its findings on its 2-year investigation into alleged abuse and neglect at residential treatment facilities. The AAP expresses our profound sorrow and condolences to the many young people who have been affected by the abuses that have occurred at these residential treatment facilities. The AAP is deeply concerned by the Committee's report which found numerous incidents of physical, sexual, and verbal abuse, inappropriate restraints and seclusions, unsafe and unsanitary conditions, and the lack of necessary behavioral health care at several of these residential facilities. These findings reflect why children and youth should be placed in family-based settings with strong community-based mental health services, and not these long-term, inappropriate residential treatment facilities.

The AAP supports many of the Committee's report recommendations including investing in community-based alternatives for care. As the report shows, Medicaid dollars and child welfare funding are too often being sent to inappropriate residential treatment facilities instead of more appropriate community-based alternatives. The AAP applauds the Committee's recommendation in the report to increase investments in community-based alternatives for care, and we look forward to working with the Committee to invest in community-based alternatives for care, including for high-quality, trauma-informed mental health services mental health services.

The AAP is grateful for the Committee's continued review of youth residential treatment facilities and offers the following feedback to further guide the Committee's work in its oversight of youth residential treatment facilities:

General Feedback on Youth Residential Treatment Facilities: For years, the AAP has advocated to improve child welfare policies to better address the needs of children and families. The AAP has long held that the long-term institutionalization of children and youth is harmful to their health and well-being, and we have instead called for increased community-based mental health supports that allow them to live safely in family settings.

This is why the AAP was proud to have endorsed and championed the Family First Prevention Services Act ("Family First"). The bipartisan Family First is a landmark child welfare reform law that is creating critical policy change to better serve vulnerable children and families in two ways: (1) preventing unnecessary foster care placements with services to keep families safely together; and (2) prioritizing family-based placements for children who do need to enter foster care, and ensuring that residential treatment settings are high-quality and appropriate when children require specialized time-limited care not available in a family setting. This law has the potential to continue to significantly shift child welfare policy upstream and emphasize the importance of prevention.

Family First made critical policy changes to improve standards for residential treatment. These reforms emphasize that children and youth only enter such a setting if they have a need that cannot be met in a family placement, and if a particular setting is high-quality enough to meet those needs. Family First does this by creating a new program model, the Qualified Residential Treatment Programs (QRTP). The law is designed to ensure QRTP placements are appropriate, time-limited, and meet a child's treatment needs so that they do not languish in settings which do not support their growth, development, and healing. QRTPs also must offer aftercare supports to facilitate a transition to the community after residential treatment. These standards align with what physicians and other child health experts know: children fare best in families.

The Senate Committee on Finance ("Committee") plays a critical role in ensuring that Family First is properly implemented so that children in foster care have access to coordinated, high-quality, and trauma-informed care and support, as well as ensuring that all youth residential treatment facilities are meeting the standards as required by law. Children in foster care experience disproportionate exposure to trauma and, as a result, often have complex health needs across multiple domains, including medical, developmental, educational, and behavioral and mental health problems. Safety, permanency, and the well-being of children in foster care are three key precepts that inform the work of the Department of Health and Human Services (HHS), the Administration for Children and Families (ACF), state child welfare agencies, and professionals serving children in foster care, including pediatricians. The AAP encourages the Committee to ensure that the actions of federal, state, and local governments involved with the child welfare system, as well as all youth residential treatment facilities, adhere to these three key precepts and properly implement laws like Family First.

Provide Funding for Community-Based Mental Health Services: As the Committee considers investing in community-based alternatives for care, the AAP encourages Congress to provide funding, training, technical support, and accountability so states and Tribes can improve access to community-based mental health services for youth and families, to address trauma, improve outcomes, and reduce unnecessary institutionalization. For example, state Health Oversight and Coordination Plans offer an opportunity to advance improved mental health for youth in foster care, but the lack of funding and technical assistance to support their implementation is a key barrier to their effectiveness.

The AAP urges Congress to enact legislation that will help facilitate the recruitment and training of staff and caregivers, including treatment foster care providers, with skills and motivation necessary to nurture family bonding, affirm the racial, cultural, and ethnic diversity of children and families served by child welfare, and effectively treat trauma, including secondary trauma among staff. Recruiting and training staff and caregivers who are equipped with these skills and motivation is necessary for the mental health of children and families.

Research is clear that children thrive in family-based settings. The AAP opposes any efforts to increase unnecessary institutionalization and interventions via residential treatment. A 2015 Children's Bureau report indicated that 40% of young people in congregate care settings had no acute clinical need for that placement. AAP recognizes the need for residential treatment only when an acute clinical need is present. The AAP encourages Congress to invest in community-based services that support young people's healing and success in families. This will help both avoid unnecessary institutionalization and ensure there are needed supports for those transitioning from residential treatment to a family.

Continue Congregate Care Reforms: The AAP appreciates the Committee's report recommendation to strengthen oversight of congregate care facilities. Last year, the AAP published a new report, "Family First Implementation: A One-Year Review of State Progress in Reforming Congregate Care," which reviewed state-level imple-

mentation of the congregate care reforms included in Family First.[1] This report was developed with experts from Chapin Hall of the University of Chicago, individuals with lived experience in foster care, and pediatricians to examine state-level implementation of the congregate care reforms contained in Family First. Through a survey of all 50 states and targeted focus groups, the research examined issues like: how states are reforming their congregate care settings, how they are implementing and financing congregate care reform, and what barriers, success, and recommendations states have for implementing changes to congregate care outlined within Family First.

From this report, the AAP was pleased to see that the majority of states have changed their provision of congregate care to align with Family First. This was accomplished after extensive engagement with diverse stakeholders, including child welfare agency staff, congregate care providers, legislators, among other involved groups, to implement Family First. The majority of states attributed those changes to both Family First and pre-existing and ongoing state-led reforms. Additionally, compared to pre-Family First implementation, fewer youth are entering congregate care in some states. More states reported placing 10% or less of youth in foster care in congregate care. Kinship foster care has come to play a larger role in states' placement array, with congregate care playing a smaller role.

However, while the report showed some improvements due to Family First, the report also showed that there is work to be done to support youth in foster care. First, many states indicated that top barriers to Family First and congregate care reform implementation are related to resource needs in: (1) workforce and staff; (2) therapeutic foster care models; (3) funding; and (4) foster families. Many states also indicated that in order to address workforce and staff issues, ensure therapeutic models are available, and successfully recruit foster families, more funding is necessary to overcome these barriers. Additionally, the report's group participants, including young people with lived experiences, child welfare administrators implementing Qualified Residential Treatment Programs (QRTPs), and leaders of QRTP facilities, all reported significant concerns regarding QRTP staff training and capacity and capacity to tailor treatment to youth's needs. Many participants noted that staff shortages, retention, compensation, and a lack of sustainable careers for staff in QRTPs have contributed to these concerns.

The report offers the following recommendations to better support youth in foster care and the child welfare systems throughout this country: (1) Provide states with additional state and federal resources such as technical assistance and funding; (2) Facilitate cross-system collaboration to successfully implement Family First; (3) Provide clear funding guidance to implement QRTPs; (4) Require oversight for the full array of congregate care placements, including supervised independent living and settings for survivors of sex trafficking, and the use of out-of-state QRTP placements; (5) Professionalize and invest in QRTP staff to ensure high-quality, individualized treatment; (6) Establish standards and youth advisory boards for youth- and family-driven QRTP treatment; (7) Integrate QRTPs into a continuum of prevention and aftercare; (8) Establish performance- and outcome-based monitoring of QRTPs.

The AAP encourages the Committee and the rest of Congress to invest in and support family support services by expanding funding and resources as well as invest in mental health services based on the recommendations in the report above.

Oppose Unnecessary Institutionalization: While there are many community-based mental health services and reforms that the AAP supports, the AAP strongly opposes any bills that could lead to the further institutionalization of children and youth in foster care. The Committee's report on the abuses and neglect at several youth residential treatment facilities makes it clear why the federal government should not incentivize these facilities with further federal funding.

In particular, the AAP strongly opposes the Ensuring Medicaid Continuity for Children in Foster Care Act (S. 3196). The AAP is concerned this legislation will cause significant unintended harm by prioritizing institutionalization of children and youth who instead need more community-based mental health supports to live safely in family settings.

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[1] American Academy of Pediatrics, Chapin Hall. "Family First Implementation: A One-Year Review of State Progress in Reforming Congregate Care." *https://downloads.aap.org/DOFA/AAP%2050%20state%20Review%20of%20Congregate%20Care%20Reform%20Across%20America.pdf*.

The AAP would like to emphasize that this bill is unnecessary as Congress does not need to enact a new policy to prevent children in foster care from losing Medicaid eligibility as a result of institutional placement. Nothing in current Medicaid law pertaining to institutional placements rescinds an individual's Medicaid eligibility. Under existing law, children in foster care are already eligible for Medicaid. Current Medicaid protections against over-institutionalization of children do not change a child's Medicaid eligibility. Rather, these policies prevent a state from receiving federal funds for impermissible institutionalization, without impacting a child's Medicaid eligibility or enrollment.

Family First made critical policy changes to improve standards for residential treatment. These reforms emphasize that children and youth only enter such a setting if they have a need that cannot be met in a family placement, and if a particular setting can provide the specialized services and high-quality care tailored to that individual child or young person's needs. Family First does this by creating a new program model, the Qualified Residential Treatment Programs (QRTP). The law is designed to ensure QRTP placements are appropriate, time-limited, and meet a child's treatment needs so that they do not languish in settings which do not support their growth, development, and healing. QRTPs also must offer aftercare supports to facilitate a transition to the community after residential treatment. These standards align with what physicians and other child health experts know: children fare best in families.

The Ensuring Medicaid Continuity for Children in Foster Care Act of 2023 (S. 3196) would create a major federal exemption from Medicaid oversight law for QRTPs. The Medicaid Institution for Mental Disease (IMD) exclusion generally prohibits federal Medicaid funding for services provided by facilities that primarily provide mental health and substance use disorder treatment services if they have more than 16 beds. By significantly expanding investment in residential treatment instead of community-based settings, S. 3196 would create an incentive to place more children in large-scale institutions, undermining the bipartisan Congressional intent behind Family First.

At a time of pediatric mental health crisis, we need more bipartisan investment in community-based mental health services. Prioritizing institutionalization through significant changes to longstanding Medicaid policy will not expand those needed services and will instead drive interventions via residential treatment. The AAP encourages Congress to invest instead in the community-based services that support young people's success in families. This will help both avoid unnecessary institutionalization and ensure there are needed supports for those transitioning from residential treatment to a family.

The AAP is fully committed to the success of Family First. It is essential to ensure that there are not unintended consequences from interactions between the IMD exclusion and Family First's QRTP requirements. Today, Medicaid waiver authority supports states in creating a comprehensive, coordinated system of care for serious mental illness and serious emotional disturbance that can include residential care such as a QRTP; this targeted authority ensures that Medicaid can meet the needs of its enrollees when states take a holistic approach to mental and behavioral health. However, enacting a sweeping federal exemption for all QRTPs could create unintended consequences that lead to children and youth languishing in large facilities, without the community-based supports they need to thrive in families.

We would welcome the opportunity to have discussions with the Committee and other critical stakeholders about how to ensure the effective implementation of Family First without creating unintended harms or undermining the intent of Family First, particularly through investment in community-based services that can promote the least restrictive environment.

Conclusion: Thank you for the opportunity to submit this testimony. The AAP urges the Senate Committee on Finance and Congress to continue its oversight of youth residential treatment facilities, increase investments in community-based alternatives for care, including appropriate mental health services, and to ensure that all levels of government are supporting the safety, permanency, and the well-being of all children in foster care. The AAP looks forward to working with the Committee and the rest of Congress to improve the child welfare system and improve the health and well-being of children and their families. If the AAP can be of any further assistance, please do not hesitate to contact Nathaniel Lim in our Washington, D.C. office at nlim@aap.org.

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Statement of Tami D. Benton, M.D., President

Chairman Wyden, Ranking Member Crapo, and members of the Committee, thank you for hosting the hearing titled, "Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions." The American Association of Child and Adolescent Psychiatry (AACAP) is the professional home of more than 11,000 child and adolescent psychiatrists, fellows, residents and medical students.

Background

Residential treatment programs provide intensive help for youth with serious emotional and behavior problems. While receiving care in residential treatment facilities, children temporarily live outside of their homes and instead in a facility where they can be supervised and monitored by trained staff. Residential treatment can help children and adolescents whose health is at risk while living in their community. This type of program is for those who have not responded to outpatient treatments or who need further intensive treatment following inpatient psychiatric care.

The continuum of care for youth with psychiatric challenges spans from the least restrictive levels to the most restrictive, with outpatient care representing the former and inpatient and residential care representing the most restrictive and intensive. Child and adolescent psychiatrists aim to provide treatment in the least restrictive setting possible, which naturally varies depending on each patient's needs.

Residential care is a crucial treatment modality designed to provide intense comprehensive treatment in a highly structured and supervised environment. Youth with severe ongoing mental or behavioral dysregulation may not be suited to the other levels of care including outpatient, intensive outpatient, partial hospitalization, or even inpatient. These youth have often failed lower levels of care or more intensive but time limited options, such as inpatient care. Residential care represents the treatment setting of choice for youth who have repeatedly demonstrated severe emotional dysregulation and difficult to treat mental illness.

The Role of Child and Adolescent Psychiatrists in Youth Residential Treatments

Ideally, each patient's assessment and treatment program is under the direction of a qualified child and adolescent psychiatrist (CAP). Children and adolescents are evaluated no less than weekly by CAPs and/or mid-level practitioners or child psychiatry fellows, under supervision of child psychiatrists. The treating psychiatric team works in concert with an interdisciplinary treatment team, which includes some combination of nursing staff, social work/case management, psychology and affiliated counselors, therapists, and trained direct care staff. Components of a residential program often include therapy, family involvement, academics, and a structured schedule to reinforce healthy behaviors.

Additionally, registered psychiatric nurses with experience in mental health services direct programming 24 hours per day, 7 days per week. Mental health programming includes appropriate child supervision, the first goal of which is always patient safety. Nurses also collaborate with CAPs and other physicians in medical management, medication administration, and monitoring. The nursing staff delivers care that is developmentally appropriate, supportive, and family centered.

Opportunities for Improvements

It is imperative that residential treatment facilities maintain a safe environment to ensure the safety and well-being of the youth it seeks to serve. Staffing numbers must be appropriate to the needs of the facility and all personnel must be adequately trained. Therapeutic environments should never be coercive or punishment-based. Use of physical restraints or additional emergency medication administration is done in emergencies only—when the patient poses a legitimate risk of harm to themselves or others and fails more conservative measures of de-escalation. We oppose the unnecessary use of force in treatment settings. Federal licensing standards for youth residential treatment programs must address the issue of institutional child abuse. Staff must be trained on compliance with national and local regulatory standards and be familiar with the process of identifying, reporting, and taking action on any risk found in the environment.

Length of stay decisions should be driven by the patient's needs, not on insurance status. The treatment team has the responsibility to continue to provide care until the patient proves able to engage in appropriate aftercare.

AACAP believes that effective residential treatment programs provide:

- A comprehensive evaluation to assess emotional, behavioral, medical, educational, and social needs.
- An Individualized Treatment Plan that puts into place interventions that help the child or adolescent to attain these goals.
- Individual and group therapy.
- Psychiatric care coordinated by a child and adolescent psychiatrist.
- Involvement of the child's family or support system. Model residential programs encourage and provide opportunities for family therapy and contact through on-site visits, home passes, telephone calls, and other modes of communication.
- Nonviolent and predictable ways to help youth with emotional and behavioral issues. The use of physical punishment, manipulation, or intimidation should not occur in any residential treatment program.

Recommendations

AACAP maintains that residential treatment facilities are a crucial delivery modality of psychiatric care for youth and must provide a safe, therapeutic environment to ensure that patients receive high quality care that meets their needs. AACAP calls on the Committee to consider the following policy recommendations:

- Convene a roundtable with stakeholder groups, including professional medical associations, to develop definitions, standards, and best practices.
- Increase Medicaid reimbursement rates, particularly for services provided to children and youth adults who require a high level of care.

AACAP thanks the Senate Finance Committee for its work and is ready to work with the Committee on this issue to improve the care and safety of children and adolescents.

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Why Foster Kids Are Sleeping in Offices and What We Can Do About It

AEI Child Welfare Innovation Working Group

Key Points

- Efforts to deinstitutionalize foster care have significantly reduced placement capacity and forced older children and those with higher levels of need to live in a range of inappropriate settings—child welfare offices, emergency rooms, hotels, and homeless shelters.
- Deinstitutionalization efforts in juvenile justice, increasing acuity levels within the child welfare population, and the failure to develop alternative placements capable of serving the children and youth previously in congregate care have compounded the crisis.
- The federal government must exempt Qualified Residential Treatment Programs (QRTPs) from classification as institutions for mental disease under Medicaid, amend the Family First Prevention Services Act to provide an exemption from QRTP standards for programs serving youth in the juvenile justice system, and significantly increase federal investment in developing alternative placements to congregate care that can capably serve and support older youth with higher levels of need.

Across the country, child welfare systems are struggling to find placements for children and youth in foster care—especially for those who are older and have higher levels of need. While bed shortages have long plagued child welfare systems, a confluence of issues has caused the problem to metastasize into a crisis. These issues include increasing levels of need within the foster care population, financial challenges facing direct service providers, and ideological shifts that have driven new legislative and regulatory requirements and new restrictions on funding and administrative decision-making.

The result is that states and counties are rapidly losing residential treatment and congregate care capacity while struggling to recruit and retain foster homes capable of serving higher-needs foster children. Consequently, foster children across the country are increasingly being housed in a range of temporary settings, including county and state offices, hospitals, hotels, and shelters. These placements' unsuitability and frequency have attracted significant press attention.

An August 2022 story in the *Philadelphia Inquirer* investigated the Philadelphia Department of Human Services' use of its conference rooms as temporary housing for foster children. According to its own data, the department has housed more than 300 kids in its offices for at least one night over the previous year. Most nights, 5 to 10 children with complex needs are sleeping in the "childcare room," where young children are commingled with teenagers. Safety concerns—including assault, vandalism, and trafficking—are rampant. Some children spend weeks if not months there. Children are likewise languishing for extended periods in other inappropriate settings such as emergency rooms and juvenile detention centers.[1]

Michigan is also suffering from a shortage of behavioral and psychiatric treatment programs. An August 2022 *Detroit News* article featured one 9-year-old foster child who spent at least 6 weeks in a hospital emergency department as he awaited placement. In the same article, the head of the Michigan Health and Human Services Department described the placement issue as "very pervasive."[2] The state is currently under federal court monitoring to develop corrective action to address these issues.

The crisis is perhaps most acute in Illinois, where, as reported by the Illinois Answers Project, the Illinois Department of Children and Family Services (DCFS) has documented since 2018 more than 2,000 cases of foster children being improperly held in inappropriate settings, including offices, shelters, and psychiatric hospitals. The DCFS director was held in contempt of court 12 separate times in 2022 for failing to provide an appropriate placement for foster children—the last finding centering on a 15-year-old girl who was held in a mental hospital for nearly 6 months while awaiting placement. Since 2015, the state has lost at least 460 children's residential treatment beds.[3]

In West Virginia and Montana, hundreds of foster youth have been sent to facilities out of state, where program quality is a concern, oversight is more difficult, and many have experienced unsafe and abusive situations, including improper restraint, isolation, and alleged sexual assault. According to West Virginia Public Broadcasting,[4] the lack of in-state youth mental health care is cited as a primary reason children are sent out of state. Likewise, in Montana, children are sent out of state due to bed shortages at in-state facilities, according to *Kaiser Health News.*[5]

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[1] Samantha Melamed, "Missing Kids, Illicit Activity: Staff Warn of Chaos at Philly DHS Office That Houses Stranded Kids," *Philadelphia Inquirer,* August 4, 2022, *https://pccyfs.org/missing-kids-illicit-activity-staff-warn-of-chaos-at-philly-dhs-office-that-houses-stranded-kids/*.

[2] Carol Thompson, "Foster Kids Spend Weeks Confined in Warren Hospital ER Awaiting Placement," *Detroit News,* August 4, 2022, *https://www.detroitnews.com/story/news/local/michigan/2022/08/04/michigan-foster-children-spend-weeks-confined-warren-hospital-emergency-room-awaiting-placement/10183856002/#:~:text=Foster%20kids%20spend%20weeks%20confined%20in%20Warren%20hospital%20ER%20awaiting%20placement&text=Warren%20%E2%80%94%20A%209%2Dyear%2D,did%20not%20need%20inpatient%20care.*

[3] David Jackson and Rachel Hilton, "Foster Children Held in Jails, Shelters—Workers Threatened, Attacked: A State Agency in Crisis," Illinois Answers Project, May 26, 2022, *https://illinoisanswers.org/2022/05/26/foster-children-held-in-jails-shelters-workers-threatened-attacked-a-state-agency-in-crisis/*.

[4] West Virginia Public Broadcasting, "West Virginia's Reliance on Out-of-State Group Homes Leaves Some Foster Kids in Unsafe, Abusive Situations," September 21, 2021, *https://wvpublic.org/west-virginias-reliance-on-out-of-state-group-homes-leaves-some-foster-kids-in-unsafe-abusive-situations/*.

[5] Cameron Evans, "Montana Is Sending Troubled Kids to Out-of-State Programs That Have Been Accused of Abuse," *Kaiser Health News,* March 24, 2022, *https://kffhealthnews.org/news/article/montana-troubled-teen-industry-medicaid-children-out-of-state-abuse-allegations/#:~:text=Nearly%20all%20the%20out%2Dof,and%20investigations%20by%20news%20organizations*.

These states are not outliers. Similar stories have emerged in Colorado,[6] Georgia,[7] New Mexico,[8] North Dakota,[9] Oregon,[10] Virginia,[11] and Washington,[12] among others.

Who Is Affected?

Of the nearly 400,000 children and youth who were in care on September 30, 2021, about one third are age 12 and older.[13] While placement shortages persist across child welfare systems, they are most acute for older children, especially those with behavioral health challenges. Foster parents rarely sign up to host a teenager, and unfortunately these youth are the least likely to be adopted. Kinship care can be a solution for many older youth who come into the system, as relatives are more likely to take them in. However, states must support these families in navigating the licensing process and ensure they have access to sufficient resources and services to adequately support the youth in their care. Both kinship and foster families struggle to access essential support services in adjacent child-serving systems such as education. For children and youth who do not have kin able to take them in, the options are few.

Due to the combination of the maltreatment they experienced prior to removal and the trauma associated with being in care, foster children experience significantly higher levels of mental and behavioral health challenges than their peers do. Adolescence is a time when mental and behavioral health challenges often manifest or compound. Older foster youth often require placements that can provide a higher level of support to address their needs.

Meanwhile, the severity of behavioral and mental health problems experienced by children and youth entering foster care has also been steadily increasing, due largely to three major factors. First, states have reduced the number of children and youth they take into foster care by more than 30 percent since 2000,[14] effectively raising the threshold for removal and increasing the likelihood that children coming into foster care have experienced extensive abuse, neglect, adverse childhood experiences, and associated traumas.

Second, the US is experiencing a broader youth mental health crisis.[15] Rates of self-reported depression, anxiety, self-harm, related emergency room visits, and suicides among American youth are all increasing. These trends are also reflected among children and youth in foster care. Finally, deinstitutionalization efforts in other systems have caused many states to close juvenile detention centers, funneling

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[6] Jennifer Brown, "Colorado County Leaders Blast State Officials over Concerns About Mental Health for Foster Kids," 9NEWS, September 22, 2021, *https://www.9news.com/article/news/health/mental-health/mental-health-foster-kids-colorado/73-0fc99ccb-8719-43e5-8baa-8e37d7f4e0f8.*

[7] Sam Whitehead, "High-Needs Foster Kids Sometimes Have to Sleep in Hotels or Offices. The Pandemic Made the Problem Worse," PBS NewsHour, May 31, 2022, *https://www.pbs.org/newshour/nation/high-needs-foster-kids-sometimes-have-to-sleep-in-hotels-or-offices-the-pandemic-made-the-problem-worse#:~:text=There's%20no%20nationwide%20count%20of,that%20hit%20health%20care%20facilities.*

[8] Ed Williams, "These Foster Kids Need Mental Health Care. New Mexico Is Putting Them in Homeless Shelters," Searchlight New Mexico, October 7, 2022, *https://searchlightnm.org/new-mexico-foster-care-rtc-teens/.*

[9] April Baumgarten, "Lack of Emergency Foster Care Means Some North Dakota Kids Must Stay in Hotels, Offices," InForum, June 4, 2022, *https://www.inforum.com/news/north-dakota/lack-of-emergency-foster-care-means-some-north-dakota-kids-must-stay-in-hotels-offices.*

[10] Libby Dowsett, "Lack of Placement Stability for Oregon Foster Youth Causes Traumatic Disruptions," Street Roots, October 13, 2021, *https://www.streetroots.org/news/2021/10/13/placement-stability.*

[11] Kate Masters, "Foster Kids are Getting Swept Up in Virginia's Mental Health Crisis," *Virginia Mercury,* May 9, 2022, *https://virginiamercury.com/2022/05/09/foster-kids-are-getting-swept-up-in-virginias-mental-health-crisis/#:~:text=By%3A%20Kate%20Masters%20%2D%20May%209%2C%202022%2012%3A02%20am&text=At%20the%20beginning%20of%20April,lack%20of%20available%20placement%20options.*

[12] Elizabeth Amon, "WA Foster System to Stop Housing Kids in Hotels, Offices. But Then What?", Crosscut, July 9, 2021, *https://crosscut.com/news/2021/07/wa-foster-system-stop-housing-kids-hotels-offices-then-what#:~:text=The%20proposed%20court%20order%20will,point%20list%20of%20treatment%20guidelines.*

[13] US Department of Health and Human Services, Administration for Children and Families, Children's Bureau. "The AFCARS Report."

[14] US Department of Health and Human Services, Administration for Children and Families, Children's Bureau. "Data and Statistics: AFCARS," June 28, 2022, *https://www.acf.hhs.gov/sites/default/files/documents/cb/afcars-report-29.pdf.*

[15] US Department of Health and Human Services, Office of the Surgeon General, "Protecting Youth Mental Health," 2021, *https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf.*

increasing numbers of youth who have previously been served in the juvenile justice system and cannot be sent home into the foster care system.

Historically, child welfare systems have placed a significant number of older children with mental and behavioral health challenges in a range of congregate care programs, from community group homes to more restrictive residential treatment programs.[16] In 2015, the US Department of Health and Human Services Children's Bureau published "A National Look at the Use of Congregate Care in Child Welfare," a brief examining congregate care data trends across the country. The authors found that, compared to their peers in foster care, children who are placed in congregate care are three times as likely to have a mental health diagnosis and six times as likely to have had a "child behavior problem" cited as a contributing factor to their removal from home.[17] More recent research indicates that approximately four in five children and youth in congregate care have a mental health diagnosis.[18] The federal brief found that nearly 70 percent of the children in congregate care were age 13 and older.[19]

As systems have steadily shed congregate care capacity, though, they have not developed suitable alternative placements to serve the children who have historically been placed in these programs. At the very time when higher proportions of children in foster care require placements capable of delivering intensive mental health services and supports, systems' capacity for meeting these needs has shrunk.

An Evolving Approach to Congregate Care

There is a consensus in the child welfare field that foster children generally have better outcomes when they are placed in family-based settings whenever safe and appropriate. Acting from this principle, most child welfare systems have significantly reduced the number and percentage of foster children placed in congregate care over the past 2 decades. According to the 2015 Children's Bureau brief, the use of congregate care by child welfare systems declined by 37 percent between 2004 and 2013.[20]

Some states and service-provider associations have also pushed congregate care providers to transform their program models away from long-term boarding toward short-term, intensive stabilization and treatment with aftercare services that follow the child back into family-based care. California began implementing its Continuum of Care Reform (CCR) in 2015. CCR was designed to ensure that foster children live in family-based care whenever possible and reenvisioned congregate care as a short-term, therapeutic intervention. The state phased out lower-level community group homes and created a new licensing category of short-term residential therapeutic programs that are required to provide integrated, specialized, and intensive services and supports to children whose needs cannot be met in family-based care. California also invested significant state resources in developing alternative placements for children and youth who had previously been served in group homes, including additional foster parent recruitment and retention and expansion of therapeutic foster care.

The transformation of congregate care's role in the child welfare continuum has been inconsistent across the country; a few states have even increased its use in recent years. Growing frustration with this uneven pace of progress to reduce congregate care has spurred advocates and policymakers to pressure states into further action.

The Federal Government Steps In

Driven by the goal of keeping foster children in family-based placements and strictly limiting the use of congregate care, national advocates and legislators teamed up to advance new federal restrictions. In 2013, the Annie E. Casey Founda-

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[16] Greg McKay and Naomi Schaefer Riley, "The Horrifying Misuse of Foster Care," Commentary, January 2022, *https://www.commentary.org/articles/greg-mckay/the-horrifying-misuse-of-foster-care/*.

[17] US Department of Health and Human Services, Administration for Children and Families, Children's Bureau, "A National Look at the Use of Congregate Care in Child Welfare," May 13, 2015, *https://www.acf.hhs.gov/cb/report/national-look-use-congregate-care-child-welfare.*

[18] Lindsey Palmer et al., "Rates of Emotional Disturbance Among Children in Foster Care: Comparing Federal Child Welfare Data and Medicaid Records in Two States," *Child Maltreatment* 29 (1): 8–13, (August 11, 2022), *https://pubmed.ncbi.nlm.nih.gov/35950631/*.

[19] US Department of Health and Human Services, Administration for Children and Families, Children's Bureau, "A National Look at the Use of Congregate Care in Child Welfare."

[20] US Department of Health and Human Services, Administration for Children and Families, Children's Bureau, "A National Look at the Use of Congregate Care in Child Welfare."

tion released a policy brief, "When Child Welfare Works," calling for "system disincentives" to "ensure that group care is used exclusively as a short-term treatment intervention." The foundation proposed eliminating federal reimbursement for all forms of congregate care for children under age 13, limiting the length of federal reimbursement for residential treatment to a maximum of 12 months for youth age 13 and older, and eliminating federal reimbursement for shelter care.[21]

In the same year, Senator Orrin Hatch (R–UT) introduced Senate Bill 1518,[22] which proposed similar new restrictions and time limits on federal reimbursement for congregate care programs. Two years later, Senator Hatch became chairman of the US Senate Finance Committee and began working closely with Senator Ron Wyden (D–OR), the committee's ranking member, on a bipartisan foster care reform effort. One of Hatch's primary objectives in this process was to impose the "system disincentives" proposed by the Casey Foundation to reduce congregate care.

In May 2015, the Senate Finance Committee held a hearing titled "No Place to Grow Up: How to Safely Reduce Reliance on Foster Care Group Homes." Much of the hearing comprised anecdotes to illustrate how congregate care programs were "warehousing" children who did not need to be there, frequently overmedicating or abusing them and profiting off them.[23]

Several factors led to the development of this misguided narrative. First, some states have done an inexcusably poor job of overseeing and regulating congregate care programs, and as a result, there have been cases of horrifying abuse and even death of children residing in these programs. Second, there was definitional confusion about "congregate care" and the differences among the various types of programs referred to with that umbrella term. As a result, many policymakers had a hard time differentiating among programs intended to serve as a step down from locked detention for juvenile offenders, programs providing round-the-clock intensive mental health services, and programs that provided for transition-age youth to live independently as they approached adulthood.

Family First Prevention Services Act Implications

Following the Senate Finance Committee hearing, Congress began work on what is now known as the Family First Prevention Services Act (FFPSA). When enacted in 2018, the law imposed new restrictions on federal funding for all forms of congregate care despite warnings from some states about potential unintended consequences, including placement shortages and youth crossing over into other systems. Whereas historically the federal government had reimbursed states through Title IV–E for a broad range of congregate care placements for children in foster care, FFPSA established a new category of congregate care programs—qualified residential treatment programs (QRTPs)—and required direct service agencies to meet specific standards to remain eligible for federal reimbursement.

With few exceptions, programs that did not offer a therapeutic model and meet QRTP standards would be ineligible for federal funding after 2 weeks of placement, including community group homes and programs designed to "step down" youth from the juvenile justice system back into the community. Though FFPSA was ostensibly modeled after California's CCR initiative—which, despite significant state investments, was already struggling to achieve its goals—the two initiatives had significant differences, including that FFPSA invests essentially nothing in the development of congregate care alternatives. Passage of FFPSA and the resulting establishment in 2021 of restrictions on federal reimbursement have led to significant further reductions in state congregate care capacity. At the same time, FFPSA also triggered a regulatory issue in the Medicaid program known as the institutions for mental disease (IMD) exclusion. Under the IMD exclusion, the federal government has historically prohibited Medicaid reimbursement for services to individuals under age 65 who are served in institutions with more than 16 beds that are primarily engaged in the "diagnosis, treatment or care of persons with mental disease."[24]

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[21] Annie E. Casey Foundation, "When Child Welfare Works: A Working Paper," October 23, 2013, *https://www.aecf.org/resources/when-child-welfare-works-a-working-paper.*

[22] Improving Outcomes for Youth at Risk for Sex Trafficking Act of 2013, Pub. L. No. 110–351.

[23] No Place to Grow Up: How to Safely Reduce Reliance on Foster Care Group Homes Hearing Before the Senate Committee on Finance, 114th Cong. (2015), *https://www.finance.senate.gov/hearings/no-place-to-grow-up-how-to-safely-reduce-reliance-on-foster-care-group-homes.*

[24] US Social Security Administration, "Compilation of the Social Security Laws," § 1905. *https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.*

When Congress established the QRTP licensing category for children's residential treatment programs under FFPSA, it drew the Centers for Medicare and Medicaid Services' attention to these programs, which generally use Title IV–E funding to pay for room and board and Medicaid to pay for health and behavioral health care. As a result, most of the therapeutic residential programs that meet QRTP standards to remain eligible for Title IV–E reimbursement under FFPSA have simultaneously had to reduce their capacity to 16 or fewer beds to ensure their patients remain eligible for Medicaid reimbursement. This has further reduced residential treatment facility capacity for foster children in states across the country.

These changes have exacerbated the fiscal challenges that congregate care programs have long experienced. While we often hear that congregate care programs "profit" off children, the vast majority are actually nonprofit organizations, and their contracts with public systems typically do not cover the full cost of care for their residents, meaning they are forced to raise private funds to sustain their operations. Inflation, staffing challenges, increased compliance costs, and rising insurance premiums have all placed enormous stress on the fiscal viability of many programs. Having to operate at further reduced capacity due to the IMD exclusion is causing many of these programs to either go out of business entirely or close their doors to the foster care system and focus the delivery of their therapeutic services on other child populations, such as unaccompanied minors or children with acute behavioral challenges who are covered through their parents' private insurance plans.

Meanwhile, without federal support to develop alternatives to congregate care, states have no other options, resulting all too often in inappropriate office, shelter, and hospital stays. By delegating responsibility to states to resolve the question of where to place children and youth who have historically been served in congregate care, the federal government has shirked its responsibility to ensure the safety and well-being of all children in foster care. It has also helped create the current situation in which some of the most vulnerable children and youth in the system are falling through the cracks.

Recommendations

In the 1950s and 1960s, the United States began the process of adult deinstitutionalization as a response to growing awareness about the poor living conditions experienced by many residents of the country's psychiatric hospitals and homes. Unfortunately, this mental health reform effort was severely flawed, largely due to the country's failure to simultaneously invest in the development of sufficient community-based alternatives to institutional mental health care and inability to properly distinguish which individuals can be served through community-based services and which cannot. The outcomes of this failure are well-documented and include significantly high rates of homelessness and criminal justice system involvement for individuals suffering from mental health issues. The United States is currently making the same deinstitutionalization mistake in the field of child welfare.

To avoid the worst outcomes for children in need of intensive mental health services and reverse the placement trends outlined in this report, the country needs to reimagine the role of congregate care within the child welfare system. In line with the broader goals of FFPSA, we offer the following immediate and actionable recommendations to ensure that residential treatment facilities provide short-term, intensive, and developmentally appropriate mental health stabilization and treatment to foster children with acute needs while addressing the law's unintended consequences.

- Congress should pass legislation exempting QRTPs from classification as IMDs under Medicaid. This would expand the availability of the high-quality residential treatment programs identified in FFPSA as crucial components of the child welfare continuum. Similar exemptions already exist for psychiatric residential treatment facilities and inpatient psychiatric services provided in psychiatric hospitals or in the psychiatric wings of general hospitals.
- Under FFPSA, the federal government now allows three types of non-QRTP congregate care programs to maintain IV–E eligibility beyond 2 weeks: programs serving pregnant and parenting youth, programs providing supervised independent living for non-minor dependents who are at least 18 years old, and programs focused on sexually trafficked children and youth. Congress should amend FFPSA to allow ongoing Title IV–E reimbursement eligibility for congregate care programs designed to serve youth in the juvenile justice system as a fourth exempted programmatic category, while regulating how states commingle this population with other foster youth who have not crossed over into juvenile justice.

- The federal government and states must significantly increase investment in the development of alternative placements capable of serving older youth or youth with behavioral challenges. This includes ensuring the availability and accessibility of intensive behavioral health services in community-based placements, expanding the therapeutic foster home model, and providing strategic foster parent recruitment and retention efforts to increase the availability of foster homes that will take in the children and youth who have historically been served in congregate care.

Sincerely,

Sean Hughes is a child welfare consultant and former congressional staffer.

Naomi Schaefer Riley is a senior fellow at the American Enterprise Institute.

Thea Ramirez is the founder of Adoption-Share.

Cassie Statuto Bevan is a former staff member of the Committee on Ways and Means, Subcommittee on Human Resources, US House of Representatives.

James G. Dwyer is the Arthur B. Hanson Professor of Law at the William & Mary Law School.

Elizabeth Bartholet is the Morris Wasserstein Professor of Law, emeritus, at Harvard Law School.

Marie Cohen is the author of the Child Welfare Monitor Blog.

Eloise Anderson is the retired secretary of the Wisconsin Department of Children and Families.

Herbie Newell is the president and executive director of Lifeline Children's Services.

Margaret Coyne is the co-founder and executive director of Advokids.

Lynn Johnson is the president of All in Fostering Futures and the former assistant secretary at the US Department of Health and Human Services Administration for Children and Families.

Sarah A. Font is an associate professor of sociology at Pennsylvania State University.

Emily Putnam-Hornstein is the John A. Tate Distinguished Professor for Children in Need at the University of North Carolina at Chapel Hill.

Greg McKay is the former director of the Arizona Department of Child Safety.

Bob J. Bruder-Mattson is the president and CEO of FaithBridge Foster Care.

Ronald E. Richter is CEO and director of JCCA and former New York City family court judge and commissioner of New York City's Administration for Children's Services.

Brett Drake is the Professor of Data Science for the Social Good in Practice at the Brown School of Social Work and Public Health, Washington University in St. Louis.

LETTER SUBMITTED BY TASCHA BABITCH

June 24, 2024

U.S. Senate,
Committee on Finance,
Dirksen Senate Office Bldg.,
Washington, DC 20510-6200.

Re: June 12, 2024 Committee Hearing: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

Dear Senate Finance Committee Members,

I am writing to you from Oregon. Thank you for prioritizing the critical issue of Residential Treatment Facilities (RTFs).

I am writing to ask you to recognize the barriers to paid family caregiving and their role in abuse and neglect in our nation's care network. Home and Community-Based Services (HCBS) current regulations (Section 1905(a)(24) of the Social Security Act, 42 CFR § 440.167, and 42 CFR § 441.105) prevent family caregivers from being paid

to provide care at home. This forces many families to place their loved ones in RTFs due to the lack of affordable care options.

During the COVID–19 pandemic, 39 states allowed parents and spouses to be paid caregivers through CMS waivers. This led to better care, fewer hospitalizations, healthier homes, reduced dependency on welfare, and increased tax revenue. The National Council on Disability supports making this change permanent.

CMS officials, including Dan Tsai, have acknowledged the benefits of paid family caregivers. However, current federal regulations remain a barrier. Congress must "ban the bans" on paid family caregivers and incentivize states to adopt this model.

This change is crucial to prevent the abuse and neglect often seen in RTFs and to support families in providing safe, effective care at home.

Appreciatively,

Tascha Babitch

STATEMENT SUBMITTED BY JULIEN BELAIR

Between April 28th, 2024 and May 2nd, 2024, I was a patient of two for profit medical organizations, Acadia and Universal Health Services. I received care at The Refuge: A Healing Place, owned and operated by Acadia, from 4/28/24–4/30/24. I suffer from complex posttraumatic stress disorder as a result of compounded childhood trauma, and was seeking specialized care. The Refuge advertises itself as such a center and I had been in contact with them for around 2 years. Specifically, they state provide high-quality care to people living with PTSD, including its more difficult manifestations, including suicidal ideation.

I traveled to Ocala, FL and was admitted to the Refuge on April 28th. A release of information was completed for multiple health care providers, including my primary care provider, psychiatrist, and therapist. An additional ROI was completed for my wife, Jaime Lawson. A majority of my medications were approved for my stay, with the exception of my diazepam prescription. This medication has been prescribed by my psychiatrist for a number of years, and is used to assist with panic and sleep as needed. The Refuge did not provide my diazepam with my other medications, instead opting to prescribe risperidone, which I do not react well to. As a result, from 4/28/24 to 4/30/24, I was unable to sleep more than 4 hours, mostly being able to sleep through pure exhaustion.

By the very early morning of 4/30/24, I began to experience suicidal ideation as a result of this sleep deprivation. I informed the nursing staff, who brought me to another room. I believed they were helping me deescalate, as they advertise themselves as a center willing and equipped to do so. Instead, I was approached by two armed police officers and coerced into transferring care to the Vines Hospital, an organization owned by Universal Health Care.

I remained at the Vines Hospital from around 3:00 AM on 4/30/24 until around 12:00 PM on May 2nd, 2024. The nursing and patient care staff at the Vines Hospital were belligerent to patients and concealed their identity, providing false names and hiding their ID pages from patients. After consultation between mental health providers and my wife, I was allowed to leave the Vines Hospital on 5/2/24. I was not allowed to leave the facility until my wife could prove to staff that a flight from Florida to Virginia had been purchased. The Refuge declined to readmit me. This caused a significant financial burden to my family that is still impacting us.

All of my belongings were supposed to be returned to me upon discharge from the Vines Hospital. Both facilities collaborated to return my belongings. However, the only items returned to me were the initial contents of my suitcase. My medications and my cell phone were not among my belongings. I was able to rely on the kindness of strangers and public payphones as I traveled from Florida to Virginia, as the only method of communication to my wife. I returned home without my cell phone, my toiletries, or medications, which of course, caused symptoms of withdrawal.

My cell phone and toiletries had been held by the Vines Hospital after discharge without my knowledge. I requested that the Vines Hospital mail these items to my residence. I received pushback, with the facility requesting I travel to reclaim my belongings despite the considerable distance and expense that had occurred as a result of the discharge. In the end, they did return my items, placing them all in one

shipping box. This has caused damage to my cell phone as loose toiletries bent my device and weakened its hinges.

My medications were not returned, as the Refuge had declined to even provide them to the Vines Hospital. As a majority of my medications were not on their "discharge" list, they initially refused to ship my medications. I had to engage with law enforcement to receive my medications, calling the local sheriff's office for assistance. I informed them that the Refuge was holding on to a number of my medications, including my Otezla, with a total combined cost of over $5,760 in medications not returned to me. The Refuge finally did mail my medications to me after this call, with the gap between discharge and medication return spanning about a week and a half. Without access to my medications, I experienced withdrawal from my psychiatric medications and experienced severe flare ups of my psoriasis and psoriatic arthritis.

Lastly, the Refuge has refused to communicate after my discharge. I was informed that I would potentially be entitled to a refund for services 30 days after discharge. As of the writing of this letter, no refund has been received, and the financial counselor employed by the Refuge, Mike Weed, has not responded to me or my wife regarding said refund, either by email or phone call. Additionally, despite the patient handbook stating that I am entitled to my medical records, the medical records administrator will not respond to calls from myself or my wife and are not accessible from the online portal. During my inpatient stay and after, my wife was never able to reach the medical director or my case manager, with all calls going to voicemail. Lastly, the ethics complaint portal provided to address patient concerns specifies a 7 day turnaround for submitted complaints. An initial complaint was logged the week of May 6th, and as of the writing of this letter, there has been no response from the Refuge or Acadia.

STATEMENT SUBMITTED BY ERIC BILOTTI

Regarding Senate Finance and Senate HELP Investigation Into
Acadia, Devereux, Universal Health Services, and Vivant

My name is Eric Bilotti and I am a former resident of Devereux. I am testifying about the rampant violence and abuse that occurs within institutions like Devereux, Acadia, Universal Health Services, and Vivant. These experiences have had profound impacts on my life and the lives of countless others.

I am here to provide testimony regarding the pervasive violence and abuse within residential treatment centers managed by Acadia, Devereux, Universal Health Services, and Vivant. As a former resident of Devereux, I have firsthand experience of the systemic failures that allow such environments of brutality to persist. My testimony will focus on specific instances of staff-on-student violence, student-on-student violence, and the sexual violence I personally endured.

These institutions, which are meant to provide therapeutic care and protection, have instead become breeding grounds for aggression and trauma. The psychological and physical impacts of these experiences are profound and long-lasting. It is imperative to address these issues with the urgency they demand.

I aim to highlight the critical need for reform in these facilities. The systemic abuse and neglect must be confronted and eradicated to protect current and future residents. Through my testimony, I hope to advocate for measures that ensure the safety, dignity, and proper care of vulnerable individuals in these settings. The Committee's investigation into these institutions is a monumental step towards accountability and change, and I am honored to contribute to this crucial effort.

I am here today as a survivor, bearing witness to the horrors that have unfolded within the walls of Devereux. I stand before you to shine a light on the darkness, to unveil the atrocities of the violence, and the deeply disturbing instances that have scarred countless lives, including my own.

I speak not just of statistics and reports, but of the raw, gut-wrenching experiences that I and others have endured within these institutions. I recall the terror in the eyes of my fellow residents as they were subjected to the brute force of staff members who wielded power without compassion. I have witnessed firsthand the detrimental effects of staff-on-student violence while I was a resident at one of these institutions. The use of excessive force by staff members resulted in physical and emo-

tional harm, leaving lasting scars on those who were supposed to receive care and support.

Additionally, incidents of student-on-student violence were alarmingly common within the facility. The lack of adequate supervision and intervention allowed for these incidents to occur unchecked, creating an environment of fear and insecurity among the residents.

During my time at Devereux, I witnessed and experienced extreme violence. One harrowing incident involved staff-on-student violence where I saw a child have his teeth knocked out by supervisors. The brutality of this act was not an isolated event but a manifestation of the pervasive culture of abuse within the institution. Staff members frequently resorted to physical aggression to exert control over the students, often leading to severe injuries. The psychological impact of witnessing such violence was profound, instilling a pervasive sense of fear and helplessness among the residents.

This environment of constant threat and violence created a toxic atmosphere, where the students were perpetually on edge. The staff's use of force was not merely disciplinary but punitive, often escalating to levels of excessive cruelty. The normalization of such brutality eroded any sense of safety and trust within the institution. The trauma inflicted by these violent encounters was compounded by the lack of supportive and therapeutic interventions. As a result, the emotional and psychological well-being of the residents was severely compromised, leading to long-term detrimental effects on their mental health.

In another distressing episode, I observed a student-on-student altercation in which one student violently assaulted another, resulting in a traumatic head injury. The lack of adequate supervision and intervention during these incidents was glaringly evident. The aggressor repeatedly struck the victim with a pitcher, knocking him out and splitting his head.

The absence of timely intervention by staff members allowed the situation to escalate to a dangerous level. This incident highlighted a significant failure in maintaining a safe and controlled environment for the residents. The injured student was left to suffer without immediate medical attention, exacerbating the physical and psychological trauma.

The inadequate response from the institution's personnel reflected a systemic issue of negligence and disregard for resident safety.

This event, like many others, underscored the pervasive environment of violence and chaos within the institution. The failure to prevent and address such violent episodes contributed to an atmosphere of fear and instability among the residents. The long-term psychological impact on both the victim and witnesses of such brutality cannot be overstated; it fostered a deep sense of insecurity and mistrust in the institution's ability to protect its residents.

The assault was not an isolated incident but part of a pattern of pervasive abuse that was allowed to fester within the institution. The lack of effective monitoring and intervention by the staff facilitated an environment where such violations could occur with alarming frequency.

The trauma from this violence profoundly impacted my mental health. The betrayal of trust, both from the perpetrator and the institution that failed to protect me, was deeply destabilizing. This experience left me feeling vulnerable, powerless, and profoundly unsafe in a place that was supposed to provide care and protection.

The institution's inadequate response further compounded the trauma, as there was little to no support offered to survivors. The absence of appropriate therapeutic interventions exacerbated the emotional and psychological damage, leaving long-lasting effects on our ability to trust and form healthy relationships.

The pervasive culture of neglect and abuse within the institution underscored the urgent need for systemic reforms to ensure the safety and well-being of all residents. The scars from this ordeal are a stark reminder of the profound failures of the system meant to protect vulnerable individuals.

The environment at Devereux was one where violence and abuse were normalized, and the well-being of the residents was consistently compromised. This toxic culture permeated every aspect of daily life, creating an atmosphere of perpetual fear and anxiety. The normalization of physical and psychological abuse eroded any sense of safety or stability for the residents.

Incidents of violence were often ignored or inadequately addressed by the staff, reinforcing a sense of helplessness and despair among the residents. The lack of appropriate therapeutic interventions further compounded the trauma, leaving many, including myself, to suffer in silence.

These experiences have had long-lasting effects a manifesting as chronic anxiety, depression, and post-traumatic stress disorder. The enduring psychological scars are a testament to the profound failures of the institution to provide a safe and nurturing environment. This highlights the urgent need for systemic change within such institutions to prevent further harm and ensure the protection and well-being of vulnerable individuals.

Comprehensive reforms are necessary to address the deep-seated issues within these facilities and to promote a culture of care and accountability. Furthermore, I myself have been a victim of sexual violence perpetrated by other students within the institution. This traumatic experience has left me with deep emotional scars and a sense of betrayal by the very system that was supposed to protect and rehabilitate individuals like myself.

I stand before you today with a heavy heart, burdened by the weight of these memories, but also with a fierce determination to demand justice and accountability. Each recollection of the abuse and neglect I endured and witnessed fuels my resolve to advocate for systemic change.

I testify not only for myself but for all those who have been silenced by fear and shame, their voices stifled by a pervasive culture of intimidation and repression. Their stories, like mine, are marked by profound suffering and a desperate need for recognition and redress.

I testify because I refuse to let their suffering be in vain, knowing that their pain demands acknowledgment and action. By speaking out, I aim to illuminate the dark corners of these institutions where abuse thrives unchecked. I believe that by sharing our experiences, we can spark a revolution of empathy and compassion that will shake these institutions to their core.

This revolution is not just about reforming policies but about fundamentally changing the culture of care and protection within these facilities. It is about creating an environment where safety, dignity, and respect are paramount. I stand here with the hope that our collective voices will lead to a future where such atrocities are no longer tolerated, and where every resident is treated with the humanity and compassion they deserve.

I implore the Senate to listen to our voices, to heed our cries for help, and to take decisive action to root out the rot that festers within these walls. The pervasive abuse and neglect that we have endured cannot be ignored or minimized any longer. We cannot afford to look away, to turn a blind eye to the suffering of our fellow human beings, whose lives have been irreparably harmed by the systemic failures of these institutions.

We must confront the darkness head-on, acknowledging the full extent of the atrocities committed. Armed with nothing but the light of truth, we have the power to expose the injustices that have been hidden for far too long.

It is imperative that we hold those responsible accountable for their actions and implement comprehensive reforms to prevent further abuse. The unwavering resolve to make things right must drive us to enact policies that prioritize the safety and well-being of all residents. We must ensure that these institutions are transformed into places of genuine care and support.

The time for complacency is over; the time for action is now. I urge you to take these necessary steps to bring about lasting change and to restore hope to those who have suffered in silence.

It is not enough to simply acknowledge the existence of these horrors; we must take concrete steps to prevent them from ever happening again. I urge the Senate to implement comprehensive reforms that prioritize the safety and well-being of all individuals within these institutions. This includes establishing stringent oversight mechanisms to ensure that all facilities are regularly inspected and held accountable for their practices.

Implementing mandatory training programs for staff on trauma-informed care and non-violent crisis intervention is essential to fostering a safe and supportive environment. There should also be robust channels for residents to report abuse without fear of retaliation, ensuring their voices are heard and acted upon promptly.

Additionally, creating independent review boards to investigate allegations of abuse and misconduct can provide an impartial assessment and ensure justice is served.

Establishing clear, enforceable standards for care that emphasize respect, dignity, and human rights is vital to transforming the culture within these facilities. Collaboration with advocacy groups and survivors in developing these reforms can provide valuable insights and ensure that the measures implemented are effective and comprehensive.

Finally, continuous monitoring and evaluation of these reforms will be necessary to ensure their ongoing effectiveness and to make adjustments as needed. By taking these steps, we can create a system that genuinely protects and supports the vulnerable individuals entrusted to its care.

These bodies must be empowered to operate autonomously, free from institutional biases, and have the authority to enforce corrective actions. It means providing adequate resources for staff training in trauma-informed care and de-escalation techniques, equipping them with the skills necessary to manage challenging situations with compassion and professionalism.

Comprehensive training programs and regular certification should be mandatory and regularly updated to reflect best practices in mental health care and crisis intervention. Additionally, implementing robust reporting mechanisms is crucial to hold perpetrators accountable for their actions, ensuring that all allegations of abuse are thoroughly investigated and addressed.

These mechanisms must guarantee confidentiality and protection for whistleblowers, encouraging residents and staff to come forward without fear of retribution. Furthermore, establishing a transparent system for tracking and reporting incidents of abuse can help identify patterns and prevent future occurrences.

Adequate mental health support services should be readily available to all residents, providing them with the necessary resources to heal and recover from trauma.

Integrating feedback from residents and their families into policy development can ensure that the reforms are responsive to their needs and experiences.

Collaboration with external experts and advocacy groups can also enhance the effectiveness of these measures, bringing in diverse perspectives and expertise.

Access to legal assistance should be provided to help residents navigate any legal challenges related to their abuse.

By committing to these comprehensive reforms, we can create a safer, more humane environment that prioritizes the dignity and well-being of all individuals within these institutions.

In closing, I would like to express my deepest gratitude to the Senate Finance and Senate HELP Committees for affording me the opportunity to share my story today. Your willingness to listen and engage with these difficult issues gives me hope for meaningful change.

I pray that my testimony will serve as a catalyst for change, inspiring you to take bold and decisive action to ensure that no one else suffers the horrors that I and so many others have endured. The lives and well-being of countless individuals depend on your leadership and commitment to justice.

Your consideration of these matters and solutions is not only appreciated but essential to the cause of justice and humanity. I sincerely hope that the stories and suggestions shared here today will lead to substantial reforms that protect and support the most vulnerable among us.

Thank you, Chairman Wyden, and the entire Committee, for your dedication to addressing these critical issues. Your efforts to create a safer, more compassionate system are invaluable.

Please know that your actions have the potential to bring about profound and lasting change.

LETTER SUBMITTED BY ALLAN BOUQUIN

June 24, 2024

U.S. Senate,
Committee on Finance,
Dirksen Senate Office Bldg.,
Washington, DC 20510–6200.

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

Dear Senate Finance Committee Members,

I am writing to you from New York. Thank you for prioritizing the critical issue of Residential Treatment Facilities (RTFs).

I am writing to ask you to recognize the barriers to paid family caregiving and their role in abuse and neglect in our nation's care network. Home and Community-Based Services (HCBS) current regulations (Section 1905(a)(24) of the Social Security Act, 42 CFR § 440.167, and 42 CFR § 441.105) prevent family caregivers from being paid to provide care at home. This forces many families to place their loved ones in RTFs due to the lack of affordable care options.

During the COVID–19 pandemic, 39 states allowed parents and spouses to be paid caregivers through CMS waivers. This led to better care, fewer hospitalizations, healthier homes, reduced dependency on welfare, and increased tax revenue. The National Council on Disability supports making this change permanent.

CMS officials, including Dan Tsai, have acknowledged the benefits of paid family caregivers. However, current federal regulations remain a barrier. Congress must "ban the bans" on paid family caregivers and incentivize states to adopt this model.

This change is crucial to prevent the abuse and neglect often seen in RTFs and to support families in providing safe, effective care at home.

Appreciatively,

Allan Bouquin

LETTER SUBMITTED BY JUSTIN BUELL

June 25, 2024

U.S. Senate,
Committee on Finance,
Dirksen Senate Office Bldg.,
Washington, DC 20510-6200.

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

Dear Senate Finance Committee Members,

I am writing to you from Idaho. Thank you for prioritizing the critical issue of Residential Treatment Facilities (RTFs).

The reasons why family caregiving is important to me, is that I get to teach my daughter therapies that we learn, it keeps her in environment that she feels comfortable in, keeps her from being exposed to germs due to having a permanent IV line in her chest. Allows me to be able to take her to all her doctor appointments and therapies without missing work. She requires 24–7 care due to her medical conditions.

I am writing to ask you to recognize the barriers to paid family caregiving and their role in abuse and neglect in our nation's care network. Home and Community-Based Services (HCBS) current regulations (Section 1905(a)(24) of the Social Security Act, 42 CFR § 440.167, and 42 CFR § 441.105) prevent family caregivers from being paid to provide care at home. This forces many families to place their loved ones in RTFs due to the lack of affordable care options.

During the COVID–19 pandemic, 39 states allowed parents and spouses to be paid caregivers through CMS waivers. This led to better care, fewer hospitalizations, healthier homes, reduced dependency on welfare, and increased tax revenue. The National Council on Disability supports making this change permanent.

CMS officials, including Dan Tsai, have acknowledged the benefits of paid family caregivers. However, current federal regulations remain a barrier. Congress must "ban the bans" on paid family caregivers and incentivize states to adopt this model.

This change is crucial to prevent the abuse and neglect often seen in RTFs and to support families in providing safe, effective care at home.

Appreciatively,

Justin Buell

LETTER SUBMITTED BY CHRISTINA BUTTONS

June 25, 2024

U.S. Senate,
Committee on Finance,
Dirksen Senate Office Bldg.,
Washington, DC 20510–6200.

Dear Senate Finance Committee,

I hope this hearing will be open to a range of perspectives, including those who benefitted from placement in a residential treatment center as a teen, like I did.

Adolescence was very difficult for me, as I did not receive my Asperger's syndrome diagnosis until adulthood. I struggled in school and had trouble making friends, which led to worsening depression and low self-esteem. By age 15, my relationship with my parents deteriorated, and my mental health took a severe downward spiral. I became anorexic, started cutting myself, dealt with obsessive compulsive disorder (OCD), and began experimenting with drugs and associating with other teens who used drugs. All of these struggles reached a critical point when I was sexually assaulted by a man in his forties, which led to my suicide attempt.

My parents tried everything to help me. I saw therapists and psychiatrists and was in short-term programs, including inpatient psychiatric facilities, outpatient treatment programs, and group homes. When my parents needed to find longer-term care, I was initially placed in less restrictive facilities closer to home in California, which I promptly ran away from. Then I was placed in a wilderness program in Idaho, which I refused to participate in. This led to my final placement in a lockdown residential treatment center called Provo Canyon School (PCS) in Orem, Utah. It was a difficult decision for my parents to make, but I needed a higher level of care than they could provide at home. My Individual Education Plan (IEP) helped place me in PCS for one year and two weeks, from October 2004 to October 2005, when I was 15–16 years old.

There was a very difficult adjustment period at the beginning of my stay at PCS. It was strict, and there were a lot of rules. I learned quickly that my actions had consequences. The program was very structured, which was challenging at times, but overall, it was beneficial for me. I felt my depression lessen because I was working towards a goal and had less time to ruminate on negative thoughts. Over the course of the year I was there, I advanced through the various levels of the program and reached a high status, which bolstered my self-esteem.

I had good relations with the staff; I felt that they were caring, and I had a great therapist whom I liked and felt cared about me and his other patients. I received weekly individual therapy and participated in various weekly group therapy sessions. I learned valuable coping skills and cognitive behavioral therapy, which was extremely helpful in challenging my negative self-talk.

The education component was sufficient, allowing me to resume my high school studies seamlessly upon returning home. I saw a psychiatrist for medication adjustments and was never forced to take medications I did not agree to. As a vegetarian, I was provided with vegetarian alternatives for all meals. I participated in the work program and was paid minimum wage, and I was also expected to keep my room and living area tidy. These were reasonable expectations and never felt forced.

I had regular contact with my family. I could write and receive letters from them and other approved contacts. I had weekly phone calls with my parents, and they visited me several times. Once I reached a certain status, I could participate in off-campus trips, including rock climbing, attending a local theater's Shakespeare play, and sorting cans of food at a food drive for the homeless.

Overall, I learned that I needed to be accountable for my actions and that I had control over my life. Understanding that my actions had led me to where I was proved extremely helpful. It gave me an internal locus of control that I desperately needed, instead of blaming my circumstances on external factors.

I felt safe and witnessed no abuse of any kind. When students became unruly and violent, interventions such as restraint and seclusion were used appropriately based on their behavior. In each case, the behavior warranted these measures. From my perspective, these interventions were meant to ensure the safety of everyone, including the individual, the staff, and the other residents.

I want to make it clear that I did not enjoy being there, but treatment is not meant to be enjoyable. It was extremely difficult but necessary rehabilitation. There is a high probability that I would not be alive today without this treatment. I am grateful for facilities like Provo Canyon School, and I hope they will continue to provide care for individuals facing similar challenges.

I urge the committee to consider the diversity of experiences in residential treatment centers and the potential life-saving impact they can have. Thank you for your attention to this matter.

Sincerely,

Christina Buttons

STATEMENT SUBMITTED BY REBECCA CAINE

I was a child in one of these facilities for 22 months starting in 1995.

My parents packed me in a car between 2 large men, not telling me where I was going and dropped me off there. They had no idea the horror I would be facing. The religious indoctrination, the sexual abuse, the fear mongering, the isolation, the maggots in our food daily, the medical neglect, the lack of education.

All of the abuse we suffered while being told our parents asked for us to be put through this because we were bad children who needed to be changed.

Please put a stop to these places! There's not even CPS oversight of them because they are supposed to be self reporting.

It's terrifying!

CHILD WELFARE LEAGUE OF AMERICA
727 15th Street, NW, Suite 1200
Washington, DC 20005

Chairman Wyden, Ranking Member Crapo, and Members of the Senate Committee on Finance, thank you for the opportunity to submit this statement for the record.

The Child Welfare League of America (CWLA) is a coalition of hundreds of private and public agencies that, since 1920, has worked to serve children and families who are vulnerable. Our expertise, leadership and innovation on policies, programs, and practices help improve the lives of millions of children across the country. Our impact is felt worldwide.

We thank the Committee and Members for the hearing held on Wednesday, June 12, 2024, and the accompanying report, "Warehouses of Neglect: How Taxpayers are Funding Systemic Abuse in Youth Residential Treatment Facilities." We are grateful for the Committee's investigative efforts and the comprehensive documentation and reporting of the abuses found. The safety of children is paramount and is a fundamental requirement for successful treatment of mental and behavioral health concerns. Our hope is that this report, the hearing, and the subsequent testimony submitted will lead to increased safety for all children and youth, and particularly for the children and youth in residential treatment programs.

As the nation's oldest and largest child welfare membership organization, CWLA has developed 13 volumes of Standards of Excellence in Child Welfare, covering a range of services and programs in the child welfare field. For 70 years, CWLA's Standards have played a unique national role in shaping quality child welfare practice. They have been a foundational tool for improving the national child welfare system, guiding policymakers, practitioners, advocates, and the broader public. The Standards are widely accepted as the foundation for sound U.S. child welfare prac-

tice. The CWLA Standards of Excellence in Residential Services encompass all aspects of residential care, from service delivery to staffing to improved services both before and after residential care.

In addition to the Standards of Excellence, CWLA published the National Blueprint for Excellence in Child Welfare in 2013. The National Blueprint "presents a vision for the future of child welfare that all children will grow up safely in loving families and supportive communities."[1] This Blueprint is intended to drive change and to spur communities and agencies to pursue improvement and reform. It also forms the foundation for current and future updates to the Standards.

The Role of Residential Treatment Services

The Blueprint states that children have the right to health care.

> "***Children should have access to quality health care.*** *Each child should be provided with health care based on practical, scientifically sound, methods, and technology. Health care should include promotion of health, early diagnosis of disease or disability, prevention of disease, immunizations, access to medicines, when needed, regular check-ups, dental care, and behavioral health care. Health care should be accessible, age-appropriate, and responsive to the child's culture. No child should be denied access to these resources for a healthy childhood*.[2]

In order to meet the mental and behavioral health needs of our children and youth, there must be a robust and sufficient amount of high-quality and developmentally-, culturally- and trauma-responsive mental health and behavioral health prevention, community-based services that include early identification and treatment services, 24/7 respite and crisis intervention services, intensive in-home treatment services and when it is needed, high quality trauma-responsive 24-hour residential treatment interventions.

"The primary purpose of residential services is to provide specialized therapeutic services in a structured environment for children with special developmental, therapeutic, physical, or emotional needs."[3] CWLA agrees with the testimony of expert witness Ms. Manley:

> "Residential treatment facilities have an important role in the provision of care for young people with complex behavioral health care needs when they have a clinical or behavioral health treatment need that cannot be met in a family and community setting due to the intensity of their treatment and supervision needs. In those instances, we need the care to be delivered in trauma-responsive environments that embrace parent and caregiver engagement throughout the treatment intervention and continually focus on best practice. These residential treatment facilities can have a significant benefit to the young person and their family." (From Ms. Manley's written testimony.)

Residential services are a small but important part of the full array of services. "[Residential] Services and programs today are viewed as part of a comprehensive, integrated system designed to support and assist families and ensure safety, permanency, and well-being for children."[4]

There are many providers and programs providing or striving to provide trauma-responsive, time-limited, effective residential care. They are informed by the emerging literature highlighting promising practices in residential interventions:

> "[A]ssociated with positive benefits, such as: actively engaging youth and families, ensuring active school and community connection, and keeping residential intervention as short as possible (Blau, Caldwell & Lieberman, 2014; Frensch & Cameron, 2002; James, 2011; James, Zhang, & Landsverk, 2012; Nofle et al., 2011). Exemplary leaders are not only heeding this information, they are becoming ". . . the new generation of passionate, hard-working leaders willing to 'do whatever it takes' to build a new model for residential . . ." (Blau, Caldwell & Lieberman, 2014, p. 228). They are taking bold action to improve their service and achieve better results. They are

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[1] CWLA National Blueprint for Excellence in Child Welfare. Child Welfare League of America. Washington, DC 2013. P. 1.
[2] *Ibid.,* p. 30.
[3] Child Welfare League of America. CWLA Standards of Excellence in Residential Services. Washington, DC 2004. P. 20.
[4] *Ibid.,* p. 2.

> creating meaningful, positive outcomes by: promoting time spent at home and in the community (Huefner, Pick, Smith, Stevens, & Mason, 2015); minimizing lengths of stay; engaging families during and after residential intervention (Casey Family Programs, 2016); and actively supporting staff and persons-served in relevant, important ways (Blau, Caldwell & Lieberman, 2014; Levison-Johnson & Kohomban, 2014)."[5]

The Building Bridges Initiative developed a guide, *Implementing Effective Short-Term Residential Interventions,* produced by the Building Bridges Initiative with funding from the Annie E. Casey Foundation to provide residential intervention providers and state oversight agencies with information about the key strategies for effectively transforming residential interventions to deliver quality shorter-term 24-hour residential interventions and provided examples of agencies that have been implementing the essential elements, which are effective leadership, family and youth engagement and inclusion, workforce development, practice strategies and tools, using data to inform practice, quality improvement, and fiscal strategies.[6]

The following agencies illustrate the elements with examples of actions they have taken: The Children's Village (New York), KVC Health Systems (Kansas), Sweetser (Maine), Damar Services (Indiana), Kairos (Oregon), Youth Development Institute (YDI) (Arizona), Excelsior Youth Centers, Inc., (Colorado), Warwick House (Pennsylvania), Catholic Charities (Maryland), and Epworth Children and Family Services (Missouri).[7]

CWLA's Standards note that residential treatment should be family-centered:

> "Family-centered practice is at the heart of good residential services. According to a GAO report, one of the key elements to a successful residential care program was the involvement of family members in the formal treatment approach (1994). Family involvement is important in achieving family reunification and helping children and families maintain an optimum level of reconnection."[8]

We aspire to someday have a mental and behavioral health service system in which all children and families have access to the services they need in their homes and at the time that they need them, and thereby reduce and potentially eliminate the need for any type of 24-hour residential intervention, however, society is still far from achieving this goal. Until such time as the full array of high-quality and developmentally-, culturally- and trauma-responsive mental health and behavioral health services—including prevention, community-based services that include early identification and treatment services, 24/7 respite and crisis intervention services, intensive in-home treatment services—exist and are easily and readily accessible in the communities in which the families live, high quality trauma-responsive 24-hour residential interventions are still needed.

The Report Findings and Recommendations

The findings of the report raise vital concerns about the way that behavioral health services are sometimes provided to children and youth. The young people highlighted in the report and in the testimonials offered on film and in documents submitted to the Committee too often come to these residential treatment programs when families feel they have nowhere else to turn to help the most important part of their lives, their child.

The instances of abuse outlined in the report, including physical abuse, sexual abuse, and improper and harmful use of restraint and seclusion, are evidence that there is significant need for reform to provide the care that our children and youth deserve. The CWLA National Blueprint states that children have a right to be protected from abuse:

> "***Children must be protected from abuse, neglect, maltreatment, exploitation, and abduction.*** *These rights include protection from all forms of child abuse, neglect, exploitation, and cruelty, including the right to special protection in times of war . . . It is the responsibility of governments to legislate these protections and enforce societal adherence to its responsi-*

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[5] Building Bridges Initiative, (2017). Implementing Effective Short-Term Residential Interventions: A Building Bridges Initiative Guide, *https://buildingbridges4youth.org/wp-content/uploads/2022/05/BBI-Short-Term-Residential-Intervention-Guide1.pdf.*

[6] *Ibid.,* p. 1.

[7] *Ibid.*

[8] Child Welfare League of America. CWLA Standards of Excellence in Residential Services. Washington, DC 2004. P. 22.

bility to protect children. It is also the responsibility of governments to intervene on behalf of children when parents or other caregivers violate their rights to protection.[9]

There are steps that Congress can take to address the issues raised in the report. CWLA emphasizes that strong investment is needed to make any real progress; Chairman Wyden, Ranking Member Crapo, and Members of the Committee expressed an interest in bipartisan solutions—until Congress fully funds and incentivizes community- and home-based care for everyone who needs it, regardless of the type of insurance coverage they have, there will be no true improvement in the overall well-being of our nation's children and youth. Any bipartisan solution or agreement will need to include significant new funding.

We wish to offer comments and recommendations in the following areas.

Lack of sufficient range of high-quality community-based mental and behavioral health prevention, early intervention and treatment services.

As was mentioned by Committee members during the hearing, our nation has failed to live up to the promise of President Kennedy's 1963 Community Mental Health Act, which was meant to deinstitutionalize mental health services and create a community-based alternative. While we have largely closed the large facilities and hospitals that existed in the 1960s, we have not succeeded in replacing them with the needed robust array of services in the community. Sixty-one years later, it is time for Congress to make fulfilling this promise a national priority.

There is a significant lack of mental and behavioral health services for children, youth, and their families across the nation, and even where they exist, these services can be difficult to access due to issues such as the lack of providers with the relevant expertise and in the geographic areas where they are needed, low payment rates, Managed Care limited provider networks, insurance reimbursement barriers, and long wait times. Without a robust array of developmentally-, culturally- and trauma-responsive services that are accessible when and where they are needed it is impossible to address the growing mental health and behavioral concerns of all children and youth in this country. This lack of services makes it difficult for caregivers and child welfare agencies alike to access the services needed for children and youth in their care.

The National Blueprint also recognizes the rights and responsibilities of parents, maintaining that parents are typically the most qualified to ensure the rights and needs of their children are met:

The rights of children cannot be advanced in isolation. Rather, children's rights must reflect and respect the critical roles and responsibilities of the parents and family members who care for them. In most instances, parents are uniquely qualified to advance the rights of children and to act in their best interest. As such, parents are afforded the right to raise their child according to their beliefs; however, they may not violate the fundamental rights of that child. As such, the rights of children and parents are interconnected. It is the responsibility of every parent, family, and caregiver to recognize and protect children's rights, and it is the responsibility of individuals and entities to work together to give families/parents optimum tools, supports, and opportunities so that they can fully assume responsibility for advancing the rights of their children.[10]

CWLA affirms that parents should be afforded every opportunity to provide and care for their children and youth in their homes. Our child- and family-serving systems must prioritize children remaining in their homes whenever it is safe for them to do so; to fully protect this right, parents and caregivers must have full and complete access to mental and behavioral health services when and where they need them.

Recommendation: The Committee should invest in and support the full array of services offered by the behavioral health system, address barriers to accessing existing services, fund the expansion of options available through Medicaid, and expand funding for prevention related services accessible for all children, youth, and their families in the Mental Health Block Grants which currently are restricted for the population of children and youth with a serious emotional disturbance/disorder. This

[9] CWLA National Blueprint for Excellence in Child Welfare. Child Welfare League of America. Washington, DC 2013. Pp. 31–32.
[10] *Ibid.,* p. 26.

investment will help ensure children and families are getting the help when they need it in their homes and communities and reduce the need for any care or treatment outside of the home and reduce any unintended consequences.

Recommendation: Ensure that commercial insurance plans cover the full range of effective children's mental and behavioral health services. Although children and youth in foster care are Medicaid eligible, 54% of the children and youth in the U.S. are covered by private insurance. Private insurance plans do not cover the range of specialized community-based mental and behavioral health services for children, youth, and families to the same extent as Medicaid, often imposing strict time limits on the few services they do cover. Because of this gap, families are forced to go into debt, seek out public insurance, or forgo care until the concerns result in a crisis. This coverage gap exacerbates the difficulties that families face in accessing the support they need and pushes families to child welfare's door. This gap also pushes families to utilize privately funded unlicensed "boot camp" types of residential facilities, similar to those referenced in the testimonials. Congress must ensure parity between public and private insurance coverage of mental and behavioral health services for children, youth, and their families.

Lack of Oversight, Accountability, and Authority From Federal Agencies

CWLA thanks the Committee for highlighting the need for better mental and behavioral health care for youth and for bringing to light the system that has been created to bypass the needed state and federal oversight that is tasked with ensuring children and youth are receiving the highest quality services possible.

In their comments, both Ms. Stanford and Ms. Larin highlighted the lack of federal and state oversight and action in providing accountability to programs and organizations operating residential treatment services. Medicaid gives a lot of attention to state and program spending and exercises authority when funds are misspent, or when there are many fatalities in nursing and adult care facilities, but it does not provide the same level of scrutiny when youth residential treatment facilities are found to be out of compliance or when abuses are discovered.

The report also recognizes that private equity firms are purchasing human services, including residential treatment programs, to make a profit. These entities created for the intent of enriching their shareholders do not have the commitment to child and youth well-being as a top priority and don't adhere to best practices in service delivery, inclusion of the youth and family in decision-making, and staffing decisions. Two of the companies in the report, Acadia and Vivant, are owned by private equity firms.

Recommendation: Congress must empower and require states to license and provide regular and strict oversight of all youth residential treatment facilities, regardless of their funding stream. If a program is receiving federal dollars, there are multiple mechanisms for oversight that can be strengthened, including additional responsibility on federal and state agencies. In past years CWLA worked with members of Congress such as Congressman George Miller (D–CA) as he attempted to address the challenge of regulating unlicensed youth boot camps and wilderness camps that avoid federal funding and as a result avoid federal oversight. In many of these instances States have the final authority; however, Congress could direct the Department of Health and Human Services (HHS) to provide guidance to states or incentivize states directly to implement and enforce regulations on any program that cares for and serves youth.

Recommendation: Congress should establish an interagency task force to explore what protections the federal government can put on publicly traded entities to protect the safety and well-being of the young people served by private-equity-owned youth residential programs.

Recommendation: Congress should commission an independent study of the effect of private equity firms on human services, including the impact on the workforce and the quality of the services delivered. Many states are examining the impact of these firms including Maryland which recently passed a bill directing a similar study on the effects of private equity firms on health care markets.[11] Some Senators are also examining legislative efforts at the federal level and we urge the Finance Committee to take a closer examination of these legislative strategies.

[11] Beard, K. "A closer look at state lawmakers' efforts to bring down health-care costs." *Washington Post.* June 24, 2024. *https://www.washingtonpost.com/politics/2024/06/24/how-some-states-hope-lower-health-care-costs/*.

Use of Restraint and Seclusion, Including Medical Restraint

The report and the hearing highlighted the case of 16-year-old Cornelius Frederick, who was restrained for tossing bread at another youth and who tragically died because of the restraint. Using physical restraint and seclusion can be dangerous and even deadly for young people, and it is more likely to occur when staff who are using these methods do not have adequate experience and training in helping youth self-regulate and effective de-escalation techniques.

There are many providers who are not using or have focused on reducing and eliminating the use of restraint and seclusion, and instead turned to entities such as Building Bridges Inc. and the National Association of State Mental Health Program Directors that offer training in the evidence-based Six Core Strategies for Reducing Seclusion and Restraint Use© for help with improving the quality and effectiveness of their residential interventions. CWLA informed the early work of identification of strategies to reduce the use of restraints and seclusion. As long as funding sources such as Medicaid, Title IV–E, the Department of Education, Managed Care, private insurance, and private pay allow for the use of restraint and seclusion, the risk of harm to the children and youth served in programs using these types of coercive non-trauma responsive practices will persist with the strong likelihood of serious injuries and deaths.

Recommendation: Congress should direct each system with oversight authority for child and youth serving programs, including the child welfare, mental health/behavioral health, juvenile justice, and education systems, to work towards reducing and eliminating the use of restraint and seclusion and coercive practices in their programs through publishing guidance, sharing best practices, and any other means at their disposal.

Recommendation: Congress should incentivize states to reduce and eventually eliminate the use of restraint and seclusion and coercive practices in their residential treatment programs. In 2022, the Michigan Department of Health and Human Services finalized a rule prohibiting these practices in child-caring institutions for children in foster care.[12]

The report also calls attention to the overuse of psychotropic medications as a means of medical restraint for youth with mental and behavioral health diagnoses. Over the years we have worked with Congress and this Committee to strengthen oversight of children's health, particularly the use of psychotropic medication. Efforts included new state plan requirements in the 2006 Child and Family Services Improvement Act (Pub. L. 109–288), the 2008 Fostering Connections to Success Act (Pub. L. 110–351), the 2011 Child and Family Services Improvement and Innovations Act (Pub. L. 112–34). We also participated in a Senate Finance Committee roundtable discussion in 2013. In addition, Senator Tom Carper (D–DE), a Senate Finance Committee member, focused the attention of the Senate Homeland Security and Government Oversight on this issue in 2015.

Some states' child welfare agencies such as MA, NJ, and TN have put together excellent protocols and processes for medication management and oversight. However, for programs that are not subject to licensing and oversight requirements, no one is holding them accountable to properly prescribing and administering medication. Ultimately this points to the need for greater and better access to quality mental and behavioral health services.

Implementation of QRTPs

In the Family First Prevention Services Act of 2018, the Senate Finance Committee created the Qualified Residential Treatment Program (QRTP) to help ensure that when youth need to access residential treatment, they are provided with the best possible care and services. Implementation of QRTPs has been an opportunity to make important reforms in residential care.

As we indicated in our endorsement letter of FFPSA in 2016, we are committed to working with Congress and the Administration on some of the most challenging implementation issues, "mak[ing] sure that the oversight and implementation of the residential care parts of this law are carried out in the most effective way possible." As part of that commitment, we want to work with you to make sure that the QRTP is implemented in the way the committee and bills' sponsors envisioned through appropriate regulation and oversight.

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[12] Final Rule on Restraint and Seclusion. Department of Health and Human Services. Children Services Agency. Division of Child Welfare Licensing. May 24, 2022.

The most significant barrier states and counties experience in implementation of QRTPs has been Medicaid's IMD exclusion. Under Title XXI of the Social Security Act, Medicaid defines facilities that provide diagnosis, assessment, and treatment interventions with more than 16 beds as Institutes of Mental Disease (IMDs). It prohibits the use of Medicaid funding for any medical or therapeutic services while the patients are in these settings. The Centers for Medicare and Medicaid Services (CMS) has indicated that residential facilities meeting the QRTP requirements, as written in Title IV–E law, are to be classified as IMDs. This determination means that a youth in a program that meets the QRTP provisions, who is by definition a youth with higher needs, cannot be covered by Medicaid for any reason, even for emergency physical health needs.

Recommendation: The Committee should clarify that QRTPs are exempt from the IMD exclusion so that the rigorous requirements under the QRTPs can be implemented; there is precedent for Congress exempting young people and other vulnerable populations from the IMD exclusion. We believe we can find common ground and a bipartisan solution on an issue that must be addressed if we are to ensure high quality service provision for youth in residential treatment programs.

Workforce Issues

The report highlights the ongoing challenge of the workforce. As you note in several parts of the report, there was a shortage of competent and qualified workers at some of these facilities.

The labor-intensive and emotional nature of child welfare and residential care work along with the extremely low level of pay leads to high levels of turnover, particularly with rising concern over secondary trauma, compassion fatigue, and burnout. Increased and high turnover rates and the resulting higher caseloads perpetuate the caseworker crisis, negatively impact children and families, as workers who are experienced leave and staff who are inexperienced and inadequately trained take their place. Wages for residential direct care workers are extremely low, resulting in the least experienced workers caring for youth with the most complex and difficult-to-meet needs. An additional concern is a trend of public child welfare agencies reducing the education and competency levels of child welfare caseworkers to quickly address high vacancy rates, further exacerbating the issue of staff who are inexperienced, and without the level of knowledge, competency and skills to provide quality services.

The Standards expound on the minimum professional and personal qualities that residential treatment staff should possess.

> "To carry out its mission, the agency must attract and retain a competent, culturally diverse workforce. Staff must be trained, skilled, and knowledgeable in their particular job responsibility, in culturally competent practice, and in working with the community. All personnel must have the maturity to make the required decisions and the personal qualities required to work with children and families. Staff members should have had life experiences that can help them to understand children and families, the local community, and the cultural experiences of those served."[13]

Title IV–B reauthorization, due this year, offers an opportunity to begin to address the workforce crisis by strengthening the workforce and increasing the pay of staff doing direct work with children, youth and their families.

Recommendation: Increase funding for workforce development and training. There is $20M designated for workforce development in Title IV–B, dependent upon caseworkers visiting families on a monthly basis. Once split among all the public child welfare programs, this $20M does not go nearly far enough to truly support the workforce. We recommend that Congress substantially increase this set aside, which states can use to promote recruitment and retention of child welfare workers, including direct care workers in residential treatment programs.

Recommendation: Promote recruitment and retention. Recruitment and retention of qualified child welfare workers are essential for establishing a well-staffed and well-trained workforce. High vacancy rates and unfilled positions lead to much higher stress for direct care workers in residential programs and can compromise safety for the youth in their care and the staff. There are several promising practices that are helping agencies address these key issues, and Congress should support states and

[13] Child Welfare League of America. CWLA Standards of Excellence in Residential Services. Washington, DC 2004. P. 184.

counties in implementing and evaluating the effectiveness of these practices. Congress should create new competitive or formula grants in Title IV–B of the Social Security Act with additional funding for states to address both recruitment and retention.

Recommendation: Increase overall child welfare and mental and behavioral health funding. One of the key issues in both recruiting and retaining qualified caseworkers and direct care workers is low wages. Child welfare staff consistently point out that in many states and localities, entry-level child welfare positions pay no better than the local Target or Starbucks, even though the work is much more challenging and can change the life trajectory of children, youth and families, 74.7% of caseworkers earn an annual salary between $30,000 and $49,999, and frequently, direct care workers earn less than caseworkers.[14] Better compensation and benefits for staff would help address vacancies and turnover rates, but adequate funding for child welfare agencies is needed, as funding has not kept pace with the rising cost of living and inflation. In addition to delinking Title IV–E foster care eligibility from the 1996 AFDC standards, Congress should increase both mandatory and discretionary funding in Title IV–B programs.

It is appropriate for Congress to focus special attention on this workforce as it does in some other professional areas. A stable workforce in child welfare can and does result in better care in these facilities, a greater chance at permanency for children and youth, greater success in preventing family separation and greater ability to address prevention of child abuse and neglect.

Conclusion

CWLA again thanks Chairman Wyden, Ranking Member Crapo, Members of the Senate Finance Committee, and Committee staff for the publication of this important report, which illuminates the need for better oversight and enforcement in youth residential care. We stand ready to assist in implementing necessary reforms in service delivery and look forward to working with the Committee in improving the quality of mental and behavioral health care that is available to children, youth, and families. Thank you for your attention to these comments and recommendations.

CHILDREN'S RIGHTS
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Organizational Statement

Sandy Santana, Executive Director
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Chairman Ron Wyden, Ranking Member Mike Crapo, Members of the Senate Committee on Finance, and Senate Staff:

Children's Rights is a national advocacy organization dedicated to improving the lives of children living in or impacted by America's child welfare, immigration, juvenile legal, education, and healthcare systems. We use civil rights impact litigation, advocacy and policy expertise, and public education to hold governments accountable for keeping kids safe and healthy. Our work centers on creating lasting systemic change that will advance the rights of children for generations.

We commend the Senate Committee on Finance for launching an investigation into allegations of abuse and neglect at certain for-profit Residential Treatment Facilities (RTFs), for revealing its findings, and for bringing scrutiny and public attention to the larger issue of child institutionalization. Clinical research overwhelmingly tells us: children do better when living in a family setting and supported in their communities. Despite a growing movement nationally to drastically reduce or eliminate institutional placements, these placements are still used with alarming frequency. Every year tens of thousands of young people are locked in prison-like settings where they are abused, neglected, and denied vital services.

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[14] National Survey of Child and Adolescent Well-being. NSCAW II Baseline Report. Caseworker Characteristics, Child Welfare Services, and Experiences of Children Placed in Out-of-Home Care. Retrieved from: *https://www.acf.hhs.gov/sites/default/files/documents/opre/nscaw2_cw.pdf.*

THE HARMS OF INSTITUTIONALIZATION

The unnecessary placement of children in institutions and other group settings is one of the most pernicious ways that child-serving government systems inflict violence on children. Ending this brutal practice is a priority for Children's Rights, and we are using every advocacy and legal tool at our disposal to do so.

In 2021, Children's Rights, along with our partners, sparked a national movement to end the unnecessary institutionalization of children. Our seminal Families over Facilities report [1] details the violations of children's civil and human rights and the significant cost to taxpayers. Our findings echo Senator Wyden's description of "taxpayer-funded child abuse," which he described as "like something out of a horror novel." We've read that book. We have witnessed the violations of children's human and civil rights in state systems fueled by federal taxpayers' dollars.

Institutions are inherently dangerous places for children. Yet over 50,000 children in the US are living in congregate, juvenile detention, and other group settings instead of loving homes, while thousands more migrant children are detained by the federal government in brutal facilities. Many will experience physical violence, dismal living conditions, and inhumane, traumatizing treatment. Institutional settings expose youth to the use of physical and chemical restraints and seclusion; physical and sexual abuse; deprivation of family relationships; inadequate education; profound stigmatization; loss of identity; and loneliness. Our "Are You Listening?" report [2] provides first-hand accounts of these experiences, and informs our support of a youth-led collaborative [3] of lived experts and advocates calling on New York legislators to stop institutionalizing kids and instead strengthen access to community services and supports that prioritize families and communities.

Healthy child development requires a nurturing environment. Children who spend even brief periods in institutions experience worse outcomes [4] as adults than their peers. Young adults placed in institutions and group facilities who age out of the foster system are more likely to be involved in the criminal legal system,[5] have their education interrupted,[6] and suffer economic hardships.[7] The human cost falls heavily on LGBTQ+ youth [8] and youth of color, especially Black children,[9] who are disproportionately investigated by child protective services, unnecessarily removed from their families, and placed in institutions. There are also massive direct and indirect economic costs associated with institutionalization. Institutions and group facility placements typically cost seven to ten times more [10] for a child than family-based placements. Some estimate that child welfare systems incur nearly $4.1 billion in avoidable costs [11] associated with the abysmal outcomes when youth housed in group facilities "age out" or exit state custody. Reducing the use of institutions and group facilities results in significant savings that can be reinvested to support prevention, preservation, and family placements (especially with kin).[12]

FAMILY FIRST MUST MEAN FAMILIES FIRST

The Senate Finance Committee investigation and hearing provide ample evidence that it's time to shut down these brutal facilities and stop those who would profit from the mistreatment of children. Instead of focusing on how to make inherently bad places better, the federal government must meaningfully consider policies and practices that can provide families with the community supports that really do put "family first."

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[1] *https://www.childrensrights.org/wp-content/uploads/imported-files/CR-Families-Over-Facilities-Report.pdf.*

[2] *https://www.childrensrights.org/wp-content/uploads/2023/01/CR-2023-AreYouListening_report_web.pdf.*

[3] *https://www.childrensrights.org/news-voices/holding-the-door.*

[4] *https://www.casey.org/group-placement-impacts/.*

[5] *https://jlc.org/news/what-foster-care-prison-pipeline#:~:text=Youth%20in%20group%20homes%20are,increase%20the%20likelihood%20of%20incarceration.*

[6] *https://www.casey.org/group-placement-impacts/.*

[7] *https://www.aecf.org/resources/the-economic-well-being-of-youth-transitioning-from-foster-care.*

[8] *https://www.nyc.gov/assets/acs/pdf/about/2020/LGBTQActionPlan.pdf.*

[9] *https://assets.aecf.org/m/resourcedoc/aecf-keepingkidsinfamilies-2019.pdf.*

[10] *http://www.aecf.org/m/resourcedoc/aecf-EveryKidNeedsAFamily-2015.pdf.*

[11] *https://assets.aecf.org/m/resourcedoc/aecf-futuresavings-2019.pdf.*

[12] *https://www.aecf.org/resources/rightsizing-congregate-care.*

1. The Federal Government Must Work to Keep Families Together

Every day, the U.S. government, through state child welfare agencies, unnecessarily removes far too many children from their homes. In 2021, 62% of children[13] removed from their families were removed because of "neglect." According to a January 2021 memo by the U.S. Administration for Children and Families,[14] "neglect" removals—including removals for "inadequate housing" or "failure to provide adequate nutrition"—are often the result of families living in conditions of poverty.

We have proposed a sweeping plan[15] to dramatically and safely reduce the number of children entering the foster system through a series of high-impact legal, legislative, and policy recommendations concentrated on the front end of a child's journey into government custody, and ultimately to being placed in harmful institutions. Our call[16] to end the unjust surveillance, investigation, and separation of Black families has been endorsed by advocates and policymakers across a wide spectrum of political perspectives. At the state, national and international levels we are working to amend or eliminate child welfare laws and practices that result in unjust removals and the placement of children in institutional facilities, and instead ensure that families receive the community supports and services that can keep their children safe, at home, and thriving.

2. Federal Funding Must Support Keeping Families Together

In a May 2024 Senate Finance Committee hearing on Family First, Chairman Wyden acknowledged,[17] "a good place to start is making sure kids can remain with their families whenever possible."

Although the passage of the Family First Prevention Services Act in 2018 ended federal funding for many non-therapeutic group placements, they are still used[18] with alarming frequency. Congregate settings can still receive federal funding beyond two weeks if they meet the requirements of a qualified residential treatment program ("QRTP"). The children and youth held in QRTPs are often subjected to the same abusive practices[19]—isolation, inadequate therapeutic treatment, poor and unregulated education—as their institutionalized counterparts.

Some of the worst practices can be found in states that are willing to fund institutions that do not meet QRTP standards. For example, in New York the majority of youth in congregate placements are *not* in QRTPs. As of June 2024, more than half of the congregate population is currently placed in unspecified settings (these include shelters), which do not have to comply with QRTP program requirements. Oversight of existing institutions is important, but these facilities—QRTPs or otherwise—are not the solution. Children have a right to be with their families, and the allocation of child welfare and Medicaid funding should reflect this goal by investing in families and communities.

Family First also provides new funding streams for family and community-based services, leveraging Title IV–E funds to prevent family involvement in the child welfare system. This is a critical start, but we must do much more. Stopping government overreach into the lives of families by eliminating unnecessary removals and increasing family preservation and kinship placement and support will require a substantial reallocation of funds to communities even beyond what Family First provides.

To keep families together safely will require meaningful federal investments in resources for families and community supports and services, including tapping funding streams outside of child welfare. One solution is to reapportion existing Child Abuse Prevention and Treatment Act (CAPTA) funding to direct family support and community-based services by reallocating funding from Title I (state grants) to Title II (Community-Based Child Abuse Prevention—CBCAP). Reallocating funding from state grants to CBCAP, and ensuring this funding is de-linked from state or local

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[13] *https://www.acf.hhs.gov/sites/default/files/documents/cb/afcars-report-30.pdf.*
[14] *https://www.acf.hhs.gov/sites/default/files/documents/cb/im2102.pdf.*
[15] *https://www.childrensrights.org/wp-content/uploads/imported-files/CR-2021-Fighting-Racism-in-Child-Welfare-Advocacy-Paper-Summary-1.pdf.*
[16] *https://www.childrensrights.org/wp-content/uploads/2021/05/Childrens-Rights-2021-Call-to-Action-Report.pdf.*
[17] *https://www.finance.senate.gov/imo/media/doc/05222024_wyden_statement.pdf.*
[18] *https://downloads.aap.org/DOFA/AAP 50 state Review of Congregate Care Reform Across America.pdf.*
[19] *https://downloads.aap.org/DOFA/AAP 50 state Review of Congregate Care Reform Across America.pdf.*

child welfare agencies, would strengthen and multiply community assets by investing in local projects and organizations.

This reorientation of CAPTA funding will not only support healthy families and thriving children; it will save money and put our public resources to better use in the long term. Investing in families and in neighborhoods can reduce health disparities, improve educational outcomes, and reduce the well-documented harms of family policing on economically and resource-deprived American families.

3. Medicaid and Other Federal Funding Must be Used to Build In-Home and Community Supports and Services for Children and Families

In the courts, Children's Rights has brought several lawsuits [20] focused on ensuring Medicaid-eligible children [21] have access to the in-home and community mental and behavioral health supports that they need and have a right to under law.

Due to the lack of home and community-based mental health services, Medicaid-eligible children across the United States languish as their mental health conditions deteriorate. Without intensive services in their homes and communities, children with mental health conditions are unnecessarily placed in psychiatric hospitals and similar institutions for extended periods, where they are separated from their families and communities and fail to thrive. The benefits of home and community-based mental health services have been borne out by expert medical opinion and court decisions across the country. Such services are vital and result in the best long-term outcomes for children, including significant improvement in their quality of life, improved school attendance and performance, increases in emotional and behavioral strength, more stable living situations, reduced suicide attempts, and fewer contacts with law enforcement.

As the community-based service array increases, the pipeline into institutions and group facilities will decrease. At the same time, efforts to depopulate existing institutions and group facilities will yield short and medium-term successes and savings that will increase over time. New IV–E funding and cost savings can be re-invested into family preservation, community-based services, and supporting family-based placements for the dwindling population of children and youth for whom placement in the foster system might remain necessary.

CONGRESS MUST TAKE ACTION

The Committee has put the spotlight on a pervasive national shame that must be corrected. We reiterate our call for ending the use of harmful and unnecessary institutions and other group facilities in child welfare systems and offer the following recommendations:

1. **End Unjust Family Separation and Work to Keep Families Together.** Nationally, 62% of children are removed from their families for reasons of neglect, which the federal government has concluded is all too often conflated with poverty. Preserving and supporting families and communities will put families first and prevent youth from entering the foster system. The federal government must make every effort to keep children at home, prevent removals, and increase supports for children and families in their homes and communities; adopt policies that increase financial and social supports to help families stay together in the first place, such as expanding the availability, affordability, and access to community mental health resources, child care, and housing; reinvest savings from depopulating congregate settings into preserving families; and increase utilization of, and remove barriers to, kinship placements for youth when they absolutely cannot remain at home.
2. **Depopulate Existing Institutions and Group Facilities and End Institutionalization.** The unnecessary placement of children in institutions and group facilities must be eliminated. We can do this by developing an infrastructure to promote family stability and justice for children, now and into the future. The risk of harm is too great to spend more time and resources hoping for a different outcome. No child belongs in an institution. It's time to shift our focus and our resources to assessing the individual needs of young people driven into these settings and, in partnership with youth and families, take steps to plan their safe return to their homes and communities. Furthermore, eliminating the use of institutions and group facilities will result in significant cost savings that can be reinvested in family preservation and family placements (especially with kin).

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[20] *https://www.childrensrights.org/in-the-courts/ia-c-a-vs-garcia.*
[21] *https://www.childrensrights.org/in-the-courts/OMm05*.*

3. **Leverage Medicaid and Other Federal Funding to Build In-Home and Community Supports and Services for Children and Families.** Access to intensive home and community-based mental health services—including intensive care coordination, in-home behavioral supports, and police-free mobile crisis intervention—is critical for keeping Medicaid-eligible children and youth at home and out of psychiatric hospitals and institutions. The federal government has a financial interest in ensuring states are providing the services required by Medicaid laws and the Americans with Disabilities Act and investing in community and in-home mental and behavioral health services and support.

   The federal government should also right-size CAPTA appropriations by reallocating funding from Title I (state grants) to Title II (Community-Based Child Abuse Prevention—CBCAP) to prioritize family support over family separation. This reallocation should include clear eligibility and implementation criteria to ensure that federal dollars provided under CAPTA, and their state and local matches, are de-linked from state and local child welfare agencies and are used for direct financial and material support for families and communities.

Eliminating the policies, practices and billion-dollar industry whose business model has resulted in the trauma, abuse and neglect and even death of children, must be pursued with great urgency. Ending "taxpayer-funded abuse" is thoroughly achievable with policies and funding that prioritize community and family support, and the recommendations outlined here build on the intent of Family First, while also demanding bolder action in order to meet the urgency of this issue.

CITIZENS COMMISSION ON HUMAN RIGHTS INTERNATIONAL
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https://www.cchrint.org/

24 June 2024

U.S. Senate,
Committee on Finance,
Dirksen Senate Office Bldg.,
Washington, DC 20510–6200.

Re: Senate Committee on Finance Hearing into Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions, 12 July 2024

The Citizens Commission on Human Rights International is a 55-year mental health industry watchdog based in the United States, at 6616 Sunset Blvd., Los Angeles, CA, and has been investigating youth residential psychiatric treatment facilities and wilderness camps for at least 35 years. We assist families whose children have been wrongly incarcerated in these facilities, putting them in contact with attorneys to help secure their child's release and we also make representations ourselves to the hospitals concerned, if requested by the family.

We congratulate all the members of the Senate Finance Committee and staff who worked so diligently on the investigation into youth residential treatment centers and the subsequent report.

The below information is provided to further assist the committee and is also available with endnotes upon request and will also be posted on our website, *https://www.cchrint.org.* This contains additional information and recommendations.

One of our most recent cases reported to us was a father whose 14-year-old son had been admitted to an Acadia Healthcare hospital in California after friends erroneously believed he was suicidal and had called the police who took him directly to the facility without any knowledge of the parents. The teen had no history of mental disorder. The boy was only discharged several days later after CCHR wrote to the hospital on behalf of the father, listing the concerns about the treatment he had been given, which included an antidepressant not recommended for his age because of the risk of suicidal ideation.

Rightfully so, the report recommends accrediting bodies, such as the Joint Commission, to closely monitor facilities following the discovery of noncompliance with requirements or elements and accrediting bodies should consider withholding accreditation when they identify sustained, longitudinal noncompliance.

As these companies have known for 2 years that their behavioral facilities have been under Senate investigation, it is unconscionable that the abuses have continued and without any disciplinary measures. For example:

- May 2024: Employees at Brynn Marr Hospital owned by UHS in NC alleged that management told nurses to avoid documenting a patient's denial of suicidal or homicidal thoughts or hallucinations. If it was in the record, the former employee said, then it would have to be reported to the insurance company. The better the insurance, including Tricare, the longer some patients could stay. UHS denies the allegation.
- March 2024: UHS's Holly Hill hospital for children in NC was in the news, with allegations from a mother alleging her daughter was attacked by another patient within days of being admitted and the parents only discovered this during a visit seeing bruises and spots on her head where her hair had been pulled out.
- In Detroit, MI, a serious situation was reported in relation to StoneCrest psychiatric hospital owned by Acadia. Allegations against Dr. Nagy Kheir, a psychiatrist with privileges to treat there, say he forcibly held patients for periods lasting longer than necessary to bill their insurance. Dr. Kheir allegedly presigned blank court forms called clinical certificates that are used in the civil commitment process. Such forms are signed under the penalty of perjury, but medical residents were filling out the pre-signed forms without Dr. Kheir examining or even meeting the patient, according to a compelling investigation and story by WXYZ ABC 7 Investigators, "Trapped in a psych ward: Michigan doc pre-signed blank forms that can rob you of your freedom." As such, patients could be forcibly admitted without any evaluation, raising significant concerns about the violation of patients' rights, and putting financial incentives above patient lives by driving prolonged hospital stays. It was estimated that Medicaid incurred substantial costs (over $24 million) due to prolonged hospital stays and potentially unnecessary treatments at the hospital.
- Dr. Kheir allegedly billed for the time these pre-signed forms were used, yet investigators found that the psychiatrist was driving at the same time he supposedly was filling out one of the clinical certificates. The Michigan Psychiatric Society told ABC that the use of pre-signed forms was "unethical and unprofessional and possibly illegal . . ."

As a comparison, the Food and Drug Administration (FDA), along with many states, bans physicians from pre-signing prescriptions. Signing a blank prescription is illegal because you can never know with certainty how others will use it. Such misuse can result in monetary penalties, board disciplinary action, or criminal charges. We argue that the same should apply for pre-signed involuntary commitment forms.

As recognized, the abuses extend far beyond the four companies the Senate looked into.

- On July 21, 2022, the Committee announced its investigation. Four days earlier, on July 17th, at Brooklawn RTC in Louisville, Kentucky, Ja'Ceon Terry, a 7-year-old foster care child, was restrained, and, unable to breathe during a restraint procedure, died at 4:48 p.m. A staffer said that they'd had the boy in a "bear hug" due to an "outburst" and suddenly felt him stop resisting. There was vomit everywhere, first responders said. It was in Ja'Ceon's mouth and throat, running down his cheeks and on the floor. The EMTs had to suction it out before they could intubate him, to try to save his life. The medical examiner ruled his death a *homicide,* determining that he had been suffocated. In a compelling account of his short life, journalist Jasmine Demers wrote: "The 122-page investigation into Ja'Ceon Terry's death makes at least one thing exceedingly clear: The system that was supposed to protect him failed." No charges were filed. Brooklawn, owned and operated by, had a temporary revocation of license in December 2022 but by May 2023 had resumed foster care replacements.
- In June 2023, a wrongful death lawsuit relating to Ja'Ceon's death settled. According to court documents, he was rushed to Norton Children's Hospital after two employees at Brooklawn Child and Family Services placed him in a physical restraint for 5 to 6 minutes. The position he was put in prevented him from breathing and ultimately caused his death. Attorneys for his estate subpoenaed a former Brooklawn employee who could establish a pattern of abuse at the facility. Nicole Richardson claims she was fired for reporting emotional and physical abuse by staff that she witnessed, including: Dragging juveniles naked on

the floor and yelling loudly; Waterboarding a juvenile in the hallway with a cooler full of water; Threats of violence from staff members to juveniles. She also claimed she was aware of another co-worker breaking the elbow of a juvenile, and more.

- In November 2023, Louisville Public Media reported the case of a boy allegedly body slammed by a staff member at Uspiritus Bellewood. The boy said he had pain in the right side of his body and was limping for 2 weeks after it happened. He said he thought no one would believe him, so he didn't report the incident until after he had been discharged from the facility 3 months later. When the DRCC contacted the facility, they said there were no incident reports on file and no video evidence to review since the boy couldn't provide a specific date. The state never spoke to the boy and closed the case as unsubstantiated.

Common sense would tell you to stop a restraint procedure the minute the recipient is gasping, "I can't breathe." Proper training would reinforce this. *As such, guidelines are needed whereby the restrainer hears the words, "I can't breathe," the practice must immediately stop.*

In October 2020, CCHR posted a sample of 32 incidents of child abuse in UHS psychiatric facilities since 2003, including restraint deaths and sexual assault. CCHR had documented reports of about a dozen youth suicides or attempted suicides in approximately eight behavioral facilities owned by UHS. This included Justin Skidmore, a 19-year-old with autism who died during an incident with staff at HIS's Laurel Heights in Atlanta. Austin was subjected to a manual hold in "a manner that would potentially impair the patient's ability to breathe resulting in the death of the patient," an investigation found. He choked on his own vomit but the medical examiner also classified the crime a homicide.

One of these cases occurred in 2017 at UHS' Timberlawn psychiatric hospital in Texas, which closed after the 13-year-old girl was reportedly raped by another patient. In a letter to *The Dallas Morning News,* Timberlawn's chief executive asserted that "our rate of serious incidents [of sexual abuse] associated with the patient population treated at Timberlawn is *within industry norm*."

It's an "industry norm" that is unacceptable, with little action taken by health and judicial authorities to rectify it, as evidenced by the continuing incidents of reported abuse in other facilities.

In 2013, Steve Filton, UHS's then CFO *emphasized that the company's behavioral health business receives "fairly minimal" scrutiny from payers, allowing the business to "operate, I don't want to say sort of invisibly, but certainly under radar."* This related to the federal and state regulators charged with overseeing Medicare and Medicaid providers who are stretched so thin, they cannot adequately perform their oversight functions.

You report that in 2020 UHS paid $132 million to settle federal and state fraud and abuse allegations. However, what does not seem to have been addressed is that in settling the case, UHS admitted no liability and agreed to a Corporate Integrity Agreement (CIA) with the Office of the Inspector General. Despite the CIA, a multitude of allegations against UHS hospitals continued, with no adverse consequence or preventing it from acquiring more hospitals. CCHR has filed several complaints to authorities regarding alleged violations of the CIA.

There does not seem to be any oversight of this, or, if there is, effective oversight.

- A year after the CIA was signed, a lawsuit was filed against UHS's Cumberland Child and Adolescent behavioral hospital in Virginia which exemplified ongoing risks: 20 former patients from the hospital alleged sexual abuse, physical assaults, and attempts to deceive the public and state health officials.
- In 2022, UHS was sued over allegations of an 11-year-old girl being sexually abused in Brynn Marr hospital in North Carolina. Two years later, a jury found in favor of another girl who, at age 13, was sexually abused at UHS's Pavilion Behavioral Health in Illinois. As the Senate report covers, a whopping $535 million jury verdict was delivered. (Under appeal at the time of writing.)
- Violation Tracker, a database on corporate misconduct, lists 11 fraud cases against Acadia between 2000 and 2019 resulting in $26,521,878 in fines and settlements. Of this, $26.4 million was government-contracting-related offenses, including False Claims Act actions; $110,878 was employment-related and $11,000 was safety-related issues.

- As the Senate reports, "in May 2019, Acadia settled healthcare fraud charges brought by the U.S. Attorney in West Virginia for $17 million. The government alleged that a subsidiary (CRC Health, LLC) of Acadia, defrauded Medicaid over several years through false claims for laboratory tests related to the opioid epidemic." No liability was admitted. The Office of the Inspector General (OIG) issued a CIA to Acadia and CRC Health, effective for 5 years. All of the requirements of the CIA involved internal Acadia functions and responsibilities relative to compliance with CIA requirements with a heavy emphasis on its Medicaid billing; none of the CIA addressed issues of patient care.
- Three months later, a 10-year-old boy was held in restraints for an hour at Acadia Healthcare's Desert Hills psychiatric facility and then injected with and overdosed on the antipsychotic, Haldol. Desert Hills of New Mexico was "shut down amid egregious abuse allegations, multiple lawsuits and losing its certification from state regulators," according to *The Nashville Post.* It cited seven lawsuits against the facility which included excessive use of restraints on children—more than 30 times in 60 days. Four months after that came *The New York Times* exposure of Piney Ridge Treatment Center in Fayetteville, Arkansas using chemical injections to restrain young people in seclusion, a violation of federal rules.
- CCHR has numerous articles on its website *(cchrint.org)* about Acadia facility abuse dating back to 2016.

The Corporate Integrity Agreements that companies sign and the oversight of them appear essentially useless and the effectiveness of the process should be investigated.

Vivant Behavioral Healthcare-Midwest Autism

The Senate report's coverage of Sequel Youth and Family Service's transposition to Vivant Behavioral Health was appreciated, especially the point made that "Public reporting has alleged that this move to private ownership has allowed providers to escape liability for serious allegations. . . ."

Vivant changed the name of its Alabama facilities from "Sequel TSI" to "Brighter Path" and in Florida, to "Brighter Heights." Brighter Path Alabama, LLC is managed or directed by TrueCore Acquisitions. This is a Delaware Domestic Limited-Liability Company. TrueCore Behavior Solutions Inc. is based in Tampa, FL. Its website says: "TrueCore Behavioral Solutions is a name you can trust when it comes to quality behavioral treatment services." In December 2020, the Okeechobee Youth Development Center (OYDC), operated by TrueCore Behavioral, closed after the FL DOJJ refused to renew its contract.

In October 2021, WBNS TV "10 Investigates" reported, "But the potential ability to close, re-brand and re-open a youth behavioral facility with little oversight from states or federal authorities is part of the reason why advocates are pushing for change with the so-called 'troubled teen industry.'"

- Vivant is involved in servicing autistic children under the company name—Midwest Autism & ABA ("applied behavioral analysis") Therapy in Iowa, and Heartleaf ABA in Maine. A March 11, 2022 release announced, *"Heartleaf ABA, a subsidiary of Vivant Behavioral Health, is bringing center-based Applied Behavioral Analysis (ABA) therapy to Northeast Maine this Spring. Their new center, located in Bangor, will be the first program of its kind in the region."*
- Heartleaf ABA is registered and incorporated in Maine; the company's address is 2516 N. Great Western Dr. Ste. P, Prescott, Arizona—almost the same address as that of Vivant Behavioral Health, which is listed as # 2517. The Vice President for Operations of Heartleaf in Maine is Brian Steinberg, who lists his contact as brian.steinberg@vivantbh.com (832–674–6566, TX area code). He is also listed as President of Vivant Behavioral Health. The Director of Marketing of Heartleaf is Allie McClintock, also with a Vivant email address allie.mcclintock@vivantbh.com (585–737–4488, Rochester, NY).

In 2022, Curtis Gilbert of America Public Media published an excellent report on the abuses at Sequel facilities and the Vivant takeover. He stated, ". . . Sequel the name might be gone, but the problems appear to be continuing under the new brand, Vivant Behavioral Health Care."

Parents taking their children to Vivant subsidiary centers may be unaware of the history and abuses at facilities owned by Vivant nee Sequel.

Gilbert quoted Oregon state Senator Sara Gelser who said she would continue the crusade against Vivant. "It's like this many-headed Hydra. You cut off the head.

You think you're making progress, and then it just comes back stronger. How can the same people continue to be trusted with what they say are the most vulnerable kids that we have? . . . The name isn't the problem. The leadership is the problem."

Increasing Criminal Background Checks

As the Senate Committee found, "staff credentials and background checks are haphazardly conducted. On page 107, your report states: "Background checks, including state abuse registry checks and licensure checks, are not completed properly. In some cases, criminal history or background checks reveal that staff have histories that may disqualify them from working with children."

Subsequent to the release of the report, on June 14th, media outlets in San Antonio, Texas, reported on the arrest of Jacob Cuellar, the recently resigned CEO of UHS's Laurel Ridge Treatment Center. He has been charged with continuous sexual abuse of a child, with the alleged offense dating back to 2022. His indictment lists two alleged aggravated sexual assaults and one indecency with a child with contact with the same victim. According to KSAT News, an 11-year-old girl he is accused of abusing was not connected to Laurel Ridge. During the past 2 years, Mr. Cueller remained as CEO and has been since 2012, resigning voluntarily only about 3 weeks prior to his arrest.

But as KSAT 12 News learned, Cuellar applied for a license as a medical doctor in North Carolina in 2008 but was denied. Information on the North Carolina Medical Board's website indicated that the reason for the denial was due to "a 1999 criminal conviction for preparing an obscene photo." Further, "Another website revealed that the conviction stemmed from an August 1998 arrest on six counts of pornography."

According to KSAT, Laurel Ridge issued a statement that reads in part: *"Jacob Cuellar was subject to fingerprinting and background clearances as part of his eligibility for hire. The position he was hired for did not require a medical license nor did he ever practice as a physician in any of his roles with the organization; therefore, the medical license was not part of his required checks. Mr. Cuellar became CEO of Laurel Ridge Treatment Center in 2012."*

How is it that the media could find these earlier charges but apparently Laurel Ridge could not? The CCHR Texas office has brought this to the attention of the Chair of the Texas Senate Committee on Health and Human Services and the Chair of the House Public Health Committee, calling for an investigation and drawing their attention to your report.

We are concerned about the caliber of executives hired by Laurel Ridge/UHS and whether incidents of sexual abuse of patients may have occurred and gone unaddressed while Mr. Cuellar was CEO. If so, perhaps an effective criminal check may have prevented his being hired.

We have good reason to be concerned. While Mr. Cueller was CEO, in 2016, a family filed a $1.5 million lawsuit against Laurel Ridge alleging the center failed to protect their daughter, who was sexually assaulted by one of its counselors, a 24-year-old.

The Broader Scope: Wilderness-Boot Camps

A 2004 *Chicago Tribune* story on wilderness or boot camps cited 31 juvenile deaths over the previous 11 years. Many children ended up in boot camps after years of failed psychiatric treatment prescribed for diagnoses that changed as rapidly as the child deteriorated.

As a brief background to some of CCHR's work, in the 1990s, we conducted intensive investigations of restraint use and deaths in residential treatment centers, schools and wilderness camps. In 1992, we investigated Rite of Passage (ROP) in Nevada. A teenage boy, who was strangled by staff in a "take-down," was pronounced brain dead and put on life-support, never waking up. No one faced criminal charges and the facility has stayed open. The company started in 1984 and still boasts more than 40 programs in 15 states. The abuses continued.

In 2018, the Colorado Department of Human Services shut down ROP's DeNier Youth Services Center, after finding children improperly restrained. In 2020 and 2022, two youths died of drug overdoses at ROP Arizona facilities. In June 2021, Colorado revoked ROP's license to operate the Ridge View adolescent residential treatment facility after allegations of drugs, fights, and improper use of restraint on patients. In 2023, ROP was accused of youths being sexually assaulted and improperly isolated for extended periods in its facilities.

Websites for three former Sequel facilities in Utah and Tennessee indicate that they are now run by Rite of Passage.

On February 3, 2024, a 12-year-old boy at Trails Carolina in North Carolina, died within 24 hours of his admission. Transylvania County detectives found him lying on the floor of a bunkhouse, naked from the waist down, with his pants and underwear on the floor at his right shoulder. When the boy arrived at the camp, he refused dinner and was loud and irate, so he was put to sleep in a "bivy" (zip up tent) in a sleeping bag on the floor. Around midnight, the boy began to experience a panic attack. Counselors claim the boy was checked at midnight, 3 a.m., and 6 a.m. and was found dead at 7:45 a.m.

In its defense, Trials claims the state had approved the bivy. However, camp staff said, "Suffocation is always possible if equipment is being used wrong," according to the NC Health Service Regulation Report issued in May. Media reported the lack of inspections by the NC Department of Health and Human Services (NCDHHS), with the last inspection conducted in 2021 and that the regulators frequently went more than a year without visiting the facility, often taking between 13 and 18 months in between visits.

In 2001, Mark Soler, President, Youth Law Center, Washington, DC said: ". . . in terms of rehabilitating youngsters . . . and making them into productive citizens (the wilderness boot camp model) has failed. It has only lent to excessive use of force and punishment on kids that has failed to do anyone any good."

Recommendations

CCHR's commitment to cleaning up the behavioral industry and RTCs is ongoing. In addition to the Senate report's recommendations, we propose the following:

- As a requirement for acquiring a state license and/or contracting with the Centers for Medicare and Medicaid Services (CMS), mental health and behavioral treatment (congregate) facilities must ascribe in writing to a code of ethics and practice and legally swear to abide by it at all times, which includes agreeing to a policy of non-coercive or punitive use of restraints and seclusion, or other forms of physical or chemical restraint, including the use of medication to control behavior.
- Increase the penalties for hospitals and congregate treatment facilities that repeatedly violate plans of correction for deficiencies that put residents at risk, including closure.
- Uniform state restraint legislation throughout the country that aligns with the October 2023 World Health Organization that "all forms of restraint and seclusion in mental health services should be eliminated" because "Not only are seclusion and restraint contrary to international human rights law, their use is incompatible with a recovery approach, counters the purpose of care and can lead to physical and psychological harm, even death." Legislation should "prohibit the use of seclusion and restraint in any health or social care facility."
- Demand proven, effective and curative results for treatment programs offered to children and teens and implement a policy that works towards the de-escalation and reduction of psychotropic drug use in these age groups, also prohibiting such drug use as "chemical restraint" to control behavior.
- A national reporting system be established similar to the Food and Drug Administration's MedWatch and Maude reporting system, where consumers, their families and others can report incidents of abuse (confidentially and without fear of reprisal.) All patients upon admission to a hospital to be informed in writing of this right.
- Investigate the effectiveness (ability to curtail future abuse) of Corporate Integrity Agreements (CIA) that companies, including UHS and Acadia, have signed to settle federal and state lawsuits.
- Review the Federal Trade Commission's approval of new mental health, substance abuse, or troubled teen behavioral hospitals/congregate care facilities, and make recommendations to ensure all hospital acquisition applications fully disclose all completed lawsuits against the applicant, any Corporate Integrity Agreements against it, and other state agency disciplinary sanctions, including fines against the company.

Sincerely,

Jan Eastgate

President
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LETTER SUBMITTED BY CHRISTINA "CHRISSY" CLARK-ATKINS

Re: The Senate Finance Committee Investigation into Youth Residential Treatment Facilities

June 4, 2024

Dear Senate Finance Committee,

My name is Christina "Chrissy" Clark-Atkins, and I am a survivor of one of Acadia's facilities formerly known as Peninsula Village and now known as Village Behavioral Health. I am testifying about the abusive and neglectful conditions I experienced in their youth residential treatment facility.

I was placed in Peninsula Village, now known as Village Behaviorial Health, at the age of 16 (1996–1997). I was experiencing severe emotional and psychological abuse at home and as a side effect I started losing an extremely unhealthy amount of weight due to being too nervous to eat as my stomach felt sick all of the time. At the time I asked for help, I was 5′10″ and 95 pounds. I approached a guidance counselor at my school and informed her of the abuse I was experiencing at home, how I felt sick all of the time, and I really wanted some help to calm my stomach and start gaining weight again as I was experiencing some very distressing issues secondary to it. I expressed my fear of my abusive parent trying to control my therapy and control all narratives around me, and how I needed some help free of their control. She recommended an in-patient stay at Peninsula Hospital. I was told it was to be 2 weeks with individual and group therapy and medication help should I need it. I agreed as I trusted therapists and was trying to find some way to help myself. I stayed at their hospital facility for 2 weeks and then was discharged to Peninsula Lighthouse, their outpatient facility, to continue to monitor medications, continue therapy, group therapy, and possibly family therapy. I felt like I was doing better. However, what I did not know was that I put myself into a system that can be easily corrupted by the very person who was perpetuating my abuse. My abusive parent began to call the staff and my assigned psychiatrist and lie about my behavior to them. She would often do this on the phone in front of me preceding the phone call with the threat of having me locked away for years. I was terrified. Being from Knoxville, TN, I had heard rumors about Peninsula Village and how horrible it was. She continued to terrorize me with these threats and, while at my outpatient therapies, would often monopolize some of my treating psychiatrist's time with outlandish stories of my behavior at home. My treating psychiatrist then gave me an ultimatum: Gain 5 pounds in 1 week or we are sending you away to Peninsula Village. Given that my anorexia was not body image motivated and induced by anxiety through abuse, I failed to gain the weight. My abusive parent took the opportunity to be extra harmful to me that week as well to help guarantee my failure.

During my time there, I experienced no real mental health care. The program had 2 sections at the time. You started in the STU unit (Special Treatment Unit), which is their indoor lockdown facility. Upon my intake into the program, we had to write personal inventories of our bad behavior and drug inventories of what we had used. At first, I thought that if I really tried to be honest and work hard that they would see that I really did want help but my abuser had manipulated the system to put me here. I was brutally honest in both, but I had not done many of what they considered "bad" things.

When I turned in both inventories, they read them and threw the pages at me and called me a liar. I was angry, hurt, confused, and devastated. I realized then and there that I was not in a place that cared about my wellness. I refused to raise my hand and do a check-in with them 10 minutes later because I was so angry. We were made to sit on beds all day in silence, so my refusing to check in was just crossing my arms and shaking my head no. That is when I experienced my very first PCI (physical control intervention), which is physical restraint. The counselor pressed a button around her neck which set off an alarm all across the indoor and outdoor units. I, at 16 and 95 pounds, was suddenly yanked off my bed and thrown face down and laid on by 3 adults. Then more came piling through the door. I was so scared. I could not believe what they were doing to me. I was confused. I had

about 5–6 adults by the end fully holding me down and pressing their collective weight on me. Then, I was suddenly stuck with a needle and injected with something into my hip, which I later found out was likely Thorazine, to sedate me. I was screaming what are you doing? What are you giving me? They never told you.

We were not allowed to know what medications they were giving us and not told what you were taking or why, you just had to swallow your pills or risk another physical restraint. I had to rewrite both of my inventories and had to make up things I never did. I used things I saw on TV and drugs I had heard about to write my stories. They finally accepted them after that.

You were further dehumanized by not being allowed to have clothes. You started in hospital gowns, which were uncomfortable and didn't always quite cover you. The next step was scrubs. You had to earn these, and then at last you could earn your clothes. The way in which you moved up in these 3 levels of the indoor part of the program was based on peer bullying not support. To be "successful" in their program, you had to participate in this bullying during group therapy sessions and a consequences period of the day. During the consequences time, you would tell on each other. It did not matter if you did what you were being accused of or not, you just had to remain silent, take it, and accept the consequence. In order to move ahead, you had to do this to others. There was no opting out. They encouraged us to victim blame each other for the abuse that was perpetuated on us by our abusers. There was no safe space for our feelings here. There was another girl in our unit that was constantly acting out. At one point, shortly after I arrived, they had restrained her to a bed by leather straps to the arms and legs. She had been screaming and we couldn't sleep, so they made us stand in a circle around her and tell her how awful she was. I didn't want to participate, but it was clear I had to. The counselor told me that if I didn't that I would probably end up like her.

Since I was on eating disorder precautions, I had to shower with the curtain open and use the bathroom with the door open so they could watch me. Being watched while showering, urinating, and defecating was beyond humiliating and degrading. They claimed it was to make sure I didn't throw up. I had anorexia, not bulimia. I never threw up my food. I was also not allowed to look in the mirror the entire time I was in the facility, but that was true for all of the girls, not just me. They put me on a high-calorie diet and threatened me with IV nutrition and other things if I didn't eat it all. My abuser purposefully didn't tell them I was allergic to milk, so I was made to drink whole milk every day, which caused me to feel sick all of the time. If I complained about how badly my stomach hurt, they accused me of attention seeking and I was punished, so I just had to suffer in silence. You learned quickly in there that if you were hurting, felt sick, or had any complaints not to tell them. Anything that was wrong with you was met with accusations of attention seeking and an encouragement of your peers to bully you.

As I stated before, we were made to sit on our beds in silence most of the day. We had some brief exercise at our beds in the morning, but there was no going outside. The only time we were allowed to speak to our peers was during the 2 group therapy sessions daily, and maybe during one extracurricular during the day. The rest of the time we sat in silence. If you were caught looking out of the window, you were punished. If you looked around the room, you were punished. If you fell asleep because you were on new unknown medications causing this side effect, they woke you up and you were punished. If you were in a bed cubicle facing another person, you had to do everything you could to not look at them while also not looking around the room, etc. You basically just looked at your legs all day. There were 2–3 staff on the floor at all times. They stood up on something that was higher than our cubicles so they could watch us at all times, and they could hand out consequences for all of our imagined transgressions they accused us of.

We had "school" on Tuesdays and Thursdays. This "school time" consisted of us continuing to sit on our beds in silence while this woman who I guess was a teacher gave us individual assignments as we were all different ages and grades. If you had any questions, she would come to you but then admonish you for attention seeking if you didn't understand something or the assignment itself. You learned quickly not to ask questions of her. If you needed help, you were not going to get it. You just had to do the assignment wrong and suffer through the bad grades and more admonishment for not paying attention or being a diligent student. You could also be punished by the staff for attempting to manipulate the teacher, which meant asking too many questions.

Everything you were required to do there, making beds, teeth brushing, showering, urinating, defecating, cleaning, was timed. If you could not accomplish these tasks

in the ridiculously short times allotted, you were punished. During my time in the STU unit, I witnessed physical restraint by staff, people being tied to beds with leather arm and leg restraints by staff, constant staff bullying of us, not allowing us to use the toilet facilities outside of allotted bathroom times, and more.

In the STU unit was what they called the "Quiet Room". The Quiet Room was a fully padded room with one window and nothing else. We were threatened with being put into a straight jacket, which they referred to as "the burrito", shot with drugs, and left in there if we misbehaved. I witnessed them threatening others with being sent to a worse place than the one we were in if we didn't cooperate. I really thought that my experience couldn't get any worse and then I was "graduated" to the outdoor cabin part of the program.

I was in the Moose Clan cabin. It was a transitional cabin for those they felt needed to keep extra watch on. When I came to my cabin, they were on something they referred to as "blackout". This meant that the group was not able to get to different activities on time regularly and thus had become so dysfunctional that all normal activities were stopped. Despite me not being there when this happened, I was made to be punished with them. I learned that we were do our laundry once a week, but because of being on blackout, we could not use the washer and dryers. Instead, in the middle of winter, they filled wash basins with cold water from the garden hose and given washboards and soap to wash our clothing outside in the cold. It was extremely painful as your hands would turn blue and then purple from the cold air and water until they finally went numb. We had to sit in our cabins with our backs to each other and not speak all day until our group therapy sessions twice a day.

Even when normalcy in the cabin returned, it was not much better. We were constantly given physical punishments. They would assign 25–75 push-ups at a time, and this was multiple times a day on top of all of the other physical labor they made us do. Under the guise of needing to maintain a supply of wood for the fires in our cabins, they required us 3 times a week to roll giant tree trunks off of a pile and then saw them using a 2-person pull saw. If you weren't on saw duty, then you had to maul wood. We were made to do this for hours on top of the physical punishments. Even though we couldn't speak to each other but a couple of times a day, we were allowed to speak to the staff if you raised your hand and they actually allowed you to speak.

One of the punishments was called silence. When you were on silence, you were not allowed to speak to anyone including the staff, so you couldn't ask to use the restroom or for anything else you needed. One of the exercise punishments was called a "geloha", which is commonly known as a burpee. I was accused by staff and peers multiple times that day of imagined issues, and by the end of the day I had 150 burpees I had to do before I went to bed. This is on top of the physical labor, the group physical punishments, and the individual other physical punishments I had received that day. I made it through maybe half before I couldn't get up. They kept yelling that if I didn't finish that I would have to start over.

I was so physically exhausted that my body seemed to just shut down. I could not move. For that, I was being uncooperative and I was physically restrained. We were kept in a constant state of pain and physical exhaustion. My body hurt all day every day. They did not care. If you complained that something hurt, you were accused of attention seeking behavior and punished. We had a sand bucket we had to carry from one place to another. It was an old metal pail full of sand. They claimed we needed to carry it everywhere for safety reasons in case one of the fires in any one of the cabins got out of control. It was beyond heavy and there was nothing but a wire for a handle. It would cut into the skin of your hand. Then having to saw or maul wood or do any other physical activity with your hand became excruciating.

The cabins had no AC and an iron wood furnace for heat in the winter. The worst physical restraint I personally experienced happened after I was frustrated one day. I was put on silence. We were digging something up in front of our cabin and I really had to use the restroom. I raised my hand but the staff ignored me. I waved my raised hand and pointed to the bathroom, and they added another hour of silence to my punishment bringing it up to a total of 11 hours (sleep time didn't count towards your silent time). In my frustration and desperation to use the bathroom, I threw my shovel on the ground and started pointing at the bathroom with both arms without saying anything. This prompted them to hit the alarm and I was promptly tackled by the staff. By this point, the force of the tackle and the pressure of the people on me caused my bladder to involuntarily release and I urinated all over myself, the ground, and some of them in the process which made them angry. I had 5–6 adults on top of me, and because I urinated, they decided to move me

onto the deck of the cabin. They placed me facedown in a puddle of dry mud on the cabin deck. I couldn't breathe. When I took a breath in through my nose, it would fill with this dirt. I moved my head sideways to take a breath and they slammed my head into the deck.

This happened 4–5 times and every time I moved my head to breathe they slammed my head into deck. At that point, I was woozy from the head trauma and the lack of air and could not fight any longer. Thankfully, they moved me to roll me into the straight jacket and then carried me into the STU unit where I stayed in that straight jacket in the padded room for a couple of days.

In my entire time there, I had only 2 family therapy sessions. I was able to complete one, but the second one was after this incident. We were not allowed to tell our parents about our daily abuse or they would end the session. By the time I had my second session months into the program, I did not care anymore. I didn't care what they did to me. I had several goose eggs across the top of my head and my dad was extremely upset after seeing this. I told him that they slammed my head into the ground repeatedly and they ended the session. It lasted all of 5 minutes. I was punished for that but I didn't care. I didn't care what else they did to me at that point. I would rather die than continue to allow them to abuse me and from that point on I refused to cooperate with them. I was released a few weeks after that.

To say this treatment had a profound negative impact on me is an understatement. This changed the entire trajectory of my life. I could not finish high school because my school told me that my educational credits there meant nothing. I had intense PTSD including nightmares, night terrors, extreme anxiety, trust issues, social anxiety, things I still suffer from to this day, although it is not as intense as it once was. I do not trust therapists. I have had a difficult time seeking help as I do not trust any therapist who would willingly recommend these places as I feel they cannot be legitimate if they do. It damaged my relationships with my family, and my abuser was never held accountable for what she did to me. At the time I went in 1996–1997 mental health care like this was still highly stigmatized and I couldn't really tell anyone what I went through because everyone in this area knew that if you were sent to Peninsula Village that you must have been a horrible child who deserved it or you must be a crazy person and to stay away from you. I felt so alone for so long.

I felt compelled to share my story to prevent this from ever happening to another child again and to shed light on what others and I experienced, raise awareness, and to hold Acadia and other places like it accountable for the abuse they perpetuated on all of us. I also hope turning my testimony over will be healing for me. I want the Committee to understand the real-life consequences of inadequate care and oversight in residential treatment facilities.

To prevent these negative experiences, I believe the Senate Finance Committee should consider implementing stricter regulations and oversight of youth residential treatment facilities. This includes mandatory reporting of abuse, transparent data collection, increased staff training on trauma-informed care, regular and unannounced inspections, and ensuring that all facilities provide adequate mental health and educational services. Additionally, there should be accessible channels for residents to report abuse without fear of retaliation.

Thank you, Chair Wyden, and members of the Senate Finance Committee, for reading my testimony. I hope that my story and the stories of others like me will inspire you to take immediate action to protect vulnerable youth in residential treatment facilities. I hope you will pass the Stop Institutional Child Abuse Act (S. 1351) and follow that legislation up with additional reform policy to ensure all youth are safe from abuse, neglect, and preventable death in youth residential treatment facilities.

Sincerely,

Christina "Chrissy" Clark-Atkins

LETTER SUBMITTED BY MATTHEW DAVID COHN

June 12, 2024

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

Senate Finance Committee:

It is my hope that my words might move some of you to act against Residential Treatment Centers and their ilk. I am a Series 7 licensed institutional stockbroker with advanced degrees in Philosophy, Psychology, and Finance, but 20 years ago I was a scared child thrown out onto the streets after aging out of a Devereux program. Aging out implies that amongst "the worst of the worst," Devereux had failed to "rehabilitate" me, resulting in my staying in a program until I was 18; So why am I so successful now?

When I was ~14, strife with my adopted parents had come to a head. A middle school love triangle had blown up in my face, my crush and the girl who crushed on me both turning against me and making up some disturbing stories about me to get me in trouble. It worked, and I was expelled. Stuck at home with my parents, I struggled at the young age—I was *very* immature—to handle the pressure of the situation and ran away, was arrested, and ultimately found myself in the first of three programs—Cedar Ridge Academy in Roosevelt, Utah.

Upon arrival, I was told we would learn martial arts, and shown the park-like property, landscaped grounds in the Utah wilderness, miles from civilization. I had about 5 minutes of thinking it could be a positive experience. I soon discovered the landscaping was done by the children via slave labor, we were kept there to work the land and make it look the way the owner wanted. Disobedience was met with viciousness.

The rules were overwhelming, overbearing, and draconian. We couldn't talk, every action, our attire, our expressions, everything was highly regulated. Within days, I didn't want to eat yogurt at breakfast (I hate yogurt, tastes like flavored rotten milk), and was sent to shovel compost. At the compost pit, 1 shovelful was 1/50 of a point, and by earning points I could earn my food, a shower, the right to sleep indoors, a sleeping bag. . . . I think I spent months there. It's hard to tell. The days blurred together and it's all a haze, 20 years later. I spent the entirety of my time at Cedar Ridge isolated from my peers, digging compost—I always refused to eat yogurt.

After some time, my refusal to play ball culminated in my being sent to a more serious facility, **Youth Care Treatment Center** in Draper, Utah. Youth Care was run out of a single-story house, just a regular house converted to imprison ~16 children. Beige walls and dim lighting throughout the house, which was decorated sparsely with ornaments that probably came from Wal Mart. There was one large room we used as a schoolroom, but we spent most of our time in our bedrooms or the living room. The back yard was ringed by a white fence and pretty barren, if memory serves. Youth Care was an Aspen Education/CRC Health Group company, but it is currently owned by **Acadia.**

My time there was especially confusing, as they did not blatantly torture, outright physically or sexually abuse, or starve me; but Youth Care's program almost broke me through and through. In contrast to being trapped outdoors in the compost field, I spent a year not leaving the house with limited exception.

Try this for yourself. Rent a normal sized single-family house and do not leave it for a year. Do not go to the store, do not go to the movies, do not go to a restaurant. Stay in your house for 1 year eating nothing but baked chicken and crock pot and tell me how your mental health is once the year is up.

Highlights of the year I spent at Youth Care include:

- My therapist Suzanna telling me I would spend rest of my life in prison;
- Another therapist stealing my journal and reading it aloud to a group therapy session;
- Watching 'Finding Forrester' at least 15 times as it was one of the only tapes we had;
- The aforementioned diet of baked chicken and crock pot;
- The cheap vo5 shampoo that I never want to smell again; and
- The padded gray isolation room in which I slowly whittled away my days.

I did not respond well to this confinement. I would act out, talk back, not follow directions, one time I even I walked into an office room, barricaded the door, and called my crush in California. In response, I was regularly slammed on the ground, shot full of Thorazine and left in the padded, gray isolation room. It was easier than being conscious, spending my time in a drug induced coma. Anything was easier than being trapped in a single-family home at the age I was ready to climb mountains.

When I speak to survivors who played by Youth Care's rules, many of them are now much worse off than me. Youth Care—Like **Devereux Cleo Wallace**—operates under the mistaken belief that submission/obedience = vital adolescent personal growth. One staff told me that the administration drilled into them, that "all (we, the children) needed was structure." But who decided that? What person among you believes that structure is the sole requisite growth medium for healthy human beings? Not allowing boys and girls to kiss or hold hands, the aggressive therapy led by under-educated ~25-year-old, low-paid staff, over-medication at this crucial age destroys lives, simply put. Many of us cannot find our way back when they learn to submit instead of grow, at this crucial juncture.

Youth Care is still open, and they've expanded by constructed several other, much larger, houses—A sign of their strong business. But after about a year there, the powers that be determined I had bombed out of a second residential program, and I was told I'd be shipped to a third.

And so, after a year, I was moved to Devereux Cleo Wallace. Devereux's Westminster, Colorado facility was a massive operation. The first thing I noticed driving in was the large building with the blue roof which housed administrative offices and the schoolrooms. The ~28-acre property also had a gym with a pool, a sports field, a cafeteria, and seven residential units: The inpatient intensive care unit A, B West for older boys & B East for younger, C for more developmentally disabled boys, D as a high discipline unit for boys, and E & F for girls. Having been tossed by two programs, I was placed in D. The unit itself had a large common area in the middle with a staff desk, with wings on either side with rooms. For the years I would make this place my home, my space was most often a urine stained mattress on the floor of the common area. I would rarely stray from my unit, the school, the cafeteria, or the gym for the next few years. My world view, already damaged from the previous two placements, would not benefit from more years spent behind different walls.

At Cleo, I finally accepted that I simply do not respond well to authoritarian regimes. My time there was characterized by constant physical restraints and time spent locked in isolation. Days, upon days, upon days spent in a small, cold room, where the light was always on and there was no surface to sleep on but a linoleum floor. I would remain at Cleo until June 2004 when I turned 18.

In many ways, Devereux Cleo Wallace was the most abusive program I attended. The restraints were the most brutal, we marched everywhere, our unit was notorious even within other units at the program for being heavily disciplinarian. I learned this when I was instructed to stop watching Star Wars for some insignificant act like talking, only to be brutally thrown to the floor, beaten down, and dragged—bleeding—to the isolation room.

I spent my days there working on useless therapeutic packets, nonsense paperwork filled with half-baked psychology, seeing poorly trained clinicians, and navigating my peers (largely Sioux gangsters, sexual deviants (read: traumatized children who had been abused and struggled to break the cycle), and schizophrenics. I bonded most closely with the Sioux.

In my early days, I was able briefly touch the hand of a beautiful redhead who was clearly interested in me. Staff immediately saw, and we both spent some time in the isolation room. This would be the last glimpse of intimacy I had for the entirety of my "high school" experience, and perfectly encapsulates how detrimental the experience was for a developing young person—Right as I ought to be discovering attraction and romance and intimacy, I instead braved an insane experiment in isolation and punishment. I wonder about her, even now. I hope she is well.

I will mention at this point that in the nearly 4 years I spent in these institutions, I would be hard pressed to say I ever actually went to school. At Devereux, there was a full year of "school" where we just watched TV—American Idol and the Eco-Challenge were favorites that year—and my hazy recollection identifies any other schoolwork I completed as meant for elementary ages. It was so difficult to come across books that I'd read anything I could, psych pamphlets and the backs of bottles, there was never enough around to keep a mind from slipping away. This would become one of the hardest points to accept in adulthood: the incarceration was already a loss of time, a high school experience stolen, but by taking my education, my future was stolen as well.

I continued getting struggling and getting restrained until the last 6–8 months I was in treatment. By the end, restraints were simply a coping mechanism, the only way I could physically struggle against my bonds without hurting anyone. One

day, after they'd dragged me off to the isolation room, the unit supervisor came in and asked me "what they were going to do with (me)?" And I responded that I won't get in another restraint if he took me out for a decent lunch when I discharge. That would my last restraint, and the day before I left he took me to a hibachi steakhouse.

Years later, I would relay to that man how much that small gesture of kindness meant to me. What it meant for someone to finally reason and work with me instead of giving me the hardline. He surprised me by telling me that his act of kindness was an inappropriate mistake that he should not have done. I struggle to understand this even now. This deal was one of the only positive experiences I had in my time there. That was it. That was the moment when he reaffirmed my humanity. But there is a fundamental misunderstanding between those who run these facilities and the children inside them.

Shortly before I aged out of Devereux, two boys ran away and came back at night, attacking two staff in an attempt to rescue two girls. One staff was stabbed, another bludgeoned. I remember being shocked by the violence—even then, after years in these institutions, surrounded by nothing but filth and violence. This, ultimately, poses an honest question: I was 17, I had never done drugs nor had I ever acted out sexually, and when I heard of horrific violence, real violence, I was horrified. So what was I doing there for so long?

I hit the ground running when I aged out, never wanting to be tied down again, but jumping into college yielded grim discoveries as I quickly became very aware of everything I'd lost and missed out on. My lack of education precluded me from studying medicine as I'd once hoped, I did not have the math, and I began to watch my relationships fail as I struggled to adapt socially. I was in a different place, and it was hard to establish empathetic connections with these people who had never known torture. As one ex-girlfriend said, she "dipped a toe into me and was instantly overwhelmed."

Now? I'm 38, I have a nice career, I box and play bass guitar. I have not been to prison and don't use hard drugs. You could pass me in the store and see *only* a stockbroker resplendent in his Brooks Brothers; but unseen is the constant pressure wrought by my time in residential facilities. Despite my academic aptitude, I received no scholarships—I had not been to school—and so I now owe $150,000 of student loan debt. My relationships are non-existent, torturous. I find cruel women, and they hurt me. The cycle continues.

I know now I am not alone. There are thousands of us. Thousands of warriors who once taken from their homes who fought, in their own way, to survive, even in the midst of overwhelming hopelessness. That, finally, is the biggest dilemma of all. I have learned to love myself. I know I'm strong. I know how I've fought, what I've survived. I believe we deserve to love ourselves, not *despite* of our time in RTCs, but *because* we were able to survive these hellholes. Who could be more deserving of self-love than someone who would brave such circumstances?

But I am still very lonely and unhappy. I still remember and I still hurt. And I am not alone in this pain. Institutional child abuse must end. The Senate Finance Committee must address the near total lack of regulation and oversight of youth residential treatment facilities. The standard of care must be raised. Over-medication cannot be used, isolation, keeping adolescents from exploring is cruel.

Please consider my words and act accordingly.

Sincerely,

Matthew David Cohn

LETTER SUBMITTED BY COURTNEY COLEMAN

June 23, 2024

U.S. Senate
Committee on Finance
Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

Dear Senate Finance Committee Members,

I am writing to you from Oregon. Thank you for prioritizing the critical issue of Residential Treatment Facilities (RTFs).

My name is Courtney Coleman. I am the proud mother of a 14-year-old girl named Frankie with Rett Syndrome and CAA. As Frankie has gotten older, her medical complexities have become more involved. Right at the height of our pandemic, she had to have pelvic and spinal fusion surgery, a g-tube placed and a VNS to help try to better control her seizures. She is a brilliant, beautiful and expressive young woman that uses an eye gaze and gestures to communicate. She loves music, being outdoors, the beach and all things girl. She also requires 24/7 care in which I am the most qualified person to provide. Not just because I have a good medical background (both learned and through education) but also because I know all things Frankie. She is my favorite person in the world and the care I provide for her makes her feel happy and safe. I am an educated woman with an unfinished LCSW due to my child's needs. I am not a lazy individual that wants to sit back and collect a paycheck at my daughter's expense. The group of parent's fighting to make a paid parent benefit for children under the age of 18 and spouses a National option are fighting because our children were thriving during the pandemic. Our children were thriving because their families were able to stress just a little less. We were and are incredibly grateful for the paycheck that allowed us to have a sense of worth, kept our children safe and drained far less on otherwise necessary resources (EBT, TANF, SSI, etc.)

I know how these systems work and it's a lot of bureaucratic red tape. At this point it seems like a matter of problem solving, looking at the legislation passed in states like California, Minnesota, Colorado, Idaho and Arizona where this is a permanent benefit, as well as, figuring out how to bring in additional funds to cover paying parents. Taking this benefit away when it was clearly working left us behind again. It is very frustrating that this benefit is provided to literally anyone else but the parents. In most cases we are the best and most qualified people to care for our children. Furthermore, if we can't afford to keep a roof over our heads, we can't employ others as PSW's regardless and are forcing families to put their complex children into facilities or Foster Care. Why is the Government paying other's up to $75,000 a year to care for our children, but we can't figure out a way to pay us $30,000?

Parents who are able to be paid caregivers will be less likely to access other social services and drain snap/tanf/ssi because they will be able to help support their family! How is it more acceptable or okay to pay strangers (with zero skill set) to take care of our kids. PSW's and DSP's are in short supply (they were prior to the pandemic) and have very little skill set, especially with our medically and behaviorally complex Kido's. We can't find them in the first place!

This is not a COVID (PHE) issue, this has always been an issue. I am so frustrated and confused. . . . I get that we need federal funding but for the love, why are the people we turn to for help giving up on helping us with this. We shouldn't just settle on "well this is the way it is" or "we would lose money here so it can't be done." It can be done! It's been done and we need to get the right people working on it. People who want to make actual changes that truly benefit our children, their families and society as a whole.

How can we solve this problem? . . . it sounds like people are just throwing their hands up and saying this is just the way it is—not an acceptable answer and it doesn't have to be like this! Change is hard, but now we know that this is a program that was/is benefiting families all around so where or who do we as parents start in order to make changes happen? Will you be the ones that help us take a stand?

How much were the state kickbacks for the last year? How much has been paid out to parents? . . . is there a fix within that link?

My head is just spinning a bit and I'm more than frustrated . . . I understand there are rules and regulations, but now we know we can do better and so it's time to figure out how to continue doing better!

Thanks for all that you do! Please don't leave us behind!

I am writing to ask you to recognize the barriers to paid family caregiving and their role in abuse and neglect in our nation's care network. Home and Community-Based Services (HCBS) current regulations (Section 1905(a)(24) of the Social Security Act, 42 CFR § 440.167, and 42 CFR § 441.105) prevent family caregivers from being paid

to provide care at home. This forces many families to place their loved ones in RTFs due to the lack of affordable care options.

During the COVID–19 pandemic, 39 states allowed parents and spouses to be paid caregivers through CMS waivers. This led to better care, fewer hospitalizations, healthier homes, reduced dependency on welfare, and increased tax revenue. The National Council on Disability supports making this change permanent.

CMS officials, including Dan Tsai, have acknowledged the benefits of paid family caregivers. However, current federal regulations remain a barrier. Congress must "ban the bans" on paid family caregivers and incentivize states to adopt this model.

This change is crucial to prevent the abuse and neglect often seen in RTFs and to support families in providing safe, effective care at home.

Appreciatively,

Courtney Coleman

CONSORTIUM FOR CONSTITUENTS WITH DISABILITIES
820 First Street, NE, Suite 740
Washington, DC 20002

Statement of the Long Term Services and Supports Task Force Co-Chairs

The undersigned co-chairs of the Consortium for Constituents with Disabilities (CCD) Long Term Services and Supports (LTSS) Task Force appreciate the opportunity to submit a statement for the record for the hearing, *Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions,* held on June 12, 2024. We thank the Committee for holding a hearing on the grave abuses that children and youth have suffered in residential treatment facilities, and appreciate the focus on building solutions through expanding and improving intensive home and community-based services.

CCD is the largest coalition of national organizations working together to advocate for federal public policy that ensures the self-determination, independence, empowerment, integration, and inclusion of children and adults with disabilities in all aspects of society free from racism, ableism, sexism, and xenophobia, as well as LGBTQ+ based discrimination and religious intolerance. The CCD LTSS Task Force advocates for the services and supports that enable individuals with disabilities of all ages to live in their own homes and communities.

One of the Task Forces' priorities is to reduce the use of long-term institutional care for children with disabilities, and to advocate for robust implementation of children's right to community-based mental health services pursuant to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) mandate, the Americans with Disabilities Act, and Family First Prevention Services Act.

Several days ago, we celebrated the 25th anniversary of the *Olmstead v. Lois Curtis and Elaine Wilson,* where the Supreme Court held that segregation of people with disabilities is a form of discrimination under the Americans with Disabilities Act. As Justice Ginsberg explained: "[C]onfinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."[1] What was true in 1999 is still true today: prolonged segregation of youth in residential treatment facilities deprives them of all the benefits that come with community living—including opportunities to be with their families and friends, to learn in school, and to develop strengths and pursue their interests.

Instead of long-term stays in residential facilities, children with disabilities belong with families, receiving high quality, intensive home and community-based mental health services when necessary.[2] As the U.S. Department of Health and Human Services' (HHS) regulation implementing Section 504 of the Rehabilitation Act

[1] 527 U.S. 581, 583.

[2] American Academy of Pediatrics, Children's Defense Fund, Foster Club, Think of Us, and Youth Law Center (Jan. 2022), The Path to Well-being for Children and Youth in Foster Care Relies on Quality Family-Based Care, *https://familyfirstact.org/resources/path-well-being-children-and-youth-foster-care-relies-quality-family-based-care-what%E2%80%99s.*

states, "[C]ongregate care is virtually never the most appropriate long-term placement for children."[3]

Focused expansion of quality intensive home and community-based Medicaid services would meaningfully address the needs of youth with complex behavioral health conditions and prevent harmful out-of-home placements in residential treatment facilities. Such services include: (1) intensive care coordination, (2) intensive in-home behavioral services, (3) mobile crisis response and stabilization services, and (4) therapeutic foster care (also sometimes referred to as "treatment foster care,"). These services are essential to a functional youth behavioral health system. Expansion of these services would work to rebalance utilization of community-based services and institutional behavioral health treatment, and with it, begin to correct the overreliance on residential treatment facilities that is so harmful for the youth trapped in them.[4]

Pursuant to Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, all of these services can (and must) be available to Medicaid-enrolled youth when necessary.[5] However, this care is often not widely available, due in part to underinvestment in community-based care and insufficient provider networks, leading to long wait times or complete denial of access. When the services are available, they are often not provided in a highly coordinated manner, nor in accordance with appropriate standards or guidelines designed to ensure their therapeutic effectiveness.

To help remedy these issues, we offer the following recommendations:

(1) Support states in ensuring services are provided with fidelity to the model.

Some services that youth need should be delivered through practice models that have fidelity scales that allow practitioners to assess whether services are being delivered in the way that they were designed.[6] For such services, we suggest requiring states to implement these evaluations and publicly share data. States could be provided additional funding to develop the data systems, high fidelity monitoring, and training that is necessary to demonstrate adherence to the model and to continuously improve these services. For example, Intensive Care Coordination delivered via High Fidelity Wraparound, includes scales to monitor fidelity to the practice model in service delivery and indicated ways to collect data about enrollment and outcomes.[7] Additional funding can support states to effectively implement this service and carry out these evaluations.

(2) Allow 1915(c) waivers for youth with a Psychiatric Residential Treatment Facilities (PRTF) level of care.

Because PRTFs are not a designated institutional setting for the purposes of § 1915(c), it can be difficult to target home and community-based waivers to this population through 1915(c) waivers.[8] While the EPSDT mandate requires states to

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[3] U.S. Dep't of Health & Human Servs., Discrimination on the Basis of Disability in Health and Human Service Programs or Activities, 89 Fed. Reg. 40106 (May 9, 2024), *https://www.federalregister.gov/documents/2024/05/09/2024-09237/nondiscrimination-on-the-basis-of-disability-in-programs-or-activities-receiving-federal-financial.*

[4] *See generally* Jocelyn Guyer et al., Manatt & The Commonwealth Fund, Leveraging Medicaid to Support Children and Youth Living with Complex Behavioral Health Needs: Framework and Strategies (Nov. 2023), *https://www.manatt.com/insights/white-papers/2023/leveraging-medicaid-to-support-children-and-youth-2;* Jennifer Lav & Kim Lewis, Nat'l Health Law Prog., Children's Mental Health Services: The Right to Community-Based Care (Aug. 2018) (hereinafter "The Right to Community-Based Care"), *https://healthlaw.org/wp-content/uploads/2018/09/NHeLP-Issue-Brief_Children%E2%80%99s-Mental-Health-Services.pdf.*

[5] 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B); 1396d(r).

[6] *See, e.g.,* University of Washington Wraparound Evaluation & Research Team, National Wraparound Implementation Center, and the National Wraparound Initiative Webinar, Keeping Wrap on Track: A Panel of Leaders of Large-Scale Wraparound Evaluation Projects (April 16, 2024), *https://nwi.pdx.edu/webinars/Webinar54-keeping-wrap-on-track.pdf.*

[7] National Wraparound Initiative, National Wraparound Implementation Center, & Wraparound Evaluation and Research Team, Guidance for Family First Prevention Services Act Evaluation Plans for High Fidelity Wraparound (2022), *https://nwi.pdx.edu/pdf/Guidance-FFPSA-High-Fidelity-Wraparound-Updated-02-2022.pdf.*

[8] *See* 42 U.S.C. § 1396n(c)(2)(B) (permitting states to target waivers to those "entitled to medical assistance for inpatient hospital services, nursing facility services, or services in an intermediate care facility.") We recognize that states have other options to target services to youth with specific needs and that 1915(c)s are used to target some individuals with mental health needs, but to do so the individual would still have to meet an inpatient hospital, nursing facility, or intermediate care facility level of care.

cover all necessary services for youth under age 21, there are also certain advantages to utilizing a 1915(c) waiver for this population to provide services that are not otherwise covered (or coverable) as medical assistance, such as respite services. A state may also utilize a 1915(c) waiver to provide services for children and youth with slightly higher income levels, which can also be utilized to limit the practice of "custody relinquishment" just to access community-based services for families with higher incomes.[9] Last, as noted above, even though states have a federal obligation to cover such services, this does not always result in robust access. Given these challenges, legislation that would deem a PRTF an institutional level of care for purposes of HCBS waivers may be a successful strategy. Such a strategy could help develop service structures, recruit providers, extend coverage to families with slightly higher incomes, and to supplement children's existing entitlement.

We ask that if this policy is pursued, safeguards are put in place to ensure that waivers do not in any way curtail or limit a state's EPSDT obligation to provide youth with all medically necessary services that are included within the categories of mandatory and optional services, regardless of whether such services are covered under the State Plan.[10]

(3) Require additional rate analysis for intensive home and community-based mental health services.

As noted above, although formal wait-lists are not permitted for State Plan services, and waivers cannot be used to circumvent EPSDT entitlements, youth still all too often wait for services due to poor access and provider shortages. Recently, CMS finalized the Ensuring Access to Medicaid Services rule, in part to rectify this lack of access.[11] Laudably, CMS will require comparative payment rate analysis for outpatient mental health and substance use disorder services, and this analysis must measure Medicaid fee for service rates against Medicare payment rates for the same time period (and track rates for the pediatric population separately).[12] However, for various reasons, many of the services needed to serve this population of youth may not be adequately addressed in the rate analysis.[13] Thus, while we appreciate that

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[9] HHS recently amended Section 504 regulations to clarify that the practice of requiring children, on the basis of disability, "to be based outside the family home through custody relinquishment, voluntary placement, or other forfeiture of parental rights in order to receive services" is prohibited. 42 CFR § 84.60 (effective July 8, 2024), U.S. Dep't of Health & Human Servs., Discrimination on the Basis of Disability in Health and Human Service Programs or Activities, 89 Fed. Reg. 40189 (May 9, 2024), *https://www.federalregister.gov/documents/2024/05/09/2024-09237/nondiscrimination-on-the-basis-of-disability-in-programs-or-activities-receiving-federal-financial.*

[10] 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B); 1396d(r). CMS, EPSDT—A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents 26 (2014), *https://www.medicaid.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf;* ("Children under age 21 who are enrolled in an HCBS waiver program are also entitled to all EPSDT screening, diagnostic, and treatment services. Because HCBS waivers can provide services not otherwise covered under Medicaid, waivers and EPSDT can be used together to provide a comprehensive benefit for children with disabilities who would otherwise need the level of care provided in an institutional setting. . . . The HCBS waiver services essentially "wrap-around" the EPSDT benefit.".) CMS, Application for a § 1915(c) Home and Community-Based Waiver [Version 3.6, January 2019] Instructions, Technical Guide and Review Criteria 131–132 (2019), *https://wms-mmdl.cms.gov/WMS/help/35/Instructions_TechnicalGuide_V3.6.pdf* ("States have an affirmative responsibility to ensure that all child waiver participants (including children who become eligible for Medicaid by virtue of their enrollment in a HCBS waiver) receive the medically necessary services that they require, including Medicaid coverable services available under EPSDT. Because the HCBS waiver can provide services not otherwise covered under Medicaid and can also be used to expand coverage to children with special health care needs, EPSDT and HCBS waivers can work well in tandem. However, a child's enrollment in an HCBS waiver cannot be used to deny, delay, or limit access to medically necessary services that are required to be available to all Medicaid-eligible children under federal EPSDT rules.").

[11] CMS, Medicaid Program; Ensuring Access to Medicaid Services, 89 Fed. Reg. 40542 (May 10, 2024).

[12] *Id.* at 40872. 42 CFR 447.203(b)(2), (b)(3)(i)(B).

[13] CMS has already stated that to narrow the analysis, it will exclude certain codes. In order to be included as a mental health service, the service must have an E/M CPT/HCPCS code that was in effect for calendar year 2023, the code must be on the Berenson-Eggers Type of Service (BETOS) code list for the same period, and it must fall into the E/M family grouping for outpatient mental health and substance use disorder services. Examples CMS gives of services that will be excluded include peer support, psychosocial rehab, and assertive community treatment. The final list of CPT/HCPCS codes that are subject to comparative rate analysis will be published no later than July 1, 2025, and are subject to change. However, it seems likely that core services essential to support children with intensive mental health needs may not be included

Continued

CMS has an enormous task ahead to effectively implement the Access Rule, we are concerned that payment rates for services for this population may not be adequately examined. Additional funding directed towards studying payment rates and access to core community-based services for youth with complex behavioral health conditions and significant needs could address these gaps and help inform future rulemaking.

Thank you for your attention to these important issues. The Task Force looks forward to continued partnership as the committee works to move forward legislation that would support people with disabilities and improve access for Medicaid services. Please feel free to contact Jennifer Lav at lav@healthlaw.org with any questions or comments.

Dan Berland
National Association of State Directors of Developmental Disabilities Services (NASDDDS)

Tory Cross
Caring Across Generations

Lydia Dawson
American Network of Community Options and Resources (ANCOR)

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National Health Law Program (NHeLP)

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American Association of People with Disabilities

Gelila Selassie
Justice in Aging

LETTER SUBMITTED BY RACHEL DAMROW

June 24, 2024

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

Dear Senate Finance Committee Members,

I am writing to you from Michigan. Thank you for prioritizing the critical issue of Residential Treatment Facilities (RTFs).

I have a 7-year-old son with autism spectrum disorder who requires support for all self-care and daily living skills. He is nonspeaking and has behavioral issues, which makes it very difficult to find a qualified, trustworthy caregiver. My son is highly vulnerable to abuse due to his challenges with communication. I am unable to commit to a job so that I can always be available for his unpredictable needs, which has an enormous financial impact on my family. If I was able to be his paid caregiver, I would always know he was safe, understood, and receiving the full assistance he needs. In Michigan, we also need more spots available on the Medicaid waiver so we have a program comparable to other states. Michigan is leaving hundreds of children on a never-ending wait-list, which affects their families as well.

I am writing to ask you to recognize the barriers to paid family caregiving and their role in abuse and neglect in our nation's care network. Home and Community-Based Services (HCBS) current regulations (Section 1905(a)(24) of the Social Security Act, 42 CFR § 440.167, and 42 CFR § 441.105) prevent family caregivers from being paid to provide care at home. This forces many families to place their loved ones in RTFs due to the lack of affordable care options.

During the COVID–19 pandemic, 39 states allowed parents and spouses to be paid caregivers through CMS waivers. This led to better care, fewer hospitalizations,

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in this analysis. CMS, Medicaid Program; Ensuring Access to Medicaid Services, 89 Fed. Reg. 40680, 40733 (May 10, 2024).

healthier homes, reduced dependency on welfare, and increased tax revenue. The National Council on Disability supports making this change permanent.

CMS officials, including Dan Tsai, have acknowledged the benefits of paid family caregivers. However, current federal regulations remain a barrier. Congress must "ban the bans" on paid family caregivers and incentivize states to adopt this model.

This change is crucial to prevent the abuse and neglect often seen in RTFs and to support families in providing safe, effective care at home.

Appreciatively,

Rachel Damrow

LETTER SUBMITTED BY JONATHAN DEJESUS

June 10, 2024

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

To whom it may concern,

Please submit the following statement into the record for the June 12, 2024 Senate Finance Hearing, Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions.

I have a partner, a baby and three cats. One of the cats is named Phoenix. He entered my life just as I came out of the ashes. Phoenix was the first time I felt unconditional love, a pure love that I now feel at a deeper level from my son.

I have a great job. I work for You Gotta Believe, a nonprofit that helps find permanent families for young adults and teens in foster care. I am also involved in various advocacy organizations that help kids aging out of the system. This is something I care passionately about. It is unfair and cruel to expect young people who have already suffered so much, been denied support and the unconditional love every child deserves to get no help in the biggest transition of their lives—adulthood. Imagine being expected to pay the rent and be responsible with no information and no resources. Not fair.

I was recently part of a team of advocates looking into the harms of congregate care in New York. We put together an in-depth report that calls out what is wrong, and what needs to change. That includes making sure that people like me are at the table making change happen, pushing for the placement of youth with relatives instead of institutions, and ending the mistreatment and abuse of children in these places.

In congregate care we saw:

- A carceral environment, including severe limitations on privacy, bathroom use, poor food quality, and inadequate medical care.
- Threats to safety, such as severe punishments, feeling endangered by staff and other youth, and living in an environment rife with violence and bullying.
- Loneliness, stemming from facing restrictions in communications and visits from family and friends, feeling disconnected from their relationships, and experiencing apathy from staff.
- Lasting barriers to well-being and stability, specifically leaving the foster system feeling hopeless, traumatized, ill-equipped for future education and career opportunities, and unprepared for independent living.

I feel like I have packed a lot of living into my 23 years. I am a trans male who was born and lived in Ecuador for 10 years and have since lived in Queens, the Bronx, Upstate New York, and Brooklyn. I went into foster care when I was 12 and spent 8 years in congregate and residential treatment facilities. I never had much consistency in my life. My mother and father didn't figure much in it. I've had help along the way, but I raised myself.

In care, you never get a chance to breathe—you were in survival mode. I know what I didn't have as a child and I am going to make sure my son gets those things. I

am going to teach him how to manage his emotions. To be okay with his feelings, to give them space and understand and learn from them.

At You Gotta Believe I work with an unforgettable team of people. We share ideas and a deepcommitment to our work. Together we train parents on how to ease the gap for young people by giving them the love, attention, acceptance and most of all the patience they need to recognize and understand their trauma. We listen to young people, make them feel comfortable and seen. I only wish I could do more. If someday I have my own nonprofit, I would give them the most targeted and intense services available—whatever it takes to heal and grow.

I've been through a lot of hurt. There was a time when I truly believed I wasn't going to make it. But I wouldn't change anything. If I did I wouldn't be me. Maybe I'd be arrogant or closed minded. If I hadn't gone through everything I have, I wouldn't be able to help the people I help. There's no better learning than living.

Sincerely,

Jonathan DeJesus

LETTER SUBMITTED BY MELODY KAY DERKSEN

June 12, 2024

U.S. Senate
Committee on Finance

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

My name is Melody Derksen.

I am the former wife of Jason Derksen owner of Stone of Help home for troubled boys and former principal of Agape Boarding School in Stockton Missouri. I am a survivor of the TTI industry but in a different way than the other survivors.

My story is different from the other survivors because I am the ex wife of the former principal of Agape boarding school. I wasn't married while my ex husband was principal but my kids were kids in the middle. I was also the daughter of my now deceased father who worked for JP, the founder of Reclamation Ranch. My parents' relationship with JP was first a worker relationship and grew into a family friendship relationship. Both of my parents would have considered JP as a really good family friend. If they needed anything he would be there for them. Well until we were left stranded and homeless anyway.

This camp or branch if you will of TTI is of a cult called the Independent Fundamental Baptist which I was raised in. I will refer to it as IFB. In its very design and at it's core many believers believe that this "Biblical" discipline is part of God's plan. There is a book which is passed around in some of these communities Titled "To Train Up a Child" which gives horribly abusive advice by taking biblical scriptures and using them to teach that the Bible wants parents to discipline children in a way that amounts to criminal abuse. It in more detail describes these fundamental teachings in that book. I would recommend the committee and those tasked with investigating this industry especially those faith based organizations that are IFB or it's affiliates and associated with this culture of abuse read the book to understand these dangerous teachings and dangers this poses to the public when it relates to the troubled teen industry and group homes.

In my experience I would say that it is more than fair to say a large group within the IFB believe that abuse is Biblical discipline. What they believe is biblical discipline those outside believe it is criminal abuse. I was raised in this very twisted way. My dad was a very strong believer in that "To train up a child/Biblical Discipline mentality" that amounted to horrible abuse. I want this committee tasked with safeguarding vulnerable children to understand that there is a whole culture of people who also believe that the Bible teaches abuse of children. The IFB by it's nature and at it's core believes the Bible very literally and radically. Specifically only the 1911 King James Version.

I was denied access to an education and raised that a woman's place was in the home under the guise of being homeschooled. I was molested by my father multiple times. I don't know how many. A lot. I was physically and mentally abused by my father. I told my mom and she turned everything around on me. Preached about forgiveness to me. Acted disabled and incapable. Made me take care of her and feel

like she depended on me instead of me depending on her. Later in my life I learned from my uncle that my mom's family (mom, dad, and two brothers) had tried to take us away from my parents. As told to me only a few years ago by my uncle. My mom had told him he was abusing us. My mom's family came and busted down the door to my parents house and forcefully took us away. They took us to the doctor, a Dr Chris something, he couldn't remember, but he told me we had broken bones and old broken bones.

They (my parents) eventually got us back and DHS had them in some sort of probation. DHS was supposed to be doing visits. When DHS concluded their probation my father immediately moved us far away from the family who all live in south Texas to isolate us all the way in Idaho and then in Washington State, and then into the IFB cult to further insulate themselves. From my father's perspective as an abuser and pedophile he found comfort, security, support and validation within the IFB which of course made my life even worse. Also I want to speak about the strange sorts of abuses which I feel amounted to torture which I endured without help or anyone to even ask for help because I was fully isolated and my parents insulated within the IFB community and with their connection to JP.

My dad would take a large plank and tie it around my waist and load it with bricks as a form of punishment for simply crying and to "toughen me up." I have leg pain from the broken bones and also from the shin splints which I have had since I was a child. My mom lied to me about why my legs always hurt and said I was born with my legs twisted and had to wear braces. I didn't figure out what was really wrong until the conversation with my uncle. Also I asked him if I needed braces after I was born and he said what my mom told me wasn't true and I wasn't born that way. My legs were fine at birth.

It was some wrong medical advice about my pain in my own body, my mom told me lies instead of important medical information I needed and deserved to know. She has passed away and I'll never get the truth from her. I also endured grueling work in extreme Texas heat doing work that was too hard for a small child. Forcing me to lift heavy rocks too heavy for my ability, pull felled trees that I couldn't haul, lift bags of cement, dig a sewage system, this was about the age of 7–11. I was also a small petite frame as a little girl. Once on accident while working he was pitching big rocks but accidentally threw the rock on my head that was about the size of a bag of flour and cut the back of my head. I wasn't taken to get medical attention and I was ok but it's just that it wasn't really a good idea to have me out there trying to work like a grown man and getting hurt.

Another time when I couldn't pull a tree that was too heavy and I was crying so my dad just came behind me and kicked me in my buttocks and sent me whirling forward and I scraped my face up on the tree trunk and my nose bled. He would tell me a no win situation such as I'm going to go check on my mom (she lived next door to us) and come back and when I get back the clothes better be folded, put away and the dishes washed and if they aren't done when I get back, your going to get a good beating with my belt. There wasn't a specific time limit and I had no idea how long he would be gone and come back. Another time he just picked me up by my hair and threw me down the hall because I talked back to my mom. He would beat me mercilessly with a belt for things I couldn't help, that weren't my fault or I felt were out of my control.

I remember my mom trying to pull me away and getting hit too. He would quote bible verses and preach the Bible while beating me. One specific verse he always used was that "rebellion was as the sin of witchcraft" and that "I was a rebellious witch for not obeying." My dad was abusive before we went to Washington to work with JP. I do want to point that out unless it becomes a question of making unfounded accusations. This though gave him a covering for his abuse. A safe harbor if you will of similarly minded individuals where he could fit in. It was the perfect situation. It was like attracting like.

During the end of the Reclamation Ranch Othello Washington days, there was some falling out between JP and DB the owner of the property of some kind, I didn't quite understand. We were living in a home owned by DB and due to this falling out between the two men, JP and DB, we were also kicked out and left homeless as a result. JP moved the ranch and we went homeless.

My dad took us to live in Leavenworth, WA in the national forest by a creek called Icicle Creek. It was hard and cold and we had very little food. We camped from campsite to campsite and we had to keep moving campsites because you can only camp for a certain number of days and then we had to pull up the tents, pack up

and move to another park. I ate moldy bread and whatever limited food we had that was edible. I remember a horrible memory of not having feminine products and I had to use grass leaves or whatever I could. We had the creek to wash our clothes in but my dad had forbidden me from using any soap on the clothes. I decided to steal the soap anyway and wash my bloody underwear and was too embarrassed to ask permission for that.

I was at the creek trying to wash them when my dad found me and came up behind me and kicked me hard in my buttocks which sent me falling forward and scraping up my forehead on the rocks. He was screaming and yelling at me about using the soap and lying and stealing. He then punished me by making me take down my tent and moving it further from the fire and into the darkness so that I would be less safe and more scared. Also I would heat up rocks and put them into my tent under my bedding because the nights were so cold so I wasn't allowed to have the warm rocks anymore to keep myself warmed up which increased my suffering. I lost a lot of weight.

We were out there for 3 months until the pastor of the church in Pasco, WA came searching for us, to see what happened to us. Although this man was an IFB pastor he was still a good hearted man from my perspective of goodness which is often not that good. I'm getting better with experience. Still he saved us so that's the good thing. Anyway, he stayed in the small town of Leavenworth, WA with a picture of us asking people if they had seen us. Very infrequently we had to go to the town but on a particular day someone saw us and called him and he came and talked to my dad and gave him the option of living in the church and helping him get a job or else he was going to take me and my little sister from him.

He went with the pastor and when we got back a lady from the church helped clean me up and also weighed me by asking me to step on a scale. I was 17 years old and 75 pounds I don't know my weight before being homeless and didn't have time to step on a scale but I think I weighed around 100 or more and that I lost 25 pounds in those 3 months which had that continued any longer out there in the woods with so little nourishment without the intervention of that kind pastor I would have been in bad shape. Thankfully he found us in time.

We were there with JP in Othello, WA then lived in the forest, then the church, then eventually to a house. I moved with my sister to Oklahoma but my parents then moved with JP to Oneida, TN where JP helped my parents hide my sister away from me and a man who was planning to marry her. I moved to Oklahoma to live with my older sister and then met my now ex husband. At Oklahoma Baptist College in OKC, OK. I thought he was good. He was a less abusive form of my father and I didn't have any measure of what good was. Just to avoid judgment of how I came to just go back into the same situation. It was abusive soon after the wedding. I found out right away he didn't believe in any form of birth control. I got pregnant right away. He was in a lot of debt he had lied about that. I had zero control over the money or anything else. He wouldn't give me access to money to buy groceries and often the electricity or water wasn't paid so I didn't have necessities. He would give me 20 bucks I remember and expect me to buy food with that.

I wasn't allowed to work because he believed a woman's place was in the home having his children and caring for him and his children. My first baby was found to have Acrania and would die at birth so the doctor recommended to terminate because the birth would be too hard on me and cause me problems in future pregnancies. I didn't have a choice and was made to carry her for 7½ months. She died but as the doctor told me it would be horrible and it was. I was in labor for 3 days and finally they had to manually dilate me causing injuries. She was stillborn in March 2, 2001 and I wasn't given any information about where she was taken or buried though I begged and I asked about it and had wanted certain things to be done. He told me to forget about it she was just somewhere in a marked grave.

I found out years later this was all lies and I was able to locate her and I named her Gracie, as well, the hospital had saved a memory box and pictures for me for 15 years. Everything was controlled. I didn't even know where she was buried. He got me pregnant again soon after this loss and I had my first son in March 16, 2003. I had a miscarriage in between my first son and second son. My second son was born December 5, 2004. This information is important so it makes sense when I tell you the next thing.

While I was 4 months pregnant with my second son he forced me against my will to go hunting. I fought and fought with him but he refused to let me stay home. This was in Montana in the mountains half melted snow which was boggy and dif-

ficult to navigate for someone not pregnant. Also, I was high risk pregnancy for preterm labor and my first son was preterm by a few weeks and I had preterm labor starting at 7 months with him. This was due to the injuries from the first baby that died, So the fact that this man got me pregnant right after a DNC for miscarriage and then forced me to go hunting is crazy. Then I shot a deer and then he forced me to drag it out of the forest and down the mountain through the bog of snow. Each step my heavy boots would sink 6 + inches and it was extremely difficult just to walk. I wouldn't do it but he kept grabbing my arm and wrenching it back and so I had to do it.

I went into labor but he wouldn't believe me or take me to the hospital. When I finally did make it to the truck, he said in a sort of impersonal manner, "See I'm proud of you, I told you you could do it" and in total disregard of my labor cramps. He drove a couple hours home with me in labor and hung the deer up for me to dress and because he was a truck driver he left me. I laid down for a while and finally drove myself to the hospital with my toddler in tow while in labor. I had dilated two centimeters at only 4 months pregnant by the time I got there. They were able to stop my labor with medication, thank God, and put me on medication and full bed rest. I could have lost my baby from that.

These were the same strange controlling and abusive things that were similar to my dad or the way I was raised. Highly abnormal abusive behaviors. I didn't know I was in a cult and I didn't understand. He was abusive to the kids by not providing their needs. I can't detail every single incident, because there were just so many things on a daily basis, but I will try to speak of some important examples of the types of things that I hope will show the sort of crazy home situation I was in. When my oldest was around 2, and my middle son was around 1, we had moved to work in a church in Conway, AK. The pastor there noticed I was being mistreated, okay, so even bad treatment for being in an IFB church. Which should be explained that not everyone in the IFB are monsters. The ones that aren't monsters are still misguided often but not criminals. Their misguided actions, however, are a safe haven for attracting criminals and this is what I want to explain, which I hope my testimony will shed some understanding about.

If you take the profile of some of the worst crimes against children and add that with a cult that has similar beliefs it creates a safe haven for that profile of abusers. I don't think the IFB is taking accountability for that. They turn against the victims of child abuse to keep it silenced. If they weren't in cooperation then they would be standing with the victims and not with the perpetrators. I think the churches and pastors should be held accountable to the fact that they are building an attractive environment and a safe haven for the type of profile of the worst child abusers.

Anyway, to get back on track with my story, the Arkansas pastor decided to question me about some instances and because of that decided JD needed help and counseling. One of the problems he saw was that JD never helped me with the children and stayed preoccupied. This was true. One of the questions VM asked was about who does what in the home. I hadn't had a break ever from the children and I would take them to the store to buy groceries or something, I always kept them with me because I was concerned about how he would treat them. He played video games a lot, was mentally absent and a big time gamer. Not a good combination for keeping my babies safe.

So if I needed to buy food, and JD gave me cash, I took them. Also, he refused to change diapers—he never once changed his children's diapers. One of the things that the pastor was requiring JD to do to keep his job was to step up and be a better father and husband and example if he was going to be an assistant pastor. He told me to go ahead and leave the kids with him and make JD accountable and he would deal with him. That was a bad idea.

JD was angry and got in a verbal fight with me. He then said, okay, and then finally agreed, but said if they poop he will call and I better get back immediately. I got to the store and shortly before I had started to get anything he called and said that my oldest had pooped and I needed to come home and change him. I told him to do it and hung up. I was wrong to do that but this was supposed to be how the pastor would deal with him or hold him accountable, but I didn't know how horrible he would neglect and mistreat my poor baby, so I did try to hurry and get a few things, check out and get back home. I mean, I didn't fool around, I just got the necessary things and got back home.

JD had just taken my baby, put him in a bathtub in the bathroom and shut him in the bathroom. When I got home he was sweating and red faced from crying and

he had taken off his diaper and had poop all over himself and the bathroom walls and tub. I never left the kids with him alone again and didn't trust him ever after that to take care of my kids. I call them my kids because he didn't act like these were his children to love and care for. I don't feel like JD was human, but an empty shell of a person without a soul because who would do that to their own baby. This was his way of punishing me for leaving him to babysit my son.

My second son seemed different and I was worried that something was wrong with him. He was reaching milestones slower than I felt was normal and I was having a hard time teaching him. He talked late, he walked late, and other things. I felt that he needed attention and an evaluation, but his dad just said it was my fault for not spanking him enough, so now, I was in trouble along with my son. It's the only way I know how to describe it. I tried to tell him maybe it was a learning disability but he didn't believe in that. He believed and to this day believes the Bible said to train up a child in the way they should go and he won't depart from it. That that is a promise of God, if I followed that, how God intended with biblical discipline, then he wouldn't behave like he was. Since that is a promise of God there is no such thing as a learning disability and if I would submit myself to the word of God and do what God commands me to do (meaning biblical discipline that amounts to criminal abuse) then my son will not depart from that.

When my son didn't listen or quickly respond or obey it was my fault and a sign I wasn't obeying God. This is specifically what he told me to do. He would inspect my discipline and tell me that it's because I'm not spanking him hard enough, take the belt paddle or whatever else he found and spank him way too hard in a way that amounted, in my opinion, to criminal child abuse and which would leave welts and bruises. This was on a small toddler mind you. If he cried, JD saw this as defiance and spanked him more. It was a full spanking session that would leave bruises. It was my childhood on repeat.

When I saw it happening to my kids it snapped me out of it. I got pregnant with my third child in August 27, 2008, but left him when she was 5 months old. Two times before I actually finally got away. I had tried to get away but he found me and forced me back by using the church people to stalk and harass me. They had OKC PD officers in the church that they used as well. I had no way to get away but a lady who was a Realtor noticed me looking upset in a store and asked me if I needed help. I broke down and told her, "Yes, I needed help really badly." She pulled a key out of her purse to a home she was in the process of renovating and said, "When you are not being watched, and if you feel safe to go there, then it's open for you, I'll leave the utilities on for you." The key had a tag with an address. I waited until he was gone and put my van in the garage and put the kids in the van. I went first to some stores to look like I was running errands, and then to Walmart, and then went there. It had a back driveway which was covered in trees and overgrown so it was the perfect place to hide and the home looked like it was not in use.

That was our first new safe home. I got services and assistance and got on a HUD list for emergency housing. The lady who owned the house eventually stopped by to do something and realized she had me stowed away there and soon started bringing me and the kids clothes and food and diapers and formula and all the necessities. After a time, JD eventually found me and took the kids, then used them as bait to lure me out to his parent's house. He had told me I could come get the kids, then he tried to force me into the house with a loaded gun. I said, "Let me walk around and turn the car off, and I'll go in," but instead I got to the door, jumped in, and stepped on the gas all in one motion, while also getting my phone and calling 911, the driver door still open, it closed itself on the way. Then he and his pastor/dad came chasing me down still with the gun, but the dispatcher told me to pull into a gas station and the police were there.

They arrested him and went and surrounded his parents house in full SWAT style and rescued my kids. On the day before this, I had gotten a key to the HUD apartment, so while JD was in jail, I went and hurriedly packed whatever I could in the car. Again, having to leave behind what I couldn't take with me or that was just given to me, so that hopefully, I wouldn't be followed by the church or family to the new place.

I filed a VPO but it wasn't very helpful. Eventually his charges were just simple gun charges. I had gotten sole custody and a VPO, but eventually, he got custody back after a year or so and parenting and anger management classes. Then in 3 months of unsupervised visits he beat my son with a cutting board and then kidnapped the kids to hide that. I had to get an emergency order to find them. When

I got them back my son was bruised and beaten. I got sole custody because of that. The dad still had visitation rights; they were supervised for a timeframe then again not.

The judge put in the order no corporal punishment as if that would help. Then after a couple of months of unsupervised visits, this time, his sister threw him in a bathtub and held him under the water, threatening to drown him all because he didn't know how to turn the water on in the house, they were in at some family reunion in South Dakota. I'm not sure where they were, so I couldn't file that report to the right agency and no one really helped me. My son wasn't being bad or defiant and wasn't being disobedient. He just thought there wasn't hot water so he got out fast.

When I got him back I took him to the doctor. His wrist had swelling and was sprained because he said his arm got caught under him when they were restraining him under the water in the bathtub. After this there was a trial over this, so they kept interfering and interrogating my son and trying to make him talk to his aunt who did this to him and forgive her like Jesus wanted him to do. He wouldn't do that so JD and another family member held him down in a chair and shaved his head. He had really beautiful curly hair that he didn't want cut off. They got a GAL but she said she determined it must all be exaggerated. They claimed he was just getting a haircut and that's all it was. It wasn't just a haircut. I believed my son and I know their psychological tactics.

They continued to have visitation with their dad and the abuse continued. Then he became the principal of Agape boarding school in Stockton Missouri. When Agape was finally closed down due to the horrific abuses in that home, they just swapped the name and moved the kids around. JD then just opened up Stone of Help. We don't know where he lives and now his oldest two children are adults now and I don't think he wants his children to know where he is. I want to add this to the report because it shows the profile, nature, and mindset of the sort of people who run the schools and homes.

I think it will be really important in the future for my testimony and story to be heard. I kept all of the court documents on my end hoping somebody would look at it again someday and see the lack of justice. I believe if I had been heard and believed that there would be one less person let loose to carry on this system of abuse. Nobody really did that.

I hope I will be heard for others and that this will stop. I worry that faith based homes will still be allowed to "practice their faith" and "exercise their freedom of religion" on innocent children who need love not abuse.

In my situation with my children's father he isn't someone that could be rehabilitated or helped to not be abusive to his children. Instead of listening to me, the mother of his children, and when he lost control of us and his children and when he couldn't do this to his own children instead of coming around to make the changes for his family, he instead went and found more children that he could do this to. It is my belief that he wasn't fit to care for his own children and shouldn't be allowed to do this to other peoples children.

This is why I want to tell my story and to validate the stories of the other children. A lot of the things that they have said was done to them I believe them more than 100%, because I wasn't in the institution. People like this were my family and I had no way to get away from them except through some miracle, which I believe was for me to speak up for them and fight for all the children.

My children and I were not fully believed nor could I get justice for them. The attorneys and GAL and judges profited off of us but didn't get justice for us. I fought with what I could by mowing lawns and cleaning houses, but it wasn't enough to get justice done for them. Due to the trauma they went through and also witnessed, all three of my children were evaluated and diagnosed with mental illnesses. Major depressive disorders, anxiety disorders, PTSD as well as learning disabilities. My middle son has specific learning disability and dyslexia. My youngest seams to have been affected the worst and diagnosed with anxiety disorder and conduct disorder as well as has been on and off suicidal and is in ongoing therapy and counseling. I want to get justice for the children still suffering and abused in this system. I want people to realize the dangers of this IFB cult and the part that it has played in the troubled teen industry.

People with this culture of belief on biblical discipline that amounts to criminal abuse should not be the ones responsible to care for vulnerable children. In my experience they shouldn't be allowed around any child. I don't think we can legally

tell people what to believe, but we should find a way to stop them from practicing their misguided beliefs on vulnerable children.

I have told my story here today in these summarized few pages to bring awareness and attention to this committee that this is the terrible danger that exists in the United States of America and around the world in hopes that it will help as we begin this journey and process and seek to reform this industry. I still especially worry that the faith based homes will be allowed to continue doing this by finding the loopholes and by using their rights to freedom of religion in a manner it wasn't intended and by making a political circus out of our efforts. I have found them to be very strategic and crafty in trying to find a way to continue by finding ways around the laws instead of trying to follow them. This is why I'm needing to tell my story and I find it important to stress—and I can't stress enough—how badly this is needed to make sure we close all the loopholes and build a language that leaves no loopholes. For surely if we do not, there will be people like this that exist in the world to find a way to use that to abuse children.

I believe from my experience they will surely try to undo all our efforts and that we must continually seek to understand the various types of people that play a part in the troubled teen industry.

Thank you for your time and attention to all of the survivors. I have waited so long to be heard and hoped that someone someday would listen to my story. It means so much. I never got justice but I hope for change for the children. I have tried my best to put as much as possible, there was so much more I could have said, and certainly more instances I could have pointed out over the 29 years I was inside the cult and the 14 years of trying to save myself and my children outside of the cult, but still trying to escape it.

This testimony is truthful and to my best ability as accurate and I hope informative as possible and within my ability and allowed space. Thank you for allowing me this opportunity and for fighting now to right the wrongs of so many children.

Melody Kay Derksen

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Response of Devereux Advanced Behavioral Health to June 12, 2024 Senate Finance Committee Report and Hearing on Youth Residential Treatment Facilities

Executive Summary

Devereux Advanced Behavioral Health ("Devereux") appreciates the interest of the Senate Finance Committee (the "Committee") in ensuring the safety and well-being of children facing extraordinary challenges and receiving care in Residential Treatment Facilities ("RTFs"). Devereux fully cooperated with the Committee's efforts, proposed to the Committee several of the policy recommendations the Committee makes in its June 12, 2024 Report (the "Report") and implemented those recommendations on its own initiative long before the Report was issued. The Report focuses extensively on RTF providers other than Devereux, all of which operate under the for-profit model which the Committee believes is directly responsible for the pattern of abuse described in the Report. Devereux, unlike all of the other providers referenced in the Report, is a 501(c)(3) non-profit corporation operating under an entirely different model. Under this model, even when payment rates do not cover its reasonable costs of services, Devereux never compromises the scope and quality of the services that it provides to persons in its care. Accordingly, while much of the Report is not relevant to Devereux, Devereux responds briefly as follows:

1. The Committee's core conclusion, repeated multiple times throughout the Report and restated in the one paragraph conclusion, is that the abuse of children in RTFs is "the direct causal result of a business model that has incentive to treat children as payouts and provide less than adequate safety and behavioral health treatment in order to maximize operating and profit margin." (Report at 127). Devereux is a non-profit corporation. It does not operate under the for-

profit business model that the Report blames for causing harm to children on a systemic basis. The personal well-being, safety and individualized treatment success of its residents—not profits—are its only motivators. Devereux does not have the fundamental problem the Committee seeks to solve.

2. Devereux and its team of dedicated professionals work tirelessly to provide residents with the best available treatment and experience in every respect, and it takes great pride in the positive outcomes it has consistently enabled for its RTF residents. Devereux extended an open invitation to Committee staff to visit any Devereux facility so that the staff could observe firsthand both the physical facilities and operations of its RTFs, an invitation that remains open today. The facts disprove any suggestion of unremediated or systemic abuse or neglect at Devereux.
3. On its own, and well before the Senate inquiry, Devereux implemented every one of the recommendations the Committee suggests for providers.
4. Devereux has always shared the Committee's view that RTFs must be reserved for only the most acute patients needing highly specialized care for short periods of time. As a result, Devereux currently admits 6% of patients referred to its RTFs and routinely operates with a substantial number of open beds. It has no profit motive to "warehouse" patients, and it has never done so. The data demonstrates that conclusively.
5. Devereux not only shares the Committee's view that community-based and home care is the superior model in most instances, it has long advocated that position and has made enormous investments to implement it. Over a period of years, Devereux has reduced its RTF capacity by more than 700 beds and constructed community-based day schools, among other measures, to advance this model. Devereux has already made major investments to build out the very model the Report advocates, and Devereux is committed to finishing the job.

Response

For more than 100 years, the singular mission of Devereux—a non-profit organization—has been to provide safe, compassionate and effective treatment to the most vulnerable children and adults with behavioral, developmental and emotional disorders. Accordingly, when the Committee asked Devereux to assist in its investigation by providing documents and information, Devereux cooperated fully. Over the course of nearly 2 years and in response to a series of requests, Devereux produced to the Committee nearly 2,000 pages of documents along with multiple detailed, narrative responses. Without being asked, Devereux extended an open invitation to Committee staff to visit any Devereux facility so that the staff could observe firsthand both the physical facilities and operations of its RTFs, an invitation that remains open today. Additionally, at the Committee's request, Devereux Chief Medical Officer and Chief Clinical Officer Yolanda Graham, M.D. and Chief Operating Officer Rhea Fernandes, Psy.D. were pleased to meet in person on May 21, 2024 with Committee staff to address personally and directly all of the Committee's questions.

The Committee's June 12, 2024 Report on Residential Treatment Facilities (the "Report") provides information regarding the services and programs offered by multiple providers of RTFs, including Devereux. The Report summarizes past press reports on numerous incidents of alleged mistreatment of children. While many of these incidents allegedly occurred at facilities owned by operators completely unrelated to Devereux, several are alleged to have occurred at Devereux. To whatever degree such allegations respecting Devereux are true, the conduct ascribed to Devereux employees is squarely inconsistent with Devereux's values, policies, procedures, and training and is wholly unacceptable. Devereux has never maintained otherwise and has consistently demonstrated by its actions that it is fully committed to protecting all of the children in its care and preventing all such conduct from occurring again.

The overwhelming majority of the Report focuses on providers other than Devereux, citing facts, data and incidents about which Devereux knows nothing. In the Report's limited discussion of Devereux, the Committee did not include certain key factual information that Devereux supplied to Committee staff over the past 2 years. Devereux believes that some of that information is critically necessary context for any objective understanding of the important issues raised in the Report. The Committee's work on behalf of these vulnerable children is vital and Devereux remains hopeful that this work will facilitate reforms Devereux has long advocated across this industry. To that end, Devereux provides this Response to: (1) ensure that certain key facts bearing directly on these issues are fully disclosed and prop-

erly considered, and (2) highlight critical reforms and policy recommendations Devereux shared with the Committee staff and believes are needed to both improve treatment and protect children served by any behavioral health provider.

The children and adolescents in Devereux's RTFs have acute needs for the customized psychiatric treatment that Devereux provides. Common diagnoses at the time of admission include Oppositional Defiant Disorder, Bipolar Disorder, and Posttraumatic Stress Disorder. Devereux also serves children with severe intellectual developmental disabilities and autism spectrum disorders. In many cases, Devereux's RTFs are facilities of last resort for youth facing such dire challenges. A significant majority of its residents come to Devereux from other facilities where treatment has failed. This is particularly true at centers with the highest acuity populations.

Devereux only accepts children in its RTFs who require the high level of care those facilities provide, as demonstrated by its admissions data. So far in 2024, for example, Devereux has received 3,290 referrals for admission into its RTFs and admitted only 202—an acceptance rate of just 6%. This is intentional, reflecting both Devereux's commitment to limiting Psychiatric Residential Treatment Facility ("PRTF") access to only the most acute patients and its strategic plan to build out a continuum of care further upstream. As a direct result of this commitment, Devereux operates 760 fewer beds in PRTFs today than it did just 5 years ago. At the same time, Devereux has invested heavily in early intervention programs, outpatient programs, home-based care, diversionary programs, therapeutic foster care, and related family and community-based programs, including the construction of 3 new highly specialized day schools built specifically to meet the unique education and treatment needs of children within their own communities. For children who are accepted into its RTFs, Devereux has expended significant resources to create new, highly specialized facilities with staffing ratios that exceed state or local requirements to provide the highest level of care, shorten lengths of stay and engage families in treatment so that the discharge home is successful.

Devereux is a 501(c)(3) non-profit organization. It invests 100% of its operating revenue in excess of expense (when such excess occurs) to deliver the best available treatment and care for its patients. Medicaid represents the single source of public funding Devereux receives from State Medicaid agencies and Medicaid Managed Care Organizations in the 8 states in which it operates these residential treatment programs. Notably, the standards that govern the determination of payment rates for its services are opaque and the rates themselves often are inadequate to meet the reasonable costs Devereux routinely must incur to meet the treatment needs of individuals in its care. MCO payment rates, for example, typically are not indexed to inflation that, in recent years, has essentially resulted in rate reductions. The inability of providers to rely on even modest annual cost of living adjustments and regular redetermination of payment rates to reflect market based cost experiences, particularly in a challenging labor market, impacts their ability to retain and recruit employees who otherwise want to work in the human services industry.

As outlined briefly below, Devereux bridges the significant funding gap each year with substantial donor dollars to ensure the best possible care for its patients.

The high levels of acuity in the youth who populate Devereux's RTFs pose unique challenges, both clinically and practically. Devereux has demonstrated its ongoing commitment to ensuring the safety and security of these youths through a series of major initiatives and investments. Over the last three years, Devereux has invested nearly $60 million to support safety enhancements. Recent examples include the following:

- Devereux uses the comprehensive prevention and intervention program, Safe and Positive Approaches for Preventing and Responding to Crisis ("S&PA"), to promote staff knowledge and competence in preventing, defusing and managing crisis situations. S&PA details a continuum of intervention built upon a least-restrictive approach designed to reduce the use of seclusion and restraint. The S&PA curriculum created by Devereux professionals includes modules on Staff Effectiveness Training, Safety Techniques Training, and Personal Emergency Intervention Training. Devereux's full-time trainers have trained more than 100 outside providers, certifying trainers in each of those organizations in an ongoing effort to increase safety across the industry.
- Devereux has invested significant capital into upgrading its video camera technology in all RTF common areas to deter instances of abuse, increase staff accountability and detect potential problems before they occur. Footage from those cameras is routinely reviewed, escalated to supervisory staff and

senior management where warranted, and preserved to facilitate accurate investigation of alleged misconduct.
- Devereux has installed Guard1® in every RTF bedroom to ensure instant verification and accountability for nightly bed checks to prevent elopement. Guard1 requires staff to digitally scan an RFID code in each bedroom. Any failure to scan prompts a digital alert to the on-site supervisor. Since installing Guard1, Devereux has been able to confirm patient bed checks every 15 minutes through the night with a 98% compliance rate.
- Devereux constructed or is in the midst of constructing physical fences (designed to integrate into the natural setting and minimize any sense of confinement) around each of its RTFs as an additional measure to reduce elopements.
- Devereux has dedicated and trained Quality Improvement Directors and additional quality support staff at each children's residential facility.
- In addition to achieving organizational accreditation from Praesidium, as more fully detailed below, Devereux has at least one Praesidium certified Guardian® at each children's residential facility.
- Devereux expanded investigation protocols including oversight by the National Quality Improvement Department that concentrates on the quality of the investigations and appropriateness of corrective actions. The department also tracks and data related to incidents and allegations for timely reporting to management and governing body.
- Devereux has installed anti-ligature equipment in bedrooms and bathrooms at children's residential campuses to reduce suicide risk.
- Devereux is committed to the safe and appropriate use of psychotropic medications within all of its settings. Devereux participated in a 3-year multisite SAMHSA collaborative to develop best practices for the reduction of polypharmacy in RTFs.

The foregoing initiatives and investments were not required by law or licensure agency and none were reimbursed by Medicaid.

Apart from the quality and safety initiatives noted above, in June of 2023, Devereux earned sexual abuse prevention accreditation from Praesidium®,[1] a nationally recognized abuse prevention organization. Praesidium's model includes 125 standards relating directly to sexual abuse prevention. These standards address the full spectrum of relevant issues including policies, hiring practices, training, monitoring and supervision, internal feedback systems, consumer participation, and administrative practices. To ensure ongoing practice consistent with its standards, Praesidium performs accreditation reviews every 3 years.

In addition to organizational accreditation, Praesidium also offers a Guardian Certification course in sexual abuse prevention. To assure highest levels of organizational understanding of sexual abuse preventions, more than 40 Devereux staff have completed the Praesidium Guardian Certification.

The staffing crisis across the healthcare industry poses significant challenges for every provider, and Devereux is no exception. According to SAMSHA, by the end of 2025 U.S. demand for direct care professionals ("DCPs") is expected to exceed 4.5 million, while the projected availability of DCPs will fall somewhere shy of 1 million. More than half of all counties in the U.S. do not have one single Board Certified Behavioral Analyst to support people with Autism. The American Psychological Association predicts a shortage of more than 100,000 clinicians by 2030. Recognizing that the recruitment and retention of qualified staff is critical to the fulfillment of its mission and consistent with its culture rooted in servant leadership, Devereux has made major, sustained investments in its employees to address this challenge.

For example, in 2023, Devereux created and launched its ASCEND behavioral healthcare career accelerator program. Through this privately (donor and grant) funded initiative of at least $20 million for just the first 5 years of the program, Devereux offers upfront college tuition, higher education loan repayment, career coaching and professional mentoring to aspiring behavioral healthcare workers from across the nation. Devereux already has hundreds of engaged young professionals enrolled in the ASCEND program.

Additionally, Devereux has committed substantial resources to retaining quality front line staff. Over the last 3 years alone, Devereux has increased wages to its DCPs by $95 million in the aggregate. It has made health and dental insurance

[1] *https://www.praesidiuminc.com/*.

available to all employees working at least 30 hours per week, down from the prior threshold of 40 hours per week. And Devereux has continued to cover 71% of all health and dental costs for its employees even in the face of rapidly rising insurance premiums. Moreover, in advancement of its charitable mission, Devereux accepts individuals with limited or no ability to pay for services; the economic shortfall attributable to unreimbursed costs of certain Devereux programs aggregated approximately $66 million in 2023 and 2022.

From its founding in 1912 until the present, Devereux has been devoted to providing safe, compassionate and effective treatment to the most vulnerable children and adults with behavioral, developmental and emotional disorders. It shares the goal of this Committee to ensure the safety and security of all patients in its care and in the care of any other provider of these vital services. To that end, Devereux asked the Committee to consider certain specific policy recommendations, as follows:

- Convene stakeholder groups to develop common definitions, standards, and best practices with respect to restraint reduction, less restrictive levels of care, and other practices at residential treatment facilities.
- Increase Medicaid reimbursement rates, particularly for services provided to children and young adults who require a high level of care.
- Provide incentives (*e.g.,* increased FMAP rates) to address the workforce shortage, including improved training, compensation, and benefits (*e.g.,* ASCEND).
- Provide incentives to promote the adoption of comprehensive abuse-prevention frameworks.
- Promote value-based care by providing reimbursement for providers who implement evidence-based practices designed to reduce the length of stay in residential and improve outcomes.

Devereux respects the work of the Committee and is grateful for the opportunity to provide both relevant information and proposed reforms it believes will further the shared goal of improving the care and safety of all children.

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Statement of Emily Harvey, Community Access and Youth Advocacy Team Leader

Chairman Wyden, Ranking Member Crapo, and members of the Senate Finance Committee, thank you for the opportunity to testify in writing. My name is Emily Harvey. I am the Community Access & Youth Advocacy Team Leader at Disability Law Colorado (DLC). DLC is the Protection and Advocacy (P&A) agency in Colorado. The P&A system is a federally mandated network of legally based agencies that advocate for and protect the rights of individuals with disabilities. Under federal law, P&As have authority to access facilities in which individuals with disabilities reside.

In my role, I oversee DLC's work in various areas, including our work on behalf of system-involved children, many of whom live or have lived in youth residential treatment facilities. DLC's goal is to ensure that individuals receive the services they need in a safe and therapeutic environment in the least restrictive environment, wherever that may be. We monitor facilities throughout Colorado that serve youth on a 24–7 basis, including youth residential facilities.

In these facilities:

- We have seen children taken down to the ground by multiple staff in a prone (face down) position.
- We have heard from children that instances of restraint are frequent, with staff being very quick to go hands-on with them.
- We have seen filthy living areas and touched sticky doors and door handles.
- We have smelled dorm hallways that reeked of urine.
- We have observed dirty shower stalls with no shower curtains because when children tried to use the shower curtains to hang themselves, the facility responded by removing the curtains altogether.
- We have seen metal beds bolted to the floor, with largely barren walls that are devoid of color and personal touches.

- We have heard from children who get a "corporate diet" and tell us they receive food that is not nourishing—and are sometimes fed things like undercooked chicken.
- We have observed children in classrooms with no licensed staff available in-person, and only online programming available.

Children have told us that they wanted and expected mental health treatment yet received little to none. Instead, they felt unsupported, punished, helpless, and hopeless. Instead of gaining skills and learning to build relationships, many of these children experience an increase both in suicidal ideation and in the number and intensity of self-harming behaviors. Many children we've spoken with have numerous scars on their arms due to self-harm that occurred while under the supervision of staff in a youth residential facility. Some of them have told us self-harm is the only way to get staff to respond to their requests for help. One child we've met has attempted multiple times to hang themselves using pieces of clothing—all while under the care of staff in a youth residential treatment facility. Youth in these facilities sometimes go AWOL to escape.

In addition, police are often called on children for minor infractions such as damaging a window or throwing something. As the P&A, our agency receives critical incident reports from psychiatric residential treatment facilities; many such incidents are reported to the Child Abuse and Neglect Hotline. However, while these incidents are usually investigated on an individual level, they are often quickly closed. To our knowledge, there are no investigations of systemic and institutional abuse at these facilities despite the high volume of reports.

These facilities resemble adult jails and prisons. Some of the children we met had previously spent time in juvenile detention and/or commitment and said the conditions in residential facilities were far worse.

As a nation, we should be ashamed of the system we have developed for our most vulnerable children. Our research makes clear that youth residential facilities cannot provide an adequate therapeutic and educational environment. We urge Congress to eliminate such facilities, or at least minimize their use and dramatically improve their conditions and oversight.

In contrast, we have also visited smaller settings in the community for youth with similar needs as those in large congregate facilities. These settings have been much more home-like, with youth attending local public schools and allowed to participate in community activities, such as going to the library to check out books. The children we have spoken with in these community-based settings have expressed a greater feeling of safety and security than those in larger facilities. These children also speak more highly of the therapeutic services available to them and the staff who work with them. They weigh in on what they will do in their spare time and what they will have for dinner. Unlike the children in youth residential facilities, children in community-based settings express hope for their future.

Through our work with the P&A network, we know that these problems are not specific to Colorado. The conditions and systemic issues are well documented in countless reports by individual P&As and by the National Disability Rights Network's Desperation without Dignity Report. This is a national problem that demands congressional action, which can include:

1. ***Increase investment in community-based services and supports to prevent the use of congregate care.***

In Colorado, the Medicaid reimbursement rate for psychiatric residential treatment facilities is $787.95/day. Fee Schedule_PRTF_07012023_v1.0.pdf *(colorado.gov)*.[1] This funding could be much more appropriately and effectively invested in intensive, community-based services for children.

2. ***Require meaningful outcome measures and discontinue payments for models that fail to provide active treatment and individualized services.***

We must critically examine our continuum of care and the role of residential treatment facilities on that continuum. The data shows that residential treatment is not the answer for most children. Instead, we must prioritize evidence-based treatment and invest in community-based options.

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[1] *https://hcpf.colorado.gov/sites/hcpf/files/CO_Fee%20Schedule_PRTF_07012023_v1.0.pdf.*

We need a unified system of tracking outcomes for systems-involved children to determine the impact of treatment and their experiences in specific facilities. We need better oversight of these facilities to ensure that children are in their least restrictive environment, receive appropriate and effective therapeutic services, and are not subjected to rights violations, abuse or neglect.

3. Discourage out-of-state placements.

Out-of-state placements make it more difficult to maintain family connections, more difficult for state agencies to monitor and uphold state standards, and extremely difficult for discharge planning. Facilities often evade regulations by accepting children only from states that overlook subpar conditions.

Sending children out of state also increases costs because teams must travel to visit annual inspections, and caseworkers must still maintain a connection with the child. These funds could be better used to support direct services in the child's home, community, and state.

4. Remedy the failures of oversight.

P&A agencies form a backstop. Our involvement in this area indicates a profound failure of the intended governmental oversight mechanisms and of the system.

5. Create an accessible and navigable system that identifies all youth residential treatment facilities and publishes incident data and surveys on quality of care.

While the Quality, Certification & Oversight Reports (QCOR) database contains surveys and complaints about psychiatric residential treatment facilities, the information is inaccurate and incomplete. The information contained in the QCOR is opaque, requiring technical knowledge of CMS to access and sort information. The surveys themselves may not capture the true conditions and incidents at youth residential settings. Thus, the QCOR is not an effective mechanism for public accountability.

6. Invest in research and pilot programs to identify and validate effective options.

Rather than pouring money into a system that has proven both ineffective and likely to result in abuse and neglect, we must invest in researching and developing a comprehensive community-based system of care for our children.

Thank you for the opportunity to provide this testimony and for considering it in determining a path forward for our nation's children.

DISABILITY RIGHTS IDAHO
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Statement of Disability Rights Youth Unit staff Abbey Schulz, Chloe Palmer, and Briseida Trapero; Youth Unit Director of Legal & Advocacy Services Courtney Holthus; and Executive Director Amy Cunningham

I. Introduction

Disability Rights Idaho (DRI) is the designated Protection and Advocacy agency for the State of Idaho pursuant to the Protection and Advocacy for Individuals with Mental Illness Act, 42 U.S.C. § 10801 *et seq.*, and the Developmental Disabilities Assistance and Bill of Rights Act, 42 U.S.C. § 15001 *et. seq*. Both Acts were enacted in response to congressional hearings such as this one, evidencing widespread abuse and neglect of individuals with disabilities in facilities, resulting in the creation of a system of protection and advocacy agencies throughout the United States and its territories armed with authority under federal law to investigate allegations of abuse and neglect, respond to rights violations, and provide general advocacy services on behalf of individual with disabilities.

In fall of 2020, DRI re-organized into two units: an adult unit and a youth unit, each staffed with attorneys and non-attorney advocates specifically focused on serving the needs of either adults or youth with disabilities in Idaho. For the past 4 years, DRI's Youth Unit has made a concerted effort to conduct monitors as well as abuse and neglect investigations within facilities licensed by the Idaho Department of Health and Welfare to provide care and treatment to youth with disabilities. So far, this work has included monitors and investigations at ten (10) facilities

throughout the state of Idaho including private and public psychiatric hospitals, children's residential treatment facilities, and Idaho's psychiatric residential treatment facility (PRTF).

Unfortunately, our work has uncovered many of the same issues featured in the testimony of Reagan Stanford of Disability Rights Arkansas as well as in the Senate Finance Committee's Staff Report: *that youth placed in residential treatment facilities in Idaho are often subjected to abuse and neglect, including the inappropriate and excessive use of physical restraints, and are denied adequate treatment and supervision. Even though multiple state agencies are involved in the placement and oversight of these facilities, such harms fail to be identified and/or addressed. To further compound these issues, Idaho sorely lacks appropriate community-based services and supports to address the needs of these youth to either avoid or successfully discharge from placement in these facilities—resulting in a revolving cycle of institutionalization for Idaho youth with severe emotional disturbance (SED) and those who are dually diagnosed with a developmental disability and severe emotional disturbance (DD/SED).*

We applaud the efforts of this Committee to investigate residential treatment facilities and hope that the information provided in our testimony below helps to support much-needed change for youth placed or at risk of being placed in such facilities.

II. PRTFs—Psychiatric Residential Treatment Facilities in Idaho

In 1980, a class action lawsuit was filed against the Governor of Idaho and other state officials to address the lack of appropriate treatment and education for children who were patients at one of Idaho's state-run psychiatric facilities, as well as a lack of community-based mental health services across Idaho for children with SED. Thirty-five (35) years later, the case was resolved through a comprehensive Settlement Agreement which outlines specific provisions that the State of Idaho must provide for children with SED. While the settlement agreement in this case is intended to establish a robust system of care and support for Idaho children with SED, the actual implementation of the settlement agreement provisions continues to be in various stages of development.

Part of the implementation of this settlement agreement includes the creation of three (3) Psychiatric Residential Treatment Facilities (PRTF) which are funded by Medicaid. A PRTF is a subacute, hospital-like setting typically directed by a psychiatrist, with support from licensed counselors and social workers and 24/7 supervision by nursing staff which provides a high level of care and supervision to youth with complex mental health needs under the age of twenty-one (21). Although Idaho previously had a PRTF operating at the Eastern Idaho Medical Center, it ultimately transitioned back to providing short term, acute hospitalization level of care in 2022. As a result, Idaho children needing that level of care have and continue to be sent out of state and across the country, including to facilities operated by some of the for-profit providers highlighted in the Committee's investigative report such as Devereaux Advanced Behavioral Health (Devereaux) and Acadia Healthcare (Acadia).

In December of 2022, the State of Idaho budgeted $15 million to establish three (3) PRTFs. The Idaho Department of Health and Welfare (Department) awarded grants to three facilities to establish PRTFs: The Idaho Youth Ranch in Boise; Jackson House in Eastern Idaho; and Northwest Children's Home in Northern Idaho.

Although the Idaho Youth Ranch opened its residential center in August of 2023, it has yet to be granted a PRTF license as of June of 2024. As a result, Idaho Medicaid eligible children in need of PRTF treatment cannot be placed at this facility. Jackson House, a parent organization which will oversee the Eastern Idaho PRTF, is a California-based company with several treatment-facilities and rehabilitation centers all in Southern-California. Ground was broken at Jackson House in Eastern Idaho in May of 2024.

The third contract was awarded to Northwest Children's Home with plans to become operational as a PRTF at the end of the summer 2024. Northwest Children's Home currently operates as a children's residential treatment facility, licensed to house up to forty-six (46) children, ages six (6) to seventeen (17). This past year, the facility became the subject of an investigation by media outlet InvestigteWest highlighting the need for increased monitoring over Idaho youth residential facilities. In an article published on December 29, 2023, InvestigateWest journalist Wilson Criscione identified Northwest Children's Home as one of the "several" facilities of which have "repeatedly failed to keep children safe," citing to a 2016 investigation by the Department which found that "[c]hildren routinely elope, evade supervision,

commit crimes, are detained by juvenile corrections, are victims of sexual crimes and perpetrators of physical results." Idaho Investigators Repeatedly Found Kids in Danger. Youth Treatment Programs Faced Few Consequences, *https://www.invw.org/2023/12/29/idaho-investigators-repeatedly-found-kids-in-danger-youth-treatment-programs-faced-few-consequences/*. Although the Department originally indicated it would revoke the facility's license, the revocation decision was appealed by the facility and, eventually, overturned. The facility has continued to operate despite subsequent investigations by the Department identifying additional problems as well as continued calls to law enforcement at a rate three times higher than the average of all similarly situated facilities in the state. DRI is also currently investigating a recent report of the excessive, inappropriate use of physical restraint at this facility and has made the Department aware of concerns originating out of its investigation. Despite such documented concerns, to DRI's knowledge, the Department intends to move forward with its choice to award the facility state and federal tax dollars to operate as a PRTF in the future.

III. CRTFs—Children's Residential Youth Facilities in Idaho

Currently, Idaho is home to twenty-eight (28) facilities licensed as "children's residential treatment facilities" and one (1) facility licensed as a "children's therapeutic outdoor program." CRTFs are licensed to provide a less intense level of care, for (twenty-four) 24 hours a day in a residential setting, essentially as step-down from a PRTF.

In total, the twenty-eight (28) CRTFs are licensed to house up to seven hundred and forty-five (745) children from as young as the age of five (5) to age seventeen (17). Idaho's sole children's therapeutic outdoor program, located in rural central Idaho, is licensed to house up to one hundred (100) children ages eleven (11) to seventeen (17). Children placed in these facilities are most commonly on Medicaid, and their stay is funded using state and federal Medicaid dollars.

Children placed in these facilities come from a variety of backgrounds and locations. Some may be placed in these facilities voluntarily by their parent or guardian. Others because of being involved in the foster care or juvenile justice system. While many of the children in these facilities are from Idaho, there are also facilities whose entire patient population consists of children from out of state.

Several state agencies play a role in the oversight of these facilities, all of which are housed under the Department. Such agencies include Children's Residential Licensing (Licensing), the Division of Family and Community Services (FACS) which includes Child Protection Services, as well as the Divisions of Medicaid (Medicaid) and Behavioral Health. In many instances, FACs, Medicaid, and Behavioral Health are directly involved in arranging for the placement of children these facilities. In order to become licensed as a children's residential treatment center, a facility must meet the requirements set forth in Idaho Administrative Code, specifically IDAPA 16.04.18, available at *https://adminrules.idaho.gov/rules/current/16/160418.* It is important to note, however, that in accordance with Idaho Governor Little's Zero-Based Regulation initiative, Idaho has "cut or simplified 95 percent of regulations" from its administrative code. Office of the Governor, Cutting Red Tape (last accessed on June 24, 2024), *https://gov.idaho.gov/cutting-red-tape/*. Such cuts have included cuts to the regulations which govern licensing and oversight over children's residential treatment facilities.

Multiple media reports from the past year have highlighted the need to review of the oversight of these facilities, cumulating in Idaho's own Joint Legislative Oversight Committee approving the Office of Performance Evaluations to investigate and develop recommendations to ensure that the Department's Division of Licensing and Certification is "functioning effectively as applied to Children's Residential Treatment Facilities, Children's Therapeutic Outdoor Programs, and Psychiatric Residential Treatment Facilities (PRTFs)." Wilson Criscione, "Idaho Oversight to Investigate Youth Treatment After 'Shock' Over Complaints," *Idaho Statesman,* March 24, 2024, *https://www.idahostatesman.com/news/politics-government/state-politics/article287021680.html*. As stated in the article, "The state has no record of suspending or revoking the license of any Idaho youth residential program, despite finding instances of serious danger to children at several facilities in the last decade." *Id.*

IV. Observations and Concerns from DRI Monitors and Investigations of Idaho Children's Residential Treatment Facilities

The following provides an overview of our concerns identified from our work in these facilities.

A. Excessive Elopements and Inconsistent Reporting of Incidents

In fall 2023, DRI monitored a children's residential treatment facility in Northern Idaho that housed female youth between the ages of (eleven) 11 and (eighteen) 18, the majority of whom were in the foster care system. Prior to the monitor, DRI gathered public police records and reviewed Licensing's survey results and media reports detailing incidents of abuse, including rape, against youth housed there. Based on these reports, DRI also became aware of multiple incidents of children eloping at the facility within the last year. This was particularly concerning given that the facility was located near a very busy highway. In fact, an elopement occurred during DRI's 2-day monitor. Youth reported to DRI that they knew they could get away with eloping because during the evening shift staff were untrained and therefore unable to stop them. To dissuade youth from elopement, facility staff indicated they would take away the youth's shoes and warm clothing. However, several youth stated they did not care if they ran away in socks instead of shoes and even admitted to getting into cars with strangers, sleeping outside during winter, and attempting to steal illegal substances. Beyond the policy of taking their shoes away, the facility did not appear concerned as to the ongoing elopement and did not change/update their policies.

After the monitor, DRI met with state Licensing staff to review DRI's concerns. Licensing stated they would conduct an unannounced visit to monitor the situation. DRI then completed a review of records from January 2023 through September 2023 comparing Licensing's records to local police records to determine if Licensing received all incidents that the facility reported to the police, as required by Idaho law. DRI found several discrepancies between the reports to the Licensing and the incidents at the facility. In fact, the facility failed to report the elopement that took place during DRI's monitor, as well as several police/EMS calls recorded in the police record, during at least one of which a child was dragged out of her bedroom by police and hospitalized following threats of suicide.

B. Inappropriate, Excessive Use of Restraint and Seclusion

One of the most common issues we have observed regarding these facilities is the inappropriate and altogether excessive use of physical restraint and seclusion. At another children's residential treatment facility in rural Idaho, DRI received a report that a child was being excessively restrained by staff, including "multiple times a week" and DRI staff themselves even observed noticeable bruising on the child's arms, reportedly caused by staff restraints. Upon initiating an investigation into these allegations, DRI observed video of the restraint and events leading up to the restraint. In the video, the child can be seen with their hands in their pockets backing away from a staff member. The staff member then rushes the child, pulling them to the ground in a restraint. When the incident was further investigated by Licensing, facility staff referred to the restraint (which resulted in an injury) as "a therapeutic hug." Facility administration initially found that the staff member had not violated their restraint policy during the interaction, although later admitted they had failed to review the footage and that the staff member had acted inappropriately.

The use of restraints traumatizes not only the youth restrained, but also the youth who witness the incidents. During an interview, another youth at the same facility indicated that other kids are restrained a lot and that it makes them extremely anxious when this happens. To escape the trauma, they often decide to isolate themselves in their room. No counseling or debrief is offered to the youth restrained or those who may have witnessed the restraint. They are left to console themselves in a "therapeutic" facility.

At another facility, DRI was able to obtain documentation showing that children were restrained multiple times a week, even multiple times a day. Although it has since closed, the facility was owned/operated by Sequel, a company notorious for abuse and neglect allegations. Additional documentation provided to DRI demonstrated that facility policy allowed for restraints to last for up to an hour at a time in direct violation of Idaho facility licensure rules which limit restraints to no more than fifteen (15) consecutive minutes. In a 6-month span, the facility documented twenty-five (25) incidents of restraint lasting longer than the required fifteen minutes. There were also frequent examples of youth being restrained multiple times in one week with as many as eleven (11) restraints in a week for one child and fifteen (15) restraints in one day for another.

C. Restrictions on Communications and Access to the Community

Access to private, confidential communications as well as access to the community are non-existent or severely and regularly restricted in these settings. Such re-

stricted and censored access only adds to the risk that instances of abuse or neglect remain unreported as the children have no means in which to report such allegations outside of the facility, nor are they regularly observed by others outside of the facility who could report these instances on their behalf. Neither state statute nor licensure regulations for these facilities require the facility to offer or provide children with a private, confidential means of communication. At one Idaho facility, residents are prohibited from communicating with their family within the first thirty (30) days of admission. After that, all calls (including those to other providers or family members) are listened to and monitored by facility staff. Facility staff warn parents/guardians that their child will attempt to "manipulate" them by reporting negative things about the facility, encouraging parents to disregard such reports as false.

In another facility example, youth were not permitted to make telephone calls until they had been at the facility for forty-five (45) days, at which time the calls were limited only to immediate family members, twice a month. In a handbook at this same facility, youth were warned that home/family visits will be canceled or limited in time/location if the youth choose to break facility rules. Elsewhere, youth were required obtain a certain status before they were allowed on outings outside of the facility's walls—even to the local McDonald's. Because of how stringent the status or level requirements were, some children never obtained the appropriate "level" or "status" to have an outing—potentially being restricted to the facility's campus for the entirety of their eighteen (18) month stay. None of these are therapeutic, evidence-based practices. Rather, they are more akin to practices you would expect to find in a correctional facility.

D. Questionable Therapeutic Techniques

Despite being licensed to provide twenty-four (24) hour care, treatment, and rehabilitation, DRI has observed that such care, treatment, and rehabilitation is often minimal, at best, and even includes the use of non-evidence-based practices. For instance, one facility utilized polygraph examinations initially upon admission and then again throughout the child's stay at the facility. Although the facility's clinical director claimed the purpose of the polygraph is for the treatment process and was not used in a manner to criminally charge the client, children were required to acknowledge that they may be prosecuted for previously committed crimes. If they were suspected of committing a new sex offense the facility would then recommend to law enforcement that the child be prosecuted. Not only is there a plethora of evidence demonstrating that such examinations can be coercive and harmful to youth, but such use also calls into question violations of the youth's right against self-incrimination.

V. Additional Concerns

A. Lack of Oversight of Out of State Placements for Idaho Children

Through our work in representing youth attempting to access medically necessary services, including residential treatment, we have uncovered additional concerns regarding facilities outside of the state. As enumerated above, Idaho lacks placements that can care for youth who need treatment, resulting in Idaho youth being sent to facilities out of state to receive care and treatment in a residential setting. In fact, it is estimated "[o]n average, every three days an Idaho family on Medicaid sends their child out state in search of treatment." Idaho Youth Ranch Residential Center for Healing & Resilience, *The Need, https://www.youthranch.org/the-need-to-bring-them-home* (last visited August 23, 2023). Often, these out-of-state facilities have a known history of abuse, neglect, and licensure issues, failing to provide any therapeutic benefit to the child and, instead, exposing them to more harm.

It is unknown what, if any, vetting is conducted by Idaho state agencies prior to the referral and placement of a child in these out of state settings. In a recent case, DRI learned that Department staff routinely send youth to the Judge Rotenberg Education Center (JRC) in Massachusetts, an approved Medicaid provider. The JRC is marketed as a school for emotionally disturbed youth that uses Applied Behavior Analysis (ABA) treatment plans. However, to this day it is the only placement in the country that uses electric shock devices to stop unwanted student behavior. The U.S. Food and Drug Administration unsuccessfully sought to ban this practice in 2020 and the JRC has been condemned for torture for these practices by the United Nations. Six residents have died at this facility since it was founded in 1971. Once placed in such a facility, it is also unknown what, if any, oversight is conducted by Idaho state agencies in terms of ensuring the youth is not being subjected to such practices.

Another frequent out of state placement for Idaho children is Copper Hills Youth Center in Utah. DRI is aware of Department staff attempting to refer and place a child in this facility as recently as 2022, despite the Idaho Department of Juvenile Corrections terminating its contract with the facility after reports of sexual misconduct surfaced in 2015. *Idaho Press-Tribune,* "Copper Hills Youth Center Investigated in Early 2000s," May 9, 2015, *https://www.idahopress.com/members/copper-hills-youth-center-investigated-in-early-2000s/article—17da5580-f60b-11e4-91cf-07a2cc035c21.html*. DRI staff have also discovered that Department staff were reaching out to facilities in Indiana and Utah for potential placement while such facilities were on admissions holds due to serious incidents by their own state facility licensure agency. Abuse allegations as recent as March of this year have been substantiated at Utah facilities which have been used as Medicaid-funded placements for Idaho youth.

DRI shares the same concerns Disability Rights Arkansas identified regarding the inherent lack of transparency that exists for those concerned about out-of-state placements that Medicaid routinely funds. In some states, little information can be found about these facilities, leaving Idaho families unaware of the conditions their youth are subject to. Families are forced to trust that Medicaid or other state agencies would not put their youth in danger.

However, in some instances, facilities will only admit youth from out-of-state, further complicating which state, if any, is conducting oversight of the facility and ensuring the safety of the youth placed within it.

B. Documentation of Abuse, Neglect in Reports to Law Enforcement

Instances of abuse or neglect in these facilities can also be uncovered through a public records request from the local law enforcement agency. Through its investigative work, media outlet InvestigateWest has accumulated police call log data to demonstrate high numbers of police calls from Idaho facilities. DRI is also starting to accumulate police call log data on facilities licensed in Idaho, including calls related to a children's therapeutic outdoor program in rural Idaho. Based on our review of records provided through a public records request, parents, staff members, or youth themselves have reported potential child abuse at the outdoor program at least nine (9) times since 2021. Such reports have alleged staff abusing and medically neglecting children, unsafe working conditions for staff, unclean living conditions for the children, and allegations that the program hires staff to clean the campsites only when Licensing is going to visit for their annual survey. Reports have also alleged that the staff have their personal phones checked by the administration before leaving their sites, to ensure no pictures can be reported to state agencies or the public. Despite numerous calls to law enforcement, DRI is unaware of any criminal charges being brought against staff of the facility. Records also indicate that a complaint was filed with and investigated by Licensing. When Licensing visited the facility, most of the youth and staff were not present. Records indicate that Licensing only visited the administrative building, not the campsites in which the youth lived and as a result, the complaint went unsubstantiated.

VI. Conclusion & Recommendations

As evidenced by the work of our fellow agencies within the P&A Network, we know that these problems are not specific to Idaho. We echo the recommendations made in the testimony submitted by Reagan Stanford of Disability Rights Arkansas and would emphasize that this national problem demands congressional action, including but not limited to:

1. ***Increased investment in community-based services and concrete supports that can help prevent the use of congregate care.***

Many youth facilities receive several million dollars each year in state and federal funding. In Idaho, many of these treatment facilities are used to house foster children. Yet, foster families in Idaho can receive as low as $90 per day. A better investment of state and federal funding would include investment in intensive, community-based services, rather than congregate care. Until a substantial system of community-based care is developed in Idaho, youth will continue to be subjected to an endless cycle of unnecessary institutionalization.

2. ***Require meaningful outcome measures and discontinue payments for models that do not provide active treatment and individualized services, including residential treatment.***

The role of residential treatment on any continuum of care needs to be critically examined. Although there has been a focus and even insistence on evidence-based

treatment in most other areas, there has been heavy investment in residential treatment despite no evidence to support its efficacy.

For example, research has demonstrated time and time again that prone restraints are dangerous, and that seclusion exacerbates existing trauma, however, both practices continue across the country with little to no regulation.

3. De-incentivize out-of-state placements.

It is well known that sending youth out of state for care and treatment causes a plethora of issues including: (a) making it more difficult to maintain connections with family; (b) making it more difficult for out of state agencies to monitor the facility and uphold their own state standards (which may be a higher standard than the receiving state); (c) extremely difficult for meaningful discharge planning to occur due to the out of state facility not having relationships with providers or even understanding the community that the child is returning to; and (d) it can allow a facility to evade regulation by shifting to court children from another state if one state stops sending children because of subpar conditions.

4. Remedy the failures of oversight that exist at all levels.

While oversight failures are not unique to Idaho, they are an extensive problem here. The primary organizations charged with protecting Idaho youth in these facilities are all housed within the same state agency—the Department—demonstrating a lack of impartial oversight into reported abuse and neglect in youth facilities licensed by the same department.

However, stronger oversight is meaningless without strong legislation and regulations to protect these vulnerable youth. The State of Idaho's zero-based rule making regulation prevents state administrative agencies from creating new rules without ending old ones. This method of regulation is ineffective in an under-regulated industry where the most vulnerable children are sent to live and receive treatment in isolated environments.

In Idaho, failure in the oversight of youth facilities is so prevalent that the State Legislature requested the Office of Performance Evaluations investigate the state licensure agency, further demonstrating that current oversight procedures are not strong enough to protect youth and reiterating the need for impartial oversight.

5. Create an easy to access and navigate system that accurately identifies all youth residential treatment facilities and publishes surveys conducted by state survey agencies, quality of care, and incident data.

No database exists that accurately contains information on complaints, surveys, and incidents at youth treatment facilities across the country. Additionally, surveys do not capture individual abusers, who can move from facility to facility following abuse allegations. Unless these individuals are prosecuted, facilities have no way to check whether the person they are hiring to work with vulnerable children has been accused of abuse in the past.

6. Requiring the Administrators of Children's Facilities to be Licensed - similar to the Administrator Licensing Requirements of Nursing Homes and Assisted Living Facilities, for additional accountability and oversight.

7. Requiring that all state agencies involved in the placement of children in these facilities work together to identify and address concerns regarding the care and treatment of children in these facilities - in Idaho, this would include Children's Residential Licensing, Idaho Medicaid, Children's Mental Health, Child Protection Services, and the Idaho Department of Juvenile Corrections.

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Disability Rights North Carolina (DRNC), a nonprofit organization, is the Protection & Advocacy (P&A) system that serves North Carolina. DRNC is federally mandated to advance and defend the legal rights of people with all types of disabilities, of all

ages, statewide. DRNC is a proud member of the National Disability Rights Network. We provide free legal advocacy services to people with disabilities in NC including information and referral, outreach and education, self-advocacy information and technical assistance, policy and coalition work, individual representation and impact litigation.

As the state's P&A, DRNC has access authority to monitor facilities where people with disabilities receive care, treatment, or services. Where there is probable cause to believe that disabled people have been or are being neglected or abused in these settings, DRNC can initiate an investigation. Due to our grave concerns about the abuse, neglect, and lack of appropriate treatment of children institutionalized in psychiatric residential treatment facilities (PRTFs), we have spent time and resources for many years monitoring these facilities, filing complaints with the appropriate state agency, the Division of Health Service Regulation (DHSR), and taken other action to protect disabled youth who are abused and neglected in PRTFs. We are grateful to the Senate Finance Committee for focusing on these serious issues.

This Committee heard testimony from our colleagues at the Arkansas P&A about the conditions found during their monitoring of PRTFs. Their testimony accurately describes conditions that DRNC observes in North Carolina PRTFs in addition to the conditions North Carolina children have experienced when placed in Arkansas PRTFs. We would therefore like to underscore the previous testimony and recommendations, keep our testimony concise, and focus on some issues not already covered.

PRTFs are designed to provide intensive, short-term, residential psychiatric treatment for stabilization and are unsuitable and not intended for long-term placement. Yet DRNC sees many children who languish in PRTFs, where they regularly face trauma and maltreatment, for extended periods of time, sometimes years. Often, they are confined to prison-like settings under the care of a poorly trained and understaffed workforce; are subject to broken bones, sprains, bruises, and dangerous physical and chemical restraints, many of which are also illegal; withstand sexual and physical abuse, bullying, and hate speech by both other youth and staff; and face mental health deterioration and cocktails of strong psychotropic medications.

In addition to our ongoing monitoring of these facilities, in December 2022, DRNC and co-counsel filed the lawsuit known as *Timothy B. et. al. v. NC DHHS*[1] against the NC Department of Health and Human Services (DHHS) on behalf of a class of children with mental and behavioral health needs in the custody of the child welfare system who are institutionalized in these heavily restrictive, often clinically inappropriate PRTFs due to the lack of home and community-based services and placements, in violation of the Americans with Disabilities Act (ADA) and other laws. On any given day, hundreds of children with disabilities in child welfare custody remain confined inside PRTFs, away from their communities. Most of these children would be far better and more cost-effectively supported with integrated community-based placements and services, including mental and behavioral health services. We are advocating for increased investment in community-based care and reduction in wasteful spending on ineffective facility-based services.

We highlight that one of DRNC's co-counsel and co-plaintiffs in the litigation is the NAACP North Carolina State Conference given that the state's practice of inappropriately warehousing children in PRTFs disproportionately harms Black and Brown children. Black and Brown children are disproportionately represented in DHHS's foster care system in the first instance. Once in the system, Black and Brown children with disabilities are disproportionately confined to PRTFs, where they bear the brunt of the harms with which those facilities are rife. According to state data from fiscal year 2019 to 2020, Black and Brown (including multiracial) children make up more than 40% of the children receiving Medicaid who are confined to PRTFs. When you include children identified as "other," the number increases to almost 50%.

Not only are children in foster care in North Carolina routinely sent to PRTFs unnecessarily, more than a third of those children are sent into PRTFs out of state. DHHS ships children of all ages as far away as Utah, Missouri, Arkansas, and Indiana—too far for their caseworkers (or DRNC) to keep an eye on their safety or for their families to visit them. Overwhelmingly, the children NC warehouses in PRTFs would be better served by community placements and, in many instances, they should never have been placed in a PRTF at all. They are sent there because North

[1] *https://disabilityrightsnc.org/news-events/public-reports/timothy-b-litigation/*.

Carolina has failed to ensure an array of appropriate, accessible community-based services. Out-of-state placements must be sharply decreased and closely monitored.

A USA Today series of investigative reports entitled "Locked Away"[2] issued shortly before the *Timothy B* litigation was filed revealed the abuse to which disabled children are routinely subject in NC PRTFs[3] as well as in out-of-state PRTFs.[4] Research also shows that children with disabilities confined to PRTFs suffer much worse outcomes than non-institutionalized children. These outcomes include spending longer periods of time in child welfare custody without a permanent home; losing critical family connections with parents, siblings, and extended family due to their confinement; and experiencing higher rates of maltreatment while in child welfare custody. The findings make obvious the need for much stronger oversight and meaningful outcome measures for PRTFs.

DRNC's monitoring and advocacy work continues to uncover troubling issues within the PRTFs, such as the use of strip searches. Much more like a carceral setting, and completely antithetic to a therapeutic setting, vulnerable children without the protections of their parents or interested adults, are stripped naked and then told to "jump, squat, cough" in front of staff. We learned last fall that at least some of NC's PRTFs routinely strip search all children upon admission, in addition to kids who leave the facility unaccompanied by staff and then return. So, for example, if a family member wants to take a child to lunch off the premises of the PRTF, the child will be strip searched immediately upon returning to the facility by whomever is available, including individuals of the opposite sex.

These physically invasive searches are being performed on children as a default policy or practice without any consideration as to an individual child's psychological history of abuse or sexual trauma. The strip searches are dehumanizing and degrading. This practice is neither trauma-informed nor therapeutic. It is simply abusive and has a chilling effect on anyone who wants to leave the facility for fear of being strip searched when they return. One facility failed to keep records of such incidents as required by state law and failed to respond to DRNC's request for a copy of their strip search policy. It has now been more than 9 months since we notified (and subsequently followed up with) the NC DHHS and submitted a complaint to DHSR regarding the dehumanizing practice, and yet there seems to be limited understanding that strip searches are an abusive practice. We amended our initial complaint and have still not received any findings whether the state agrees that this strip-searching of children constitutes abuse. DRNC recommends federal law that makes strip searches illegal or limited to rare, critically important situations to prevent harm to self or others and only when performed within strict guidelines and with adequate oversight.

DRNC also bears witness to the misuse and overuse of medication as chemical restraint in lieu of therapeutic interventions in PRTFs. The medication lists we reviewed for children in PRTFs show that children are routinely prescribed one or more antipsychotic medications when the child has no diagnosis of psychosis, many medications are prescribed "off label" and/or are not FDA approved for use in children, and that many of the medications on their lengthy medication list are contraindicated and can lead to serious side effects like seizures, fainting, and confusion. We are left with no doubt about the pervasive use of chemical restraints in PRTFs. DRNC urges Congressional action to make abusive chemical restraint and polypharmacy of children in PRTFs an illegal practice and one that invites federal oversight and corrective action.

PRTFs constantly make false claims about their programming. In one DRNC case, neither DHHS nor the Medicaid managed care organization (MCO) responsible for service provision seemed able to arrange appropriate services for a 14-year-old. After months of waiting for services, the child's mother was contacted by the Piney Ridge PRTF in Arkansas. It is unknown to us how Piney Ridge, which has a well-known record of regulatory failures and abuse, got a hold of the mother's information, but they communicated to her that this PRTF was a great fit for her son and could address his specific issues (mental health and sexually reactive behaviors from being sexually abused at a younger age). The parent, like many families, was exhausted from trying to get help and despaired of any assistance ever being forth-

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[2] *https://www.usatoday.com/in-depth/news/2021/11/08/investigation-uncovers-treatment-failures-inside-mental-health-facilities-for-youth/8581506002/*.
[3] *https://disabilityrightsnc.org/general/news-reports-on-prtfs/*.
[4] *https://disabilityrightsnc.org/news/drnc-newsfeed/ncs-hidden-children/*.

coming. She leapt at the opportunity Piney Ridge offered and the MCO agreed to the placement.

Of course, little of what the mother was told was true. Her son was physically abused, had his medications changed and increased without her consent or even letting her know, failed to receive much if any "treatment," and lost a significant amount of weight while in the facility. (DRNC frequently hears from children in PRTFs that they don't get enough to eat and we observe that the quality and quantity of food served is poor.) When the parent started raising questions and DRNC got the Arkansas P&A involved, the facility threatened to discharge the boy without any plan in place and ultimately did so.

If these facilities can prey on vulnerable children and families, make inaccurate claims, and earn profits while causing children's outcomes to worsen, perhaps there are or can be federal laws used to punish them for this conduct.

Children have the right to live in their communities where they can be nurtured and cared for and thrive. Children removed from their homes due to abuse or neglect and taken into the custody of a child welfare agency are entitled, at a minimum, to safer, more supportive living conditions. Instead, the federal and state governments send millions of taxpayer dollars each year to private PRTFs that neglect and abuse the most vulnerable among us, leaving children worse off than when they went in. We strongly urge Congress to take every action possible as outlined in the Senate Finance Committee's Findings and Recommendations. We must act immediately and assiduously to end these damaging practices and stop state-sanctioned abuse and neglect of children. Please take prompt and comprehensive action so the lives and futures of our children are safe and supported. Too much time is being lost and too many lives are being destroyed while states fail to take action to protect children from these proliferating, profit-generating facilities. Thank you for considering DRNC's testimony. Please contact Virginia Knowlton Marcus, CEO, with any questions: virginia.knowltonmarcus@disabilityrightsnc.org or 919–856-2195.

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June 26, 2024

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Youth Residential Facilities in Ohio

Senate Finance Committee:

Thank you for allowing Disability Rights Ohio (DRO) the opportunity to provide written testimony regarding the June 12th, 2024, hearing regarding residential treatment facilities (RTFs) "serving" children with mental health and other behavioral needs. DRO is Ohio's designated protection and advocacy system with the mission to advocate for an equitable Ohio for people with disabilities.

Recently, the Senate Finance Committee released *Warehouses of Neglect: How Taxpayers are Funding Systemic Abuse in Youth Residential Treatment Facilities* (report), following a 2-year investigation, that found children in these facilities face physical, sexual, and verbal abuse. The report details four of the largest providers including Universal, Acadia, Devereux, and Vivant. Three facilities in our state are operated by Universal Health Services Inc., and one was previously operated by now Vivant. DRO applauds the Senate for taking up this important work, conducting this investigation, and holding a hearing to accept testimony on the harmful behaviors taking place in youth residential treatment facilities.

As part of our core functions as the protection and advocacy system, DRO monitors facilities that provide services to children with disabilities and investigates instances of abuse and neglect. This included thirty-three (33) monitoring activities at RTFs from October 1, 2022, through June 30, 2024. Throughout these monitoring activities DRO has reported issues that include painful restraints, lack of access to

individualized treatment services, lack of trauma-informed care, poor incident reporting practices, and inappropriate labeling of youth in several facilities.

In addition to our monitoring activities, DRO investigated five (5) RTFs from October 21, 2022, through June 30, 2024. In September of 2021 and May of 2024 DRO released reports on two facilities in Ohio after nine (9) and sixteen (16) month investigations, respectively. The nine (9) month investigation of the Sequel Pomegranate facility (aba Torii Behavioral Health) in Columbus, Ohio, found inappropriate restraint techniques, rights violations, and lack of adequate nutrition, among other reports of abuse and neglect. Most of the former Sequel treatment centers that remain open nationwide are now operated by Vivant Behavioral Healthcare. Most recently, the investigation into Youth Intensive Services (YIS) in northeast Ohio found instances of children leaving the facilities and exposed to dangerous conditions, reports of sexual assault, inappropriate use of restraint, and failure of agency leadership to provide a safe, trauma-free culture, among other reports of abuse. Nearly everything released in the report are issues youth in residential treatment facilities are facing here in Ohio.

In addition, over the past several years, DRO's Education Team has reviewed the educational programs provided by Ohio's youth residential treatment facilities and has uncovered multiple concerns regarding the quality of educational services provided to youth with disabilities. These concerns, including the failure to provide appropriate special education services and transition planning to youth, make is less likely youth in these treatment facilities will graduate and move on to further education or competitive employment.

Our reports, combined with the details of the Senate hearings and report, show the need for federal intervention. These instances are not unique and show the systemic issues that need to be immediately addressed to prevent this kind of abuse from occurring and ensure children are being provided quality care. Further, the reporting shows the failure of state governments to intervene and revoke licensures of these harmful facilities.

Congress and state governments can intervene and improve conditions for children with disabilities. These hearings and reports shine light on the need to invest in community-based services and supports. States rely heavily on institutionalization, that includes RTFs. Additional investments from Congress and states are necessary to remove children from these harmful facilities, ensure services are provided in the community, and support states to expand their oversight of RTFs. Children with disabilities should not have to face abuse, neglect, and exploitation. By not enforcing better standards, focusing on community-based services, or complying with current guidelines, states are failing these youth.

To address these ongoing concerns, DRO would like to elevate several of the recommendations within the Congressional report:

1. **Raising standards inside residential treatment facilities;**
2. **Prioritizing community-based services and placements;**
3. **Effective oversight mechanisms of residential treatment facilities;**
4. **Assessing placements for potential Olmstead violations; and**
5. **Heightened scrutiny by accrediting bodies, like Joint Commission.**

DRO appreciates the Senate for bringing this issue to the public attention. Too long have children in these facilities faced abuse and neglect. Conditions must improve and standards must be raised. Attached to this testimony are the two reports DRO issued based on the investigations of two facilities here in Ohio. If you wish to discuss this testimony, or the attached reports, further please do not hesitate to reach out to me or Jordan Ballinger, Policy Director at (614) 466–7264 x135 or jballinger@disabilityrightsohio.org.

Sincerely,

Kerstin Sjoberg
President and CEO

Dangerous Inaction: A Culture of Chaos at Youngstown's Youth Intensive Services

Disability Rights Ohio ("DRO") serves as the federally authorized protection and advocacy (P&A) system for people with disabilities in Ohio. We are a non-profit organization with a mission to advocate for an equitable Ohio for people with disabilities. Part of our role as the P&A system is to investigate reports of abuse or neglect of Ohioans with disabilities in state-operated, certified, and licensed facilities within various systems of care. This work includes probable abuse or neglect in residential treatment facilities for children and youth in our state.

This report focuses on an investigation completed by Disability Rights Ohio at a residential facility, **Youth Intensive Services** (YIS), which provides mental and behavioral health treatment to children ages 12 to 18 in Youngstown, Ohio. The investigation took place over a period of approximately 16 months and included numerous interviews with children and staff, hours of video review, and review of hundreds of records.

DRO's investigation uncovered pervasive and disturbing problems embedded in the treatment culture at YIS and the inability of the facility to protect children's rights. Children live at YIS to receive needed therapeutic behavioral health treatment. Yet, they were instead exposed to:

- AWOL, meaning children leaving the facility grounds without permission and often being exposed to unsafe and dangerous conditions while off-grounds.
- Inappropriate, unapproved and painful restraint techniques and physical abuse (including staff placing kids in choke holds, pushing kids to the ground, slapping a child on the head) that often resulted in injuries.
- A failure by agency leadership to provide a safe, trauma-informed culture for childhood survivors of physical, sexual, and emotional abuse.

DRO has raised these issues repeatedly with YIS leadership and with the Ohio Department of Mental Health and Addiction Services ("OhioMHAS"), the state agency that licenses and certifies the facility. In one of its recent letters to YIS, DRO asked the facility to suspend admissions to the facility and relocate the children there until YIS can safely care for the youth. **YIS declined.** DRO believes we have exhausted our effective advocacy with the facility and OhioMHAS.

DRO's hope through issuing this report is to inform the public, elevate youth voices, and urge significant changes to occur at YIS.

This report contains a collection of the accounts the children at YIS provided to DRO through interviews along with information that DRO collected through videos and records.

BACKGROUND

Ohio has approximately 60 residential facility locations for youth licensed by the Ohio Department of Mental Health and Addiction Service (OhioMHAS) serving some of the most vulnerable and at-risk Ohio children. Many of these live-in settings more closely resemble institutions in environment and operations. The facilities are intended to be safe, structured, and welcoming environments where children can participate in therapeutic programming and activities that help promote their healing and growth. Children are often placed in these facilities by their parents or guardians who have made the exceedingly difficult decision to turn over the care of their child, and at times their custody, to unknown people across the state or even out-of-state to get the child the help they deserve.

To obtain a license, providers must demonstrate to OhioMHAS that they meet sets of standards related to, among other things, the physical environment, provision of mental health services, safety, resident/patient rights, and administration and management.

Youth Intensive Services is licensed by OhioMHAS as a Class 1 residential facility. Class one facilities provide accommodations, supervision, personal care services, and mental health services for one or more unrelated children or adolescents with behavioral health needs.

OhioMHAS may additionally certify facilities to operate specific services and activities. One such certification is to operate as a Qualified Residential Treatment Program ("QRTP"). A QRTP certification means that a facility must implement a trauma-informed approach in their policies, trainings, and staff interactions with

youth.[1] Youth Intensive Services received its QRTP certification from OhioMHAS on September 29, 2021.

When OhioMHAS licenses and certifies facilities for services, the public should be able to rely upon those licenses/certifications as an assurance that OhioMHAS has verified that the services required are being provided and that the standards set are being met consistently for as long as the entity is licensed. Based on DRO's investigation at YIS, the public should not rely on OhioMHAS for the assurance that the services and conditions experienced by the children at YIS meet these standards.

INVESTIGATION

According to their website, Youth Intensive Services "is a 4–6-month intense residential program that maintains a staff-secure, trauma-informed environment for adolescent males and females between the ages of 12–18. We provide evidence-based therapy in a home-like setting that's therapeutic, family-centered, and community-involved."

> We are stuck in here, we have no parents, we have no rules, and we're just kids.
> —Child interviewed at YIS

DRO first went to YIS in October 2022 to conduct a monitoring visit. At that time, DRO found concerning trends in restraint practices, staff abuse, privacy, and programming. DRO sent a letter to YIS to address these trends, and while YIS responded to DRO's letter, it did not address DRO's concerns sufficiently. DRO brought the issues to OhioMHAS's attention in December 2022. DRO then opened an investigation at YIS in January 2023 to continue investigating the reported problems.

Since October 26, 2022, Disability Rights Ohio has made 3 visits to the facility, interviewed 28 youth and staff, viewed hours of video, reviewed hundreds of records, and issued 4 recommendation letters. These combined efforts have documented systemic themes of pervasive rights violations and harmful practices to some of the most vulnerable youth in our state.

AWOLs:

The term AWOL (absent without leave) refers to children leaving the facility grounds without permission. It is the facility's responsibility to identify effective strategies to mitigate frequent AWOL occurrences. DRO is concerned that YIS is not meeting this responsibility.

Police reports:

Based on police reports for YIS from January 1, 2024 to May 19, 2024, there were 31 reports of AWOL. In the AWOL reports, multiple youth are reported leaving the facility together.

- In some reports, the same children ran away from the facility multiple times in one day and were gone from the facility for several hours or days and returned by police.
- Several youth returned to the facility with injuries, reported possible sexual assault, or tested positive for drugs.
- One youth described to police that she was being sexually assaulted at the facility.
- In a different incident, this same youth was reported to have left the facility after the facility received two phone calls from men about the youth. The youth spent the day with an unknown male while off the facility property. This report aligns with what staff informed DRO at our most recent visit—the youth will leave the facility to visit unknown men and return to the facility to shower.
- When one youth was returned to the facility by police, facility "management" informed police that the youth was "banned" and could not return. This meant that the police were tasked with arranging the youth's care with the custodial children services agency.

[1] QRTP certification means all employees within the facility are trained in that trauma-informed approach. A trauma-informed approach is one that recognizes the widespread impact of trauma and understands the potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others in the system; responds by fully integrating information about trauma into the policies, procedures and practices, and seeks to actively resist re-traumatization.

Throughout interviews with children, they reported:

- Staff do not consistently follow through with AWOL procedures. One youth reported that they felt that staff don't care if the youth are AWOL or not from the facility.
- There was a confirmed incident where a child was able to make it approximately 3.4 miles to the bus station before the police found them. The bus station where the child was found was in an area where there had been recent shootings.

During an on-site visit, YIS staff reported:

- A staff reported that they serve children who are survivors of sex-trafficking and that it was upsetting that some of the children leave to go to men's houses then come back to the facility to shower.
- Staff reported that children will leave to go to a mailbox known to have drugs in it and then come back to the facility.
- YIS staff explained that if a child "AWOLs" over the fence, staff must return and fax the police. In police reports, it showed that it can take over 30 minutes for staff to fax the police about a missing child.

Through video review, DRO observed:

- Children easily jumped the fence surrounding YIS.
- Children leave the grounds with little clothing and no shoes.
- Two children attempting to leave the grounds were left outside in the middle of winter for approximately 20 minutes while staff periodically checked in from the doorway.
- Staff made statements to the children such as, "be safe" and to avoid a certain neighborhood because they kidnap kids.
- One staff person followed five youth as they jumped the fence but did not attempt to redirect them back to the facility.

DRO followed up with YIS and OhioMHAS for more information about the concerning frequency of AWOLs. YIS reported that they are working on these issues with OhioMHAS and local authorities. In a letter from YIS to "stakeholders," YIS states that the increase in AWOLs was a result of YIS not being able to restrain the youth to prevent them from leaving. DRO acknowledges that AWOL is a difficult issue to address. However, based on the information received from YIS, DRO is concerned that YIS is not doing enough to treat the behaviors leading to recurrent AWOLs or to treat the children when they return to the facility. **A recent response from OhioMHAS confirmed that it has not taken any formal corrective action to address any of the dangerous deficiencies at YIS since April 2023. This inaction is great cause for concern.**

Inappropriate, unapproved, and dangerous restraint techniques and physically abusive behaviors by staff:

In youth residential treatment facilities, restraints should only be used when youth are a danger to themselves or others and only after verbal or non-verbal calming techniques have been unsuccessful. If a restraint is used, staff are prohibited from using techniques such as laying a youth face down on the ground, restricting breathing, or placing body weight on top of a child.

> I used to be restrained all of the time. Staff would never listen to me. I just wanted help, but they didn't understand that.
> —Child interviewed at YIS

When children are victims of inappropriate physical restraint and physical abuse, they are placed at risk of further traumatization, serious injury, or death. Moreover, children with trauma histories, who witness their peers being restrained or physically abused, are at high risk of re-traumatization.

Throughout interviews with children, they reported:

- Children reported having injuries such as bruising and cuts that were a result of restraints.
- One child reported that a staff sat on their chest, and they told the staff that they could not breathe.
- One child reported that staff would apply pressure during a restraint, that it sometimes felt like they couldn't breathe.

> Sometimes when there are restraints, kids accidentally get hurt. It's very traumatic.
> —Child interviewed at YIS

Through video reviews, DRO observed:

- Prone restraints where a child is held face-down on the ground, which is known to restrict breathing;
- Staff laying on top of children with their entire body weight;
- Staff having their arms around youths' necks;
- Several incidents of staff conducting dangerous restraints that could impact a child's ability to breath;
- Children being restrained against objects such as trash cans and chairs with their heads being placed in dangerous ways;
- Staff rarely attempting verbal and non-verbal calming strategies with children prior to initiating a restraint;
- Children helping to restrain other kids.

Physically abusive behaviors by staff:

The staff behaviors described and seen in these incidents lack positive therapeutic value and repeatedly put children at risk of further traumatization and regression in treatment.

Through interviews with children, they reported:

- A staff had their neck against the window, then the staff hit them in their face. The child reported that this staff was a supervisor and the child thought that they were supposed to be better trained than others.
- A child reported that staff are not talkative, and that staff have no problem slamming kids to the floor. They reported that staff will only give kids 10 seconds to calm down before putting their hands on kids.

Through video review, DRO observed:

- In one incident, a child was showing their peer a picture from the hallway when staff came to them and slapped them on their head. The staff then placed the child in an unapproved restraint that put the child in clear distress. Two other staff members observed the staff member slap the child on the head and assisted with the inappropriate restraint. Both staff members were laughing during the restraint while the child was visibly upset.
- One incident showed an agitated child getting pushed to the ground by a staff member causing the child to become more distressed. The child was then restrained as a result.
- One incident showed an upset youth trying to calm themselves down by going down the hallway. A staff member followed them and then repeatedly shoved the child in a corner and used inappropriate language with the child. After the staff member leaves the hallway, the staff person can be heard off-camera laughing, while the child remains noticeably upset in the hallway. In the written incident report, staff involved stated that the child was "talking smart" as justification for their behavior towards the youth.
- Staff were observed placing children in choke holds during a restraint.

Though some abusive staff have been terminated and other staff have been re-trained in de-escalation and restraint techniques, *DRO continues to receive reports of abusive staff behavior.*

- Despite staff being retrained, a recent incident captured on video depicts two separate physical interactions between two youth and five staff.
    - Video shows the children at a door with staff and the youth want to go through the door. A staff chemical dependency counselor tells the youth to "back up" and places his hands out to stop the kids. One child pushes the counselor's hand away while the other child pushes the counselor. The counselor then lunges at one of the children. The counselor and child place their hands around each other's necks and go to the ground in what resembles a physical brawl rather than a restraint intended to maintain safety and to assist the child in regaining control.
    - At the same time, two staff members can be seen grabbing the other child by the arms and throwing them to the floor into the corner. The child's head appears to hit the wall as they say "oh, sorry . . . I'm sorry." Two staff members lay on top of the child with their bodies and elbows on the child's chest and near their neck. During the restraint, the child's head is against the wall at an angle.

Failure by agency leadership to provide a trauma-informed organizational culture:

Trauma-informed care follows core principles of safety, choice, collaboration, trustworthiness, and empowerment in the interactions with children and in policies and procedures. As stated by the CDC, "Adopting a trauma-informed approach is not accomplished through any single technique or checklist. It requires constant attention, caring awareness, empathy, and possibly a cultural change at an organizational level."

> Staff say all the time they are gonna make our stay here hard. It's already hard.
> —Child interviewed at YIS

YIS has been unable to maintain a consistent trauma-informed environment for youth that meets the requirements of the QRTP certification from OhioMHAS.

Throughout interviews, children reported:

Traumatizing Staff Conduct—

- Staff treat them poorly and felt that staff will take out their bad days on the kids.
- One child reported feeling frustrated because staff are disrespectful, always on their phones, and do not help. At one point, the child asked staff multiple times to just be around them because they were having a hard time and having suicidal thoughts. The child reported that no one listened to them, which resulted in them attempting suicide. After, the child was punished for attempting suicide by losing privileges, like going on outings off the facility premises.
- They have heard staff arguing amongst each other and have heard staff fighting outside in the parking lot.
- One child reported that after an incident, they overheard staff say that they could not write "wanted to beat her ass" in the incident report when talking about another child.
- Many children reported that staff will ignore or deny access to the restroom. Bathrooms at YIS are locked and children are reliant on staff to open the door for them.

Ineffective Grievance System—

- Children have the right to make a complaint ("grievance") about the facility and they have a right to a response. Many children reported inconsistencies in how their complaints or grievances are handled with some children reporting that no one responded to their complaint.
- Grievance forms that kids wrote that YIS provided to DRO, expressed concerns about staff treatment, programming, and peer related issues.
- One child reported to staff that another staff member made an inappropriate comment to them. The child was then told that nothing would be done because "he knows a good staff when he sees one" and that was the end of their grievance. Other children reported that they had similar experiences of grievances going unanswered.

> Chaos, yelling, restraints.
> —A child describing a typical day at YIS

Through video reviews and interviews with staff, DRO observed:

- Staff waiting to respond to incidents until they have escalated rather than intervening in the incident early.
- Staff not engaging with children on the units and, instead, are on their phones.
- Staff making statements such as "I don't want to chase you because it is cold" or "I don't want to mess with you right now" to distressed youth.
- A lack of programming, particularly on second shift. One child described being "hyper" and asking to go to the gym, but staff refused.
- Staff escalating situations with children in distress.
- One incident showed a staff shoving a youth against a wall and getting in their face just minutes before a large fight broke out on the unit. Staff were aware of the growing tension between the kids but did nothing to de-escalate the situation, and children were put in dangerous restraints as a result.

Lack of timely, accurate, and consistent incident reporting practices:

There appears to be a lack of follow-through on incident reports:

- DRO has found that YIS does not report incidents to OhioMHAS when it would be required to do so. For example, several of the incidents described in the po-

lice reports or internal reports should have likely been reported to OhioMHAS, particularly when the incident resulted in injury or possible sexual assault.
- When incidents are reported, DRO has found that many times the incident report does not accurately describe the incident that occurred.
- YIS is unable to show documentation that complete investigations of some incidents have occurred.
- There is a lack of consistency with YIS obtaining statements from staff who witnessed the event or from the youth involved.
- In interviews with staff, they reported confusion about how they would file or report an incident.

A CALL TO ACTION

> This is our time to meet the moment. Our time to do the hard things that matter and will make a lasting difference for our children and their future.
> —Governor DeWine, State of State Address, April 2024

Disability Rights Ohio has consistently brought the issues in this report to the attention of OhioMHAS and YIS and advocated for both entities to do more to improve the care and safety provided to children at YIS.

To date, neither OhioMHAS nor YIS has done enough. DRO is aware that YIS and OhioMHAS meet monthly to talk about these issues. Despite these monthly meetings, DRO continues to receive information about dangerous conditions at YIS. DRO is concerned that the problems at YIS will only increase because YIS and OhioMHAS have not taken the necessary actions to stop them.

The issues that persist at YIS are unacceptable and do not meet even the minimum standards set by OhioMHAS. OhioMHAS's failure to thoroughly protect the children's safety or address rule violations is intolerable. Disability Rights Ohio calls on both YIS and the Ohio Department of Mental Health and Addiction Services to take more significant, corrective action immediately.

OhioMHAS and YIS leadership must spend time talking with the children at the facility to understand their perceptions and realities of the treatment that they are receiving at YIS. Children have a right to receive treatment that is focused on their healing, wellness, and life readiness. Children at YIS have the right to be kids and to have their childhoods restored.

Disability Rights Ohio asks OhioMHAS, as the state licensing body, to suspend Youth Intensive Services' license until a time that the facility can consistently demonstrate that it meets minimum standards and that sustainable trauma-informed care practices are implemented in accordance with OhioMHAS' stated values, trauma-informed initiatives, and the QRTP certification and license status granted to the facility.

If YIS is unable or unwilling to meet these standards, DRO asks OhioMHAS to revoke its license.

Disability Rights Ohio is a nonprofit organization committed to advocating for an equitable Ohio for people with disabilities. As Ohio's Protection and Advocacy System and Client Assistance Program, DRO works so that Ohioans with disabilities are free to live, work, learn, and go where they choose, are equal participants in civic engagement, are free from abuse, neglect and exploitation, and are able to live their lives with dignity, free from harm, prejudice and discrimination *(https://www.disabilityrightsohio.org)*.

Disability Rights Ohio

> Our goal at SEQUEL-Pomegranate Health Systems is to alleviate suffering, promote holistic development, and provide an enabling environment in which disenfranchised and traumatized children can thrive.[1]

INTRODUCTION

Disability Rights Ohio conducted a 9-month investigation into complaints received and incidents reported about serious and systemic allegations of abuse and neglect, violations of safety, inappropriate use of restraint, peer-to-peer bullying, staff intimi-

[1] Sequel Pomegranate Health System Website: *http://www.sequel-pomegranatehealthsystems.com/Staff-and-Licensing.html.*

dation, violations of treatment standards, and infringement of other rights at Sequel Pomegranate, a 74-bed Residential Treatment Facility (RTF) and 20-bed Acute Psychiatric Hospital, located at 765 Pierce Drive, Columbus, Ohio 43223 in Franklin County. Both the RTF and Acute Psychiatric Hospital are licensed by the Ohio Department of Mental Health and Addiction Services (OhioMHAS).

This report primarily highlights concerns found within Sequel Pomegranate's RTF. Disability Rights Ohio is pleased to learn that OhioMHAS has taken recent administrative action against the Residential Treatment Facility. Disability Rights Ohio remains worried, however, for all children in Sequel Pomegranate's care and feels strongly that new training and oversight are necessary to address systemic failures at the facility.

Disability Rights Ohio's investigation has uncovered pervasive and disturbing problems embedded in the treatment culture at the RTF. Children who were there to receive therapeutic behavioral health treatment were instead exposed to:

- **Unapproved and painful restraint techniques and physical abuse (including choke holds and punches)** that often resulted in injuries;
- **Problematic staff behavior,** including little staff intervention during peer bullying and fighting and instances of probable staff encouragement and direction;
- **A poorly supervised, unstructured, re-traumatizing environment** lacking programming and containing disturbing levels of staff bullying, intimidation and lack of boundaries;
- **A failure by agency leadership to provide a safe, trauma-informed culture** for childhood survivors of physical, sexual and emotional abuse;
- **A failure to protect children's rights** through an unbiased, client-directed grievance process.

Disability Rights Ohio is not the only organization concerned with issues at this RTF. Sequel Pomegranate continues to experience ongoing public media attention and scrutiny from referral agencies and licensing bodies regarding the harmful culture surrounding the treatment of children in its care.

BACKGROUND

Sequel Pomegranate RTF serves children between ages 12 and 17 with mental health, emotional, and behavioral disorders. The facility offers "secure residential treatment, emergency shelter care, and acute hospital services for teens in crisis." The vast majority of children receiving services from Sequel Pomegranate's secure residential treatment program are in the custody of child protective services (CPS) agencies from counties throughout Ohio. Sequel Youth and Family Services, a privately owned company with its headquarters in Huntsville, Alabama, owns the facility. Children are referred to Sequel Pomegranate primarily through a professional referral process. All children accepted into treatment at Sequel Pomegranate have gone through the agency's screening and intake processes. After a child is admitted into treatment, children can be moved across treatment programs.

Beginning in June 2019, Disability Rights Ohio received **reports of physical abuse, peer-on-peer bullying, bullying by staff, and children's elopement** from the facility. Disability Rights Ohio began investigating these incidents and, to date, has reviewed hundreds of records, including incident reports, video footage, and children's treatment records. Disability Rights Ohio completed three unannounced visits of the Residential Treatment Facility on July 11, 2019, December 2, 2019, and February 10, 2020 and two unannounced visits to the Acute Psychiatric Hospital on December 2, 2019 and February 10, 2020.

During the same time of Disability Rights Ohio's investigation, OhioMHAS conducted surveys of Sequel Pomegranate's Acute Psychiatric Hospital including the review of a video from an October 25, 2019, incident. On November 1, 2019, OhioMHAS proposed to suspend Sequel Pomegranate's license to operate the Acute Psychiatric Hospital. The findings established by OhioMHAS determined the use of:

- **Unapproved restraint technique** in which a staff Licensed Practical Nurse (LPN) placed and held a child by wrapping her arm around the child's neck and subsequently taking the child to the floor;
- **Inappropriate and dangerous restraint technique** that may have restricted the child's ability to breath by placing staff's body weight on the child's back while the child laid face down on the floor by an LPN and Mental Health Associate (MHA);

- **Physically abusive behaviors,** by staff, LPN, and MHA, who were observed striking the child's face five times with a fist, grabbing the child's hair, and pushing the child's head against the concrete block wall;
- **Staff uncertified to provide restraint** as LPNs implemented the restraint without annual non-violent crisis intervention training;
- **Violation of the child's right** to reasonable protections from physical abuse;
- **Failure to provide follow up care** as there is no documented nursing assessment of the child by the nurse or physical examination of the child by the psychiatrist.

On February 26, 2020, Disability Rights Ohio requested a complaint-based survey of the RTF by OhioMHAS.

PHYSICAL ABUSE AND PAINFUL RESTRAINTS

Beginning on July 11, 2019, Disability Rights Ohio conducted several on-site visits to interview children. Disability Rights Ohio spoke to over 43 children, many of whom reported that they had experienced painful crisis holds or had observed their peers being injured.

> They put their elbows in our jaws and tell us to stop talking . . . Our arms are up in such a way that they can get broken or our shoulders pop out of place . . . Staff throw kids against walls.

After learning of these events, Disability Rights Ohio attempted to work with Sequel Pomegranate to address these issues. Though Sequel Pomegranate tried to implement a new crisis intervention model based on the concerns and recommendations from Disability Rights Ohio, Disability Rights Ohio gathered additional testimonies from children who continued to witness or experience restraints:

- A child stated she was concerned about how **"staff throw them [children]"** and continue **"to be rough with them."** Regardless of the code being called **"someone is getting restrained";**
- **"It [restraint] hurts";**
- A child stated that staff threatened to restrain him by saying, **"I'll wrap you up"** and the threat is used **"constantly";** and
- **"Put in a hold so strong that it almost broke my arm; they kept holding me tighter and tighter; my hands and arms were tingling and going numb."**

One reporter stated that Sequel Pomegranate staff had a **"last resort first"** approach and had observed staff **"pulling arms too high, too tight."** Another report described Sequel as not a safe environment because restraints were conducted in ways that eliminated a child's ability to communicate.

The issues Disability Rights Ohio uncovered in Sequel Pomegranate's RTF are similar and equally disturbing as those occurring in its Acute Psychiatric Hospital. On February 26, 2020, Disability Rights Ohio requested a complaint-based survey of the RTF by OhioMHAS. OhioMHAS has used its licensing authority to initiate action against the RTF.

Many of the children served by Sequel are victims of traumatic experience. These children are at risk of further traumatization when they are the victims of inappropriate physical restraint and physical abuse. Moreover, children with trauma histories who witness their peers being inappropriately restrained or physically abused are at risk of re-traumatization.

PROBLEMATIC STAFF BEHAVIOR

Disability Rights Ohio received reports about:

- **Lack of staff intervention** during peer bullying and fighting and even instances of seemingly staff encouragement of peer conflicts.
- **Bullying by staff** including staff making fun of their hair, cussing at them, telling them that they stink and need to go take a shower, and talking about confidential information in front of their peers.

Children describe staff as repeatedly failing to prevent or intervene when children become verbally aggressive with one another, which frequently escalates to physical confrontations. It was reported to Disability Rights Ohio that often the children not involved in the altercation attempt to stop physical fights due to staff inaction or when staff have left their assigned unit to respond to needs on other units. It is not uncommon for one unit to be left understaffed.

For example, Disability Rights Ohio investigated a February 9, 2020, peer-to-peer incident that was reported by youth to Disability Right Ohio during an unannounced visit on February 10, 2020, in which two children, while sitting shoulder to shoulder, began provoking each other in the presence of staff. While one staff member makes three attempts to intervene, they eventually walk off the unit, leaving one staff member with nine children. Both children begin striking and kicking as staff respond from other units. Approximately 2 minutes and 44 seconds elapsed before one child was able to be "therapeutically guided off unit."

Children at Sequel Pomegranate provided the following testimonies describing some staff's dismissive demeanors during growing tensions and staff's probable encouragement during peer-on-peer fights:

- Staff oftentimes say, **"If you [child] fight, I'm not breaking it up."**
- Staff often let peers fight with other peers and just sit back and **"watch and fight"** and only **"good staff will hurry and do something about it."**
- Staff not believing children, administration not believing children.
- Not feeling protected; **"I don't feel safe."**

Limited staff intervention during peer bullying and fighting and instances of probable staff encouragement and direction create unsafe situations for children receiving treatment at Sequel Pomegranate. Staff are required to play an important role in establishing and maintaining a supportive and therapeutic treatment environment. Fostering a trauma free relationship with peers, staff, and therapists would establish pro-social behaviors vital for discharge into the community.

RIGHTS VIOLATIONS

During our investigation, Disability Rights Ohio heard numerous complaints about additional rights violations. For example,

- **The right to confidentiality of communications and personal identifying information.** On the July 11, 2019 investigation visit, Disability Rights Ohio was informed by one child that staff frequently break the youths/residents right to confidentiality;
- **The right to be verbally informed of all resident rights.** *"Staff tell us we do not have rights—that we are not entitled to anything"*;
- **The right to exercise one's own rights without reprisal.** *"Children do not have the right to refuse group"*;
- **The right to decline medication.** *"If you don't want to take your meds, they will write you up and you will lose your level"*;
- **The right to file a grievance.** *"If a resident makes a complaint staff don't want you around or they say 'Go ahead and do it, I am not going to get in trouble'"*; and
- **The right to exercise one's own rights without reprisal.** *"Staff hold grudges. They either refuse to do things for you or pick arguments so they can put you in a hold, especially when they are told that you have filed a grievance."*

LACK OF CARE AND PROGRAMMING

Disability Rights Ohio noted the lack of programming and structure available to the children at Sequel Pomegranate, particularly in the living and social environments.

Numerous children reported the following concerns during interviews with Disability Rights Ohio:

- **Lack of activities in the day room** which led to peer bullying and fighting.
- **Wanting less peer run groups/activities** and more staff led activities and therapy.

Children report that programming does not happen at all or presenters get frustrated and give up: ***"We are supposed to have programming but never do. We almost never have any kind of programming."***

Children's concerns were echoed by one reporter who stated that weekends, due to no programming, are best described as a ***"free for all."*** The environment reported does not support an engaging, safe, secure, and interactive facility that provides any therapeutic value towards recovery and wellness.

LACK OF ADEQUATE FOOD

Disability Rights Ohio noted reports of inadequate meal portions including poor quality and taste, inappropriate nutrition, and witnessed staff eating children's food prior to children feeling adequately fed.

With respect to concerns about inadequate food, children reported:

- ***"The food portions are too small. They are child-sized and many of us have adult-sized bodies."***
- Having food withheld and being told that food was a ***"privilege."***

Furthermore, Disability Rights Ohio witnessed staff seated and eating facility meals while children were still actively being served. With no access to food other than what the facility provides, Disability Rights Ohio believes that staff should only have access to facility food after children have finished eating and have been served portions appropriated to their developmental needs.

INEFFECTIVE GRIEVANCE PROCESS

Disability Rights Ohio is concerned about Sequel Pomegranate's implementation of its grievance process.

Early in the investigation, Disability Rights Ohio identified issues with Sequel Pomegranate's grievance process. On Friday, August 2, 2019 Disability Rights Ohio requested changes be made to Sequel Pomegranate's grievance process. Disability Rights Ohio specifically requested the following changes be made to the grievance form:

- Removal of the requirement for staff signature in order for a child to submit a formal written grievance;
- Modifications to include more "developmentally appropriate" language; and
- Forms to be made available in the common room on each unit where children could access them independently.

Sequel Pomegranate confirmed via letter that all the requested changes had been implemented effective September 1, 2019. Five months later, February, 2020, Disability Rights Ohio discovered that children continued to possess and utilize old forms.

Also, in February 2020, Disability Rights Ohio further investigated Sequel Pomegranate's grievance process when it was discovered that a child had recently recanted his grievance, which alleged physical abuse by staff, only hours after it was submitted. A review of records by Disability Rights Ohio revealed the internal investigation of the staff intervention had been halted when the child agreed to participate in a staff-initiated mediation process.

The purpose of any established grievance process is to provide children with a safe and consistent way to use their self-advocacy skills to raise concerns regarding potential rights violations and to have those concerns objectively investigated by an unbiased, neutral trusted adult. Suggesting mediation as a viable response to a grievance alleging abuse is acutely concerning. **An attempt to mediate possible abuse threatens the child's rights, devalues the child's experience and furthermore places a child in danger of re-traumatization by placing them in the same room as the potential aggressor.** Disability Rights Ohio does not reasonably believe genuine responses and resolutions can be achieved by placing a child with a potential perpetrator for mediation.

During interviews one child stated she had never participated in mediation; however, confidently confirmed mediation is an option on the unit. Another child stated he personally participated in mediation with two peers and one staff. The child stated ***"I just don't feel like mediation helps. It just makes me more mad."***

Disability Rights Ohio requested Sequel Pomegranate's policy on mediation after the February 9, 2020 interviews. **In response, Sequel corporate attorneys stated *"POM does not have a specific policy for mediation. They are in the process of creating a protocol."***

FAILURE TO IMPLEMENT A THERAPEUTIC CULTURE SHIFT

After 9 months of Investigation Disability Rights Ohio is unable to conclude that the protection of the rights of children in treatment at Sequel Pomegranate have improved.

Disability Rights Ohio's found the organization's culture deeply embedded with harmful and shaming practices. Disenfranchised and traumatized children find themselves in an environment containing:

- **A lack of emotional and physical safety** resulting from painful restraint practices often causing injuries to children;
- **An absence of empowerment, dignity and respect** when expressing their needs and concerns through the organization's grievance process without the fear of judgment or retribution; and

- **Absence of healing safe relationships** with staff.

The overall concerns about culture can be summed up by a quote from the current CEO of Sequel Pomegranate. During a visit on December 2, 2019, Disability Rights Ohio shared new complaints and concerns gathered from the children with the facility leadership. **In response, Sequel Pomegranate's new CEO asked Disability Rights Ohio if *"We're just going to believe them [children]."***

Two examples of the failed attempts to implement a therapeutic culture shift include the failure to implement a new intervention model in response to concerns about unapproved restraints, and the continuing use of a flawed grievance process even after assuring Disability Rights Ohio that changes had been made.

As part of their identified therapeutic culture improvement processes Disability Rights Ohio was informed by Sequel Pomegranate that a leadership decision had been made to retrain all staff and to implement a safer, more trauma informed crisis management approach in September 2019. Sequel Pomegranate believed that shifting the model would positively impact practices, decreasing injuries to children and shifting the organizational culture in a positive direction. However, 5 months later during an unannounced on-site investigation, February 10, 2020, Sequel Pomegranate staff expressed confusion on which restraint techniques they were to be using. When asked about the new crisis intervention model staff responded, ***"Not everyone is trained. It's not being used yet."*** It was clear to Disability Right Ohio that the communication and training strategies being identified by leadership were not having the intended impact on culture or the services children were receiving from front line staff.

Throughout the 9 months of investigation, Disability Rights Ohio held regular and mutually transparent meetings with corporate leadership and their legal representation. Continuous promises of future changes in agency culture and treatment improvements were made. After numerous lackluster attempts to change organizational culture and staff practices took place, including training and the replacement of key Sequel Pomegranate staff members, the culture and its negative impact on children persisted.

CONCLUSION

Disability Rights Ohio applauds OhioMHAS for utilizing its licensing responsibilities to hold Sequel Pomegranate accountable for the treatment to children in its RTF. **Sequel Pomegranate should not be able to provide treatment to children until systemic changes are demonstrated and appropriate training is in place that prevents the pattern of abuse from reoccurring.** DRO recognizes the importance of holding facilities accountable for the treatment of all children in its care based upon the criteria set forth in the Ohio Administrative Code. Disability Rights Ohio calls on OhioMHAS, Child Protective Services, and other referral agencies to utilize all available steps to prevent future risk and harm to children receiving services at Sequel Pomegranate.

DISABILITY RIGHTS OREGON
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Statement of Thomas Stenson, Deputy Legal Director

Chairman Wyden, Ranking Member Crapo, and members of the Senate Finance Committee, I submit this written statement for the record on behalf of Disability Rights Oregon, the Protection & Advocacy system for Oregon. My name is Thomas Stenson, I am the Deputy Legal Director of Disability Rights Oregon where I lead investigations of abuse or neglect, complex litigation, and supervise a team of attorneys and non-attorney advocates.

The Protection & Advocacy system is a federally mandated network of legally based agencies that advocate for and protect the rights of individuals with disabilities. Under federal law, P&As have authority to access facilities in which individuals with disabilities reside and access relevant records.

At Disability Rights Oregon, we are very familiar with the unique problems associated with out-of-state placements for youth in the foster care system and other youth placements. In 2019, the State of Oregon had sent dozens of children out of state to for-profit facilities. While many of these youth were teens, some were under

age 10. Essentially all of them had some kind of emotional, cognitive, or other mental health diagnosis.

We found profound and serious abuses were taking place at for-profit facilities across the nation. One Oregon youth was lodged at a Michigan facility where another child (not from Oregon) was essentially smothered to death by staff. The child's offense, leading to his death at the hands of staff, was to throw a sandwich in the lunchroom. We also found serious maltreatment of Oregon youth by staff at numerous facilities, ranging from assault to sexual harassment to the misuse of psychotropic medications to restrain children. Girls at one Utah facility were called sexually explicit names by staff.

At just one Utah facility where Oregon children were sent, police were called to the school 72 times between 2017 and its closure in 2019. Twenty-four staff were investigated for child abuse and 10 were criminally charged with child abuse related offenses. Three girls were believed to have been sexually abused by staff, and one 15-year-old may have been impregnated by staff.

Nevertheless, when things go wrong, the children are always scapegoated. These children are already labeled by many people in the system to be "bad" kids. The then-head of Oregon's child welfare program announced in 2019 that the Oregon children sent out of state were all homicidal and suicidal. These programs have an easy time blaming these marginalized children for any bad outcomes. If staff use force on youth, they have an audience of regulators and state officials ready to believe any claim the youth provoked that use of force. As conditions at the above Utah facility disintegrated, the facility blamed the breakdown in order on a "riot" by unruly youth, not the abject lack of safety and security provided by the facility, not the active participation of staff in the physical, sexual, and emotional abuse of youth.

The nationwide for-profit youth facility business model typically involves purchasing already troubled facilities—facilities that were closing down, or being closed down, because of significant problems in their care for youth. Those national for-profit entities often rebrand the previously deficient institution while demonstrating little or no improvement from the previously deficient care and safety standards.

Because of the long distance between the home state of the youth and their placement, the typical checks and balances do not apply. At an in-state facility, state child welfare workers and regulators can visit the site regularly and perform their required oversight. In addition to the routine, designated legal and regulatory oversight, in-state facilities typically receive regular visits from family members, attorneys, Protection and Advocacy staff, and all the other advocates for children in the care of the in-state facility.

At out-of-state, for-profit facilities, however, state child welfare agencies often lack the manpower to conduct their required visits. In Oregon, we found that state child welfare workers failed to visit youth at out-of-state, for-profit facilities for 6 months or more. The out-of-state facility is also regulated by the state where the facility is located, which may have different standards for licensure, different procedures, and a different priority in overseeing a facility that may house no children from that state. Sometimes, these for-profit facilities would seek out a state with particularly loose regulations or a reputation for a lax regulatory environment. Utah, for instance, at one point harbored 100 such facilities.[1] Those facilities are typically too far for family or attorneys to visit in person, and the state Protection and Advocacy organization must make extensive travel plans to visit the site. During a visit to a Utah-based for-profit facility, one of Disability Rights Oregon's staff was able to collaborate with Disability Rights Utah staff to visit facilities where Oregon youth were housed. But even diligent efforts from a Protection and Advocacy organization cannot make up for the sheer logistical challenges of visits to far-off, often remote facilities. Nor are phone calls or video conferences a substitute for an in-person visit. During a call, a family member, attorney, or disability advocate may not know if the child is able to speak freely. Even a video call provides little context for the overall conditions in the facility, especially relative to an in-person visit. These logistical challenges, impairing the opportunity for advocates for the child to understand how the child is being treated, are a feature, not a bug, from the perspective of the for-profit facility.

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[1] Jessica Miller, "Inside Utah's Troubled Teen Industry," *Salt Lake Tribune,* August 30, 2020, *available at https://www.sltrib.com/news/2020/08/30/inside-utahs-troubled/*.

In Oregon, Disability Rights Oregon was able to collaborate with other Protection and Advocacy groups to arrange visits, obtain records, share information, and otherwise try to make up for the serious logistical challenges. We are extremely grateful to collaborating colleagues at Disability Rights Utah, Disability Rights Arkansas, Disability Rights Michigan, and other statewide protection and advocacy groups who helped us overcome some of these barriers. In some states, for instance, we are unable to request records using the local state public records laws. Some local public records laws prohibit non-residents from using the public records act, which leaves an out-of-state advocate struggling to get inspection records from the state regulators of these facilities. In other cases, a different state's public records law and procedure may simply be impenetrably difficult to navigate. In one instance, we requested records in July 2019 from the State of Illinois regarding licensing, inspections, and investigations at Northern Illinois Academy. We were able to get very little information, and further efforts to get records from Illinois were finally rebuffed in December 2023, 3½ years later. Because out of state regulators or providers may not honor records requests from Protection and Advocacy groups outside of their home state, the ability to scrutinize the conditions for youth from Oregon is greatly hampered once the youth is moved out of state.

Based on our experience in Oregon, we join other Protection and Advocacy systems in recommending the following:

1. Increase investment in community-based services and concrete supports that can help prevent the use of congregate care.
2. Require meaningful outcome measures and discontinue payments for models that do not provide active treatment and individualized services, including residential treatment.
3. De-incentivize out-of-state placements through Medicaid policies.
4. Remedy the failures of oversight that exist at all levels by investing in the Protection & Advocacy system through increased funding, mandatory funding, and funding levels tied to consumer price index (CPI) increases.
5. Create an easy to access and navigate system that accurately identifies all youth residential treatment facilities and publishes surveys conducted by state survey agencies, quality of care, and incident data.
6. Invest in research and pilot programs to identify and validate effective treatment options.

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Disability Rights Pennsylvania (DRP) is the organization designated by the Commonwealth of Pennsylvania under federal law to protect the rights of and advocate for Pennsylvanians with disabilities. DRP works to ensure that individuals with disabilities can live the lives they choose, free from abuse, neglect, discrimination, and segregation.

DRP works regularly to address the issues related to residential treatment facilities for youth. Our staff advocates to address issues on behalf of both individual youth and on systemic issues that are identified. DRP has been working to address issues in Pennsylvania related to these facilities for years. We are aware that Pennsylvania is not alone in facing these issues, as our peers in the P&A system are dealing with similar concerns in other states. We believe that now is the time for federal action to ensure that youth receive the treatment that they need and do not face further trauma or abuse while receiving that care.

We are pleased to submit a statement for the record related to the problems that DRP has seen in youth residential treatment facilities.

Monitoring of Facilities:

DRP regularly monitors residential facilities for youth and requests specific changes to improve conditions for youth. In 2023, for example, DRP monitored the Philadelphia Juvenile Justice Services Center and followed up with Philadelphia officials about multiple concerns stemming primarily from overcrowded conditions. The

City's subsequent reduction of the population held there addressed most of DRP's concerns related to the overcrowding.

Systemic Litigation:

For the past several years, Disability Rights Pennsylvania has been engaged in the following systemic litigation related to youth residential issues. In 2019, DRP filed a federal lawsuit against the Pennsylvania Department of Human Services on behalf of youth with disabilities residing at the youth development centers ("YDCs"), which are owned and operated by the Pennsylvania Department of Human Services ("DHS"). DRP alleged that DHS staff had been abusively restraining YDC residents who have disabilities, often because of manifestations of their disabilities; verbally abusing and harassing residents based on their disabilities; and failing to provide them with programs, services, and rehabilitation. The lawsuit alleged that those actions violate the youths' rights under Title II of the Americans with Disabilities Act (ADA), Section 504 of Rehabilitation Act ("RA"), and the Fourteenth Amendment of the Constitution, as well as the DD and PAIMI Acts. DRP has been engaging in extensive settlement discussions with DHS and has reached an agreement in principle that will be finalized in the near future. The settlement agreement will drastically improve the treatment and rehabilitation of youth who are detained in Pennsylvania's YDCs.

In 2017, DRP filed a class action lawsuit on behalf of Pennsylvania youth who have been adjudicated dependent and have mental health disabilities. The lawsuit alleged that DHS violates the federal Medicaid law by failing to provide class members with medically necessary behavioral health services and violates the ADA and RA by, among other things, failing to provide them with services in the most integrated settings appropriate to their needs. DRP is actively engaged in settlement negotiations with DHS and hopes to reach a finalized settlement agreement within the coming months. Through the settlement agreement, DRP is seeking to improve the availability of community based mental health services for dependent youth and, in doing so, to reduce the system's reliance on residential treatment facilities and youth's lengths of stay in such facilities.

Recommendations:

As long as residential treatment remains one of the only options available to many families and placement agencies, facilities can rely on desperation placements and will continue to have little motivation to improve.

Through our work with the P&A network, we know that these problems are not specific to any one state. The conditions and systemic issues are well documented in countless reports by individual P&As and by the National Disability Rights Network's *Desperation without Dignity* Report. This is a national problem that demands congressional action, which can include:

1. ***Increase investment in community-based services and concrete supports that can help prevent the use of congregate care.***

   Some states have a higher base rate and contract for even higher rates when sending children out-of-state for residential placements. This is wrong. State and federal funding could be much more appropriately invested in intensive, community-based services.

2. ***Require meaningful outcome measures and discontinue payments for models that do not provide active treatment and individualized services, including residential treatment.***

   The role of residential treatment on any continuum of care needs to be critically examined. Although there has been a focus and even insistence on evidence-based treatment in most other areas, there has been heavy investment in residential treatment even though there is no evidence to support its efficacy.

   States are not transparent with information on how they are tracking outcomes and measuring the effectiveness of their programs. The most common response is that they have no control over where a child goes when they leave the facility and would not be able to find them to determine their status. Federal action is needed to ensure appropriate tracking of outcomes for youth.

3. ***De-incentivize out-of-state placements.***

   When children are sent out-of-state it makes it (a) more difficult to maintain connections with family, (b) more difficult for out of state agencies to monitor the facility and uphold their own state standards (which may be a higher standard than the receiving state), (c) extremely difficult for meaningful discharge

planning to occur due to the out of state facility not having relationships with providers or even understanding the community that the child is returning to, and (d) it can allow a facility to evade regulation by shifting to court children from another state if one state stops sending children because of subpar conditions.

When states send children in their custody out of state, they are also paying not only the exorbitant daily rates of these facilities, but for caseworkers to fly out and visit, and for teams to travel to facilities to complete, at a minimum, annual inspections of care. This is all money and employee resources that could be going to fund and provide direct services in their home states.

4. ***Remedy the failures of oversight that exist at all levels.***

The very fact that protection and advocacy agencies are so involved in this arena is evidence of the extent of the problem. P&A's across the country have been monitoring, investigating, writing reports about, and advocating on behalf of clients within facilities. Protection and Advocacy agencies are a backstop. Our involvement is an indication of a failure government oversight mechanisms.

5. ***Create an easy to access and navigate system that accurately identifies all youth residential treatment facilities and publishes surveys conducted by state survey agencies, quality of care, and incident data.***

While the Quality, Certification & Oversight Reports (QCOR) database contains survey and complaints from PRTFs, the information is inaccurate and incomplete. For example, a 2022 Government Accountability Office Report studied PRTFs in Arkansas and Massachusetts despite the QCOR database listing that Massachusetts has no PRTFs dating back to 2010. The information actually contained in the QCOR is opaque, requiring technical knowledge of CMS to access and sort information. And the surveys themselves may not capture the true conditions and incidents at youth residential settings. The QCOR is not a mechanism for public accountability.

6. ***Invest in research and pilot programs to identify and validate effective treatment options.***

We thank you for consideration of our comments.

Sincerely,

Peri Jude Radecic
Chief Executive Officer

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June 26, 2024

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Youth Residential Treatment Facilities

My name is Anna Maria Conner. I am a Senior Attorney and supervise the Monitoring and Investigations (Abuse and Neglect) Team at Disability Rights South Carolina (DRSC). DRSC is the Protection and Advocacy agency in South Carolina. The Protection and Advocacy (P&A) system is a federally mandated network of legally based agencies that advocate for and protect the rights of individuals with disabilities. Under federal law, P&As have authority to access facilities in which individuals with disabilities reside, and access relevant records.

In my role, I oversee a team that uses that access authority to monitor conditions and investigate abuse and neglect at facilities across the state. DRSC's goal is to ensure that individuals receive the services they need in a safe and therapeutic en-

vironment, wherever that may be. Over the past several years, one of the focuses of our work has been the psychiatric residential treatment facilities (PRTFs) in South Carolina.

Pursuant to our federal and state authority, in December 2019, DRSC began opening individual investigations into allegations of abuse and neglect received about South Carolina PRTFs. Due to the systemic nature of these issues, DRSC began reviewing incidents and concerns at various facilities systemically. From December 2019 to present, DRSC has investigated incidents involving more than 34 children at least five facilities. The outline below provides particularly problematic examples from three facilities. DRSC investigative findings included serious injuries during restraint and seclusion, overuse of restraint and seclusion, excessive staff involvement during restraint and seclusion, improper monitoring during restraint and seclusion, chemical restraints, vomiting during restraints, self-harming during seclusion, and a PRTF's failure to properly conduct a suicide assessment, to implement heightened suicide risk protocols, to follow general 15-minute check-ins and staff belittlement of a child contributed to a child's suicide in the facility.

Examples:

I. Serious Injuries during Restraint and Seclusion (42 CFR § 483.356(a)(1)).[1]

Due to the use of improper restraint techniques at one facility a child sustained injury to his elbow. At another facility, staff dropped a child while three staff attempted to force carry him, as he resisted, into another room. Cameras then show one staff dragged the child down the hallway while the child was face down. Three staff members followed but did not intervene. Finally, the staff member slung the child face forward onto the cement floor causing a closed fracture of the left orbit.

II. Concerning Restraint and Seclusion Practices

a. Overuse of Restraint and Seclusion (42 CFR § 483.356(a)).[2]

One child had 57 documented occurrences of seclusion/restraint over an admission of 1 year, 8 months. (27 seclusions, 30 restraints). On several occasions, the child received multiple interventions in one day. On average, the facility implemented a restraint or seclusion at least once every 11 days during the duration of the child's admission.

b. Simultaneous Use of Restraint and Seclusion (42 CFR § 483.356(a)(4)).[3]

At another facility, a video shows staff escorting a child to the seclusion room and pushing him inside. The video is unclear until the light readjusts. Once the light readjusts, it is apparent staff has the child in a seated basket hold restraint. Staff also eventually uses his legs to scissor lock the child's body. The child's arms are often close to his neck, though it does not appear to restrict his airway. The child is actively resisting and at one point staff rolls himself and the child onto their right sides toward the wall. The child eventually stops resisting but staff maintains the basket hold and scissor lock. A few female staff check on the restraint periodically. A female member enters, sits down, and observes/talks to the child. The child is visibly upset but not actively resisting. For reasons unclear, the staff then transition the child to a supine restraint. One staff holds his arms and the other staff lays across legs. Two other staff enter, Staff C restrains left arm while Staff A continues to restrain right arm. The child is not actively resisting. A medical staff enters and physically checks the child. At some point, a staff places a pillow under the child's head. Staff C views phone during the restraint. The child attempts to sit up at one point but is immediately shoved back down. The child attempts to sit up again several minutes later and at this point he is released from the restraint. He is cornered in the seclusion room by four staff. He is aggressive and attempts to hit staff with pillows. He is placed back in a supine restraint a minute and a half later. One of the staff holds his right arm, another staff holds his left arm, and a third staff lays across his legs. One staff places her hand on his chest but does not appear to be applying pressure. Another staff appears and observes. She leaves, returns, and ap-

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[1] CMS State Operations Manual Appendix N–PRTF Interpretative Guidance N0128, *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_n_prtf.pdf.*

[2] CMS State Operations Manual Appendix N–PRTF Interpretative Guidance N0126, *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_n_prtf.pdf.* ("The frequent use of emergency safety interventions may raise serious questions about the resident's right to be free from unnecessary restraint or seclusion and indicate the need for further investigation by the surveyor.")

[3] CMS State Operations Manual Appendix N–PRTF Interpretative Guidance N0131, *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_n_prtf.pdf.*

pears to offer the child some water. Staff release the child. He refuses the water and just sits in the corner surrounded by the staff. The video ends with everyone still present in the seclusion room.

c. Restraint of Actively Combative Children.

Staff initiated a restraint on a child because he had barricaded himself inside his room while on safety, engaged in "verbal and physical aggression," and was "out of area [and] refusing redirection." According to the physician's order, the restraint lasted for 14 minutes. At 00:19 of the video, staff utilize a NVCI Transport Position to remove the child from his room, while he is actively resisting and attempting to drop to the floor. The facility's Internal Investigation Report and Critical Incident Report did address this aspect of the restraint, noting that staff failed to disengage the restraint when the child continued to resist and drop to the floor. However, despite the facility identifying a lack of training as a Proximate Cause of the child's injury, only one staff member involved in the restraint received a refresher course after this incident.

At another facility, staff implementing a carry noted that the child was hitting, kicking, and screaming and was "still agitated when released from the carry into the quiet room."

d. Lack of Emergency Safety Situation (42 CFR §§ 483.352, 483.356(a)(3)).[4]

At one facility, a video begins with several patients removing bedding from their wooden beds. One child does not appear to comply with staff instructions regarding this task. After the bedding is removed and other patients leave, the child remains next to the window in the bedroom. Three staff remain in/just outside the bedroom but appear to talk to each other. The child stares out the window and takes out a piece of paper he had on his person. The child stands on top of the wooden bed, possibly 2–3 feet off the floor. Staff A (Male) confronts the child. They appear to argue. Staff B (Male) enters following Staff A. Staff A and B grab the child by the shirt and arm and pull him down and restrain him on the floor. Staff C (Female) enters and assists in the restraint. The child is initially prone but quickly turned to supine. Staff A and B restrain the child by the arms and Staff C lays across the child's legs. A fourth staff enters and places a spit hood on the child. (It is not clear whether the child attempted to spit on staff although staff do not show visible reactions suggesting child had spat on staff). The child submits and is practically motionless for the duration of the restraint. Staff eventually move away from the child but continue the restraint. Two staff are looking away from the child for the remainder of the restraint. A medical staff enters and physically checks the child. The child is released and removes the spit hood himself. He goes back on top of the wooden bed until he is led out of the room by staff.

e. Failure to Terminate Restraint after Emergency Safety Situation (42 CFR § 483.356(a)(3)(ii)).[5]

Staff initiated a restraint on a child because he had shown "aggression toward staff," "slammed doors," and "refused prompts." The video surveillance does not show the initial aggression that led to the restraint, as it occurred in a bedroom. However, as the restraint moved to the hallway, the child almost immediately stopped resisting and fully submitted to the restraint. Nevertheless, staff continued the restraint for an additional 3 minutes.

At another facility, DRSC found multiple instances of children complying after a restraint (not moving or showing any overt aggression) and yet the restraints continue for additional time

f. Excessive Staff Involved.

Staff initiated a restraint on a child because he had barricaded himself inside his room while on safety, engaged in "verbal and physical aggression," and was "out of area [and] refusing redirection." According to the physician's order, the restraint lasted for 14 minutes. At 01:47 of the video, two additional staff begin grabbing and holding the child's feet while the other two staff hold his arms and shoulder. As a result, the four staff suspend the child in midair while he is continuing to actively resist the restraint. At this point (02:00), at least six staff are involved in holding him, with four staff placing pressure on his torso. He remains suspended by all four

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[4] CMS State Operations Manual Appendix N–PRTF Interpretative Guidance N0129, *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_n_prtf.pdf.*

[5] CMS State Operations Manual Appendix N–PRTF Interpretive Guidance N0130, *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_n_prtf.pdf.*

limbs until 02:14. After staff release his feet, the child remains balanced between the staffs' backs in midair, unable to place his feet on the ground, until 02:58. The facility's Internal Investigation Report and Critical Incident Report did address this aspect of the restraint, noting that staff should not have attempted to remove the resident's shoes while staff continued to engage in the restraint. However, despite the facility identifying a lack of training as a Proximate Cause of the child's injury, only one staff member involved in the restraint received a refresher course after this incident.

g. Improper Monitoring by Staff (42 CFR § 483.362(a)).[6]

DRSC also noted an instance where the document specifically states that the duration of a seclusion was "unknown." Staff made little mention of the reason for implementing the seclusion in the documentation and stated: "Upon arriving on the unit . . . [the nurse] found [the child] in seclusion without clothes and screaming. . . . [She] hit her head while in seclusion—was a small red area on side of her head which is fading."; "Pt. has swollen area on front of forehead. Pt. Was was laying on ground without clothes, crying and screaming; staff stated she was hitting her head on the wall."; "Nurse approached patient and asked her to sit up and calm down so she that she could take her meds. Pt. complained of her head hurting . . ." These statements suggest staff were not "physically present in or immediately outside the seclusion room, continually assessing, monitoring, and evaluating the physical and psychological well-being of the resident in seclusion." In yet another instance, multiple videos show staff checking their phones during the course of restraint and/or seclusion incidents.

h. Chemical Restraints (42 CFR § 483.352).[7]

In three different PRTFs it monitors, DRSC found the facilities used chemical restraints during the use of physical restraints. One PRTF administered Benadryl 50mg IM in the course of a physical restraint to manage aggression toward staff and threats of self-harm. Benadryl has a sedative effect, which effectively restricts a resident's freedom of movement. The child's Medication Administration Records did not contain a standing order for Benadryl 50mg IM, which evidences that it was not standard treatment for his psychiatric condition. At another facility, a child was administered Zyprexa 10mg IM in the course of a physical restraint. The child's medical record notes in the physician's order that the medication was administered to manage aggression toward staff and self-injurious behavior. Zyprexa is generally prescribed to control negative behaviors associated with psychotic disorders and can have a sedative effect, which effectively restricts a resident's freedom of movement. There was no PRN or standing order for Zyprexa 10mg IM which evidences this use was not standard treatment for his psychiatric condition. Finally, in one facility, DRSC identified 25 different occasions when a facility's physician prescribed one child psychotropic medications in response to staff reports of a behavioral problem during the child's 10-month admission. The child's medical records do not contain any standing or PRN orders for these medications prescribed by any physician.

i. Vomiting During Restraints.

Staff initiated a restraint on a child because he had "disrupted the milieu," showed "aggression toward staff," refused to follow "staff prompts/directives to stop yelling out of his doorway down the zone at [other] peers," and created "an unsafe environment for himself and others." According to the physician's order, the restraint lasted for 12 minutes. Beginning at 0:10, staff held the child between their backs, placing an excessive amount of pressure on the child for over 12 minutes. This amount of pressure resulted in the child vomiting at least four times, vomiting both clear fluid and red-orange colored fluid. After each time the child vomits, staff "crab-walk" away from the vomit, putting additional pressure into the child's abdomen, while maintaining the child in the same position. Notably, no staff terminated the restraint after the child vomited, including medical staff monitoring the restraint. Despite these facts, the facility's Internal Investigation Report concluded that staff carried out the restraint appropriately.

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[6] CMS State Operations Manual Appendix N–PRTF Interpretative Guidance N0165, *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_n_prtf.pdf.*

[7] CMS Memorandum "Psychiatric Residential Treatment Facilities (PRTF) Frequently Asked Questions (FAQs)" dated May 19, 2017, Question 33, 34, and 39 at *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-28-.pdf.*

Another time, staff initiated a restraint on a child because he had barricaded himself inside his room while on safety, engaged in "verbal and physical aggression", and was "out of area [and] refusing redirection." According to the physician's order, the restraint lasted for 14 minutes. At 03:46, the child vomits during the restraint. The video surveillance captures staff leaving the area, returning with paper towels to clean the floor (04:08–04:17), and staff pulling the child's hair out of his face (03:49). Despite the child vomiting, staff continue to restrain him in a botched NVCI Team Control position for over 6 minutes. The child's statement describes his vomiting and feeling like he "could not breathe due to staffs body parts constricting my ribcage." Notably, no staff terminated the restraint after the child vomited, including an LPN and RN monitoring the restraint. The facility's Internal Investigation Report and Critical Incident Report did not address this aspect of the restraint.

j. Self-Harm During Seclusion.[8]

DRSC also noted an instance where the document specifically states that the duration of a seclusion was "unknown." Staff noted in the seclusion documentation: "Upon arriving on the unit . . . [the nurse] found [the child] in seclusion without clothes and screaming . . . [She] hit her head while in seclusion—was a small red area on side of her head which is fading." As best as DRSC could tell from the records, the seclusion did not cease until the nurse happened to find this child harming himself in seclusion.

k. Spit Hoods.

A child enters a bedroom visibly upset. He is alone when he enters. He faces a corner of the bedroom and begins banging his head against the wall. No staff visibly observed his head banging. He seems to attempt to leave the bedroom and is immediately taken down by Staff A (Male) and Staff B (Female). Staff A restrains the child's head and Staff B restraints the child's left arm. Staff C (Female) restrains the child's legs. The child complies and does not resist restraint during the entire incident. Another staff member enters and places a spit hood on the child's head. (It is not clear whether the child attempted to spit on staff although staff do not show visible reactions suggesting child had spat on staff.). Staff D (Female) appears to observe the child. Staff D appears to eventually replace Staff B. Staff A places hand over the child's face for approximately 1 minute. Later, Staff D appears to be on phone. Staff D switches position throughout the video but eventually is restraining the child's arm with her leg. The child is eventually released and removes the hood himself. He remains in the room, once again visibly upset. Medical staff enters later and checks his vital signs.

III. Documentation/CoP Violations.

In one facility, DRSC found four failures to have a physician signature in a timely manner. In another facility, DRSC reviewed documentation of 31 emergency safety interventions for three different children implemented in July 2019 and September 2019–August 2020. These interventions involved the facility's psychiatrist, APRNs, RNs, LPNs, MHAs, and other staff covering a variety of shifts. DRSC noted deficiencies in 49 separate places in 24 of these interventions. Sixteen of these deficiencies involved failure to document notification to parent(s) or guardian(s) in a timely manner. Sixteen of these deficiencies involved failure to document staff attendance or excusals in staff debriefings. Ten of these deficiencies involved failure to properly document one-hour face-to-face assessments. The rest involved either deficiencies with the ESI order itself or other documentation requirements. DRSC also noted the addition of signatures on ESI orders and psychotropic medication orders between two records requests received by DRSC.

a. Serious Occurrence Reporting (42 CFR § 483.374(b)).[9]

42 CFR § 483.374 specifies that PRTFs must report serious occurrences to the state Medicaid agency (SCDHHS) and the state protection and advocacy system. Suicide attempts are included in the definition of serious occurrences. In the course of its investigation, DRSC noted a serious occurrence that was not forwarded to our office. On September 1, 2020, a child attempted to commit suicide when he attempted to run in front of a moving vehicle after eloping from the facility.

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[8] CMS Memorandum "Psychiatric Residential Treatment Facilities (PRTF) Frequently Asked Questions (FAQs)" dated May 19, 2017, Question 40 at *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-28-.pdf.*

[9] CMS State Operations Manual Appendix N–PRTF Interpretative Guidance N0207, *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_n_prtf.pdf.*

DRSC noted an instance documented in a child's medical record where that child sustained a laceration in March 2020 after playing in the gym. The laceration required emergency treatment, sutures, and subsequent treatment for dehiscence of the sutures.

Historically, DRSC has noted a significant disparity between the receipt of serious occurrence reports by SCDHHS and by DRSC respectively. In exploring ways to ensure these reports are made and sent to both entities, DRSC found that the S.C. Department of Health and Environmental Control (DHEC), the state licensing agency for PRTFs, did not include questions about these reports in its surveys of PRTFs for legal compliance. Likewise, DRSC has been told by state agency staff that they can only go to a PRTF if they have a child there and can only check on children from South Carolina. For the past several years, P&A systems from several other states have asked DRSC to check on children from their states who are in South Carolina PRTFs. DRSC has had to advocate with the PRTFs to create a serious occurrence report form and to add a section to the forms which notes that reports are sent to both DRSC and the P&A of the child's home state.

IV. Excessive Elopements.

In reviewing records and information related to residents eloping from PRTFs, DRSC noted the following: one facility reported approximately 20 incidents of elopement in 2019. These incidents involved at least 40 residents running from the facility. The facility reported approximately 19 incidents of elopement in 2020. These incidents involved at least 38 residents running from the facility. Several of the incidents reported in 2020 involved four to six residents running away in the same incident. At least seven individuals who ran crossed state lines and were located in North Carolina. The facility refused readmission to at least three residents who ran away. It was reported in at least three instances that staff members refused to assist authorities with providing information about residents who ran or refused to assist in stopping and/or detaining residents. In reviewing the treatment plans of several residents involved in elopement incidents, DRSC noted that several had extensive history of multiple elopement attempts both prior to and during their treatment at the facility, showing that the facility had knowledge of these residents' tendency to elope.

V. Twelve-Year Old Child Commits Suicide in PRTF.

In 2021, a 12-year-old committed suicide while receiving treatment at a South Carolina PRTF. DRSC requested and received records from the facility and the Department of Health and Environmental Control (DHEC), the state licensing agency. The PRTF blocked access to certain internal investigative reports by citing privileges (including the Patient Safety and Quality Improvement Act of 2005). DRSC reviewed the records provided and identified several critical concerns, including, but not limited to: failure to properly conduct a suicide assessment, failure to implement heightened suicide risk protocols, failure to follow general 15 minute check-ins, and potential staff belittlement of the child. The facility was investigated by DHEC and the state Department of Social Services Out of Home Abuse and Neglect division.

VI. Overreliance on Law Enforcement.

In reviewing records and information related to law enforcement involvement, DRSC noted a high incidence of reliance upon law enforcement to handle a number of resident incidents, including but not limited to: elopement, alleged peer on staff assaults, alleged peer on peer assaults, alleged resident riots, alleged resident disorderly conduct, and residents allegedly setting fires.

DRSC concerns and conclusions:

As noted in the June 12th testimony from Arkansas, while government agencies had substantial documentation of abuse and neglect existing at PRTFs, it would be extremely difficult and time consuming for anyone that was considering placement at a particular facility to obtain this crucial information. This lack of transparency is even more challenging for out-of-state parents, guardians, and placement agencies. Many of them were contacting our office to inquire about facilities, because they do not have the time or resources to identify the multiple different oversight authorities in every state, their specific roles and the documentation they produce, and the overall licensing structure and level of accountability facilities are being held to. Many more do not reach us and are relying on the representations of the facility, unaware they are sending children to facilities with extensive records of abuse and neglect.

The results of this ongoing work make clear that youth residential facilities cannot provide an adequate therapeutic environment. PRTFs are rife

with countless examples of abuse, violence, and neglect. The examples above are illustrative of what occurs and do not represent the full extent of what is reported or all of the abuse and neglect that goes unreported. Children are being physically assaulted and abused, they are not being protected. The general lack of a therapeutic environment, active treatment, and systemic lack of oversight of PRTFs must be taken into account. There is this pervasive assumption that some children need such "intensive services," that they cannot be served in the community. This idea is accepted and repeated even in literature and reports that are critical of residential treatment. It is so ingrained and generally accepted that no further thought is given to what "intensive services" actually means or why such services can only be provided in a residential setting. Residential treatment is often seen as the pinnacle of treatment, the best and most intensive services a state has to offer. After a child discharges from residential treatment, states are left feeling as though they have little or nothing left to offer. The failures of the treatment facilities to provide a safe and therapeutic environment, individualized intensive services, and meaningful discharge planning and follow through are imputed to the child. The child is often seen as the failure, not the treatment facility. And because they are viewed as the failure, all too often the child gets cycled back into a residential placement.

Children share bedrooms with peers and spend most of their time idle in communal spaces under the supervision of entry level care staff, never alone but rarely engaged. Insufficient staffing levels and inadequate staff training lead to a reliance on restraint, seclusion, and increasingly law enforcement. They are not forming healing bonds with adult staff and are often cut off from their families at home. All together this creates an environment that is incompatible with what children need to learn, grow, and thrive.

Not only are these facilities ill-equipped to address the complex trauma of many of the children placed, the added trauma children experience within facilities follows them through life and is compounded by society's refusal to acknowledge the detrimental effects these placements can have. Children that experience added trauma while in congregate care are the norm and not the exception. Far too many children are directly subjected to physical, sexual, and verbal abuse. Even more are impacted by the abuse they witness. We do not believe that a child should ever have to endure or witness abuse in order to access services.

All of this occurs without meaningful oversight at any level. With limited CMS regulation and oversight, most oversight falls to state agencies assessing compliance with state licensure, even though many providers operate in multiple states. The lack of urgency and thoroughness with which incidents are addressed by the providers themselves and by oversight agencies is deeply troubling.

What is clear is that often these facilities are operating as placement alternatives and not service alternatives. States have bought into and are now reliant on the residential treatment model, failing to adequately invest in community-based settings and services necessary to meet the need. States are so reliant on residential placements that they are hesitant or outright unwilling to hold the facilities accountable.

While access to information is absolutely vital and can impact placement decisions, no amount of forced transparency can lead to truly informed choice if there are no other options. As long as residential treatment remains one of the only options available to many families and placement agencies, facilities can rely on desperation placements and will continue to have little motivation to improve.

Through our work with the P&A network, we know that these problems are not specific to South Carolina. The conditions and systemic issues are well documented in countless reports by individual P&As and by the National Disability Rights Network's *Desperation without Dignity* Report. This is a national problem that demands congressional action, which can include:

1. ***Increase investment in community-based services and concrete supports that can help prevent the use of congregate care.***

In South Carolina, the Medicaid reimbursement rate for PRTFs is $500/day. Some states have a higher base rate and contract for even higher rates when sending children out-of-state. This state and federal funding could be much more appropriately invested in intensive, community-based services.

2. ***Require meaningful outcome measures and*** discontinue payments for models that do not provide active treatment and individualized services, ***including residential treatment.***

The role of residential treatment on any continuum of care needs to be critically examined. Although there has been a focus and even insistence on evidence-based treatment in most other areas, there has been heavy investment in residential treatment despite the fact that there is no evidence to support its efficacy.

3. De-incentivize out-of-state placements.

When children are sent out-of-state it makes it (a) more difficult to maintain connections with family, (b) more difficult for out of state agencies to monitor the facility and uphold their own state standards (which may be a higher standard than the receiving state), (c) extremely difficult for meaningful discharge planning to occur due to the out of state facility not having relationships with providers or even understanding the community that the child is returning to, and (d) it can allow a facility to evade regulation by shifting to court children from another state if one state stops sending children because of subpar conditions.

When states send children in their custody out of state, they are also paying not only the exorbitant daily rates of these facilities, but for caseworkers to fly out and visit, and for teams to travel to facilities to complete, at a minimum, annual inspections of care. This is all money and employee resources that could be going to fund and provide direct services in their home states.

4. Remedy the failures of oversight that exist at all levels.

The very fact that protection and advocacy agencies are so involved in this arena is evidence of the extent of the problem. P&A's across the country have been monitoring, investigating, writing reports about, and advocating on behalf of clients within facilities. Protection and Advocacy agencies are a backstop. Our involvement is an indication of a failure of the intended government oversight mechanisms.

5. Create an easy to access and navigate system that accurately identifies all youth residential treatment facilities and publishes surveys conducted by state survey agencies, quality of care, and incident data.

While the Quality, Certification & Oversight Reports (QCOR) database contains survey and complaints from PRTFs, the information is inaccurate and incomplete. The information actually contained in the QCOR is opaque, requiring technical knowledge of CMS to access and sort information. And the surveys themselves may not capture the true conditions and incidents at youth residential settings. The QCOR is not a mechanism for public accountability.

6. Invest in research and pilot programs to identify and validate effective treatment options.

Anna Maria Conner

STATEMENT SUBMITTED BY VICTORIA DOBROWOLSKI

Note: The notes on the side were for a journalist who wanted to look over my notes after a long discussion with me. I unfortunately did not have the time to condense all this information and had to cut the last 2 pages which included some additional negative experiences of mine and negative experiences of other patients (under Additional Major Concerns at the bottom of page 10). I would be happy to send over the additional pages if ever needed.

After I sent my original letter to MA's Department of Mental Health and filed a police report regarding missing belongings, the former CEO of Fuller, Rachel Legend, contacted me personally. She denied multiple experiences that happened ever occurred. Rachel said her staff would never laugh at me, to which my mom (rest in peace) told her I'm not a liar. She also tried to convince me my belongings were never lost or stolen, even though she admitted to me there are no cameras in storage to prevent that from happening.

I believe I had one or two phone calls with Rachel Legend. One thing that was obvious to me during my stay was someone had to have died there at some point, due to how staff behave, due to how some patients could be quite violent, etc. I found a patient murder in 1997 (South Coast Today), a patient death in 2007 due to neglect (Crowe and Harris), as well as a death from abuse *(The Boston Globe)*. According to Rachel, these deaths never happened as, "No one's ever died here!" Rachel also said (these are exact quotes), "Stop reading conspiracy theories!" I will always remember her as one of the most vile human beings I've spoken to in my life.

The time I reference later in this document where I attempted suicide, a patient (my first roommate) realized what had happened. Staff would have never known I had attempted at all if she hadn't reported it. I had already completed my attempt before staff knew about it. It failed due to my lack of physical strength.

Naturally, after I was discharged, I was still suicidal, but now I could of course tell no one, because I'd rather be dead than end up hospitalized again. I also needed to be sure I could find an option where failure was not an option, so I would not be hospitalized again if I failed. I guess I said something a little too honest about how unwell I was feeling after I was discharged, and a wellness check was done for me. The police who arrived were nice to me. My dad explained the hospital was really terrible, so I was not well, and they seemed to understand. Rachel spoke with me later and sounded irate at the fact she had to put in so much trouble to get a wellness check. It clearly seemed like it was extremely inconvenient to her to make sure a patient wasn't dead.

Details of my own experience at Fuller Hospital:

On the night of January 1, 2021, a friend called an ambulance for me after I told my friend Jessica that I was not sure if I could survive for the next 24 hours. I had a plan to kill myself the next day. I spent that night in the emergency room at Milford Hospital and was sent to Fuller Hospital on January 4th. My first negative experience at Fuller Hospital began on the first day I arrived. A staff member looked through the items I had in a bag when I was transported from the emergency room. She said she found everything, but I only had one sock. This pair of socks had dachshunds on it with Santa hats, and the pair of socks was a past Christmas gift from my aunt. I was really distraught as I did not understand how the nurses in the emergency room could have lost one of my socks, especially when the bag my clothing and jewelry was in had a drawstring. I asked at the front desk for the phone number for the emergency room so I could contact Milford Hospital regarding my missing sock. A nurse told me they would look for it. After I hung up the phone, I thought about when the nurse put the socks in my bag. I felt very certain that I had seen a nurse put both of my socks into that bag. I went to ask a different staff member, one who did not look through my bag of clothing from the emergency room, if he could check my bag one more time to see if my sock was in there. I stood in front of him crying, and he just said, "No," very coldly. I asked him again politely to please look, just once, and he laughed at me and told me that he could just get me another pair of socks. I was stunned that someone who was employed by a psychiatric hospital would laugh at a crying patient. I wish I knew his name, but I do not know it since it is hard to see the name of staff members on their lanyards. It would have been helpful if they had name tags instead. The day I was discharged, I found the sock I thought the emergency room lost in the bag with the drawstring. Another staff member would have found it if he had bothered to look through it when I asked him to. **Instances like this are extremely harmful for any patient, but especially for a patient like me. I have OCD and hoarding tendencies that manifest specifically with items of clothing and photographs. By responding in this manner, this staff member made my existing condition (that they were supposed to be helping me get under control) significantly worse.**

I have severe OCD (obsessive compulsive disorder) and asked a staff member if it was possible I could use my phone or have someone use my phone to take a picture and a short video of me, which would take about 1 minute of time. Nurses at the emergency room were able to use my phone for me, which I told a staff member at Fuller. She was very nice to me. That staff member probably did not often work in Unit 3 (the unit I was in), since I only saw her a couple of times during my 23 day stay. She said to talk to my case manager Christine, and my case manager could answer that question for me. (I was unaware at that time that there was more than one worker there named Christine.) I asked a different staff member if they knew if Christine was around, and they had me talk with the other Christine, who was a nurse, not my case worker. She told me she would talk to a supervisor and would have an answer for me about the phone tomorrow.

The next day, after a group she ran, I asked Christine if she had the answer about my phone. She said the person she was going to speak with about it had already gone home and that she would have an answer tomorrow, even after I told her I needed my phone or someone to use my phone for me daily. I started having an anxiety attack in the hallway. I sat on the floor crying and screaming. **She grabbed my arm, so I shouted, "Don't fucking touch me!" I was surprised that a staff member would grab someone who was not being physically violent. I had disclosed to Christine that I had a history of sexual abuse,**

which is something I believe would be asked about during intake. After I shouted for her not to touch me, Christine and two other staff members grabbed me and took me off to my room. This was very triggering as an ex-boyfriend of mine had yanked me by my arm trying to drag me to his room as a teenager. Being manhandled like that was a painful reminder of my ex-boyfriend's abuse.

(One patient told me he and two other patients complained to staff about how Christine and the other two staff members manhandled me. One of those patients told me that he was told someone would get back to him and the other patients regarding the complaint they filed. As far as I am aware, no one ever got back to one of the patients who complained before he was discharged. I do not know if anyone got back to one of the other patients who complained. The patient who told me he and two other patients complained told me no one got back to him regarding the complaint until about a week later).

I could not believe that staff was allowed to physically manhandle me like that. I was extremely upset between that, my OCD, and my increasingly suicidal feelings. At this point, I remember I slammed my head against the window. I was given medication to try to calm me down. I started to relax a bit when a staff member said she could take a picture and quick video of me on her phone. She asked if that would work for me, and I said yes. I asked her if she could send it to my e-mail, and Christine, the nurse, said, "She will eventually." I thought Christine may have meant that the other staff member would send the photo and video to me when I was discharged. I was confused as to why the staff member could not send them to me immediately, and I was a little suspicious, but I tried not to worry about it.

The following day, I was a bit stressed considering the possibility that Christine may have been lying to me about having the staff member send the picture and video over. I was also stressed as I still did not have an answer from Christine the following day, regarding having a staff member take a picture and video of me on my phone. I asked her again in the afternoon if she had an answer regarding the picture and video, and she said it was not allowed. I then asked if a staff member could take the picture and video of me on their phone instead and send it to me directly after so it would not take up any space on their phone. I thought she would say, "Yes," especially since she watched a staff member take a picture and video of me the night before, but she said it was not allowed. **It's extremely problematic to have rules that are not consistently applied by staff or explained to patients, especially when those rules have a direct impact on a patient's psychological health and well-being. Photos and videos are heavily tied to my OCD and hoarding, and I had explained this repeatedly to staff. If I cannot perform part of my daily compulsions, I become instantly suicidal, which they sure saw later that night. I had even offered ways of accommodating my needs, but they were unwilling to work with me, even though it would make my condition worse. By refusing to work with me and changing how they applied their rules, staff made my condition worse.** I had another anxiety attack. I was in my room crying and screaming from anxiety, and she said she would get me medication. I was not able to stop crying. **She then told me, "Okay, you can go home."** I was not sure if she meant I could go home soon or go home that same night, so **I asked her, "Tonight?" She said, "Yes. You can have your phone, your family, your friends. You can get your life back."**

It was close to dinner time, so I thought that seemed suspicious, considering I was once at Walden Behavioral Center, and they only discharged patients at certain times and not on weekends. But I figured no one would lie to me about discharging me. I had dinner and told the other patients I was friends with that I was going to be discharged, and they said they were happy for me. As it started to get darker out, I realized that my parents were not coming to get me, and that only made me more anxious and upset, because I felt very unsafe knowing that some staff would willingly lie to their patients. I shouted in front of a few staff members, including Christine, and then I screamed at Christine saying, "You're a fucking liar! You told me I was going to be discharged today! Who does that?" Christine kept telling me to go back to my room as another patient in the women's hallway watched. I sat in the doorway crying. Christine walked away, I think to get medication, because she came back with medication not long after. The patient who watched me scream at Christine, calling her a fucking liar, sat by my door and said, "Need to talk to someone who will actually listen?" I vented to her about how I was stressed about my OCD, being manhandled, lied to, and having a staff member laugh at me. She told me she was sorry about everything that happened and said, "They don't give

a shit about you, and it shouldn't be that way. You got to try to stay calm so you can go home soon."

Christine told me to take some medication or she was going to inject me with it. It was perfectly clear that I was not being given the option of saying no, and that I would be forcibly drugged if I tried to refuse medication. I think that was the first dose of medication I was given that night (I was given several). I was afraid for my safety, so I told staff I was going to call 911, and **a staff member told me I was not allowed to call 911.** I was severely anxious and called my mom, terrified by the way I had been treated so far, and asked her to call 911. She did not, so I called my friend Jessica. I felt like I was about to have a heart attack and that I could not trust any of the staff there to take care of me. **Because of how they had already physically accosted me and forced me to take drugs against my will, I was afraid that I was going to either die by mistake under their supervision or that I would take my own life because I was there. I did not want to die, so I wanted to be transferred elsewhere—somewhere I would receive actual care.** After speaking with me, my friend was also very worried for my safety, and so she called the Attleboro police department. The dispatcher spoke with a Fuller employee who I believe was working at the front desk, and the employee assured the dispatcher that everything was fine. At this point, **I felt completely hopeless and desperate—even the police weren't allowed to help me.** I went to my room right after and choked myself with a blanket. I threw the clothes I had in my room on the ground out of frustration, being trapped in a facility where people could manhandle me and lie to me. Not too long after, staff came in and removed all the clothing I had on my shelf and on the floor. This made me panic more, because I intentionally did not use clothing to harm myself as I did not want clothing to be taken out of my room. I did not trust staff to take proper care of it. **They even took my face masks, so I did not even have a disposable mask to wear during a pandemic.** This made me even more upset and I cried loudly on the phone to my mom. I believe I was on the phone with my mom when I saw Christine come out of my room, holding my prayer shawl that I just got that was knit for me by some nice ladies from my Church to bring me some comfort. Christine said, "You probably won't be needing this, will you?" and left with it before giving me a chance to respond. **Clothing items are a significant part of my coping strategies, and removing all my clothes from my possession without even discussing it with me caused significant and unnecessary distress that easily could have been avoided.** I have the following written in my journal of my conversation with my mother: "Please get me out somehow, I don't feel safe here! I'm getting sicker by the day here. I haven't felt this terrible in my life until I've gotten here. Please, you have to find a way to get me back to the ER or someplace else. I think the stress is going to be enough that I'm going to die here, please! I need to go someplace else, this place makes me want to put a bullet through my brain. I need to get out!" Meanwhile, I could hear a staff member in the background say, "Veronica. Veronica. Veronica. Veronica. Veronica. Veronica!" Eventually, I realized she was talking to me, Victoria. I hung up the phone and said to her, "That's not my name." She said, "Sorry," but with a very unapologetic, insincere look on her face. **She then proceeded to become angry with me, complaining that she had had to listen to me cry and shout for 2 hours.** I think I said something like, "I'm sorry, is that hard for you?" At that point, I did not care to be any nicer toward them than they were toward me, and it is very difficult to get me that angry. The staff member then shouted, "What are you getting mad at me for?! I just got here!" This also contradicted what she had previously told me about having to listen to me panic for 2 hours. **I was only as upset as I was because Christine had lied to me about discharging me, Fuller would not accommodate me at all regarding my OCD, I had been physically manhandled and treated like my problems did not matter.** After my clothes were taken away, I was in even more of a panic than I had been before, thinking that the hospital would probably lose some of my belongings (which they did). **I told that staff member about how my OCD was giving me extra anxiety, and she said, "That's what you're worried about?!"** Her attitude was entirely unsympathetic. **Someone who works in the field of mental health care has absolutely no excuse for treating a patient so callously and with so much contempt. Even people who don't work in mental health can manage to treat others with basic decency and respect. At one point, she shouted louder at me,** so I took a step forward and said, "You think you can scream loud? I can scream loud too!" Then, I just screamed as loud as I could. One of my friends, another patient there, witnessed that. He could not really tell much what was going on from where he was, though. I believe he was in the Club Room. Not long after, **three staff members**

were near me and looked like they were about to close in on me, at least from my perspective. After being manhandled so quickly the night before, I thought the next thing they would do is tie me to my bed or put me in a straitjacket, so I had my arms at my sides to make me look bigger, and I was bearing my teeth. The three staff members backed up a little. Then, one of the staff members sounded more sympathetic, and she got me to calm down a bit. She did not have any sort of an attitude with me which helped. **I got my second dose of medication not long after. I remember the medication made me so out of it when I was lying in bed. I was lying in bed unsure if I was holding my hand out from over the sheet or if my hand was under my sheet with me. I felt like a zombie.**

The next day, I went to call my mom to vent, and **a staff member ran up from the Club Room yelling (in front of other patients, violating my privacy)** when he saw I was on the phone to tell me that I was not allowed on the phone (which I had not been told). I then went back to my room after staff guided me back and I laid down in bed for a while. Probably about five minutes later, I screamed out of frustration. I did not know then that I was allowed to have one call per shift (three shifts in a day), and I thought I was not allowed to use the phone ever again, so I felt even more unsafe than I already did. **The unit manager, John, came to my room and asked, "Do you know why you're on phone restrictions?" I said, "No," through tears. He said, "It was because you called 911.** Do you know what happens if you call 911 and there's no emergency?" I said that there was an emergency, I was going to find a way to die in here or **I thought I would die under their care,** and the way a lot of the staff had treated me was an emergency. **They were supposed to be providing me with a safe environment where I could heal and recover, but instead, they were actively exacerbating the same psychological conditions that they were supposed to be helping me manage.** I felt like I was going to have a heart attack. John later told me that I was allowed to have three calls per day, one per shift, though he did not clarify when those shifts began or ended. I found out that information from another patient. **It was really terrifying to me when I realized that patients could be punished for calling 911. People with psychological disorders are far more likely to be victimized than they are to hurt others, and it is absolutely unacceptable for the most vulnerable members of our society to be prevented from having access to life-saving law enforcement. Fuller Hospital is bullying their patients into being too afraid to call the police. Is that really a precedent we're willing to set? Is that really the message we want to send to people who are statistically more likely to be victimized? That they're not allowed to call the police? That the police are there to help everyone except for them?**

I believe it was a couple days later that I got my period. I knew it was coming as I started to get cramps and I asked for a pad before I went to bed. The pad they gave me was too thin, so **I bled through my underwear and pants. I had been wearing the same clothing for three days,** so I asked a staff member if I could have my black long sleeved shirt, my Nightwish shirt, a pair of black underwear, a sports bra, black leggings, and a pair of black socks. She looked confused as to why I was asking about getting my clothes from the front desk, and I told her all the clothes were removed from my room a few days before, so I needed my clothes. She said she would be able to get them in a little bit, but she would have to ask for approval first.

The medication nurse called me over to take my meds. **She said she had noticed I was wearing the same pajamas for three days and asked if there was a reason why.** I said that all the clothes were taken from my room, which compounded my OCD issues. Since I was not able to complete my typical OCD routine in the hospital, and I didn't have access to my other clothes, I had to wear the same outfit. I told her I needed to be given at least one other outfit, though, so that I could go back and forth between hand washing a couple of outfits in my bathroom so that I would have something else to wear. **I told her that I had already been waiting for about 45 minutes for staff to get my clothes, and I was bleeding through my pants.** The medication nurse asked staff if they could hurry things up a bit, saying I really needed my clothing. One staff member, after an hour had passed, came up to me and had a list of my items that were in their inventory. I did not get to see the list well myself, but she was checking down items as I listed them. About half an hour later, a different staff member came up with my underwear, a mint green pair of socks which were not the ones I had asked for, all of my long sleeved black shirts, and a sports bra. He came up without my leggings

or my shirt, and I really needed my pair of leggings the most as I was bleeding through my pants. **He said he could not find those items.** He could not find any of my socks or other underwear (I wanted a specific pair I remembered my mom packed). I told him my mom had just bought some so I would have plenty for my time at Fuller. He went to check again, and about half an hour later, he found the bag with my shirt, socks, and the rest of my underwear. I believe this is also at least one of my missing bags of belongings, as I came home with no socks other than the ones I kept hand washing or underwear that I had not worn. This should be visible on the security tapes **(staff lost at least one entire bag of my clothing, which I did not realize until my mom was looking through my belongings at home the day after I was discharged and discovered that multiple items she packed for me were not there).** I asked the staff member if I could please have my shirt, the specific pair of underwear that I needed (since I had my period), my socks, and my leggings. I repeated that I was bleeding through my pants, so they gave me a different pair of black leggings than the ones I had asked for. I asked if I could have my other pair of black leggings, the ones that are skin-tight, and he said he would have to see if he could get approval for that. By the time three hours had passed, I finally got approval for my shirt, the specific pair of underwear, and my black socks. For some reason, I was never allowed to have my skin-tight pair of black leggings. **It took a grand total of three hours to finally get the clothing that I had asked for, minus the correct pair of leggings.** I remember this happened on a shift when both Rosa and Cam were working, if this helps anyone pinpoint the exact day this occurred. **I was humiliated by the way I was treated, and I am still disgusted by the fact that staff let me sit in my own blood for hours. They did not provide adequate hygiene products, and they let me bleed through already-dirty clothes.**

Toward the end of my time at Fuller Hospital, I was confused as to why some staff members, my case worker, and my psychiatrist kept saying I was improving (and had been saying so for a while), yet I still did not have a discharge date, even though I had been at Fuller for nearly three weeks. My friend Jessica called to ask to speak with my case manager, Christine. I know this because she told me and because the staff member was on the phone with her when I was standing at the desk, and the staff member said she was on the phone with Jessica and could not locate the release form that I signed to allow Jessica to speak with staff. Jessica told me the staff member she spoke with said that Christine (my case manager) was not around since it was a weekend day, so Jessica told me that she was directed to Christine, the charge nurse (who I spoke about earlier). Jessica was aware of the different ways that Christine, the nurse, mistreated me, and Jessica told me that she told Christine that I needed staff to start working with me, to stop lying to me, and to give me some kind of information about what expectations I needed to meet before they would be willing to release me, because Fuller was holding me against my will when I was no longer in crisis (and hadn't been for a few weeks), but they wouldn't explain why they were justified in doing so. I wasn't even a prisoner, because even prisoners know their release dates. I was a hostage. Jessica told me Christine said, "Thank you," and then hung up on her. I finally got a discharge date on January 25th.

My discharge day finally came. I was told I could look through my bags that were brought up from storage to see if all my items were there. I did not remember most of the items that my mom packed, especially since the clothing was only in my room for my first few days at Fuller Hospital. I had a bad feeling that something would be missing, since staff had trouble finding my clothes when I had my period. I realized my hair comb was missing that staff took out of my room, my other dachshund sock, and the tan camouflage shirt and black leggings that I wore on my first full day at Fuller Hospital, the same clothes I arrived at the emergency room in. I also realized that I was missing the blue prayer shawl a group of women at Church knit for me that I never even had the chance to wear. I started crying, and the unit manager, John, asked me, "This isn't going to set you back, is it?" Essentially, he was asking if this is something that would make me unstable and need to stay longer. A staff member looked in the laundry room and found the bag of clothing that had my tan camouflage shirt and black leggings in it. I still felt anxious wondering if I was missing anything else other than my dachshund sock and hair comb, but I told myself that I was probably just being paranoid. **At some point, staff had me sign a form saying that I had all my belongings, but I wasn't actually confident that I did have them, and I knew that I didn't have a good idea of what belongings I was even supposed to have (since they had been kept from me).** A staff member brought me downstairs when I was discharged. We got off the elevator, and I got to see my parents at the doors that were right at the

exit. My parents hugged me, and then **my mom looked at the bags the staff member helped bring down with me and said, "This looks a little light," meaning she thought there were items missing. I also realized on the ride home that my pink bucket of toiletries that one staff member put in my bag (I saw it at the top of one of my bags nearly an hour before I was discharged) was missing.** I do not know why someone would remove it from my bag, but someone certainly should have been able to find my toiletries, considering my name was on many of the items in the bucket. I spoke with my friend and fellow patient, and he said he thought he saw a pink bucket in the trash not long after I was discharged. **It makes me wonder if someone threw my bucket away. There should certainly be video available of the front desk on the day I was discharged.**

The day after I was discharged, my mom asked me where my blue knit wool cardigan from L.L. Bean was. It was worth $80. She also told me she did not see some of my underwear or any extra pairs of socks. At this point, I started crying, as I then realized that two of my favorite sweaters were also missing, along with a limited-edition sweater from my favorite band. It was a gift from a friend, and it cost $100 and is no longer in production. My mom and I wrote down a list of all the items we could think of that were missing. **Most of the items I am missing are not replaceable, and the sentimental value cannot be replaced either.** The unit manager John said that if the items could not be located, he would pay for what is missing. I am not interested in the money. I just want my items back. **It is unacceptable for a psychiatric hospital to forcibly remove items from a patient's possession if they are not willing to take reasonable steps to ensure the safe storage and return of those items. Forcibly removing and then losing a patient's personal items is a gross violation of trust and can be extremely harmful for patients.**

My mom contacted my Fuller case manager, Christine, about my missing clothing. She said that she wished she could help more, but she does not have any power to find them herself as that is not her department. Christine said that it should not be hard to locate my items, though, and they should be able to see what happened to the items on the cameras. She said John, the unit manager, should be able to help. My mom spoke with John, and she thought he sounded sympathetic at the time. My mom called him back later (I believe it was on the following day) to give him the date of when a staff member brought what I am pretty sure is my missing bag of clothing up from storage. My mom said John told her that he already had the date written down. My mom told him, "This is a different date," and she said it was like a switch flipped. **She said she did not like John's attitude at all. My mom told me John was not really listening to her, and he said that I was just going to have to deal with the loss of the clothing, and that he would reimburse us for it.** My mom told him that that really wasn't the same, and that my clothes have sentimental value to me. She said that I had only had one therapy session since my release, **and that I had been hospitalized in the first place because of loss. The staff was well aware of the fact that my initial hospitalization was due to depression and anxiety triggered by a loss, and that losing so many of my clothes would be very bad for my mental health.** When my mom got off the phone with John, she was very angry, although she had remained calm on the phone. **She could not believe that John told her that I was going to have to deal with the loss when it was the staff's responsibility to look after my clothing after they removed it from my room.** When she heard what happened, my friend Jessica left a voicemail for John that was never returned, and she spoke to him very briefly later that day. Jessica told me that John said that he had already spoken with my mom "a hundred times" (at this point, my mom had only spoken with him twice) and that he would "deal with mom" for now, at which point he hung up the phone. On February 1, I was feeling very stressed out since I still had no word about my missing clothes, and I had a horrible feeling that no one was looking for them. **Jessica told me that she would try calling my case worker Christine, since they had had very productive and positive conversations throughout my stay at Fuller, and she and I both believed that my case worker actually cared about my best interests.** Christine wasn't available, so Jessica spoke with someone at the front desk. According to Jessica, this woman said that my belongings weren't at the hospital, and that staff went through all of my stuff with me before I left (which they did NOT do) and that I signed off on it, and that the only things I had said were missing were a sock and maybe a couple other things. I can't even trust them to look for just those items, since the staff member didn't even seem to be sure what besides the sock was missing, and **she kept insisting that they didn't have my belongings**

and I needed to look elsewhere (which directly contradicted what John had told both Jessica and my mom—namely, that they were looking into the situation and trying to find my things). Jessica told me she told the staff member that my mom dropped off a bunch of extra clothing items that I didn't even know about, so there was no way that I could've known what was missing when I wasn't even told that they were at the hospital to begin with. Jessica told them that my clothes and other items were there, that those items had not been returned to me, and that the hospital had lost them. Jessica also told the staff member that my mom said that she never would've brought me so many items if she had known that they would just be lost (staff assured my mom that my clothing would all be kept safe). Jessica also told the staff member that John had hung up on her once before, and that he had also hung up on my friend Joelle who had called that morning. **The staff member tried to claim that John hadn't told my mom that I'd just have to deal with the loss, so Jessica told her that John been extremely rude, and that yes, he did in fact say that I would just have to figure out how to "cope," and that if he knew anything about psychology at all, he would know that that was an extremely harmful thing to say to someone with my diagnoses.**

Jessica then told me that **the staff member offered to give her phone number to Christine** (the case manager), since that's who Jessica had been trying to reach in the first place. It seemed pretty clear to both Jessica and me that staff had not been looking for my missing items, even though **I am missing several hundred dollars worth of items.** Joelle also texted me after John hung up on her to tell me what happened and that John had been "a jerk." Jessica didn't receive a call back (which is typical for Fuller), so she told me that she was going to try calling Christine again. Jessica told me she called to speak with Christine but that John intercepted the call. **Jessica said that he said that he had spoken to her a bunch of times (which was not true—she had only spoken to him once before) and he told her that she had to stop calling or he'd report her phone number for harassment. Jessica had only spoken to him once prior to this moment, and she was not even looking to speak with him.**

Prior to this conversation, Jessica had never once been asked to stop calling the hospital by any staff member, and she had only ever had positive interactions with Christine. Shortly before John threatened to falsely report her for harassment, a staff member had offered to have Christine call Jessica back when she was available. Jessica was just trying to find someone who would be willing to help me, because she knew how important this was. I wasn't comfortable calling the hospital myself, because of the horrible, unethical way that they had treated me for weeks, and so she was only trying to advocate for me. **Instead of helping, John chose to bully her and scare her into silence.** Jessica said she replied with, "Well then, I'll have to report your behavior to the police," and John hung up on her. As I am writing this sentence, today is February 2, 2021, and Jessica told me she called the Attleboro Police department yesterday (February 1st). She spoke to a woman who seemed genuinely caring and concerned and who recommended that I come to the station and file a police report about my experiences. I am hoping that police will look into the incredibly unethical and potentially even illegal way that patients are treated at Fuller Hospital. The online reviews for Fuller Hospital are extremely disturbing, and many of them say very similar things to what I have said in this report. Many of the patients I interacted with during my stay at Fuller also say the same things. I am very concerned for the mental well-being and physical safety of the patients who are still there and of the patients who will be sent there in the future.

LETTER SUBMITTED BY MARGUERITE ELIA

June 12, 2024

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

Dear Senate Finance Committee Members,

I am writing to you from California. Thank you for prioritizing the critical issue of Residential Treatment Facilities (RTFs).

I am writing to ask you to recognize the barriers to paid family caregiving and their role in abuse and neglect in our nation's care network. Home and Community-Based Services (HCBS) current regulations (Section 1905(a)(24) of the Social Security Act, 42 CFR § 440.167, and 42 CFR § 441.105) prevent family caregivers from being paid to provide care at home. This forces many families to place their loved ones in RTFs due to the lack of affordable care options.

During the COVID–19 pandemic, 39 states allowed parents and spouses to be paid caregivers through CMS waivers. This led to better care, fewer hospitalizations, healthier homes, reduced dependency on welfare, and increased tax revenue. The National Council on Disability supports making this change permanent.

CMS officials, including Dan Tsai, have acknowledged the benefits of paid family caregivers. However, current federal regulations remain a barrier. Congress must "ban the bans" on paid family caregivers and incentivize states to adopt this model.

This change is crucial to prevent the abuse and neglect often seen in RTFs and to support families in providing safe, effective care at home.

Kind regards,

Marguerite Elia

ELM STREET PLACEMENTS, INC.
14 Tara Way
Pittstown, NJ 08867

Statement of Lucy Pritzker, MS,
Founder and Senior Educational Therapeutic Consultant

Chairman Wyden, Ranking Member Crapo, and Members of the Committee:

I would first like to thank you for understanding the importance of examining failures and evaluating solutions in Youth Residential Treatment Facilities (YRTFs), to protect our Nation's most vulnerable, its youth. My name is Lucy Pritzker, and I am an Educational Consultant and the founder of Elm Street Placements, Inc. I hold a master's degree in addiction counseling, and I have over 30 years of experience working in educational and therapeutic settings. I am a member of the Independent Educational Consultant Association (IECA), I am the head of the IECA Government Relations Task Force, and I am a proud former member of the IECA board. Additionally, I am on the Board of Trustees at Hampshire Country School. My experience advising parents on academic and therapeutic placements for their children allowed me to obtain unparalleled expertise to author a book titled "Crisis Interrupted: A Parents' Guide to Residential Placement for Children, Teens and Young Adults." My professional role allows me the opportunity to travel extensively to visit and evaluate schools, and treatment programs, in the USA and beyond and uniquely positions me to advise on the importance of enacting trauma-informed legislation for Youth Residential Treatment Facilities.

Context:

Enacting trauma-informed legislation to provide oversight of Youth Residential Treatment Facilities (YRTFs) is crucial for several compelling reasons:

- Ensuring Proper Treatment Protocols: Trained medical and clinical professionals oversee the treatment plans for youth in these facilities. They ensure that therapies and interventions are evidence-based and appropriate for each individual's needs. This oversight helps in providing effective treatment outcomes.
- Safety and Well-being of Residents: Medical oversight ensures that the physical health of residents is monitored, and any medical issues are promptly addressed. Clinical oversight focuses on the mental and emotional well-being of the youth, ensuring that therapeutic interventions are safe and beneficial.
- Regulatory Compliance: YRTFs are often subject to regulatory standards that require medical and clinical oversight. Compliance with these standards ensures that the facility operates ethically and legally, maintaining the safety and rights of its residents.

- Quality Assurance: Oversight and accountability mechanisms such as regular reviews, audits, and assessments help maintain the quality of care provided in YRTFs. These measures ensure that staff are trained, protocols are followed, and residents receive the best possible care.
- Ethical Considerations: Medical and clinical oversight upholds ethical principles in treatment practices. This includes respecting the autonomy and dignity of residents, ensuring confidentiality, and adhering to professional codes of conduct.
- Trauma-Informed Emergency Response and Crisis Management: Trained medical staff are essential for handling medical emergencies that may arise among residents. Clinical oversight helps in managing crises related to mental health, behavioral issues, or emotional distress effectively.
- Safe and Supportive Environment: Oversight ensures that the environment within YRTFs is safe and conducive to healing. This includes implementing trauma-informed care practices where staff are trained to recognize and respond to trauma-related symptoms and behaviors with sensitivity and understanding. Such an environment fosters trust and reduces the likelihood of triggering past traumatic experiences.
- Family and Community Involvement: Oversight includes engaging families and communities in the treatment process. This collaborative approach helps build a supportive network around the youth, providing them with additional resources and stability as they work through their trauma. Family involvement also facilitates smoother transitions back into community life post-treatment, reducing the risk of isolation or re-traumatization.

In conclusion, enacting trauma-informed legislation for YRTFs is essential for safeguarding the well-being of youth, promoting effective treatment practices, and fostering environments that support healing and recovery. By establishing clear standards, ensuring accountability, and prioritizing trauma-informed care, legislation plays a pivotal role in shaping a compassionate and supportive system of care for vulnerable youth in residential treatment settings. I commend you all for addressing this important matter, I am fully supportive of the "Stop Institutional Child Abuse Act" (SICAA), and I look forward to collaborating with you to implement solutions.

FAMILY-RUN EXECUTIVE DIRECTOR LEADERSHIP ASSOCIATION
P.O. Box 385
Turner, ME 04282
Phone: (207) 754–2768

Response to the Senate Committee on Finance Staff Report—"Warehouses of Neglect: How Taxpayers Are Funding Systemic Abuse in Youth Residential Treatment Facilities"

On behalf of the only national association of family-run organizations dedicated solely to the behavioral health of children and youth.

Families across the country are grateful for the efforts that have yielded the Senate Report "Warehouses of Neglect: How Taxpayers Are Funding Systemic Abuse in Youth Residential Treatment Facilities." The issues cited in the report have been revealed by families and brought to the attention of policymakers, funding sources, and feeder systems (such as leadership in mental health, child welfare, and juvenile justice agencies) for 30 years. Families continue to work collaboratively with researchers, community practitioners, and others to advocate for change toward *realizing* a comprehensive system of prevention, intervention, and intensive home- and community-based services. As a nation, we have spent too much money and time (for some children their lives) on teaching children and youth to live in institutions rather than providing the treatment and skills required for them and their families to thrive in their communities.

This report reflects a microcosm of the experiences within far more than the number of agencies represented therein. Lack of sustained leadership for children, youth, and families at state and national levels has resulted in vast increases in the use of these programs. Adult models have received immense funding increases, funding for children and youth has not kept pace, and support for family-run organizations has diminished.

We must embrace a Child-First approach to the systems and agencies responsible for their care. This calls for replacing current models of funding, program development, and oversight with ones that significantly engage families in their processes and are not focused on grants management. The institutions that currently provide those elements have gotten us where we are today. We must embrace and realize the 2019 Declaration of the United Nations: "We, as nations of the world, are no longer going to tolerate our children being raised in institutions. The time has come for change."

Respectfully submitted for FREDLA

Patricia Hunt,
Executive Director

LETTER SUBMITTED BY LISA GIAMETTE

June 23, 2024

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

Dear Senate Finance Committee Members,

I am writing to you from Virginia. Thank you for prioritizing the critical issue of Residential Treatment Facilities (RTFs).

My son is currently 15 years old. He has a rare genetic condition called Phelan-McDermid Syndrome, focal epilepsy, and he is autistic. He requires 24/7 care to stay safe as he needs assistance with all activities of daily living. He is still in diapers. He requires assistance with communication as he is completely non-speaking and has minimal functional communication skills. He has no sense of danger and elopes from care if not constantly watched.

I tried for years to find help outside of our home. It was somewhat easy when he was young. However, as his needs have increased and he continues to grow, finding individuals who are willing and able to care for him has become more difficult. Many caregivers are frightened of him or don't understand the full extent of his needs despite extensive training by me. I have not been able to maintain employment outside of our home because I have always been needed to either provide all his care or I have needed to support the caregivers who try working with him.

I was given the opportunity to step in as his paid caregiver during the pandemic. This was the first time that I was able to receive pay for doing the work that I had been taking on when outside caregivers were unavailable. This helped our family in two ways.

First, my son was able to gain additional skills in communication and performing daily tasks because he had consistent care across all activities. As his parent, I was able to coordinate care with his school team and specialists to help him thrive. I also knew that he was being cared for in the best way possible because I was the one providing the care. I no longer worried about caregivers who were frightened by my son's size or behaviors. I no longer worried about him being harmed and unable to tell me what happened.

Secondly, our family received a much needed financial boost. The pay I received allowed us to reduce our reliance on some public assistance programs and increased my son's access to healthy food, personal care items, and sensory items to help him function better during the day.I am writing to ask you to recognize the barriers to paid family caregiving and their role in abuse and neglect in our nation's care network. Home and Community-Based Services (HCBS) current regulations (Section 1905(a)(24) of the Social Security Act, 42 CFR § 440.167, and 42 CFR § 441.105) prevent family caregivers from being paid to provide care at home. This forces many families to place their loved ones in RTFs due to the lack of affordable care options.

During the COVID–19 pandemic, 39 states allowed parents and spouses to be paid caregivers through CMS waivers. This led to better care, fewer hospitalizations, healthier homes, reduced dependency on welfare, and increased tax revenue. The National Council on Disability supports making this change permanent.

CMS officials, including Dan Tsai, have acknowledged the benefits of paid family caregivers. However, current federal regulations remain a barrier. Congress must "ban the bans" on paid family caregivers and incentivize states to adopt this model.

This change is crucial to prevent the abuse and neglect often seen in RTFs and to support families in providing safe, effective care at home.

Appreciatively,

Lisa Giamette

LETTER SUBMITTED BY SPENCER GORDON

June 12, 2024

Re: The Senate Finance Committee Investigation into Youth Residential Treatment Facilities

Dear Senate Finance Committee,

My name is Spencer Gordon, and I am a former patient at North Spring Behavioral Healthcare (UHS) in Leesburg, Virginia, and YouthCare (Acadia) in Draper, Utah. I am testifying about the abusive and neglectful conditions I experienced in these youth residential treatment facilities.

I was placed in **North Spring** at the age of 14 in the summer of 2017 until early 2018 due to repeated suicide attempts because of bullying at school and parental abuse. I was on the Charlie unit, the younger girls unit. They had motion sensors to see if we got out of bed, but mine overlapped my bed and would go off if I so much as rolled over in my sleep. I do not remember exactly what night it was, but one night in my first week there I was crying and couldn't sleep. I was unknowingly setting off my alarm, so they ripped me out of bed and brought me to the "swing wing," the area they took kids who were being violent; or "swinging [punches]." I am not sure if the nickname originated from staff or students to begin with, but both students and staff called the area the swing wing.

When we got there, they accused me of setting off my alarm intentionally even though I had no clue it was going off. I was sitting on the floor of the swing wing, rocking back and forth, when I decided I wanted to lay on the floor. So, I rolled to my side, and started laying down. They then put me in a restraint. I had no clue why I was being restrained until the next day—while going over the incident report—I was informed I was allegedly hitting my head on the floor. I don't think my head even touched the floor, but if it did, it certainly wasn't forceful. They used a two-person restraint, one that was already known to be unsafe. One staff held my legs straight while another held my arms behind my back and pushed me down. I asked them to lighten up, that they were hurting me, and they told me to "stop resisting." The only resistance was from the tendons in my knees being pushed further than they were made to be pushed; and it's not like I was able to stretch beforehand. The next day I was told the restraint lasted either 20 or 30 minutes; I can't remember which but I know it was one of those two.

My bed was infested with stinkbugs. I remember waking up from a nap and seeing one less than an inch from my face. I blew on it, it didn't budge. I was so accustomed to them by this point that I just rolled over and went back to sleep.

They took me off my birth control pills when I got there. I'm not even sure why, maybe they thought they were being used to prevent pregnancy rather than medical. I had a full, incredibly painful, 7-day heavy period a few days after being taken off my pills, then diluted blood for about 30 days. The 30 days were far lighter than a period, but also heavier than spotting. I'm not sure if it was mixed with vaginal fluid or cervical mucus, but the blood was somewhat translucent, which is how I assume I escaped anemia. My mother had to contact them several times before they finally put me back on my birth control.

When I first got there, they took me off all my nausea medications and put me on fish oil pills. I would vomit multiple times per day. If I had eaten 2 hours prior, the vomit would look 10 minutes old. This was clearly an allergic reaction, but they threatened to put me on unit restriction if I didn't take my fish oil pills. Unit restriction took away one's access to school. School has always been important to me, so I decided I would vomit repeatedly so that I could get an education. I stayed on the pills for months until I vomited in front of my mother during a pass and she

noticed that the vomit did not look like it should have and demanded they take me off the pills.

I once squeezed my breast and lactation came out of it. I asked a nurse if this was normal, and she told me yes, not to worry about it. Galactorrhea is not normal, it was a side effect from my meds. But, I didn't concern myself with something I thought was normal until 2 years later when I showed a different nurse at YouthCare. An OBGYN tested me and found my prolactin levels were very high, high enough to cause osteoporosis. YouthCare was able to get my levels lower, though they still wanted them higher than average. Unfortunately, because I was lactating at all times for 2 years, nothing would make them stop lactating. I experienced galactorrhea until I removed my mammary glands when I was 20; 6 years. I will probably develop osteoporosis at a younger age than usual.

One night at North Spring we were told to sit in our assigned chairs and stay silent, not told why. Then I heard a siren. Then another, and another. If we opened our mouths staff would "shhh" us before noise could even come out, but we exchanged several looks of confusion. Soon you could hear talking in the hallway outside of our unit. You could hear the white noise of walkie-talkies, but they clearly weren't on the same channel as the staffs' walkies. We stopped taking new intakes the next day. I wasn't told until weeks later what happened when my mother admitted that a child was killed during a restraint on my phone call with her. The same restraint I was put in for no reason. It still hurts that she knew I was restrained, knew it could be fatal, and still decided not to pull me. When I got out I Googled the incident. I didn't recognize Jeremiah's name, but I remembered his face. We were on different units, but we'd pass by in the hallways often enough for me to recognize him. He used to walk with an unnaturally wide gait because he thought it made him look cool. It didn't, it made him look silly, but everyone did something they thought was cool that wasn't when we were 15. He had a bright smile that would encourage anyone to smile with him, even when I was actively crying. I barely knew him, and I still miss him.

I was placed in **YouthCare** at the age of 16 until a few weeks before my 18th birthday due to repeated suicide attempts and Gender Dysphoria. This was June 5, 2019 until December 18, 2020. It felt—feels—like a slap in the face since it was Pride month and 3 days before my grandfather's birthday. My grandfather was my biggest supporter and the only person I truly felt loved by growing up. YouthCare took off my pre-existing diagnosis of Gender Dysphoria and diagnosed me with Borderline Personality Disorder in an under 2 hour intake. They used BPD to justify how I wasn't really trans, I was just faking it for attention and because individuals with BPD tend to "copy societal trends." People with BPD are not known to copy societal trends, they are known to copy their romantic partner or other "favorite person." One should also rarely diagnose a 16-year-old with BPD as many of the symptoms of BPD are the same as the symptoms of being 16, and I didn't even have many of the symptoms they alleged I had. My current therapist now says with full confidence that I am not BPD, have never been BPD, and agrees that they were intentionally using a highly stigmatized disorder to discredit any claim I made of abuse or being trans. One of my listed issues in my intake documents says "Spencer considers herself a male." My notes used my chosen name as my mother signed a document stating my name would be Spencer, but almost all of my notes used she/her pronouns because there is no legal requirement to use any specific pronoun and the therapists considered me to be a girl. Even notes from the "LGBTQ group" they had used she/her pronouns for me.

My intake documents list under my trauma history that when I was 14 I had "rocks (pebbles)" thrown at me. They were not pebbles, they were rocks, but even if they were pebbles there was no point in including that for any reason short of invalidating my trauma. I once told my therapist, Emily, that my stepmother's abuse was more traumatizing than my ex-boyfriend raping me. I don't recall the exact words she used, but she did not hide that she was judging me for being more traumatized by my stepmother. Not only does trauma affect everyone differently, but my stepmother used to lock me in the basement with no food, no electronics, and no outside communication, just the same books I read over and over again including but not limited to "Sexual Homicide: Patterns and Motives" by Douglas et al. every other weekend for a year and a half. I don't think it is horribly surprising that could be more traumatic than rape for some people. My ex would rape me weekly, but the night before he dumped me he raped me and my best friend at the same time. Emily told me, "I'm not saying it's your fault because it is never the victims' fault, but you could have prevented it." This was 4½ years ago, but the memory is seared into my mind and I am 90% confident these were her words verbatim, and 100%

certain they were at least an accurate representation of what she did say. She intentionally wanted me to blame myself for Rachel being raped, to feel guilt over someone else's actions, and I am not really sure why to this day.

Emily once told me that when my depression was cured I'd likely detransition. Most of the conversion therapy they did was subtle because if I caught onto what they were doing I would oppose it, but this stuck with me based on how overt it was. Emily also tried to convince me that any complaint of abuse or bullying was me "victim stancing;" *i.e.,* playing the victim. I wasn't being bullied, I was actually the problem and the other students were in the right to exclude me or call me names. I was told this both in individual therapy and in group therapy in front of the other students. I've reconnected with many of the kids since then and many have apologized for bullying me. I have, sincerely, told them it wasn't their fault because Emily was encouraging them to bully me; and their apologies immediately discredit Emily's claims. I was often bullied for being trans, told I wasn't "really trans" and had feminine aspects of my appearance—many of which I had no control over—pointed out by my peers. I believe her goal was to make it clear I would never be loved or respected unless I detransitioned.

YouthCare put me on 200mg of Geodon. They also put me on 1mg of Klonopin to counteract the tardive dyskinesia from the Geodon. The FDA only approved up to 80mg of Geodon twice a day, not 200mg all at once, and only for Bipolar or psychosis. I was neither bipolar nor psychotic, nor did YouthCare ever diagnose me as such. One time they didn't refill my Klonopin and I went 4 days without it. By day 4 my entire body was shaking so hard and shaking my vocal cords with it that people couldn't understand what I was saying. Geodon also made my breasts grow as it raised my prolactin levels, a side effect I question if was chosen deliberately since I was a trans man (female-to-male).

YouthCare policy didn't "reward" self-harm with bandages or even topical antibiotics. One nurse even described a bandage as a "badge of honor" to me. I was frequently made to display uncovered second-degree burns—done by rubbing an eraser on my skin until the dermis was exposed—to direct sunlight. I was once made to play basketball outside with an uncovered wound, and a peer solely on accident whacked my arm while trying to get the ball from me.

One time I asked to send a letter to Nancy Pelosi, Don Beyer, and Jennifer Wexton. Beyer was my representative and I went canvassing for Wexton in 2018 and helped her get into office. Pelosi was House Speaker at the time. Emily refused to send my letter because "Nancy Pelosi isn't on your contact list." The first amendment protects my right to "petition government for redress of grievances," and since they'd send mail to my mother, this was intentionally limiting my rights rather than just the 10 cents it would take to mail the letter. We were also punished if we called fellow students their preferred pronouns without therapist approval. They limited our freedom of speech and replaced it with enforced transphobia and required disrespect. Of course, I had therapist approval to be called he/him, but students, staff, and therapists were never punished for calling me she/her.

I once had a skin infection on my knee that was progressively getting worse. Anytime I asked for medical care I was accused of "attention seeking" and lying about how much it hurt. I was not lying, but even if I was, there were visible signs of infection. There was a period of time where the skin surrounding the infection was blue. They finally got me to a doctor weeks later once red lines were spreading down my calve from the initial wound, but also made sure to inform the doctor that I would be lying about the severity my symptoms. So, the doctor put me on incredibly weak antibiotics, and it got worse the next day. I was forced to do physical activities during the Parent Days event, and in excruciating pain, I decided to sit down without permission. I opened the bandaid and saw that the infection was green, purple, brown, and white, all at the same time. My mother came and sat with me and saw the wound, then promised me she'd take me to a doctor. Unfortunately my mother and I carpooled to the location, so we had to wait for our driver to be ready to leave. While my mother and I were seated the recreational therapist, Nicki, walked over, and chastised me for sitting out. My mother had to tell her my leg was too infected for me to keep participating. When I finally got to the doctor and they cleaned the wound out, the infection was 10mm in diameter and 5mm deep. This likely started as an ingrown hair, there was no reason for it to get this bad if I was given medical attention sooner. I still have a scar from it 4 years later, and probably will for life. Interestingly, Nurse Carrie came up to me later apologizing. She informed me that Nicki, Emily, and other therapists working Parent Days asked if I would be able to participate. She told them I *could,* but it would be incredibly painful. She told

me her intent was to acknowledge that my leg wasn't broken and could bear weight if needed but that it would be way more painful than anything a medical professional would suggest pushing through. Nicki, Emily, and everyone involved knowingly and deliberately wanted me in agonizing pain.

Due to frequent understaffing in the nursing department, I was usually only able to get ibuprofen about once every 12 hours. Even when we had enough nurses, they only gave ibuprofen once every 8 hours and acetaminophen every 6. I frequently handled ovarian cysts, a pain sometimes compared to appendicitis, without any pain meds. They wouldn't let me lay down in my room or even on the couch, so I would lay down on the floor in the corner in fetal position, in too much pain to do so much as drink water. Staff didn't hesitate to make it clear that "allowing" me the floor was a privilege as they considered it sexually suggestive to lay down.

If you were considered a self-harm risk you would be strip searched nightly and had your body closely checked by two people for wounds. Both were staff, not nurses, not medical professionals. You were also put on line of sight, so one person would watch you while you showered, when you used the bathroom. When showering we were expected to wear a bathing suit so that staff could avoid a lawsuit or criminal charges. I would not be able to adequately wash my body because YouthCare was afraid that their adult staff would watch me, a minor, cleaning myself and view it as sexual. We had a limit of 10 minutes twice daily to do all of our hygiene.

The food left us malnourished. One time a staff member, Jerry, served us raw chicken. We were also once forced to go on a 7-hour hike, and I passed out later that night because I was not eating enough to sustain a 7-hour hike. My blood pressure when I was conscious enough to notice things but still too out of it to talk or move was 62/39. I am 100% certain this is what the BP machine read as I had a faint haze of remembering that number and checked with the nurse the next day, the memory solidifying with my own astonishment that it was half of what it should be. I am not sure how low it was when I was fully unconscious. The next day the same Jerry and his friend whose name I can't recall told me about how someone called a code while I was passed out. Apparently a peer was hitting his head against the wall, but when they first arrived they assumed I was the code. They started yelling at me, sprawled out on the ground to stop "zero-stating," a term they used for when a student chose to do nothing as an act of rebellion. Another staff saw them and clarified that the code was in the other room, and everyone just left me there, on the floor, unsupervised, while experiencing syncope. It was very uncomfortable for me to hear this story from them because they seemed to find it funny, not horrifying like I did. From talking to both students and staff the following days I was able to gather that it seems they were understaffed and genuinely couldn't attend to me at that time, but if my blood pressure was no higher than 62/39, that is a medical emergency and I either needed to be attended by a YouthCare nurse or have someone call 911 so I could be attended by EMS.

We were not allowed to see our psych reports. I eventually requested my records, saw the report, and immediately understood why. The doctor doing my psych report blatantly lied. I told her I first experienced Gender Dysphoria when I was 8 years old when I learned about human sexual dimorphism. I was an only child, had no brothers, and prior to this point had assumed all humans had genitals like mine. I'm not sure how I would have explained women having breasts and men not, but I certainly didn't expect to have breasts someday. I thought boys and girls were haircuts, and I had long hair, so I guess I was a girl. The logic is questionable, but I was 8. Once I learned there was a sex different than mine, I immediately felt dysphoric, wanted to be a boy, but thought I was just a weird cis girl who wanted to be a boy. When I was 15 I was finally allowed social media and learned that Gender Dysphoria is a thing, that cis women don't want beards and penises, that I was trans. I finally understood who I was, came out to my boyfriend, but stayed otherwise closeted. When I was 16 I told a doctor my mother "would not accept me as trans." What I meant was that if I came out, hypothetically, she wouldn't accept me. He thought it meant that I already came out and she refused to accept me. I do not blame him as it was genuinely an accident and miscommunication, but he outed me to my mother. My psych report did not say any of that at all. What it said was that one day I downloaded Instagram and decided to be trans to fit in with a "trend." It said that I have only identified as trans for the past few months, that my doctor outing me was me coming out intentionally and was a spur-of-the-moment "I decided to be trans today" rather than years of Dysphoria and a year knowingly in the closet. It also stated that cis girls with autism tend to have neuroanatomies closest to cis men, that trans men have neuroanatomies closest to cis men, so I probably was just a confused autistic girl rather than a trans man. I am

still flabbergasted that the doctor defined transsexualism, agreed I fit it perfectly, and used that as proof that I was not trans, somehow.

One staff was fired for being a white supremacist and then rehired because no one else would work there. He also frequently told students the COVID–19 vaccine had a government microchip in it to track him. If you Google "justin youthcare" while in Utah and likely elsewhere, his Facebook profile is on the first page. His wife looks concerningly young based on his career choice, especially since they had a kid a few months after getting married; but her profile doesn't have her age so I can't prove anything. We did hear a story about a girl who was the victim of statuatory rape from a staff member. The story was shared amongst the students, but staff would also tell us this happened. Staff also didn't hesitate to tell us that if we misbehaved enough they would send us to Provo Canyon and how Paris Hilton was raped at Provo Canyon so we would never want to go there. They were indirectly threatening us with being raped as punishment. That would be insidious regardless of who they were threatening, but especially so since most of us had histories of sexual trauma, and all were minors.

The education was abysmal. I was given a computer with a poor online school program and told to teach myself. English used printed paper, but I was still told to teach myself. My human anatomy course didn't teach the reproductive system, and didn't even teach the urinary system because it has cross-sectional diagrams of flaccid penises to illustrate how the urethra connects to the bladders and so forth. We had a different "teacher" for each subject, but they'd usually stand at the front of the room and watch us. I had to teach an 9 year old trans girl math because the computer program didn't teach math as low as her level and the teacher would rather use me as free labor than leave her throne at the front of the room. Some electives, gym, and Spanish were actually taught to us, but for core classes we were usually just left to our own devices short of the occasional reward reading of a play or watching a movie.

Emily eventually went to private practice and I got a new therapist, Amy. I continued with her after I left YouthCare. When I asked her to write me a letter approving a hysterectomy, she ghosted me. I emailed her private practice email, I emailed her YouthCare email, texted her, nothing. When I got my records I found she misgendered me with she/her pronouns in all her notes. She knew I was trans. I had shown a consistent history of Gender Dysphoria and had been on testosterone for almost a year. Instagram suggested her account to me as "Someone you may know," and I found she follows a lot of LDS influencers. She didn't want to write my letter not because I wasn't trans, but because who I am was against her religion. She is allowed to have her personal beliefs, but part of her license is agreeing that those beliefs won't impact her treating me. My current therapist is atheist but is still willing to work with my Rabbi to best help me. She ghosted me because her refusal to write my letter was a flagrant violation of ethical guidelines, so it was easier for her to run away than to tell me "no" to my face.

When it was becoming abundantly clear that I wouldn't detransition before I turned 18 they convinced my mother to move me to Utah in hopes that the discrimination I face in Utah County would do what they couldn't. I've had to move apartments twice because my "randomly assigned" roommates committed hate crimes against me. I've had my pride flags destroyed 25 times. I have difficulty finding jobs due to employment discrimination. I am yelled slurs from cars every 2 weeks to a month. I had a bomb threat which promised to kill us called into the place I work, Mosaics Community Bookstore and Venue, because we were hosting an all-ages drag show. One person told me to my face that trans people should go to conversion therapy not knowing I was trans or had already been there. Another person told me my mother was right to send me to conversion therapy, that he would do the same if his kid ends up LGBTQ, and that I should not be allowed around children. Someone tried to hit me with their car 11 months ago. In November of 2022, a guy I went home with told me "I'm straight, unlike you pushy queers" and I realized if I didn't play my cards carefully he would kill me.

These treatments had a profound negative impact on me, including multiple diagnoses of PTSD from the ordeal, flashbacks, hypervigilance and jumping at sudden noises, tardive dyskinesia that persists even though I've been off all antipsychotics for 3 years, 6 years of galactorrhea that was only stopped through surgical intervention, a distrust in my family, a rapist targeting me when I was 15 due to said distrust in family making me vulnerable, missing out on getting a prom, and never getting driver's ed. I was also at one point getting recruitment emails from Brown and Columbia, but those went away as I had no ability to do extracurriculars and

my GPA plummeted due to the poor schooling. It also left me with very few resources in a place where I'd face frequent discrimination in housing, employment, schooling, as well harassment walking down the street or in my own home.

My stay at YouthCare was funded by Blue Cross Blue Shield Federal Employee Program. My stay at North Spring was funded in part by APSVA public schools and in part by Medicaid.

I felt compelled to share my story to ensure no child ever has to go through what I went through. I want the Committee to understand the real-life consequences of inadequate care and oversight in residential treatment facilities.

To prevent these negative experiences, I believe the Senate Finance Committee should consider implementing stricter regulations and oversight of youth residential treatment facilities. This includes mandatory reporting of abuse, transparent data collection, increased staff training on trauma-informed care, regular and unannounced inspections, and ensuring that all facilities provide adequate mental health and educational services. Additionally, there should be accessible channels for residents to report abuse without fear of retaliation.

Thank you, Chair Wyden, and members of the Senate Finance Committee, for reading my testimony. I hope that my story and the stories of others like me will inspire you to take immediate action to protect vulnerable youth in residential treatment facilities. I hope you will pass the Stop Institutional Child Abuse Act (S. 1351) and follow that legislation up with additional reform policy to ensure all youth are safe from abuse, neglect, and preventable death in youth residential treatment facilities.

Sincerely,

Spencer Gordon

LETTER SUBMITTED BY ANNA GOZUN

June 9, 2024

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

Dear Senate Finance Committee,

I am here today as a concerned citizen, mother of three, wife, advocate and survivor of abuse in the Troubled Teen Industry.

For over a year, I volunteered with a prominent Youth Rights organization, where I witnessed countless testimonies of abuse and neglect, requested and sifted through data from multiple state agencies across this nation. I actively participated in investigations into these facilities and aided in bringing to light the abusive practices from the East to West coasts. Most recently, a horrible case where a precious 12-year-old boy died in North Carolina facility. This was not the first death in that specific facility, but we need to ensure it is the last. My heart was absolutely broken attending the funeral virtually, as someone who experienced the desperation and hopelessness you feel—terrified, trapped, silenced.

I am testifying about the abusive and neglectful conditions I experienced in a youth residential treatment facility I stand before you today to emphasize the urgent need for legislation that protects the rights and well-being of children in the United States in response to the Senate Finance Committee's hearing titled "Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions". As the Senate Financial Committee, your role is crucial in driving change and ensuring the safety of vulnerable children across the United States.

Allow me to share my personal story to shed light on the gravity of this issue. My experience at Trinity Teen Solutions, a ranch and residential treatment facility in Wyoming, was a nightmare of abuse, forced labor, and human trafficking. The Woodwards, the owners of this facility, along with their extended family, have a long history of subjecting children to physical, emotional, and sexual torment, while silencing those who dare to speak out against them. When I was 16 years old, I was woken up by two individuals around 5:30 am. They were standing over my bed and demanded I go with them. To where? I did not know. "We can do this the easy way or the hard way". I complied, yet they placed a boot on my leg and belt around my waist so I may not run. They took me from Texas to Wyoming.

During my time there, I experienced cruel and unusual punishments, including, but not limited to months in isolation, and being tied to animals (dogs, goats) or other girls. We routinely faced food and sleep deprivation, forced labor—day and night regardless of if we were injured or sick. We experienced emotional abuse and humiliation, lack of medical care, lack of hygiene, we had no ability to contact the authorities, and contact with our family members was routinely monitored and altered or halted completely. Girls were held against their will over 18 without a court order. We could not befriend fellow girls without severe punishment. Everything down to bathroom usage was so severely restricted that many were forced to defecate or urinate in their pants.

Additionally, communication with the outside world was strictly controlled, leaving us feeling trapped and voiceless. Our attempts to reach out to our parents were intercepted, letters were withheld, and we were threatened with severed communication if we did not comply. This deliberate isolation perpetuated the cycle of abuse and prevented us from seeking help. We had absolutely no access to law enforcement.

I, along with dozens of other survivors of Trinity, filed police reports against them in 2019. Despite WY DCFS being aware of the abuses, they were unsuccessful in stopping the Woodwards' actions through these means. The investigation, last I heard, is still ongoing. I am now a lead plaintiff in a federal TVPRA class action lawsuit against our abusers (*Sherman, Gozun and Nash vs. Trinity Teen Solutions et al.* Filed November 2020), in which the the U.S. Department of Justice is an interested party, and I am actively seeking justice for myself and other survivors of the facility I was in. While Trinity Teen Solutions has been closed since 2021 after the media coverage of our case, hundreds of thousands of children have experienced significant abuse in similar facilities across the U.S. This calls for urgent action and advocacy for change.

My primary objective is to protect children from abuse and ensure that no more lives are shattered by the horrors we endured. Even if our efforts can save just one person from experiencing the pain and trauma we endured, it will be worth it. Abuse is not therapy.

It is crucial for the Senate Financial Committee to recognize the detrimental impact of exploitation and abuse on vulnerable children.

No child should endure such exploitation and fear. I went there struggling with ADHD, and anxiety. I left with severe PTSD and both of my ankles needing surgery from the forced labor and continual injuries sustained with the forced labor and trafficking.

The Troubled Teen Industry is not limited to any religious group. Trinity Teen Solutions marketed itself as a Catholic program, exploiting religion to attract parents seeking assistance for their troubled children and avoid oversight. Similar disciplinary centers exist in other countries, regardless of religious affiliation. This highlights the global nature of the problem and the need for international cooperation and awareness.

In conclusion, I implore you, the Senate Financial Committee, to take immediate action in enacting further legislation, and funding for investigations to protect children in youth residential treatment facilities. We need stricter regulations, comprehensive oversight, and swift and severe accountability for those that abuse children in these facilities. No child should endure the horrors inflicted upon us, and that we hold the memories of daily in our adult lives, and it is our responsibility to ensure their safety, dignity, and right to a nurturing environment. The Stop Institutional Child Abuse Act is a great step in the right direction.

Together, we can create a safer and more compassionate society for our children, our future.

Thank you for your time and consideration.

Anna Gozun

LETTER SUBMITTED BY PARIS CAMPBELL GRACE

June 10, 2024

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

My name is Paris Campbell Grace and I am a survivor of **SUWS of the Carolinas** (North Carolina), **La Europa Academy** (Utah), and **Peninsula Village** (now **Village Behavioral Health,** Tennessee). I am testifying about the abusive and neglectful conditions I experienced during my time at these facilities.

When I was 13 years old, my family sent me to a non-therapeutic, performing arts boarding school called The Grier School in Pennsylvania. During my 8th grade year, my at-the-time girlfriend, Sarah, tragically passed away in a car accident. Stricken with immense grief for the first time in my life, I began to isolate myself from my classmates and no longer participated in my school or after-school activities. I started acting out, getting into trouble with my teachers and the school's staff, and having no separation between home and my school's campus made my having fallen into a deep depression all the more visible. Per my school's recommendation, I was moved off campus to what was referred to as "Home Away From Home," a teacher's house where I would be held more accountable and receive more support. After living with one of my teachers and her husband for several weeks, I begged my family to bring me home for a break. I felt at the time all I really needed was some real time away to heal from the loss of Sarah, and I felt I couldn't do that with all the external pressure of being at school. I was told a plan was being made to bring me home, to my Grandmother's house in Washington, DC. What I was unaware of—a separate, opposite plan was already being set in motion. My school's Dean of Students had put my mother in touch with Patti Murphy, an "Educational Consultant." Without my knowledge, my school had already decided I was effectively expelled, and my only chance of getting back in was to successfully complete a wilderness program. A couple days later, I was woken up in the middle of the night by two adult strangers. The first words I heard are ones I'm sure you've read amongst numerous testimonies—"do you want to do this the easy way, or the hard way?"

Despite my cooperation, I was zip-tied, pushed into the back of a van and driven to the airport, where I sat between my transporters, plastic ties digging into my wrists as we flew from Pittsburgh, Pennsylvania to what would become my first TTI facility—SUWS of the Carolinas in Asheville, North Carolina. Immediately upon my arrival, I was strip searched, all my belongings were taken, my body was poked/prodded/examined, and I was equipped with neon orange clothing, and a 60-lb pack. For the subsequent 3 months, I spent every day as a member of Group Alpha, a group of around 10 girls between the ages of 12–18. We spent the days hiking for hours in the direct sunlight, no sense of direction or time, mile after grueling mile. We never saw the base camp to which I originally arrived, the deceiving summer-camp-looking campus you'd see in the program's brochure, or on their website. We didn't have running water or electricity, and we collected a small black bag of food weekly from a drop point only our counselors knew the location of. Along with the obvious physical hardships we endured, some of which were quite dangerous (examples including: infections in open wounds, "foot rot" from wet hiking boots, hyperthermia, hypothermia, venomous bites from insects/snakes, etc. . . .), we were also made to endure psychologically tortuous and manipulative therapy tactics. Practices such as "Solo," an "experience" where you were shunned and separated from your peers—you were not allowed within 50 feet of your group, but must remain within eyesight of staff. This could go on for weeks, and you were not to make eye contact or speak with anyone (including staff). For those allowed to be in the group, "Feelings Circles" were held twice daily where we were encouraged to attack and pick on each other verbally in the name of "accountability" and "radical emotional transparency."

Wilderness programs seem to commonly be feeder programs, and while a child sent to these programs may believe it is the end of their "therapeutic" road, I have personally seen it be extremely rare that entering the TTI system doesn't result in being referred from one program directly to another. This is especially true for private pay families, such as my family at the time. Towards the end of my stay at SUWS, it was revealed to me I was not going back to my old school as planned, but SUWS believed I needed to be placed in a second facility as a "transition." Upon successfully graduating from SUWS of the Carolinas, I was transported by my mother to La Europa Academy in Murray, Utah.

Unlike SUWS, La Europa is an indoor Residential Treatment Center. We no longer endured hours of hiking daily, but the similarities in therapeutic methodology were stark. Most of the staff at La Europa were college-aged Social Work/Sociology/Psychology majors who happened to all have one thing in common—the Mormon religion. It was obvious many of the principals held by our staff and therapeutic team were founded in strict, religious beliefs. During my time at La Europa, my sexual orientation became more of a focus, my main "issue" in their opinion was

not that my girlfriend had passed away, but that my girlfriend was a girl in the first place. After getting into a verbal argument with a fellow student who I felt I was being bullied by, I was kicked out of the program. I spent 13 months at La Europa Academy before one day I was brought into the living room of the facility, and there I saw what I knew instantly to be two transporters ready to take me away to my next program. La Europa said they had "done all they could do" for me, and I needed "more intense therapy." I was then transported again, by a transport company, but this time to Peninsula Village (now known as Village Behavioral Health)—a lockdown facility in Knoxville, Tennessee. Peninsula Village was by far the most abusive, inhumane, and damaging facility I was subjected to.

Upon arriving at Peninsula Village, I was pushed through a metal door by my transporters, and the door auto-locked behind me into a double-wide, elevated trailer referred to as the "Girls Admissions and Assessment Unit—GAAU" (also commonly referred to as "STU—Special Treatment Unit"). I was, yet again, strip searched, my belongings taken, and this time given nothing more than a stained hospital gown. I remained on this locked unit for the first few months of my time at Peninsula Village, and was continuously sent back to the GAAU at various points throughout my stay. Life on the GAAU was hellish—no speaking, no eye contact, no reading, no writing, no standing, hands visible, head down, legs uncrossed, do not leave your bed bunk. The room was designed to have cubicles, all wooden structures with a flat board for you to sit on so that you were boxed in and could not see the other children around you. The staff stood on step stools, watching us from overhead like hawks. During the day, you sat on the wood frame directly, and at night they'd bring you a thin, plastic coated pad to sleep on. You were not allowed to do anything during the day outside scheduled group therapies, but you were also forbidden from falling asleep. We had scripted ways of speaking if we were to need anything. If there was not a script for what you needed, then it was not an option, and the only way to speak was to gently raise your hand above your head, but ensure not to wave it or you'd be "consequenced" for "rudeness." If called on, which was not a guarantee, the only acceptable way of speaking was to remain "respectful" by keeping your eyes to the ground and say, "Excuse me, Ms. [last name], may I stand, pass and approach, and may I please [use the restroom, take a sip of water from the fountain, tuck in my shirt, etc.]?" "Pass and approach" was required language meaning we could potentially walk past a staff member who was writing in one of our charts. There were many little phrases of this sort we were expected to know and adhere to, and deviating from any rules in the GAAU would wind you up instantly in "Time Out." The Solitary Confinement room (or "Time Out" room) was a small, concrete floored, all white cube with a metal door containing a small window like you'd see in a jail cell—let's be real, it was a jail cell. I spent many days locked in that room—no food, no water, no toilet for seemingly little to no reason—accidentally speaking out of turn, fidgeting with my shirt sleeve, accidentally glancing in the direction of another patient, the list goes on.

When you weren't on the Special Treatment Unit, you were in the "Outdoor Cabin Program". The campus was separated into a boys side, girls side, and you were strictly forbidden from even looking at anyone of the opposite sex if you were to pass a group while moving around campus. Rules in the outdoor program were just as strict as on the GAAU, the only real difference is you went from being sedentary all day to heavy manual labor. On a rotating schedule, we spent day after day in the scorching sun—spreading manure, chopping firewood, and building structures for the facility itself. Even the cabins we lived in had been built at some point by the patients before us—which explained why one month into my time as a member of the "Frog Clan" of the outdoor program, we suddenly had to be evacuated from living in the group's cabin due to structural hazards and severe mold.

Peninsula Village, while supposedly accredited as a school in Tennessee, is nothing of the sort. We attended "school" a couple hours a day, a few times a week at most. School was one of the first activities to be taken away if your group was put on "Shutdown" (sitting in a room cross-legged on the floor, facing the wall all day as a form of punishment), or if another group was unable to perform labor that day. Our school building was another trailer on campus, inside were 4 teachers' desks, and several sections of student desks with attached chairs. Staff would sit and supervise you as you went through workbooks on your own. We never had any sort of lectures, class activities, out of school assignments, anything that would resemble a typical high-school education. Our grades in school seemed to be given at random based on how the staff felt about your "attitude" that day.

We never regularly left campus, except for Alcoholics Anonymous, Narcotics Anonymous, and Overeaters Anonymous meetings, which all of us were required to at-

tend whether we had issues with these addictions or not. Peninsula Village was all about getting you to admit you were "sick"—they called us "sick", and they wanted us to admit to having done anything and everything, true or not. This behavior was also expected in public at these meetings. They would take us to adult meetings in random locations around Knoxville, TN. We were not only encouraged to share in these meetings, but unable to progress in the program without doing so. Take a moment to imagine a child as young as 12 years old, who has no concept of drug addiction, who got sent to Peninsula Village by the Tennessee foster care system because she was sexually abused by her own parents and subsequently assaulted by her foster parents, now having to make up stories about being an addict while surrounded by adults discussing the lowest points of their lives in a church basement. Her name was Olivia Jean McGahee, she was at Peninsula Village with me, and she committed suicide 4 years later, in 2013. She was only 20 when she died. There are many survivors who aren't with us today to share their testimonies, and I can't help but believe if they'd been offered real support opposed to abuse, perhaps they'd still be alive.

Peninsula Village, like many TTI facilities, ran on a level system. Peninsula Village's level system was based (according to them) on the Native American Medicine Wheel, bearing level names such as "Mouse, Bear, Eagle, Edoha." Along with our level ranking, we were ranked openly amongst the staff on a scale from "least trusted peer" to "most trusted peer." This system was used to pin us against one another, and a culture of attacking one another in the name of "accountability" was strictly enforced. Throughout the day, if you witnessed anyone breaking rules, you were supposed to approach staff and ask to hold what was referred to as a "Confront Group." During this group, staff would give you the opportunity to ridicule another's behavior in any way you saw fit, then the group as a whole would vote on an appropriate "consequence." Consequences could range from anything, such as food/snack restrictions, physical exercise-based punishments, "halts" (staring at a clock for a predetermined amount of time, typically a minimum of 1 hour, starting over if you look away or move, starting over until the task is completed without interruption), or sometimes you'd just be returned to the GAAU and put into solitary confinement. Your privileges didn't necessarily increase as you moved up the rankings, it was more of an emotional push and pull meant to break you psychologically. As you moved towards being "trusted," staff began to socialize with you, treating you as a friend. Because you weren't allowed to form relationships with the other children, you'd relish this feeling of being treated kindly by the adults around you—they'd give you little treats or let you get away with something small you weren't supposed to do. They'd use this as a manipulation tactic, pulling away and punishing you seemingly out of nowhere. Eventually everyone felt encouraged to do whatever it took to get into their good graces, but you never fully could. The most trusted peer was even given the air horn used to signal a restraint across campus. Each group had two staff members at all times, and if a restraint were to occur, the most trusted peer would blare the air horn as the two staff members held down the child—usually face down in the dirt. This would signal all available staff to suddenly appear running from all directions, piling on top of the already motionless and terrified child. They'd hold them down for what felt like ages, usually ending the restraint by injecting a medication in the buttocks, taking them back to the GAAU, and strapping them into the restraint net bed. I was restrained several times, including one time I received an injection of Haldol. After the injection, I began to have a severe side effect of Drug-Induced Acute Dystonia (involuntary muscle movements), in my case which was so severe my entire head, shoulders, and spine was moving backward as if I were trying to touch my crown to my heels. This could only be corrected by several follow-up injections of Cogentin to help with the reaction.

Physical ailments, illness, infections, and general unsanitary conditions were commonplace in all the facilities I was placed in. During my time at Peninsula Village, I was sent to the Emergency Room several times due to rectal bleeding from severe constipation. Many of us had digestion issues from the food, and after several weeks of continuous bleeding, my mother was called to fly in and take me to have a Colonoscopy procedure, at only 15 years of age. My colon was healthy, and my issues were ruled as dietary, but all I was doing was eating the foods provided to me by the program, and there were no other options. I continued to have issues for the remainder of my stay, being put on daily Miralax as an attempt to regulate my ability to use the bathroom. On top of my daily Miralax, I was put on a cocktail of medications which were frequently switched around throughout my stay. I was taken off my ADHD medication I had been on with stable success since elementary school and switched to several types of antidepressants, mood stabilizers, and even briefly antipsychotics—all without proper diagnosis of needing such medications. I

constantly felt detached from reality, overmedicated, and experienced regular headaches. When I would complain about being on medication, they wouldn't consider taking me off, just switching to something else. Eventually, I just stopped complaining and stayed on a combination of Lamictal, Concerta, and Buspar until leaving the program when I was able to wean off all medications. Unsurprisingly, all my medical issues subsided after leaving Peninsula Village, and thankfully I've remained healthy into adulthood.

During my time at Peninsula Village, I was physically abused, emotionally abused, verbally abused, neglected, manipulated, and taken advantage of. I witnessed the exact same, and even worse abuse towards the children around me—none of us were safe. I heard, and continue to hear terrible stories about people's experiences at Peninsula Village, and other facilities of its kind. There was nothing we could do to find help or have anyone believe us while we were there. One time, Robert Peglar, the Program Director of Peninsula Village at the time I was there, approached me while I was sitting on a pile of gravel at one of our work sites. I had been having a "sit down strike" (refusing to move, work) and he leaned down, got inches from my face, and began yelling at me to look at him. When I didn't look up at him, he grabbed my hair in his fist from the back of my skull, yanked my head up so my eyes met his, then forcibly threw me back face down on the ground and began to restrain me, climbing on my back. He called for other staff around to join him, which they did, pushing my skin into the sharp gravel rocks as I lay completely face down with my legs and arms stretched out. This left me with cuts, scrapes, and small bits of rock lodged into my arms and legs. A separate time, I was restrained on the GAAU by staff who dragged me across the linoleum floor, dropping me and causing me to hit my head leaving an egg-shaped lump on my skull. When I tried to report the abuse I had endured by Robert Peglar, I was called a liar and forced to apologize to him in front of my mother, on the phone during a family therapy session.

I felt compelled to share some of my story to highlight the severe abuse and shortcomings within the Troubled Teen Industry. What I have written here only cracks the surface of my individual experience. I want the Committee to understand the real-life consequences of inadequate care and oversight in residential treatment facilities. I left the TTI more traumatized than I was when I arrived, and continue to face the repercussions of that trauma daily, almost 20 years later. I'm hoping that by raising awareness we can influence policy change that holds these facilities accountable. I am writing this for the survivors who aren't here today to share their stories, for those who have lost their lives at these programs, or as a result of being held in these facilities. I am sharing my experience in hopes that one day no child faces what I faced growing up. The Troubled Teen Industry robbed me of my childhood.

To prevent these traumatic experiences, I believe the Senate Finance Committee should implement stricter regulations and oversight of youth residential treatment facilities. This includes mandatory reporting of abuse, transparent data collection, increased staff training on trauma-informed care, regular and unannounced inspections, and ensuring that all facilities provide adequate mental health and educational services. Additionally, there should be accessible third-party channels for children to report abuse without fear of retaliation. If these facilities must exist, they must exist in a way where they are helping children, not hurting them.

Thank you, Chair Wyden, and members of the Senate Finance Committee, for reading my testimony. I hope that my story and the stories of others like me will inspire you to take immediate action to protect vulnerable youth in residential treatment facilities.

Sincerely,

Paris Campbell Grace

LETTER SUBMITTED BY KAYETTA HAMMOND

June 12, 2024

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

Dear Senate Finance Committee,

My name is Kayetta Hammond, and I am a former resident and intern of TEEN CHALLENGE. I am testifying about the abusive and neglectful conditions I experienced at Teen Challenge, a youth residential treatment facility, in response to the Senate Finance Committee's hearing titled "Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions."

I was placed in Teen Challenge Kansas City Girls Academy at the age of 14. I was sent there because I had been struggling with self-harm, depression, anxiety, PTSD, and was also experimenting with my sexuality and gender.

During my time as a resident and briefly an intern of Teen Challenge I witnessed and experienced the following abuses:

- Residents being sat on, tackled, restrained, stroked, squeezed, pinned down, caressed, kissed, bruised.
- Residents being forbidden to touch each other, exchange handmade gifts, show too much affection, get too close in friendship.
- Residents being forbidden to make eye contact with others, look outside windows, show emotional expressions.
- Residents being forced to sleep in their own urine as punishment for stress-induced bed-wetting, residents being forced to soil themselves during the day due to limited bathroom Privileges. Bathroom time was very controlled including being made to count while going to the bathroom, having a limited amount of time to go, limited toilet paper sheets, and sometimes being watched.
- Residents being forced to eat rotten, burnt, expired, moldy, stale, and otherwise questionable food (cow tongue, liver), even when vomiting at the tables.
- Residents being stripped naked and locked in rooms while in nothing but shackles.
- Residents being forced on a restrictive diet of 1 can of vegetables and 1 piece of moldy bread as punishment, water fasting as punishment encouraged.
- Residents self harming and self poisoning to escape without receiving medical treatment, residents being forced off prescribed medications and going thru withdrawals without support, residents falling ill and not allowed rest or medical care, residents fainting and experiencing seizures without medical aid, residents getting lice other sicknesses and having to treat each other.
- Residents being restricted menstrual products, not allowed pain relief from cramps, no rest for debilitating cramps, toilet paper being limited to 4 squares, pap smears being performed without parental supervision, being forced off birth control that was used to manage medical conditions.
- Residents regularly experience symptoms of Malnutrition and electrolyte deficiencies such as headaches, weakness, shortness of breath and muscle cramping. Most residents lost weight due to the restrictive diets. Some residents were force fed to make them gain weight.
- Sickness was rampant. Staff work masks to prevent getting illness from us but did not provide care. On more than one occasion the whole house experienced food poisoning.
- Produce and milk/eggs were considered luxuries, most of the food received was donated despite the high tuition cost. We were frequently told how dire our food situation was.
- Overcrowding was prevalent, anywhere between 12–30 girls sharing a single bathroom, 6–30 beds in cramped rooms, 50+ residents in a facility without enough bedrooms or food to accommodate.
- Unpredictable and unreasonable punishments for benign behaviors.
- Sleep deprivation, being forced out of bed on random nights, residents being dragged outside in the pouring rain in the middle of the night for military style drills, being forced to stand in circles for hours past midnight in great room, being forced up late listening to worship music, being forced up late cleaning the house.
- Isolation, locked in a room alone, cut off from contact from parents, monitored calls where you weren't allowed to tell parents the truth.

- Physical Labor was a requirement of advancing the program, residents often had bruises and blisters, sunburns as sunscreen wasn't provided, suffered heat stroke, ice baths sometimes needed to prevent hospitalization.
- Forced conversion, conversion therapy. You cannot leave without converting to Christianity. You cannot leave without reading the entire bible and handwriting summaries of each chapter. Punishments include writing thousands of lines of scripture repeatedly.
- Strange cult-like group activities such as mock slave auctions, worship circles, hours long chapel sessions, exorcisms, indoctrination into believing in demons, induced hysteria.
- The building had a rumor about being "haunted" that was perpetuated by staff who claimed they could see demons and spirits. Many residents would have hallucinations and staff would tell them they could see it too.
- Receiving little counseling or therapy, residents being forced to counsel each other, big sister/little sisters, room leaders.
- Journals and artwork being censored or intentionally destroyed. Mail being tampered with, censored or withheld.
- Staff members taking advantage of residents by bribing them with soda/real food to do manual physical labor for them or local religious groups.
- Sexual/physical assault occurring and being covered up.
- Lesbian, bisexual and transgender residents were explicitly targeted and subjected to extra punishment and abuses.
- Residents were not allowed any personal devices or any form of entertainment. No phones, music players, laptops, cameras, headphones, books, playing cards, art/posters, letters from friends or photos of friends.
- Speech heavily restricted. Residents only allowed to speak during designated free time which was very limited. When speaking residents could not speak of anything negative or talk about past life or relationships outside the program. Residents could only talk about the program or Jesus or random mundane nonsense.
- Staff frequently had favorites. Favorites to groom, play with, and train to become future staff. And also favorites to break down, give disciplines to, and otherwise target.
- When turning 18, girls would be made to leave the facility with no help or would be dropped off at the homeless shelter with nothing.
- School time was very limited to only a few hours. We used computers but didn't have enough for everyone to use so two groups would switch from morning to afternoon. Many residents never graduated high school or fell behind on classes and had to retake a grade when they got out.

Some disciplines received were as follows:

- Restriction (of Privileges)—Shoes, sentimental/personal items, makeup, lotion, body spray, talking, food rations. Everyone starts the program on restriction.
- Relationship Restriction—Being forbidden to speak to, look at, or stand anywhere near a person. This could be due to lesbian behaviors or simply because you get along too well with someone.
- Iron Sharpens Iron—Being forbidden to speak to, look at, or stand anywhere near anyone except for one person. This was usually forced on two residents who weren't getting along, particularly where one is bullying the other, leaving the victim to be subjected to further bullying behavior while in social isolation.
- Standing—Sitting is a privilege, When on Standing punishment, you only are allowed to rest when it's time to sleep. Leaning against the wall for support is not allowed. Whole group standing punishments were common. Shoes and socks were to be removed if you are on standing.
- Silence—Being able to communicate during the limited free times is a privilege. There was a time where the whole house was on silence for a month.
- Restriction—Short for "Restriction of Privileges". You would lose access to all outside contact with your parents. No special treats. No outside time. No per-

sonal items. No makeup or jewelry or self expression. Restriction could be limited to one thing or many things.

- Signs—Being forced to wear humiliating signs that say things like "Liar."
- Skirts—Being forced to wear ugly dress or skirt. Usually assigned to run risks or too boyish.
- Shackles/Chains—Handcuffs and ankle shackles.
- Kingdom—Restriction/Standing/Silence/Signs/Skirt/Shackles all combined. Plus no shoes. Hand-washing clothes is required. Clothes would be limited to three sets, including underwear.
- Unique Punishments—Bonus punishments were tailored to the individual. Scrubbing the bus with a toothbrush to teach humility. Wearing a leather backpack full of rocks.
- Drills—Wall sits, push-ups, burpees, carrying gallons of water, etc.

These people thrived off the power over us helpless girls. Under their mercy we were starved, disregarded, our humanity taken, our spiritual path distorted, and our mental health never sane again. Their eyes lit up when they saw you in fear or crying, they purposely humiliated and degraded you for reasons big and small. Disregarding your past, your trauma, or even you as a person. They saw dollar signs, and wanted to keep people there as long as possible. Brainwashing girls into thinking the cult was the best thing that happened to them, making the girls treat other girls who KNEW IT WAS ABUSE worse, snitching on them and purposely making their program harder, and extending time for them even.

This treatment had a profound negative impact on me and I am still deprogramming the brainwashing and programming they put into my brain. I am afraid to look at people in the eyes.

Staff would regularly look in your eyes and tell you they could see your sin. One resident was forced to wear sunglasses at all times because her eyes were too lustful. One time, a staff member looked at me in my eyes and told me she could see the demons possessing me.

I struggle with religious delusions.

I believe that I am demonically possessed or that I am the antichrist. I believe god himself is deliberately orchestrating my life to force me to submit to his will. I have frequent intrusive thoughts about hellfire, hell, purgatory, whatever you call it.

I have an eating disorder.

Every day is a struggle. I was forced to eat food that had disgusting textures until I vomited at the table, I was starved when I couldn't stomach an egg salad sandwich, later in my program I begged them to let me fast as much as I could and it was strategically planned based on the menu for the week that was planned and if there was a food I truly couldn't stomach. I learned how to wash anything disgusting down with water, just slam it down, but there were some foods where even that wasn't enough.

I struggle with basic hygiene and self care.

Mundane activities like cleaning, handwashing dishes, being indoors for too long, being around crowds for too long, the smell and taste of many foods, eating, showering, exercise, and more trigger me and I'm constantly in a state of terror for no real reason except that my body remembers being in that place.

I began to experience derealization. Any time spent off the campus threw me for a loop, and I realized that every time I re-entered the facility I was entering a new reality separate from the rest of humanity. Common sense, law and order, and basic human privileges were completely erased and rewritten with a new order and new reality and social contract.

In the program I learned to dissociate from real issues such as panic attacks, bodily pains, etc. I neglect my own care and subconsciously block out pain and discomfort. I struggle to communicate my medical needs with loved ones and healthcare providers.

After returning home I began suffering from severe agoraphobia and didn't leave my bed or home for many years. I've missed flights, I think they remind me of flying back there alone after my first home pass at 12 months. I cried so hard every time.

I never graduated high school. I never went to prom or had a normal high school experience. The world changed rapidly when I was inside the program. My parents decided to move across the country a few months after I returned home—and they had already moved houses during my time in the program. They packed up my things. I never got see my bedroom again. I didn't even get a private bedroom again. I returned home and instead shared a bed with my high needs autistic baby brother. I never got to reunite with my friends. When we moved across the country we were homeless and living on the mercy of church members, my family was split apart to different houses, all strangers. My access to technology was severely restricted so I wasn't able to stay in touch with everyone I had been dying to see once I got out.

To this day I struggle with a crippling fear of abandonment. I was left on the ground begging for my parents countless times, unable to stand under the weight of my living terror. They refused to believe me and refused to take me home. I was threatened with more time added to my program if I didn't stop telling them about how bad the program was. But for my parents to refuse to believe me and abandoning me there time and time again traumatized me in a way that's unfathomable.

I can't have normal relationships with people. I can't trust people. I keep many things hidden/concealed. I can't trust them to tell them the truth. Even getting close to people puts me at risk of them making up lies to spread about me, because their closeness to me makes me complicit and them an expert of everything I do. It only took me once in the program having someone lie about something I did for me to learn that the only way I could survive was to live beyond reproach, completely embrace the ideology of the program and become someone of such strong conviction and character that anybody who dared lie and try to get me in trouble with staff would only be seen as a farce. I still live this way, unable to open up to friends or be vulnerable, terrified to touch them or say the wrong thing and they'll think I'm some sort of pervert or degenerate or monster. . . . It's so isolating and painful to live this way, terrified of everyone I meet, waiting for them to betray me. It's safer to stay alone, nobody can use anything against me, if they have nothing of me. . . .

With people who may bring me harm, I resort to fawning, as we had to try hard to get the staff to love us so they would have mercy and let us advance the program. I am overly friendly and personable in situations where I am in danger.

So often they destroyed my art and censored my writings and made me give up things that spoke the truth of what happened and gave me consequences for my honesty in my writings. To this day I still self censor, speak and write in code, keep things as vague as possible, because words, are forever, they can be used against you, especially if it's in writing. As someone who has always loved to write, having my voice stolen from me renders me . . . speechless. There are no words.

I was dehumanized and broken. They broke me, they really did. I fought the program for a long time, as long as they would let me, until they made it clear I had to get with the program or I would be there forever . . . I had no idea my parents were facing bankruptcy and running fundraisers for the program.

I have little control over my nervous system. I spend my every waking moment being triggered by the most mundane of tasks and having to navigate the full body sensations that occur and do preventative measures to keep it from disrupting my day. I cry constantly and completely fall apart when something doesn't go as expected.

I felt compelled to share my story because children are still suffering in that very same facility today. Additionally, I want the government to have record of the fact that Teen Challenge abuses their status as a religious facility and is allowed to go completely under the radar. There is no protections for children. Children are deprived of basic human rights in this country and we as a society are not doing enough to protect our kids. Hundreds of thousands of children are being subjected to institutionally-organized torture and brainwashing TODAY. There are states where children and parents are given the option between juvenile detention and Teen Challenge by a state-appointed judge, and I would urge every single parent out there to NEVER choose Teen Challenge. I also want the Committee to understand the real-life consequences of inadequate care and oversight in residential treatment facilities.

To prevent these negative experiences, I believe the Senate Finance Committee should consider implementing stricter regulations and oversight of youth residential treatment facilities. This includes mandatory reporting of abuse, transparent data collection, increased staff training on trauma-informed care, regular and unannounced inspections, and ensuring that all facilities provide adequate mental health

and educational services. Additionally, there should be accessible channels for residents to report abuse without fear of retaliation.

Thank you, Chair Wyden, and members of the Senate Finance Committee, for reading my testimony. I hope that my story and the stories of others like me will inspire you to take immediate action to protect vulnerable youth in residential treatment facilities. I hope you will pass the Stop Institutional Child Abuse Act (S. 1351) and follow that legislation up with additional reform policy to ensure all youth are safe from abuse, neglect, and preventable death in youth residential treatment facilities.

I would like to finish my testimony with a poem that I wrote ten years ago.

A girl was sexually abused in the dorms,
and I never slept soundly after.
My first punishment was wall sits,
but it's not like I had to stand for half a day—
though some girls did.
Unable to rest when ill,
mocked for fainting episodes and sickness,
and no medication to bring down that fever.
cramping. walking. Charlie horse.
Malnutrition.
humiliated and forced to wear ugly dresses
because I was a tomboy, and a bit boyish,
and I may or may not have kissed a girl.
(I didn't want them to know. but my parents told them.)
I was exorcised of spirit of homosexuality eventually
(so why did everyone still think I was a lesbian?)
Some nights I'd wake up to a whistle blast
screaming
in the middle of the night for "boot camp,"
and I remember giving one girl my socks
because I knew it would be cold outside
and they had taken all hers away.
Forced fasting, forced praying, forced smiling,
and only three changes of clothing
no socks. no shoes.
and hand washing your underwear in a sink.
Mocked by staff constantly,
belittled when crying or depressed.
Scrubbing floors with toothbrushes,
no touching or hugging or high-fiving,
and constant fear of making mistakes and being punished.
The rules will betray, even if you learn them by heart,
it will not save you.
Being forced to eat rotting, burnt, and moldy food as punishment,
or being forced to eat nothing at all.
I knew at least fifteen girls who wet their pants
because those in charge said "no."
No music no hobbies no happiness,
not even letters to my friends.
I never got to see them again.
My parents moved to Arizona.
I won, I did it mom and dad, I completed the program
so why am I crying in the closet
so nobody can hear my sobs
or wipe away my tears?
Nothing.
. . .

These are my memories,
these are all real.
I've never again taken fresh white sliced bread for granted,
or aspirin or music or chicken noodle soup.

Sincerely,
Kayetta Hammond

STATEMENT SUBMITTED BY TURA HAMRICK

I'm from West Virginia, 21 years old, and I will be sharing my testimony as a survivor of the troubled teen industry. I began in the state mental hospital, then later a short term facility in Connecticut known as Newport Academy, and finally a long term facility—New Haven RTC in Utah.

State Mental Hospital: 1 Week

When I turned 15, I was placed in Highland Hospital, which was lacking funding and constantly had a wait-list. It was a horrible place: constant understaffing, forced sedatives (lovingly called booty juice), and restraints were used incorrectly and far too often. The main thing I remember is watching a 7-year-old girl beaten for throwing a tantrum the way that 7-year-olds do. All she wanted was her deck of cards, literally one of the only things she owned. The older kids and I stood and watched, knowing we'd get sedated or worse if we intervened. She had been in the hospital for months, the state decided to leave her there because she had no available family. I hold so much survivor's guilt over not trying to help her at all. I have never stopped thinking of her, and I hate myself for forgetting her name.

The schooling was practically nonexistent—mainly consisting of random worksheets and "historic" movies. While I can understand its intended to be a very short-term facility, that's not always the case. This allows some patients to slip through the cracks and miss vital education during their developmental years.

After the mental hospital, I became much worse. I was unaware at the time that I had just experienced my first piece of trauma, nor that it would only grow. I began drinking excessively, and around this time my grades started to falter. I had gone from an honor roll student on track for valedictorian to a person who couldn't make it through a full day of school. My parents and teachers thought it was rebellion, but it was just the symptoms of PTSD rearing its ugly head.

Newport Academy—Connecticut, 3 Months

It was obvious to everyone that my stint in the hospital had not improved me at all. My parents desperately wanted to help me, but I was completely shut down. I was too scared to talk to them or any therapist at this point, which only made everyone angry at me. Several months after my stint in the hospital, my parents sat me down. They were going to take me to Connecticut for a few months to "get better"—I went to bed that night knowing it wasn't up to me at all. Somehow, I knew things were about to get worse.

I spent 3 months in Connecticut at Newport Academy. It was a kind of crunchy, health-focused center and a no-touch facility. There were far fewer beatings in Newport, but it was one of the most incompetent and negligent programs I've ever witnessed. In my first week, girls were drinking hair conditioner for the alcohol content. Makeup wipes were banned after a girl threw some up for the same reason. Bullying was immense, and staff often joined in. Police cars were on campus often, girls were hauled off to the hospital often, and it was chaos.

My memories of Newport are fuzzier, but I have one vivid memory. I also recall an instance of my roommate having a horrific migraine. As someone who has suffered from them myself, I quickly understood she was in a world of pain. For some reason, her meds were held up. After about an hour the pain was so agonizing that she threw up in the sink in our room. I told some staff and was quickly informed that the throw-up would be sitting in our room for a few days because the plumber wasn't scheduled that week. I begged them to do something, especially given the sink was 5 feet from my bed rather than in a bathroom. Plus, my roommate was only becoming more ill with the smell. I caved and told them I'd be the adult my roommate needed. They gave me a trash bag and a glove and I scooped it out myself. It took me about an hour to clean the sink and unclog the chunks blocking the drain, and somehow, I managed to not throw up myself. I was yelled at the next day for my "caretaking tendencies" and all I could do was laugh. I decided then and there that I would "caretake" if it meant shit got done, and my friends had someone to care about them.

It was around this point that trauma had built up to a near-breaking point. My undiagnosed OCD made the food incredibly difficult due to specific textures and tastes making me ill. I guess the staff assumed that the majority of picky eaters would eventually adapt, but I never did. It was either go hungry or gag my food down. Also, I developed a stress response where I threw up at any distressing event. Once again, my therapists misdiagnosed my symptoms—this time as bulimia. I understood the concern given my disordered eating in the past, but desperately wanted

someone to believe me. I needed someone to help me understand what was going wrong in my body, it was scary. I felt truly like I had lost my mind. I couldn't stop throwing up, but they called me a liar and told me I wouldn't leave until my "bulimia" ceased. After 3 months, my parents pulled me. They had become alarmed when the staff cut off my call as I begged them to come to get me.

The school at Newport was okay, but far below the average high school in the U.S. The entire schooling program was done in a room filled with computers. While I enjoy the set up of online education, I know many people dislike or even struggle with the set up. Our teachers were pretty hands off, and mainly only interacted with us to ensure we did our work or to answer a direct question.

Once I got out of Newport, things were worse once more. I had developed full-fledged alcoholism by the age of 15, though no one had noticed. I had been trained to suffer in silence, knowing the "help" I was forced was only pushing me closer to the edge. Around this time an educational consultant was feeding my parents more fear. I had NEVER met this person, but she decided I was going to die or end up in prison and told my parents such. I was a mentally ill teenager with dropping grades and a fear of confrontation, not El Chapo. None of that mattered, though. Her words held more value than mine.

Transport:

When I was 15, I woke up one night to my parents talking. Annoyed at the late hour, I flipped over and pretended to be asleep. About an hour later, the lights went on. It was 3 am, and I was only wearing my sleep shirt. Two ominous, giant figures stood in front of my bed, blocking the door.

"We can do this the easy way or the hard way" are the first words I heard. At this point, I truly believed I was being kidnapped. I was disoriented and scared, and my parents were nowhere to be found. I screamed a lot, hoping one of my brothers would come to check on me. No one came. After about 10 minutes of absolute terror, they told me my parents hired them. It began to click that I was being gooned. They won't tell me where I'm going, nor how long, nor could I say any goodbyes. I slowly got up and packed a bag, as they demanded. My legs gave out in fear as I started to walk down the stairs, so they picked me up on either side by my arms and carried me down. I can remember looking down and seeing my legs dragging behind me, my muscles refusing to gain rigidity. I started to scream louder, and the adrenaline finally hit my system. I fought, I fought hard. I knew I wasn't going to get away from two people double my size, I was 110 pounds soaking wet. But I wasn't going to make it easy for them. They slammed me into the side of the car and cuffed me, leaving my wrist sprained. They threw me in the back of their minivan, cuffs tearing into my skin. I was still fighting, so one of my transporters began to kind of lean on me into the seat. I said some crass things as she did, oxygen being deprived from my lungs. The fear of not being able to breathe was too much. While I still don't know if they intended to cut off my air or not, it was enough to force me into submission. I then asked them if they had kids. One of them had daughters. I asked what he would think of another man doing this to his child. To my horror, he told me he would hire transporters if it "became necessary." I think about that a lot, and I hope his daughters turned out ok. I apologized to my transporters later, which I deeply regret. A child should not apologize for defending themselves.

We made it to the airport, and they told me the cops would tackle or taze me if I ran. I was so tired, so sore, so bruised. I couldn't run anymore. I got on the plane and passed out. When I awoke, the pilot announced we had landed in Salt Lake City, Utah. I threw up, hard. I was thousands of miles away from my family, didn't say goodbye, and had no idea where I was going. They drove me for a while until we reached New Haven RTC.

New Haven RTC: Provo, Utah, 6 Months

It was a big campus, with multiple houses, and a stable for horses. I noted quickly that the horses didn't look well. I walked in and was shortly told I'd be there for 18 months to 3 years.

I immediately knew things were wrong. A deep pit in my stomach. But I wasn't allowed to talk to my parents for the first 2 weeks, then only in monitored letters. I also later found out that this was during the period in which my parents were mass-reading reviews, with plenty of concerning ones. Staff members assured my parents that any negative reviews were from "resentful, unhealed girls" who were pathological liars. Why those girls felt resentment was never answered, but I would soon find out for myself.

New Haven RTC is a dreadful place. Overmedication is common. Girls were often hungry, so we'd steal snacks. Sexual abuse is rampant and has been since its opening in 1995. I've already found several past staff members who were convicted of crimes against children. I've found dozens and dozens of allegations against others who never faced justice. Physical abuse was not uncommon. One of my favorite staff members was taken off the schedule for reporting a house mom for kicking a child; they refused to fire her so she couldn't seek unemployment. One of our teachers suddenly disappeared one day, which I later found out was for passing inappropriate notes to students.

Medical neglect was incredibly common. My best friend was coughing up blood one day, only to be dismissed by the nurse. She refused to even check on her. That same friend is the one who reminded me about the time she had to splint my hand, as the nurse also refused to look at me. In the past few years, I've talked to multiple students about medical neglect including severe infections, fevers, allergies, and serious medical conditions being ignored or mistreated.

Suicide attempts were common, for a place meant to keep your children alive. Being on suicide watch meant you were forced to spend your days on a mattress in front of the living room. You could not speak to anyone, nor them to anyone else. I got in trouble often for daring to smile at girls on suicide watch. It was public humiliation and dehumanization under the guise of safety.

They also were very willing to work with actively abusive parents, despite being legally mandated reporters. I knew multiple girls who were being abused by their parents, which was reported by other students. I also have talked to dozens upon dozens of other New Haven survivors under similar circumstances. No reports were ever known to be filed, no discussions with the children took place, and no investigations occurred. Therapists are legally and morally required to report instances of abuse, and New Haven failed tremendously. It was much easier to take an abuser's money than to report them to the authorities, or even acknowledge it.

I spent the first 3 months in Utah on level team. There are five levels, with safety and team being the lowest two. Safety consists of being directly next to staff at all times, showering/peeing with the door open, and sleeping in a room with a window to the family room. I still have nightmares about that window and feeling like some sort of zoo animal.

Team means you are to stay within earshot and eye view of staff at all times. Understaffing was a constant problem, which made team much worse. Sometimes we'd have six girls on one staff, which is really difficult to get anything done. Chores would take us 2 days rather than 2 hours because we had to stick in a group. I spent 3 months unable to walk, speak, or pee without a staff member listening. I showered with the door cracked. I was only allowed one 10-minute, monitored phone call once a week; I often lost my call privileges for "bad behaviors." It was the closest I've ever been to losing my mind. I was also groped by another girl while asleep on the couch. They wouldn't let me call my parents until a staff could. She told them I would call "pretending" to be upset and that it was just a joke. When I finally called, they were so disappointed in me. I could not grasp what had happened to my loving parents, or why they wouldn't believe me. Meanwhile, the staff told me that if I didn't "get over it" that she would put me in a room with the girl until we figured it out. I was so terrified and felt so so small.

My therapist was a horrible match, and my family felt that she never liked me or my parents. She lied to both of us constantly, wrecking any moment that was somewhat calm or healing. My parents had promised to visit me for my "sweet 16." The day of, I was told my parents didn't think I was "well enough or trying hard enough" for them to visit. My brothers weren't coming, my parents weren't coming, and I'd never be good enough for them. My heart still breaks for my little self, and for the damage it has done to me as an adult. I cried the entire day, with my friends doing everything to get me through it. I later found out that my parents were barred from visiting. Similarly, I was forced into a strip search several months into my stay. I asked to call my parents, to see if they knew what was occurring. I was told my parents were aware and requested it. I brought up the search several years later to my parents, angry they let strangers do such things to me. They had absolutely no idea that ever happened. My skin prickles at that thought.

They refused to treat my trauma from transport, deeming me a liar and dramatic. As a result, my throwing up was worse than ever, and I developed some awful symptoms during my period. My staff didn't like birth control and decided it would be better for me to curl up on the bathroom floor for a week, throwing up from the

sheer pain and stress. My mental health would also take a downturn, which was dismissed by the adults around me. Turns out, it was another missed symptom—I have since been diagnosed with and treated for PMDD.

My parents finally visited around the end of my stay. My mom and dad were considering pulling me to start school with my classmates. I dressed up nice, wanting to look pretty and healthy—a lie of course. I remember how fast I ran to meet my brothers, jumping into their arms, and not wanting to let go. I hadn't seen them in 4 months, and I just couldn't help but cry. I tried so hard not to, not wanting them to think I was still "sick" and leave me once more. I was angry at myself for crying I went out on a visit with my mom, the first one I was allowed. When I returned, my favorite staff told my mom I must've done drugs because I was so hyper. Luckily, this set off all kinds of alarm bells. She told him there was no way, as I had been next to her the entire time. She was also weirded out by what she describes as "a guilty expression" as he said it.

Unknown to me during any of this, my parents had never intended for me to stay the full duration. They had informed my therapist they were aiming for around 6 months. They decided to pull me after a long conversation with my therapist at home. They assumed the program would tell me, which they did not. I just noticed that everyone was meaner all of a sudden, almost like they wanted me to fail. Looking back, they were looking for proof that I needed to stay. From the very start of my stay, they fought for me to stay longer.

My mom casually mentioned I was leaving in a week during a phone call. My blood froze. I was leaving? She was confused too, they were supposed to be working on getting me ready to go home. I told my therapist I was leaving, and she acted surprised, despite already knowing. My teachers refused to give me credits for my entire semester, despite it ending only a week after I left. I promised to do the work ahead of time, but they refused. It was punishment for daring to leave. My grades never recovered. The missing credits, plus the awful school setup, put me a year behind my classmates. I scraped out of senior year with a 3.3—it had dropped from a 4.25 in just a year in a half.

Throughout my time in treatment, I was over-medicated, beaten, witnessed horrendous child abuse, and endured neglect. I discovered that very few of my staff were qualified to watch me, and multiple therapists had no license at all in the State of Utah. I've endured horrible traumas that have destroyed my quality of life. I know girls who endured far worse, and I worry constantly for all my friends from treatment days.

- **What would you say were the short- and long-term effects these experiences had on you?**

I left New Haven RTC in the worst space of my life. I had realized that the world moves on for everyone, even those I loved most; the world had adjusted to my absence. I struggled to find my place once I returned, almost as if it had simply withered up and disappeared. My nervous system was in such a hyperactive state that I began to struggle with depersonalized states; I still slip into them on occasion, and it can last months. I was unable to cry for over 6 months straight, completely detached from my body. I was agoraphobic and spent most hours of the school day throwing up in a stall. I had lost the ability to hold an opinion, always bending to make things more convenient for those around me. I truly forgot how to be an individual. I couldn't make my own choices, couldn't express my thoughts, and worked effortlessly to not be burdensome.

My classmates and teachers knew I had gone to "the crazy person's house" and treated me as such. I was so isolated, and no one around me could comprehend what had just happened to me. I could not comprehend what had happened to me. I drank often, always wanted to die, and gave up completely. I spent most nights on the ground, begging for any sort of higher power to either cure me or kill me on the spot, despite the fact I was a non-believer of anything. I had never been so depressed, so anxious, so suicidal, so genuinely physically and mentally ill. It was terrifying, but I was too tired to feel the fear fully. I planned to die on my 18th birthday when there was no longer a risk of being sent away. For some reason though, I lived. I truly believe that my siblings, my childhood dog, and the girls I met in treatment were the only reason I held on at all. I made it to school, where I faced another terrifying event. I was so unable to cope that I withdrew from college, twice.

I have since been diagnosed with PTSD as a result of my three programs and transport, as well as worsening impacts on my OCD and overall mental health. I have flashbacks in which I feel so scared and small that I hide. I'm terrified of strangers

and constantly aware that my stature makes me easy enough to kidnap and harm. My family relations took a huge hit post-New Haven. We're okay now, but there will always be a sliver of guilt, resentment, and sadness weaved into our relationships. My brothers and I are close, but they struggle to understand my childhood and the person that shaped me into it. I struggle with traveling and still haven't made it on a plane. Survivor's guilt is strong, as are the awful experiences that shaped the way I interact with others. Being taught that you are a burden, sick, or a liar leads to a constant search for flaws. I always over-explain myself for fear of not being believed, even for things as simple as where I put something in the fridge. I constantly ask permission for things, and people to please a lot. Boundaries are hard for me, and I constantly feel responsible for all the bad things that happen to people—even if I have no relation. I constantly apologize and struggle to not fawn or avoid authority figures. My stomach issues are now a life-long struggle because I was treated too late. Trauma therapy is constant, though most therapists are still unable to treat me. I've had a few genuinely defend illegal practices to me, perhaps out of guilt or simple apathy. My family has spent hundreds of thousands of dollars to treat me for my past "treatments." Brain mapping, medications, DBT, CBT, trauma therapy, exposure therapy, and more.

I have been in therapy for almost 10 years, just about half of my lifetime. I'll most likely continue therapy for the rest of my life. The consequences are so deep that they've become part of me. I cannot express how much my experience changed me, how much it hurts me, and the amount of strength required for me to just exist on bad days. I am simply a different person than I once was, and I will never walk in the shoes of an untraumatized version of myself. Still, this pushed me into my current career path, love for children, and an ever-filling pool of spiteful motivation. My experiences broke me, and I am proud to say that I am still working to build myself up again. I am grateful my experiences didn't break me because it is so common among survivors. Suicide, overdoses, and untimely death follow victims with ease because of how deep the trauma goes. I am also lucky to have parents willing to accept my experience and believe me, as well as finance my current therapy. It's a privilege very few survivors are granted, and I still struggle greatly. I cannot imagine I would be alive if I was not as privileged as I am, which scares me deeply for the well-being of all survivors.

Through all of the suffering, I found a sense of righteous anger. The older I get, the more I realize how unacceptable it is to treat children so awfully. I could not, and still cannot face the thought of other children who may be sleeping in the beds I used to sleep in. I got my medications reset, though it took years for symptoms of fogginess and memory issues to depart. I stopped drinking at the age of 17 and even convinced my parents and siblings to cut back on their intake. I withdrew from school twice, before finally switching to online classes. I'm in my senior year of studying psychology, with plans to receive my Ph.D. I am an honor roll student again. I've studied relentlessly to catch up and become the most informed I can be. I've learned a lot about how abusive and scientifically baseless the troubled teen industry is. I've decided to work with children who are complex like I was, children who desperately need someone to understand. I didn't leave my family, because I refused to let the cycle of generational trauma continue with ease. I still throw up sometimes, but now it's around once a month rather than twice a day. I still have nightmares, flashbacks, and a lot of bad days. I will never get to know the person I could be without trauma, and that's hard. I will never live a normal life, but I've made peace with that. I'm fighting, and I'm proud of myself for fighting!

- **Do you believe anything has changed regarding how these programs operate today versus how they were run when you were made to participate in them? Why or why not?**

I think very little has changed within the TTI and mental health system over the last few decades, let alone my stay just a handful of years ago. There are still no federal laws or regulations that residential programs, wilderness, or transporters must follow. There are no government databases that hold reports and complaints, nor even a list of past staff members who were convicted of child abuse; the ones existing today were made by survivors. It's also incredibly easy for abusive people and programs to move around and rebrand. Much like the Catholic Church was discovered to move around sexual predators, so was the troubled teen system. Accreditation also gets shady, with many therapists not holding licenses in Utah, or receiving degrees from unaccredited colleges. For example, Dustin Tibbets is the executive director at New Haven. His degree is from Southern Christian University, which is a biblical university that is not recognized as a higher institution of learning, nor

have specialized psychology programs. So many of the people who were in complete control of my autonomy were not qualified to work with children.

The few shifts in legislation have been met with heavy pushback. Countless survivors from recent years have shared that staff openly discussed hating the new protocol, such as girls being allowed a towel when being strip searched. It is also not surprising to see the amount of money programs have spent pushing lobbyists and conservative political figures into dismantling the small bits of state legislation in existence. It's abhorrent that the folks in charge of vulnerable children are willing to take on their parental rates and autonomy yet detest protective measures—it's painfully obvious that the very foundations of the TTIO industry were built with pillars of deep incompetency, ego, martyrdom complex, and greed. These people are not qualified, nor deserving of being around such amazingly complex minds.

- **What are some tactics or strategies you feel could be implemented to both shut down current programs and prevent the establishment of new ones? What do you believe could be done to support and rescue current TTI victims? What do you feel was the most difficult and/or dangerous aspect of living in these institutes?**

The history of the TTI system makes me hesitant to hope for any meaningful change. The moment that child abuse becomes slightly normalized in an environment, it's too far gone. I'm not naive to believe it's realistic to create a system in which abuse can never take place. However, trauma and abuse being an expected possibility during treatment is mind-boggling. The moment we accept that child abuse "might happen," is the moment too many children have already been harmed. It should be viewed with continuous horror and shock; it should be incredibly rare. Children should not have to fear beatings for asking for help. Parents should not have to sign over their rights and cut all forms of communication. Family should not be a privilege to be earned. And mental health should not be so stigmatized in a place of treatment. As someone who was once that complex kid, I understand there is an extreme need for a safe, controlled environment in which struggling individuals can seek help. But we, as a whole, are failing. Every single adult in the United States has a responsibility to call out abuse, to deem it as intolerable. What exists now isn't working and is actively harming hundreds of thousands of people.

- **Similarly, are there any reformative acts relating to the TTI and children's rights that you would like to see passed on a legislative, nationwide level?**

Many changes could be made to the industry to dramatically reduce predatory marketing and abuse. Phone calls to parents should not be monitored, and the right to communicate with family should never be a privilege. More funding to CPS systems would greatly ease the burden of the thousands of reports left unanswered, just as mine was. Bi-monthly visits (at least) from a third party should be to check on students, which doesn't occur at all currently. An open line to abuse hotlines should have been implemented from the start. Background checks on staff and therapists are needed, as well as their educational background. Undergraduate students should not be working in housing for those deemed extraordinarily vulnerable and with high needs. Governmental databases holding information on program incidents, child abuse cases, and illegal acts would allow parents so much more information than is available. Educational consultants and transporters have no use in the care of another, especially given how traumatizing and predatory the fields are. Child abusers should NEVER be allowed back into the field, and programs that were forcibly shut down should have obstacles that prevent them from easily rebranding and opening a new facility. Wilderness programs should be completely cut out. All treatment should be based on peer-reviewed, widely accepted psychological studies rather than religion or personal opinion.

The view the United States has on parental and childhood rights creates many complications as well, and we are certainly more intimidated by children than most of the world. We focus on control much more than supported development, and it shows within our legal system. You should be able to refuse medications and request a psychiatrist appointment at least monthly, rather than the measly amount that occurs right now. There should be a time frame on the length of time children can be involuntarily held within a facility, rather than the age-out process that exists today. I have met folks who spent three or more years being held against their will, despite committing no crime other than needing support.

Our mental health system is so neglected that people in crisis are scared to be treated. Children are scared of the hospitals, residentials, and the adults who are sup-

posed to care for them. Hell, many adults are traumatized by their stays in the psych ward, and they have far more legal protection. The fact that so few steps have been taken is incredibly telling. I could list a hundred more shifts that would also be of use; there is just so little control over these facilities.

- **Is there anything you wish to say to the founders of Troubled Teen Programs, lawmakers, or fellow survivors?**

To everyone.—Mental health is thought to be much less taboo, but stigmas haven't shifted as much as we'd all like to believe. Child abuse has been occurring in these programs since the 1980s, that's over 4 decades of unnecessary isolation, abuse, terror, and pain. The most commonly used excuse these programs defend themselves with is also the one with the most efficiency: label victims as liars. We still view those with illness as so lowly, we are more willing to accept them as liars than face the uncomfortable truth. Not a single girl I met lied nearly as much as those who ran my programs, not even those who lied pathologically. We need to believe in victims or face the risk of our children becoming one themselves. We need to be shocked, and not just for a moment. We need to face the realization that at any given moment in our waking hours, a child is being hurt in a place where they were supposed to receive care. At this moment, a child is being assaulted, being raped, being screamed at, being isolated. And in that next moment, there is a scared child, a hungry child, and a child who desperately wants to go home. They don't have any options or any escape plan, and those on the outside are their only hope for safety. And for each of those children, there's an adult who will struggle for the rest of their life—the one life given to them.

To survivors.—The girls I met throughout my time in treatment were nothing short of extraordinary. Yes, there were a few that were unkind or abusive themselves. But the majority of the girls I met were incredibly intelligent, creative, strong-willed, and kind-hearted. They taught me how difficult it is to turn pain into good, but that it's worth it anyways. I will never excuse any staff members for being so cruel to children who have endured so much yet stayed so kind. Those girls are my hope and my motivation. A good person isn't just kind when it's convenient but remains caring in the worst of circumstances. My friends weren't just good in the phase of abuse, they were astounding. We kept each other's hearts from breaking, tended to each other's wounds, and became the family that we so desperately craved. Those girls shaped me into the person I am today; I would be nowhere as kind, bright, or so stubborn without their influence. I get goosebumps just thinking about them, the words to describe them simply don't exist. Children labeled as "difficult" are often those who are struggling themselves, or children who dare to deviate from the norm. Children are so much brighter, more complicated, and more aware than we have ever been willing to credit them with. None of us deserved what happened to us, and all children deserve better.

To those working within programs and lawmakers in favor.—I ask that you open your minds to the simple possibility that bad things are occurring under your watch. If you are unable to even consider the idea, I ask why you are different. It's been well-established that abusers and predators flock to areas where they have more control or where the difference in power dynamic is very intense. Daycares, schools, churches, sports teams, hospitals, and residentials are all susceptible to higher rates of predators than fields that don't include children. It is absolutely not enough to have good intentions or to care, and it is incredibly arrogant to believe so. Education, awareness, training, empathy, and the ability to accept limitations would have changed so many of my experiences, perhaps enough that I wouldn't have PTSD today.

STATEMENT SUBMITTED BY COLEEN HAYBACK

Three short years ago I had never heard of the Troubled Teen Industry. Now, I am the mother of a survivor and consider myself a survivor as well.

Our journey into hell started in the fall of 2021. My son was 14 years old. I was divorced from his father for 7 years. We were living in a post-COVID world that still had all of us feeling dysregulated and seeking to get back to some sort of normalcy and my son was starting high school.

Within a matter of months, he was struggling academically. Having been diagnosed with ADHD at a young age, school was always a challenge and being unsuccessful with online school during COVID he had basically lost a year of learning and felt quickly overwhelmed. He found a friend group early on and that's where he focused

his energy. They were smoking marijuana and cigarettes and participating in fairly typical teenage shenanigans.

My son's father was looking for solutions for this behavior and hired an Educational Consultant. He recommended I speak to them, and I declined telling the Ed Con I was not interested in working with a third party and I was perfectly comfortable working through my sons' teenage years without her. I quickly learned that she was recommending that our son be sent away to Wilderness Therapy. I did not know what WT was but sending my son away wasn't an option for me.

Let's fast forward a few months where my son's father had become increasingly insistent that we send him away. He had fallen for all the lines the Ed Cons use to prey on parents in these situations, one of their favorites and most frequently used being, "If you don't send him away now, he will wind up dead or in jail."

At this point our son was failing his classes and needed some support so I started to look for local, community-based options. I discovered there were two programs that offered adolescent therapy for substance use and other areas of concern. I contacted Newport Academy and we went through the process to determine whether our son met the criteria for their PHP (Partial Hospitalization Program) or the IOP (Intensive Outpatient Program) and after a brief assessment process we were told he qualified for the PHP which was typically 45–90 days. This meant our son would go to the program Monday–Friday from 8:30 am–4:30 pm and he would be home each night and on weekends, so I felt this was a safe and potentially helpful option.

Unbeknownst to me at the time, the Educational Consultant had also weighed in on this assessment having never met my son nor having ever spoken with me. Her suggestion for treatment was based solely upon her conversations with his father and his one-sided interpretation of the situation.

Our son clicked immediately with his therapist at Newport. The family therapist was kind and overall, the situation seemed to be working out well. We had weekly meetings, and we were kept informed of his progress and participation but most importantly, he was home in his own bed at night.

There were rules to follow of course and one of them was called "the outside contact rule." This meant that the kids were not allowed to talk to each other outside of the building. They were not to communicate via cell phone, connect through social media or in real life unless they were inside the building. This is rule is flawed and designed to set the kids up to fail. They have been removed from their schools and their organic friend groups. They are not allowed to see those friends or talk to them (this must be enforced at home) and they are expected not to speak to each other. The kids they are in the program with are their only peers now, their support system and it is only natural that as teenagers they want and need connection to peers.

My son was doing great and was on his way to completing this program with only 2–3 weeks remaining when he was cited for breaking the "outside contact rule." They would take the kids cell phones each morning upon arrival and do random searches of their phones. Seems like a huge violation of privacy considering they are still allowed to have their phones. He was given a warning, and we were told that if he did it again, he would have to enter some sort of behavioral contract and to no one's surprise, he and a group of kids in the program all got caught again within a week or so.

This one violation was his ticket for admission into the TTI for what would end up being 19 months of imprisonment.

I received a call from his therapist that Newport was no longer going to be able to keep him there and that they were recommending he needed "a higher level of care". I had no idea what that meant. For what? Talking on the phone to a peer? They suggested two Residential Treatment Facilities to us, but the Ed Consultant had inserted herself into the equation and was pushing for Wilderness Therapy still.

- What's critical to our situation that left me powerless is that when we my son's father and I got divorced, my attorney was able to convince me to give my ex what is called "tie-breaking/decision making" should we reach an impasse on major decisions like medical or education. His misrepresentation of how that would play out in real life became the crux of the issue regarding my being unable to stop my son from being sent away repeatedly.

So, now my hands were tied, and the Educational Consultants had convinced my ex-husband that our son needed to leave immediately for Wilderness. They told him

that there is a program in Utah called Evoke and they said our son was, "very lucky to get in there as the therapist there usually doesn't have any room in his group and that Evoke is the 'Harvard of Wilderness' programs." They recommended that a transport company (this is called Gooning) come in the middle of the night, pull our son from his bed and take him away to the program, but I refused. Since he was with me and had been refusing to go to his father's home for weeks, I knew that I could control at least that piece of it.

This all happened so rapidly, and I had no say in my son being sent away. I was an emotional wreck. I did not want to send my child across the country! I had a phone call with the admissions team and asked a lot of questions. Many of the answers I was given turned out to be lies as I would later discover.

What I wasn't told was that he'd be 2–3 hours from civilization, deep in the desert of Utah . . . that he would be strip searched upon arrival . . . that he would have to sit alone for his first 2–3 days and not be allowed to talk to anyone . . . that he would be forced to hike miles per day with 60–80 pounds on his back . . . that he would be given just enough food to stay alive but never feel full . . . that he would be forced to learn how to rub sticks and rocks together to make fire (this is called busting) in order to advance through the program, to get to eat a hot "meal," or to earn a headlamp so he could see at night in the pitch black . . . that he would not receive my letters until the staff read them and asked me to make edits to suit their narrative . . . that he and the others were not allowed to know what time, or what day it was as this is considered "future information" . . . that he would be expected to undergo psychological testing in the field by a psychiatrist affiliated with the program (another way for them to make money) . . . that he would have no access to running water . . . that he would have to go to the bathroom in an orange Home Depot bucket shared by the entire group and that he would have to shout his name every 15 seconds while relieving himself so they could verify that he didn't run away . . . that he would have no shelter and would have to sleep, sit, eat, and live on the hard dirt ground in the scorching heat . . . that he would have no access to medical or dental care . . . that he would have no access to education . . . that he would meet with his therapist for just 1 hour per week while living out in the desert filthy, hungry, exhausted, and scared the other 23 hours per day . . . that his therapist was also the owner of the program (and of the psychological testing company, and part owner of the transport company). And finally, that he would be gone for 77 nights.

I went out there when he had earned his parent visit. What I saw there still haunts me and the fact that this is legal and being marketed as THERAPY is both infuriating and heartbreaking.

After he'd been there a few weeks, his therapist initiated the conversation about psychological testing. I asked the psychiatrist directly, "how many kids do you test out there who you don't recommend sending to aftercare (a Therapeutic Boarding School or an RTF)? and he said, "almost none."

This testing costs another $5,000 on top of the $50,000 that parents already pay for the first 60 days of Wilderness. This person is not an independent psychiatrist, but they told us he was. Come to find out, he shares an office with Evoke headquarters and his practice is owned in part by the same owners of Evoke. My son, being rather sharp, knew that getting tested was a way to keep him away longer, so he refused to participate.

After 77 days, the therapist recommended he return home. This almost NEVER happens. The Ed Consultant and my ex-husband were very unhappy with that and went out of their way to influence a change of decision but were unsuccessful and my son came home.

His father did not want him home and it was during this period that he went out of his way to make things extremely difficult for our son to find success. Despite all professional recommendations not to do so and my pleading to find another school, his father sent him back to the public school where he had the problems the previous school year. He had lost his friend group and now was "that weird kid who was sent away." He immediately backslid.

Coming back from those places is extremely difficult and transition plans need to be in place for the best interest of the child. That plan should be well orchestrated and coordinated with the school, therapist at home, other family members and friends and in the case of divorced parents like us, a solid commitment to coparenting needs to exist. Despite my efforts, none of that happened which resulted in failure and was exactly what the Ed Cons and my ex had hoped would happen.

His father also amped up the pressure and utilized the family court to help him achieve his goal of sending him away yet again. While I had shared 50/50 custody, he was able to get a judge to rule that since he had tie-breaking, he could send him away to any program he chooses until he is 18. We appealed, and we lost. That's another subject altogether of course, but the family court is complicit in allowing one parent to send their child to a TBS, RTF or in many cases reunification camps and this should not be allowed. Particularly in MD where an attorney does not have to have a background in family law or be educated in child behavior to sit on the bench in family court.

The Ed Consultant was still trolling and still recommending placements. My son came home in July 2022. Our hearing was in mid-November and upon the ruling, my ex quickly enrolled him is a Residential Treatment Facility (RTF) in Connecticut called Turnbridge. As I understand it. Turnbridge cost $3,000 per day.

Again, more dishonesty from another admissions team. I asked many questions and received many answers that proved thoroughly untrue. This placement was extremely traumatic for my son. First, he had endured the brutality of wilderness therapy and made it home. It never occurred to him (nor me) that he would be sent away again for no reason other than he was struggling with school and was vaping. He begged and pleaded with his father not to send him away. It was the last week of November, and he was devastated at the idea he would spend a Christmas locked in a facility. I was so sick over it I could barely function. My husband and I drove him to CT and had him admitted. He was supposed to be there 30–90 days max.

Turnbridge is an awful place and we figured that out almost immediately. The therapist my son was assigned to immediately started telling him she would never recommend him to go home, and she would be recommending that he go on to a therapeutic boarding school from there. This deflated my son and impacted his emotional state very deeply. We didn't understand why he was even there in the first place and to know that this woman who just met him was already planning to keep him in the system was almost unbearable. She called him names like "genetic trash bag" and lied to me on numerous occasions. Months after he left, I was able to get his records released and his intake paperwork completed by his father and the educational consultants was filled with fake diagnoses and mistruths about his history.

The kids in that facility are all over medicated and each week we would receive an email from the doctor recommending a medication increase or change which we refused. Each Wednesday the therapists would force the kids to sit in a circle and write down on a piece of paper something negative about one of the other kids. They would go around in a circle reading the papers aloud, taunting and berating one another.

There was no access to education and by this point, my son was out of school for almost 9 months which is basically an entire school year.

The kids have very limited access to fresh air and get almost no movement. They were allowed to go in the driveway and play with a basketball for an hour per day. When we were there for visits, most days they were all sedated in front of the TV. In this program, they are allowed to call home every night for 15 minutes.

Visitation was for 2 hours per week, and we lived 350 miles away (a 7-hour drive). We made the decision to leave our home for 2½ months so we could be near my son and see him each week, so we got an AirBnb not too far from him which proved to be critical to sustaining him during that time.

During his time there, again psychological testing was recommended so the Ed Con could recommend the next placement. WHAT? Why another placement? I wanted him home and it was becoming clear that was not going to happen. I asked that we bring in an independent psychiatrist to do the testing and was told they wouldn't allow that. Again, my son being savvy refused to participate in the testing so now they had no current diagnosis and no "reason" to send him to another program, but they persisted in their mission. I have learned that Ed Con's get kickbacks for placing kids in programs which makes sense given their tenacity.

The Ed Con started suggesting places like Trails North Carolina (now closed and license revoked for the death of a 12-year-old boy named Clark Harman in February 2024), Equinox RTF (now permanently closed) and a place called Catalyst RTF in Brigham City Utah (known for its incentive-based model with phases) and a place called Crossroads in Ogden, Utah (also known for its incentive-based model and phases combined with extreme sports).

In February of 2023, my son's father picked him up from Turnbridge without telling me and flew him to Las Vegas where he spent two nights taking him to dinners and shows before driving him back to Utah and leaving him in the freezing cold desert at Evoke for a second time. This time he made a "deal" with the owner to keep our son there for 3½ weeks while he waited for a bed to open at an RTF in Utah called Crossroads. I can only imagine what that cost.

Crossroads is a 9–12-month program where the focus is on extreme sports. The owner is a reformed alcoholic Mormon who decided to open up an RTF/Therapeutic Boarding School/Sober Living House for teenage boys after wrecking his car in a drunk driving accident years prior. He and his brother and a partner purchased 4 houses in residential neighborhoods in Ogden Utah, hired a few LCSW's and therapists and a bunch of 20 something young men for "staff" and call it a treatment program. It costs $14,000 a month per child. There are 4 houses with 9–15 boys in each house. That equates to anywhere from $504,000–$840,000 per month!

The house was infested with mice and the state came in several times to do inspections, my sons room was covered in mold, and there were two bathrooms for 14 boys. Each Sunday they had to do what is called "deep clean Sunday" where they had to scrub floors, toilets, kitchen, and they weren't allowed to call home until this was completed. In this program, they are allowed to call home every Sunday for 20 minutes.

They had a makeshift classroom above the garage where the boys had "school" 3 days per week from 9 am–12 pm. In this room they had to complete educational packets based on grade level for credit recovery. They had to score at least a B or keep repeating the same packet as this allowed the program to show they were successful in educating the boys. What they don't tell you is that many of those credits are not transferrable or accepted by regular schools. If they completed the packets they were they allowed to get a drink and a snack later that day or possibly earn the privilege of going to the movies on Friday. This phase-based program pits the boys against each other, and they vote to determine if one of their peers deserves to "phase up" getting them closer to leaving. The staff often take the boys out to various skate parks, skiing or snowboarding meaning they are driving around with people the parents know nothing about. I learned that on many occasions my son visited the homes of these staff members, meeting their spouses, kids, family, and friends, which is highly inappropriate and an opportunity for grooming which is common in this industry. The owner of this program had many of the boys come to his house and do construction work in his yard and rewarded them all by having a pool party in his yard. Again, the parents are not informed of this, and we had no way of knowing what was going on.

There is nothing therapeutic happening at Crossroads. It's a sober living house that is strictly a cash machine. The boys meet weekly with heir assigned therapist and otherwise, they are doing (useless) credit recovery, snowboarding or skateboarding, playing pokemon for hours, doing household chores, and being held captive until they earn the right to leave.

There is extreme medical neglect in this industry. My son came home with 17 cavities and needed two root canals at 16 years old and he is considered lucky. Other kids end up with broken bones, chronic health problems, infections, and in too many cases, the loss of their lives.

I fought like hell to get my son returned home and eventually I did. He's been home with me now for 8 months and he is safe and happy. He's back in school although he had to repeat a grade because he missed so much school. He has made friends, has a girlfriend and is adjusting quite well.

One of the biggest contributors to his success is that he had someone who believed him, he had someone he knew was fighting for him and who wasn't buying into all the lies and deceit that these places were throwing our way. He had a mom and a stepdad who were against this from day one who knew he didn't deserve this. We knew these places were not helping him in any way and that it was all an expensive punishment and that belief in him made an incredible difference to his well-being in the long run.

Most kids don't have that support as the programs are designed to deceive the parents. The handbooks and manuals point blank say, "if your child tells you it's awful here, they are just trying to manipulate you into bringing them home. Do not believe them and know this is normal. You need to trust the process."

He still hasn't worked through a lot of what happened to him. He is not comfortable talking about it with anyone but me and even that is fleeting. I know he feels shame and embarrassment which breaks my heart because he did nothing wrong and because I couldn't prevent it from happening. I couldn't protect my own boy from the horrors of this industry.

My son was sent to FIVE placements in the TTI against my will. The total cost of those placements was approximately $350,000.

I don't want to see another child's life destroyed by this industry. I am determined to raise awareness so parents can get the truth, have access to real insight and information about how this all works and what goes on. I want parents and caregivers to understand that these places are trauma disguised as treatment.

Thank you for the work you are doing to hold those places and this industry accountable for their abusive practices. I attended the Senate Finance Committee hearing on June 12th and was very impressed with the extensive research and findings in your investigation. While many programs exist outside of UHS, this is an important step in the right direction and as the mother of a survivor, I thank you for your commitment to these kids. Keep following the money!

Regards,

Coleen Hayback

STATEMENT SUBMITTED BY HEATHER R. HAYES, M.ED., LPC, CIP

Founder and CEO, Heather R. Hayes & Associates, Inc.
1735 Buford Hwy, Suite–215–335
Cumming, GA 30041

Chairman Wyden, Ranking Member Crapo, and Members of the Committee:

I would first like to thank you for understanding the importance of examining failures and evaluating solutions in Youth Residential Treatment Facilities (YRTFs), to protect our Nation's most vulnerable, its youth. My name is Heather Hayes, and I am the founder and CEO of Heather R. Hayes & Associates, Inc. I am a master's level Licensed Counselor in the State of Georgia and a Board Registered Interventionist (CIP). I have over 35 years of experience treating clients with complex mental health issues and the full spectrum of addictive disorders, and with clients of all ages. However, I specialize in the treatment of adolescents/young adults, trauma, and behavioral issues. I have been recognized as one of the country's most prominent authorities on these topics, even more specifically for my comprehensive and trauma-informed approach to intervention, and my registered and trademarked Respectful Adolescent Transport Protocol (RATP).

Context:

Enacting trauma-informed legislation to provide oversight of Youth Residential Treatment Facilities (YRTFs) is crucial for several compelling reasons:

- Protecting Vulnerable Youth: Trauma-informed legislation ensures that the rights and well-being of youth residing in these facilities are protected. It sets clear standards for the quality of care, safety protocols, and ethical treatment practices, reducing the risk of trauma, harm and exploitation.
- Promoting Evidence-Based Practices: Legislation can mandate the use of trauma-informed care practices within YRTFs. This includes training staff to recognize trauma symptoms, understand their impact, and respond appropriately. By promoting evidence-based approaches, legislation supports effective therapeutic interventions that facilitate healing and recovery.
- Ensuring Accountability and Transparency: Legislative oversight establishes mechanisms for accountability within YRTFs. This includes regular inspections, reporting requirements, and adherence to established standards of care. Transparent practices foster trust among stakeholders, including residents, families, and the broader community.
- Preventing Re-traumatization: Trauma-informed legislation emphasizes creating environments that minimize the risk of re-traumatization. It mandates trauma-sensitive policies and procedures, such as respectful communication, empowering residents in decision-making, and providing safe spaces for emotional expression. These measures help maintain a supportive atmosphere conducive to healing.
- Supporting Staff Training and Development: Legislation can mandate ongoing training for YRTF staff on trauma-informed practices and cultural competence.

This ensures that staff are equipped with the necessary skills and knowledge to effectively support youth with diverse backgrounds and experiences.
- Enhancing Collaboration and Coordination: Legislative oversight encourages collaboration among YRTFs, mental health professionals, educational institutions, and community resources. This holistic approach supports comprehensive care planning, continuity of services, and successful transitions for youth returning to their communities.
- Addressing Disparities and Inequities: Trauma-informed legislation can address disparities in access to quality mental health care and treatment services. It ensures equitable access to services and support for all youth, regardless of their socio-economic status, race, ethnicity, or other factors.
- Crisis Intervention and Long-term Stability: Effective oversight ensures that YRTFs are equipped to handle crises and emergencies in a supportive and trauma-informed manner. This capability provides residents with a sense of security and stability during challenging times, promoting resilience and minimizing the potential for further trauma.

In conclusion, enacting trauma-informed legislation for YRTFs is essential for safeguarding the well-being of youth, promoting effective treatment practices, and fostering environments that support healing and recovery. By establishing clear standards, ensuring accountability, and prioritizing trauma-informed care, legislation plays a pivotal role in shaping a compassionate and supportive system of care for vulnerable youth in residential treatment settings. I commend you all for addressing this important matter, I am fully supportive of the "Stop Institutional Child Abuse Act" (SICAA), and I look forward to collaborating with you on implementing solutions.

LETTER SUBMITTED BY LANCE HILL

June 23, 2024

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

Dear Senate Finance Committee Members,

I am writing to you from North Carolina. Thank you for prioritizing the critical issue of Residential Treatment Facilities (RTFs).

As an individual who has a niece and a nephew who have special needs and require around the clock care, I have personally seen the difference between outside paid care givers and family member paid care givers. I have seen a remarkable improvement both for the special needs child and the environment of the home and quality of family life when there is less outside care and more care coming from the parents.

The last time I visited one of these families I could see there was much less stress in the household than any of the previous times I had been there. This led to better a better relationship between the spouses. As a result of this the vibe of family unit was much more upbeat and everyone was more at peace. The only thing that changed between my visits is the parents were now the paid caregivers. Instead of them having to work a job during the day and supervise the care of their child at night, they were able to forgo the job they once had to focus on the care of their own child. This allowed care giver to take better care of themselves as well. Now, instead of seeing this one wither away physically, they are more back to their normal self again.

I know I focused on one family, but with the other one I have seen much of the same. It is amazing to see how well these families do when they can be paid for the care someone else would be providing anyway, without the stress of having to work another job on top of it. I have seen love grow and bonds grow tighter when there is not the frequent daily or nightly interruptions to the family unit. These kids feel that parental love and even with their setbacks in life have quality of life, doing things no one ever thought was possible.

The special needs have already added a great deal of difficulty to the lives of these families. The current model only pours salt in the wound by adding stress of requir-

ing them to work a day job only to have them oversee the care of their child by outsiders. It is time to change the model and give them the real help they need so they can care for their children with no greater love than only a parent can have.

I am writing to ask you to recognize the barriers to paid family caregiving and their role in abuse and neglect in our nation's care network. Home and Community-Based Services (HCBS) current regulations (Section 1905(a)(24) of the Social Security Act, 42 CFR § 440.167, and 42 CFR § 41.105) prevent family caregivers from being paid to provide care at home. This forces many families to place their loved ones in RTFs due to the lack of affordable care options.

During the COVID–19 pandemic, 39 states allowed parents and spouses to be paid caregivers through CMS waivers. This led to better care, fewer hospitalizations, healthier homes, reduced dependency on welfare, and increased tax revenue. The National Council on Disability supports making this change permanent.

CMS officials, including Dan Tsai, have acknowledged the benefits of paid family caregivers. However, current federal regulations remain a barrier. Congress must "ban the bans" on paid family caregivers and incentivize states to adopt this model.

This change is crucial to prevent the abuse and neglect often seen in RTFs and to support families in providing safe, effective care at home.

Appreciatively,

Lance Hill

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June 20, 2024

U.S. Senate
Committee on Finance

Re: Statement regarding Youth Residential Treatment Facilities

Dear Chairman Wyman, Ranking Member Crapo, and Finance Committee Members,

Indiana Disability Rights (IDR) is Indiana's federally mandated protection and advocacy system. IDR upholds the rights of individuals with disabilities through various statutory responsibilities, including activities from informal advocacy and legal representation to monitoring facilities that serve individuals with disabilities. Recently, IDR concluded a 5-year project focusing on private secure facilities (PSFs) that serve youth between the ages of 6 and 21 years. Some of Indiana's 22 PSFs are singularly designated as private residential treatment facilities (PRTFs), while others provide treatment through multiple licenses.

While IDR continues working with state agencies and PSF leadership to improve conditions for youth in these facilities, the information obtained through its project may be of value to the U.S. Senate Committee on Finance. Specifically, IDR offers this statement in response to the Committee's June 12, 2024, hearing, "Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions." The statement is organized by five major themes IDR investigators routinely identified at PSFs:

- **Unsafe and unhealthy living environments.** Policymakers could ameliorate this problem by clearly articulating minimum standards for safe and healthy home-like residential treatment facilities, as well as mandate the imposition of sanctions on facilities that fail to comply with these basic standards.
- **Violation of residents' rights, including the improper use of restraints.** Policymakers should consider strengthening the requirement that youth in residential treatment programs receive information about their rights on a single occasion, and instead require rights information to be provided, and reiterated, in various formats, to ensure youth comprehension. Policymakers could also significantly eliminate opportunities for harm by banning the use of prone restraints in youth residential treatment facilities.

- **Insufficient programming, including inadequate educational opportunities.** Policymakers could help ensure that youth at residential treatment facilities receive their right to a free and appropriate public education (FAPE) by enacting a minimum length for daily educational programming and establishing basic standards for the classroom environment that are conducive to learning. It may even be helpful for policymakers to reiterate that school-aged youth are entitled to a FAPE, regardless of their placement in residential programming. Further, policymakers should incentivize community-based (rather than facility-based) programming, as facility-based programs often create barriers that make it difficult for youth to reintegrate in their local community post-treatment.
- **Inadequate staffing and ineffective leadership.** Policymakers could address staffing shortages and improve the quality of direct care by both increasing funding for staff hiring and recruitment and establishing minimum professional qualifications for direct care staff. Similarly, policymakers could meaningfully address ineffective facility leadership by establishing minimum clinical qualifications for the role of residential treatment facility director.
- **Insufficient regulatory oversight.** Policymakers should consider clarifying current laws to ensure that the youth residential treatment facility oversight entity, as well as its responsibilities, are unambiguous to all stakeholders. Policymakers may also consider instituting an automatic and mandatory admission hold on a residential treatment facility during any period that it is subject to sanction(s) imposed by the oversight entity.

Unsurprisingly, these themes largely echo the concerns shared by fellow protection and advocacy systems throughout the country.

The five themes are discussed in greater detail below, based upon information that IDR investigators gathered during the 5-year PSF project. Each theme has a designated section within this Statement, identified with bold text. The italicized text within each section indicates IDR's suggestions for policy improvement.

Unsafe and Unhealthy Environments

IDR investigators observed a wide variety of PSF living environments. Nearly all PSFs in the state fail to offer youth a home-like environment. Common areas almost always have hard plastic, weighted furniture, arranged in rows. (See Figure 1.) Twin beds—or smaller—are also made of hard plastic, with a thin, worn pad serving as a mattress. During one visit, a 17-year-old showed IDR investigators how his feet hung over the end of his bed—by almost a foot—and his shoulders spanned its entire width. Many other youth reported discomfort and trouble sleeping to investigators.



Figure 1. Hard plastic chairs arranged in rows.

Instead of a home, many PSFs resemble detention facilities. These PSFs have steel doors with small, narrow windows. Sometimes these doors are locked by keys kept by staff. Other PSFs feature a central command center, from which locked doors throughout the facility can be opened remotely.

Living unit bathrooms feature showers rife with mold and mildew. (See Figure 2.) It was not uncommon for investigators to find exposed electrical and plumbing components. Moreover, many PSF bathrooms posed multiple opportunities for youth to hang, choke themselves, or otherwise engage in self-harm.



Figure 2. Shower chair covered in mold.

Indeed, safety hazards are a common problem at PSFs. Despite locked, heavy steel doors in some areas, IDR investigators—and youth—found other means for easy elopement from the PSF campus. While the weighted furniture is designed to dissuade its use as a weapon, it conversely creates an unacceptable barrier when located in front of fire exits. In fact, when investigators raised this concern with PSF leadership, it was conceded that the arrangement was intentional, to make it more difficult for youth to escape. Thus, it appears that many PSFs fail to engage in com-

prehensive safety planning, instead cobbling solutions together as issues arise. This approach may jeopardize safety more than the status quo.

Importantly, Indiana's PSFs are, in general, woefully unprepared for fire emergencies. Some PSFs do not require youth to fully participate in fire drills. Other PSFs feature bedroom units that are (un)locked only from the outside, preventing youth from independently exiting their bedroom during a fire. Some PSFs do not provide fire extinguishers in locked living units. At one PSF, staff could not find the fire extinguisher, nor the key to unlock it, despite having signed an acknowledgment that they received fire safety training the previous day.

IDR suggests the adoption of more explicit mandates for the provision of a home-like environment. Moreover, unless state oversight agencies sanction residential treatment facilities for failing to provide a healthy environment for residents, IDR fears safety lapses will continue to jeopardize youth safety.

Violation of Residents' Rights

Interviews with youth, conducted by IDR investigators during the PSF project, reveal that many lack a basic understanding of their rights. Although PSF administrators stated that youth are given DCS's Bill of Rights for Youth in Residential Treatment upon admission, few youth recalled receiving it. Several of those who remembered receiving the Bill of Rights shared that they did not understand it.

Despite their constitutional and conditional rights, many youth in PSFs lack daily opportunities to exercise autonomy. Clothing choices may be limited; several PSFs require youth to wear uniforms. The PSF schedule dictates when youth go to bed and rise. Many PSFs prepare a single entrée for each meal, leaving youth without nutritional alternatives. Outdoor activities are limited to whatever options the PSF makes available; few PSFs offer playground equipment, walking paths, and sports equipment. Moreover, youths' right to receive visitors and make phone calls is regularly denied by PSF staff, either due to allegations of youth misbehavior or staff inability to assist with the endeavor.

IDR investigators also found that PSFs often have inadequate mechanisms for youth to get their concerns addressed. Resident councils are a rarity at Indiana PSFs but provide a strong opportunity for youth to practice self-advocacy and communication skills. Further, although PSFs are required to have grievance procedures, these procedures are often insufficient to afford youth due process. Many PSFs lack a mechanism for youth to anonymously submit grievances. Some PSFs require youth to submit their grievance to direct care staff, rather than the ultimate recipient. This procedure allows direct care staff, who are occasionally the subject of grievances, to review (and screen) the grievance. Youth told IDR investigators that they had seen direct care staff destroy grievances or route them to parties other than the intended recipient. Youth reported rarely receiving grievance responses and, even then, only a few PSFs provide youth with an appeal procedure. PSFs also tend to only accept written grievances and fail to offer reasonable accommodations to that policy.

IDR suggests strengthening the notification mandates regarding the rights of residents in youth treatment facilities. In addition to providing youth with written information about their rights at admission, when they are likely overwhelmed, facilities should distribute rights information to youth again one week after admission. Providing this information a third time, 30 days post-admission, would reiterate the importance of resident rights, as well as allow youth to consider how those rights apply to their day-to-day experience in the facility. Additionally, because youth have different learning styles, providing rights information in more than one format—including in writing, by video, and through oral instruction—would help ensure that youth understand their rights.

Relatedly, IDR investigators found that many PSFs improperly used restraints, either by overreliance on their use to control youth or by failing to follow relevant procedure in their application. During the project, investigators uncovered numerous youth injuries that were caused by the inappropriate use of restraints. Such injuries included closed head injuries, skull fractures, Salter-Harris Type II limb fractures, lacerations that required sutures, and contusions. Beyond physical harm, youth also reported that restraint sometimes causes humiliation and exacerbates the effects of prior trauma.

Investigators found that many PSFs still allow staff to perform prone restraints on youth, despite serious danger and risk of death. Research shows that prone restraints greatly exacerbate the likelihood of positional asphyxiation. When staff do

not execute prone restraints procedures in a particular manner, the likelihood of injury and death are heightened even further.

Moreover, investigators found that direct care staff at most PSFs regularly initiate restraints—as well as seclusion and impose precautions—on youth without approval from a physician, nurse, or other licensed mental health professional. This finding exposes two deeper concerns. First, direct care staff sometimes use restraints in response to non-dangerous behaviors, for example simple verbal outbursts or throwing paper. Second, clinical staff is rarely readily available to youth and direct care staff. Although the law requires that a nurse or therapist observe secure holds within PRTFs, these professionals are often unavailable in the moment that direct care staff determine the need for a secure hold exists. Indeed, IDR investigators were present on multiple occasions during which neither a nurse nor therapist was even on the PRTFs' campus.

IDR suggests that a prohibition on the use of prone restraints in residential treatment facilities that receive federal funding is low-hanging fruit for policymakers. The likelihood of serious harm outweighs the benefit of prone restraints; direct care staff can place youth in less dangerous secure holds. Banning the use of prone restraints in facilities receiving federally funds would discontinue the practice in most youth residential treatment facilities, as well as likely prompt state oversight agencies to adopt relevant statutory language and apply it statewide.

Insufficient Programming

During the project, IDR investigators determined that education is rarely prioritized by PSF leadership. Generally, to provide education to the children in their care, Indiana's PSFs either partner with a local school corporation or become accredited schools. Unfortunately, these practices typically segregate youth, who are often instructed in or near their living unit and prevented from interacting with peers without disabilities.

IDR investigators also found that PSF administrators and teachers lack critical knowledge about the education programs for which they are responsible. For example, some administrators were unable to tell investigators how their education program was credentialed by DOE. Further, administrators regularly reported difficulty obtaining complete youth education records from their prior school. Although the youth's very presence in a PSF indicates the presence of a disability that would qualify them for an individualized education program (IEP), most PSFs reported that students are not provided with special education services because no IEPs are available. Similarly, teachers shared with investigators that they did not know whether youth had previously received special education services.

In response to the absence of complete student records, some PSFs require youth to wait up to 30 days post-admission before attending academic programming, with the expectation that additional records may arrive within the 30-day time span. Other PSFs integrate access to academic programming within their system of rewards and punishments; when youth fail to abide by the rules, they are prohibited from attending school. Clearly, these practices violate the constitutional right of youth to receive a free appropriate public education.

Before leaving this topic, IDR notes that DOE-placed youth tend to remain in residential programming far longer than necessary. IDR investigators met several DOE-placed youth who remained in residential treatment, despite having lived at the facility for more than a decade. Although their treatment goals had been met, DOE had not worked with the youths' respective support systems to identify an appropriate placement and engage in discharge planning.

IDR suggests that the Committee consider strengthening legal mandates regarding the education of students in residential treatment facilities. Specific items to consider include: setting a minimum length of educational programming each day (as students observed during the project rarely spent more than a few hours on daily academic activities); requiring students to be educated in a setting conducive to learning; and reiterating that special education services must be delivered to students in residential treatment facilities.

Investigators also found that many PSFs fail to meaningfully acknowledge and address the trauma experienced by youth, either individually or programmatically. It is important to remember that youth placed in residential treatment facilities almost always have experienced significant trauma. Some have been subjected to abuse and neglect. Some have been removed from the care and custody of their par-

ents. It is ironic, then, that many PSFs fail to address youth trauma in even the most basic manner. Fundamental needs—like adequate sleep, nutritious meals, and outdoor play and exercise—are not universal in youth residential treatment programs.

Investigators also discovered that some PSFs practice punitive measures when youth engage in inappropriate behavior. Youth regularly reported that, despite having progressed to the second or third phase of a treatment program, a single indiscretion would delay further progress for up to 21 days. Other PSFs automatically demote youth to the prior treatment phase if youth err. These practices seem to primarily benefit the facility's finances, rather than youth mental health and well-being.

Investigators further witnessed youth get stuck at various places within PSF treatment programming. Because many youth in residential treatment have been removed from parental and/or foster care, they often lack somewhere safe to go when their treatment is complete. Without assistance to find a home, these youth linger in PSFs long after their treatment goals have been achieved, in violation of their rights and unnecessarily costing tax revenue. Moreover, unnecessary delays in residential discharge can prompt symptoms and behaviors to reemerge and, subsequently, extend the rationale for continuing to provide residential care. Indeed, sometimes youth are transferred out-of-state to extend residential treatment, which further removes them from their community and support system, potentially exacerbating misbehavior.

During the project, IDR investigators met one youth, placed at a PSF by Indiana's Department of Child Services (DCS), who had lived there for more than 2 years, without any discharge discussion or planning, despite having met their treatment goals. Even more alarming, investigators encountered multiple youth placed by Indiana's Department of Education (DOE), who have resided in their respective PSFs for 10 or more years. Clearly, these youth are not receiving the attention they need and deserve.

IDR suggests that the Committee solicit ideas to ensure that youth in residential treatment facilities have every opportunity to progress, as well as avoid barriers in the treatment process where youth may get stuck. Requiring periodic assessment of the need for residential treatment, beyond the single, currently required 30-day assessment, may bring greater attention (and resources) to this issue. Additionally, encouraging and facilitating the development of community-based treatment settings, as opposed to large residential institutions, may help avert the extended stays (and consequent decompensation) of youth placed in residential treatment programs.

Inadequate Staffing and Ineffective Leadership

Each of Indiana's 22 PSFs struggle to hire and retain quality staff. Staff shortages regularly cause PSFs to fall out of compliance with mandatory youth-to-staff ratios. The practical consequences include the inability of staff to safely and effectively supervise youth in their care. IDR has observed that the lack of sufficient staff has resulted in increased injury rates among both youth and staff.

PSF administrators report that they lack funds to hire experienced staff. As a result, the PSF workforce is generally young and inexperienced. It is not uncommon for staff to call in at the last minute, arrive late, and leave early. Staff immaturity also contributes to inappropriate responses to youth behaviors, including name-calling, the inappropriate use of restraints, and physical abuse. In short, the characteristics of certain staff increase the likelihood that youth in treatment will be injured. Further, the ensuing chaos makes it even more difficult for administrators to retain and recruit additional staff.

IDR offers two potential opportunities to ease the staffing burden at youth residential facilities. First, the Committee might consider the effect of increasing reimbursement rates so that higher wages can be offered to more competent candidates for employment as direct care staff. Second, increasing the minimum education or professional experience requirements of direct care staff within residential treatment facilities may preclude the hiring of staff who are unprepared to meet essential responsibilities.

Throughout the PSF project, IDR investigators had to actively seek the attention of the facilities' chief administrator, titled the Chief Executive Officer at some facilities and the Executive Director at others. Through interviews with staff and youth, IDR investigators quickly learned that many interviewees had not met, or could not name, the facility's director. Often staff and youth reported that the director was

predominantly involved in fundraising activities or other events involving community participation.

Notably, however, some PSFs were outliers with respect to this topic. Generally, those PSFs whose directors had clinical backgrounds (as opposed to sports coaching backgrounds) fostered greater rapport between direct care staff and administrators. Perhaps even more importantly, these PSFs tended to offer more trauma-informed programming, as well as shorter lengths of stay for youth.

Given the undeniable operational differences—and disparate outcomes—between PSFs headed by clinical mental health professionals and those headed by directors from alternate backgrounds, IDR suggests that policymakers consider mandating that directors of youth residential treatment facilities must have at least a bachelor's degree in a mental health or social services field. Too often, IDR investigators found that leadership experience in any field was accepted by those responsible for hiring PSF directors, leaving the directors unprepared to assist youth with disabilities. Directors from non-clinical backgrounds also tend to lack familiarity with reporting requirements and similar regulatory procedures.

Insufficient Regulatory Oversight

Neither Congress nor Indiana's General Assembly has designated a government agency with ultimate responsibility for the oversight of PSFs. Although DCS, DOE, the Indiana Department of Health, and Indiana's Division of Mental Health and Addiction are all involved, to various degrees, in the licensure or guidance of PSFs, their scope of involvement and level of authority are ambiguous. None of these agencies, for example, claim responsibility for the oversight of youth treatment, compliance with staffing ratios, programming, or the administration of grievances from youth or their families. A 12-year-old's suicide went unreported (and uninvestigated), reportedly because PRTF administrators did not know whom to notify. Neither has Indiana designated an agency to regularly visit and conduct compliance surveys at residential treatment facilities.

Although, as a direct result of IDR's PSF project, DCS has started visiting PSFs more frequently, it has been reluctant to advocate for the health and safety of youth placed by another entity. (DCS asserts it lacks authority to direct the PSF regarding non-DCS-placed youth.) Further, despite DCS's recent efforts to improve conditions for DCS-placed youth, PSFs throughout the state continue to operate in a non-compliant manner. And, while DCS's actions have led to the closure of a PSF and put other PSF licenses in probationary status in a few unambiguously egregious situations, the agency tends to focus on PSF adherence to the terms of its provider contract rather than consider, more broadly, the daily living conditions of youth. Indiana's tendency to prioritize particular components of youth residential treatment programs, as opposed to managing a comprehensive oversight system, is further evidenced by the fact that state employees conduct routine surveys of PSF kitchens, to ensure proper sanitation and food safety practices, but conduct no surveys regarding PSF treatment conditions.

IDR suggests that the Committee might begin addressing oversight insufficiencies by requiring states that participate in Medicaid to clearly designate an agency with ultimate oversight authority for residential treatment facilities. That agency, among other authorities, would bear responsibility for sanctioning facilities that fail to comply with federal or state mandates. IDR also suggests that the Committee consider recommending the enaction of a law to prohibit residential treatment facilities from admitting patients, regardless of referral source, if the facility's relevant license is in probationary status or the facility is otherwise under a sanction period.

Thank you again for this opportunity to share concerns about the status of youth residential treatment programs, as well as to offer potential solutions for improving the experience of program residents. Should you or your staff have any questions about IDR's statement, please do not hesitate to contact Policy Director Emily Munson at emunson1@indianadisabilityrights.org. We eagerly await the Committee's response to the hearing and related statements.

Sincerely,

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Executive Director

Emily Munson
Policy Director

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Esteemed Members of the Senate Finance Committee,

On behalf of the Institutional Child Abuse Prevention and Advocacy Network, I am writing to express our unequivocal support for your ongoing investigation into the troubling reports of abuse and neglect at youth residential treatment facilities operated by Acadia Health Services, Devereux Advanced Behavioral Health, Universal Health Services, and Vivant Behavioral Healthcare. We commend your leadership and dedication to addressing these critical issues and ensuring the safety and well-being of vulnerable youth.

The alarming reports of mistreatment, inappropriate use of restraint and seclusion and insufficient mental health services have raised significant concerns within our network. These practices jeopardize the safety, health, and futures of the young individuals entrusted to these facilities.

As a survivor of institutional child abuse, I have a unique perspective, having experienced many of the abuses reported over the last 20 years, which, sadly, have not been adequately addressed. I personally submitted testimony to the GAO, which presented their findings in 2007. It was heartbreaking to see that, despite overwhelming evidence showing the need for accountability and immediate abuse prevention in this industry, no action was taken at the federal level. This is why ICAPA will continue to support federal legislation aimed at protecting youth from institutional child abuse, as we must advocate for the next generation of children trapped in the troubled teen industry, who remain without a voice and without proper oversight to protect them from abuse.

The ICAPA Network strongly supports the objectives of your investigation, which concur with the persistence of problems noted in past GAO reports, including physical abuse, psychological abuse, sexual abuse, and negligent practices, that all too often lead to tragic and avoidable deaths. Immediate action is required to ensure that these youth receive compassionate, safe, and effective care in environments that support their mental, emotional, and educational needs. We support your efforts to demand detailed information from these facilities to ensure accountability and transparency, understand policies and practices in place, identify shortcomings, and push for necessary reforms to protect the youth in these facilities.

The ICAPA Network stands ready to assist in any way possible. We offer our experience, resources, and unwavering commitment to supporting efforts that ensure all youth receive the compassionate, safe, and effective care they deserve. Thank you for your dedication to this vital cause.

Sincerely,

Chelsea Filer
CEO & Policy Director

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June 12, 2024

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

Dear Honorable Committee Members:

On behalf of Kentucky's youth with disabilities, Kentucky Protection & Advocacy (P&A) joins with Disability Rights Arkansas and our sister protection and advocacy agencies in thanking this Committee for turning a spotlight on the care provided

to youth in residential treatment facilities (RTFs). P&A is all too familiar with facility treatment of youth that echoes the abuse and neglect documented in the Committee report. And P&A is also all too familiar with an accountability and oversight system that fails these youth.

P&A is the federally mandated protection and advocacy system for the Commonwealth of Kentucky. As part of our federal mandate, P&A's advocates and attorneys routinely monitor residential facilities where youth live and receive treatment. This fiscal year (starting October 1st), our team advocates and attorneys have monitored at 38 different facilities across the Commonwealth and established a presence in seven facilities. We have interviewed over 300 children and youth at these facilities. Our team has reported sexual, physical, and verbal abuse; the abusive use of restraint; unsafe and unsanitary conditions; untrained and unqualified staff; understaffing; the failure to implement evidence-based programs with fidelity; and a lack of behavioral health care.

Under Kentucky's statutory and regulatory scheme, residential facilities for youth may be licensed as one of three types of facilities:

- Private Child Caring Agency (PCC): a residential facility for youth placed in the custody of the state. These facilities vary in size and are licensed to house as few as three children/youth or as many as 85 children/youth;
- Qualified Residential Treatment Facility (QRTP): PCCs which, under the Family First Prevention Services Act, are specifically contracted to provide trauma-informed, evidenced-based therapeutic services within specific standards to ensure youth receive appropriate quality services; and
- Psychiatric Residential Treatment Facilities (PRTF): statutorily created treatment facilities that are a step-down from psychiatric hospitalization, required to be small and home-like, with the goal of providing intensive therapeutic services while re-integrating children and youth back into the community.

Despite the dedicated efforts of P&A, our advocates and attorneys are disheartened by the minimal improvements in the care and treatment of children and youth in Kentucky RTFs. The overuse and misuse of restraint remain prevalent, overshadowing any therapeutic care that should be provided. Reports to Child Protective Services and the Office of Inspector General from P&A are frequently unsubstantiated, while instances of abusive behavior persistently recur. Staffing problems persist with inadequately trained and supervised personnel, exacerbating the situation.

In addition to Kentucky facilities, P&A tracks Kentucky youth placed in out of state RTFs. The Cabinet has identified 65 children and youth placed in out of state RTFs, many placed in facilities owned by the same four facilities of concern identified in the report. Yesterday, a sister protection and advocacy agency contacted P&A about allegations of neglect of a teen in our Cabinet's custody who is placed at an out-of-state facility. P&A was advised this resident drank a toxic substance at the facility and was subsequently hospitalized for 3 days. The facility has been unable to explain how this youth accessed and ingested a toxic substance. The case is being investigated by that state's child protective services agency.

The ultimate imperative for any RTF is to keep the children and youth entrusted into their care safe. In the last 2 years local and national news widely reported on the deaths of three Kentucky children placed in RTF care. All three of these children, two of whom were autistic, were in state custody.

Ian Jacob Sousis
September 26, 2012–June 4, 2022



On June 4, 2022, 9 year-old Ian Sousis walked away from staff at the Children's Home of Northern Kentucky PCC (CHNK), where he had been placed due to elopement concerns. Ian, who was autistic, had lived with his grandparents from early childhood until they placed him in the custody of the Cabinet for Health and Family Services (the Cabinet) because they believed they could not keep him safe. This difficult decision was made after Ian wandered away from an after-school program and was found in a half-filled pool in a neighbor's back yard.

The Cabinet placed Ian at CHNK's Covington facility, an RTF that provides therapeutic care exclusively to up to 10 boys aged 7 to 17 placed in the custody of the Cabinet. At CHNK, Ian eloped multiple times, frequently ending up less than a half mile away at a strip of fast-food restaurants. Because of these frequent elopements, Ian was on 1:1 supervision and was not allowed to go outside. The morning of June 4th, against the recommendation of supervisory staff, Ian was allowed to go outside to ride scooters with the other residents at the facility. At 9:26 a.m., video recorded Ian riding around the building and out of view of the staff and then running from the facility. Staff initially followed, but after minutes returned to the facility and contacted the police.

At 1:46 p.m. that day, boaters found Ian's body floating in the Ohio River. He had drowned.

Ava Marie Simmerly
December 12, 2006–November 18, 2023



On the evening of November 18, 2023, 16-year-old Ava Simerly was struck and killed by a car on Interstate 265 in Louisville. Ava, who had been adopted out of foster care and had returned to care after the death of her mother, had eloped with another resident from her placement at Maryhurst PCC in Louisville. Staff attempted, but failed, to catch up to the girls after they left the facility and a police report was filed. There were several calls from motorists reporting pedestrians on the Interstate, but police did not respond before Ava was struck. She was pronounced dead at the scene.

Ja'Ceon Terry
January 1, 2015–July 17, 2022



No other case in Kentucky epitomizes not just the failures, but the dangers of a lack of accountability for RTFs than the death of Ja'ceon Terry. Ja'ceon was diagnosed with autism, an intellectual disability, a mood disorder, and PTSD. His early life was shaped by neglect and suspected sexual abuse and neglect. He witnessed drug use and violence in his earliest years; parental rights were terminated on his 7th birthday. Ja'ceon was placed in the state's custody at just 4 years old, where he rotated between foster homes, psychiatric hospitals, and RTFs. It was during this time that Ja'ceon was placed at Brooklawn PRTF in Louisville where he was killed.

On the morning of July 17, 2022, a staffing shortage meant that there were only two, not the requisite three, staff working on Ja'ceon's unit. One of those staff was Shift Supervisor Deborah Francis. Francis told new youth worker Amanda Whitlow that she was upset Ja'ceon had ruined her "church day" and that she was going to "hold him until he threw up." Francis said she heard Ja'ceon had a difficult night (he had not) and confined him to his room. This room confinement was in contravention of state law and facility policy. Nevertheless, Ja'ceon stayed alone in his room with no staff supervision for the next 6 hours. He ate breakfast alone in his room. And when he tried to ask to leave his room—3 times over the next hour and a half—nobody answered him. By the time staff responded to his requests to leave his room at 12:15 p.m., he'd urinated on himself. He was allowed to shower, although Francis taunted and humiliated him in front of the other residents as she escorted him to the bathroom. After his shower, he was sent back to his room with a mop.

At 2:15 p.m., Ja'ceon had a second accident. This time, Youth Worker Jillian Parks, responded to Ja'ceon's request for help. Parks had been identified by Ja'ceon's therapist as a trigger for behaviors but still worked in his cottage and had arrived at 2:00 p.m. as the third staff on shift. Parks had been identified by Ja'ceon's therapist as a trigger for behaviors and was prohibited from being involved in any restraints with Ja'ceon. Nevertheless, Parks entered Ja'ceon's room and initiated a restraint because Ja'ceon purportedly threatened to throw a water bottle at her and cursed at her. Whitlow joined her in his room to assist. This hold also violated facility pol-

icy because all holds were to be performed in view of a camera, but resident bedrooms did not have and were not in view of any camera.

Francis entered the room to take over for Parks, but it was Whitlow who was relieved. Francis bent Ja'ceon forward so that his nose was almost touching the ground; his feet were splayed beneath him with one leg behind and one in front. Whitlow was sent back to supervise the rest of the residents. Whitlow reported that the next time she saw Ja'ceon, he was covered in vomit and unconscious. Staff tried to revive him by throwing cold water on him and eventually started CPR. EMS was called, but when they arrived Ja'ceon did not have a pulse. Paramedics suctioned vomit from his airway before attempting to resuscitate him. He was pronounced dead at the hospital. The coroner ruled that Ja'ceon's cause of death was positional asphyxia; his manner of death was homicide.

The case was turned over to the Commonwealth Attorney's office, but to date no charges have been filed. Initially, the Cabinet partially revoked the agency's license to provide PRTF level of care (two cottages remained open) and removed all foster care youth from the facility. The facility continued to provide care and treatment to privately insured children and youth. The facility has fully reopened.

It is sheer luck that no other child has died in a Kentucky RTF because the conditions that led to Ian's, Ava's, and Ja'ceon's deaths are prevalent in RTFs across the Commonwealth. In a viscous cycle, children with mental health needs spiral up through the system of care that fails to provide effective treatment. As their needs increase, there are fewer and fewer placements that will accept these children. In May 2024, the Cabinet reported that there were 33 children living in a "non-traditional" placement, which includes a social worker's office, community center, place of worship, hotel, or state park. There is a sense of desperation surrounding the placement of youth and a willingness to minimize concerns about the care and treatment provided by RTFs.

P&A's greatest concern is the vulnerability of these youth to abuse by staff. Just by the nature of the RTF, children living in these facilities are extremely isolated. Most RTFs have an on-campus school and children have little, if any, interaction with the community. The RTF where Ja'ceon died is located in Kentucky's largest city, but we are a largely rural state and the majority of RTFs are operated in isolated rural locations. One RTF, where approximately 95% of the staff are related through blood or marriage, operates on 25 rural acres.

Whether urban or rural, abuse does occur at these facilities. P&A has reported numerous allegations of abuse by staff at various facilities. Allegations have included name calling and humiliation; staff punching a youth; staff picking a child up off the floor and holding him in the air by the hood of his sweatshirt; staff showing youth photographs of pornography; and sexual assault. Even where credible, the majority of allegations are not substantiated—even where Child Protective Services states they believe the child.

Children are at a distinct disadvantage when they make allegations against staff. As children, particularly those with trauma history, mental health diagnoses, and behaviors, allegations against staff are often met with skepticism or dismissed entirely. In contrast, staff are often viewed through a lens of trust established by nothing more than their position or title. Determinations may hinge on whether an act was caught on camera, despite the fact staff are aware of camera placement and, according to many youths, confine inappropriate or abusive behavior to locations outside the camera view.

Furthermore, youth are quite aware of the inequitable power dynamic that exists between them and staff as well as the significant control staff members wield over youth's lives and the narrative. It is the staff who write the incident reports and keep the records. Moreover, staff have control over daily points, program progress, activities, phone calls, and all facets of youth's lives. In one facility, children must ask permission from staff to speak, to move about the facility, and even to go to the bathroom.

The most widespread abuse of children and youth occurs through the misuse and abusive use of restraint on children and youth in RTFs. While federal and state law limits the use of restraint, these limitations are largely ignored as restraint is generally viewed as an acceptable intervention to control out-of-control or "bad" children. It is often not a last resort, but the first response. Injuries, even significant ones, are understood as a natural and unfortunate consequence of a restraint. While in the school context, P&A published a report on the near-fatality of an autistic youth when a school aide broke both of his femur bones during a restraint. Child

Protective Services declined to investigate because the injuries occurred during a restraint; the case was ultimately opened 2 years later as a result of a request by an external review panel. Ultimately, the Cabinet substantiated neglect.

It is surprising that Kentucky has not seen more children seriously injured or killed during restraints. It is not surprising that children are being hurt. P&A advocates see the injuries. During one monitoring visit, four girls had significant bruising and abrasions or large goose-eggs on their faces/foreheads from restraints. When the administrator was asked about these injuries, he explained they purposefully ground their head into the concrete on which they were restrained or self-injured during the restraint. The facility owner told advocates these youth were the "worst of the worst" who couldn't be controlled any other way. This same facility explained a sexual assault victim's allegation that she felt a male staff's erection against her bottom when he restrained her by saying it was a vape pen. The facility is a QRTP responsible for providing trauma-informed care and treatment to girls who are at a high risk of being sex-trafficked.

The research clearly shows that the use of restraints does not reduce negative or aggressive behaviors. To the contrary, studies show that it increases aggression in both the short- and long-term. Restraint is both physically and psychologically traumatizing and it undermines the therapeutic relationship. It is not an evidence-based practice and it is not a trauma informed practice. Yet, restraint continues to be an accepted and frequent intervention used in RTFs with even the most fragile and vulnerable youth.

The abuse of children and youth in RTF care must be addressed. But we agree with our sister agency Disability Rights Arkansas that the focus must remain on addressing the broad scope of problems that exist in the RTF model. In order to ensure positive outcomes for youth, we cannot ignore the general lack of a therapeutic environment and/or active treatment, opportunities for community integration, and appropriate educational services.

The import of the therapeutic milieu on outcomes is commonly accepted, but RTFs often fail to provide a truly therapeutic environment for residents. While RTFs currently struggle to maintain full staffing, there is an underlying culture within many of these facilities that undermines the creation of a safe and nurturing environment. This culture reinforces the idea that residents are good/bad, that children must be controlled, and that negative behaviors are willful and must be punished.

P&A monitors one RTF with particularly harsh conditions. Residents are not allowed to speak to each other or to staff unless they have raised their hand and received permission. They stand in line and "count off" to be seated for meals, to get their food on a tray, and for clean-up. Only when everyone has their tray will staff give the command to start eating. They eat in silence. Residents sit in silence during "free time." They may, with permission, watch TV or play a game, but still must ask for permission before speaking. They must ask for permission to use the toilet and staff doles out squares of toilet paper outside the bathroom.

In addition to a lack of a therapeutic environment, P&A advocates also note a lack of active treatment that is equally necessary to address the complex needs of these youth. RTFs may fail to implement evidence-based therapeutic interventions with fidelity. Youth are often required to "work" generic programs with workbook-based activities that offer little individualization and may not address a child's underlying needs. There is a shortage of certified child psychiatrists; youth report psychiatrist "visits" are short, perfunctory video calls. And a shortage of qualified professionals means RTFs may rely on interns to provide critical therapies or that youth simply do not receive that service while positions are vacant.

Our advocates see in real-time the impact of such a therapeutic environment and treatment—or lack thereof—on residents. These youth do not feel empowered and understood; instead, they feel isolated, powerless, and hopeless. It is no wonder that their outcomes are more likely to be poor. But when the youth fails to make meaningful progress in a program, the failure is seen as the child's failure. There is often no accountability for the program and children continue to be placed in these facilities for treatment.

Education is often regarded as the great equalizer, but here too the RTF system fails youth they serve. Residents are rarely integrated into the public school system. Instead, they are more often educated through an on-campus school which may fail to provide a meaningful, appropriate education for these youth. While some on-campus schools are fully accountable alternative programs, others are simply home-hospital programs with teachers of varying credentials that may be present from as

little as a few hours a week to a full time teacher. And yet, even with the most motivated and talented staff, educational materials may be outdated and resources limited. Teachers may not be aware a child needs an Individual Education Program and may not follow that program if it does exist.

As a result of these deficiencies, youth fall further behind in both their own academic progress as well as their ability to successfully re-integrate into mainstream education classrooms upon their discharge back into the community. This is particularly concerning given the pivotal role of school on a youth's ability to successfully integrate back into the community.

While their outcomes have not been as tragic as for Ian, Ava, and Ja'ceon, there is no argument that the lack of oversight and accountability of RTFs has failed countless Kentucky children. Accordingly, P&A urges Congressional action to strengthen the protections for children and youth in these facilities. To this end, P&A echoes the recommendations set forth by Disability Rights Arkansas that maximize community-based solutions and would create true accountability for RTF programs.

Sincerely,

Lucy Heskins,
Attorney Supervisor,
Children and Youth Team

LETTER SUBMITTED BY JAYLENE LEWIS

Subject: Spring Ridge Academy Experience by E.Q.

Re: June 12, 2024 hearing on unregulated "treatment" facilities

Hello,

I am submitting this for a survivor, E.Q., who wishes to remain anonymous.

Thank you,

Jaylene Lewis

Personal Experience at Wilderness and Spring Ridge Academy

August 2014–July 2016 (age 14–16)

The purpose of documenting my experience is to highlight the contrast between the sunny ideals sold to parents and the stark reality of the treatment we received there. While my experience may be in the past for you, I live with the consequences of it every day.

I experienced the following during my time at Spring Ridge Academy:

Fear, terror, abandonment, suicidal thoughts and plans, emotional manipulation, grooming by staff, isolation, staff acting as therapists with no training or licensing, over sedation with Seroquel and other unknown substances, heatstroke from working outside with no access to water or shade, forced not to speak as a punishment, also forced to speak in inappropriate group therapy sessions, which included "attack therapy," we were also forced to say the things that they wanted to hear and convince them of our sincerity, we were threatened with punishments, starvation, isolation, or juvenile hall if we rebelled or told anyone what was happening, our parents were told to ignore our concerns and thus our pain, LGBT+ students were forced to repress their true selves and pretend to be straight, I was not considered feminine enough and forced to wear makeup and clothes that did not reflect my true self, trainings and workshops were based directly on the previous cult organizations such as Synanon, that the owner and her former husband previously were involved in, **the techniques were not evidenced based, and have now been documented as brain washing and torture.**

My story has many similarities to the account of Spring Ridge Academy survivors Candace Cason and Raelyn K. There are many additional narratives from a multitude of other former residents who were also subjected to **unregulated inhumane tactics, humiliation, physical and psychological intimidation, shaming, unlicensed practitioners, overmedication, medical negligence, and fraud.**

A recent lawsuit, *Sweidy v. Courtney,* corroborates and documents these types of events that occurred at Spring Ridge Academy.

In addition, my autistic tendencies were exploited against me with no accommodation for my individual needs. The cruelty of this experience remains with me today.

Thousands of desperate parents have been duped and defrauded by the Troubled Teen Industry (TTI). Hundreds of thousands of teens have been through the grinder of these institutions, ending up worse than they were before, some with lasting damage leading to C–PTSD, and some ending their own lives. Many have gone on to document or share their experiences, and to advocate for new regulations, and oversight.

Thank you for your time,

E.Q.

LETTER SUBMITTED BY BRIAN LOMBROWSKI

June 10, 2024

Re: Senate Finance Committee Hearing "Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions"

My name is Brian Lombrowski, and I am a father of two neurodivergent girls, a professional with 18 years of experience in the children's mental health field, and a former resident of a children's psychiatric facility whose conditions were reflective of the conditions described in the report "Warehouses of Neglect." I am testifying about my multiple perspectives as a former youth, a parent, and a provider in response to the Senate Finance Committee's hearing titled "Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions."

In May of 1994 I was admitted into the children's psychiatric unit at Nassau County Medical Center, and transferred to Sagamore Children's Psychiatric Center from June 1994–March 1995. Objectively, I didn't have it nearly as bad as many of the other survivors you will hear from through the course of your investigation. I wasn't "transported", I didn't have to attend "seminars", I wasn't personally restrained, I wasn't personally injected with antipsychotics, the worst punishment I received was being forced to sit on a chair for an interrupted 24 hour stretch once, I mostly was able to keep up with my academics, and I was never forced to give my peers feedback or have my progress dependent on abusing others. Yet in the end being stripped of your human dignity, your autonomy, and your agency is enough in itself to cause lasting harm.

I accepted that on some level I deserved what I received, but I internalized the struggle of others. I still have vivid images of the anorexic girl who was brutally placed in 4-point restraints for the sin of throwing a can of Ensure at a staff member, among other CODEs and STATs and alarms that would go off every time there was an incident. I remember the feeling of time being suspended for us. What were seasons if you could hardly go outside? I remember the comings and goings of patients getting discharged (mostly to RTCs) and admitted. The meeting of new people. The longing for connection. I was going to say that they never broke me—I never came to believe there was something fundamentally wrong with me—but the truth is they did.

It wasn't until November of 1994 that my parents could even bring me off campus for a haircut, I stopped anticipating that at some point I'd be going home. I accepted that I wasn't and wouldn't be for years. I came to believe that my place was in institutions. Being hospitalized wasn't something that happened to me, it became an integral part of my identify. And then in January, on the Monday after Super Bowl XXIX and after several weekend home passes without incident I interviewed for a spot at the Kidspeace Orefield campus on their secure unit. Basically back to square one in a program hundreds of miles away from home. No privileges, no home passes for 6 months, no phone calls for the first 2 weeks, an 18 month anticipated length of stay. As if nothing in the previous few months had meant anything. Fate is a funny thing. That November Sagamore had a surge of girls needing to be admitted into the facility so they turned the co-ed unit that I was on into an all-girls unit, and I moved into the younger boy's unit. At 14 I was one of the oldest boys there. It also meant a different therapist, a different psychiatrist, and a different treatment team leader.

The referral to Kidspeace was the recommendation of my first treatment team. Having been a firesetter, my placement options were limited, and the stigma attached to me profound.

I don't remember a light bulb moment in therapy, or in particular feeling that anything had changed about me, and I don't remember feeling any gratitude that the hospital "saved my life" or any of that other nonsense, other than the fact the experience humbled me and that I stopped feeling and acting like I was better than the other kids in the facility.

My new treatment team took a chance on me, and basically wrote that I had gone into remission, and convinced the judge and my new school that I was safe to be in the community.

Because the school needed time to prepare for my arrival, for two weeks I traveled to the hospital as a day student, and it might sound strange but those were two of the happiest weeks of my life. I hated the feeling of being trapped, but I never felt more connected to anyone than the peers I left behind.

When I did return home I was lucky, I found a social group who would tolerate my tales of where I was for the 18 months (11 months inpatient/7 months day treatment) that I wasn't at my neighborhood school, and I told them everything, at least everything I could remember. Trying to connect to people I was hospitalized with was frowned upon in my family, I had made a life for myself in my community, why would I want to look backwards.

But every 2 years or so, give or take, I found myself looking backwards. I stumbled into a "patient advocate" position at Sagamore between my sophomore and junior year of college. My primary job was being a non-threatening face to administer patient discharge surveys to increase honest feedback (The QI team was well aware of the fear that kids getting discharged wouldn't want to say anything that might remotely threaten that discharge).

I also got to see the way the facility had changed, but mostly how it didn't change. They traded out a behavioral modification system that they might have imported from Provo Canyon and replaced it with one they picked up from Boys Town. I think they had done away with four-point restraints by 2000, but I'm not really sure. In retrospect, I view my time working there much like the 2-week window where I was a student and not a patient. I could go home at night, but in no sense did I feel any power other than the power that comes from reliving an experience with more knowledge and control. Mostly, my experiences had left me feeling desperate to find people who could relate to the formative experience in my childhood.

If my community existed, I didn't know where it was. It wasn't until Myspace and Facebook that I was able to develop any kind of healthy relationship to other people who were institutionalized as children. And then there were so few names I could even remember, Of the ones that I did, there were people who either didn't remember me, or didn't want to know that I existed. And of the ones I did eventually end up reconnecting with, Sagamore was not the seminal traumatic event in their childhood. Even in attempting to reconnect I felt alone.

Unlike the four organizations at the center of this investigation, Sagamore is a state psychiatric hospital. There is no corrupt corporation to take out of business. But if you look around the country, there really aren't many places like it—a state run intermediate stay psychiatric facility that caters largely to the middle class. In the child-serving system culture of Long Island, Sagamore has the same gravitational force that Utah does to the L.A. County school system. There might not be anyone profiting off of what it is, but the values that undergird its existence are the same ones that undergird the Troubled Teen Industry. A place where parents of means drop off their kids to be "fixed" and a place where social service systems wash their hands of the kids that they are responsible for.

The last time I was at Sagamore Children's (Psychiatric) Center was in 2011. I was working in my capacity as the Youth Involvement Specialist at the New York State Office of Mental Health, at the suggestion of my supervisor's boss, who himself was the supervisor of the Executive Director of Sagamore. I was in an explicit oversight role at the facility I had spent 9 months of my youth in.

Most of my educational and career goals have been dedicated to reforming institutional care for youth. It only took me 16 years to be in a position where I had power in the place where I was most powerless. Along with a survivor of the foster care system, whose job it was to organize systems-involved young people, we held a private focus group with kids at Sagamore and they were very open and honest with

us that day. I was particularly miffed that the youth could only call home twice a week and at very limited times. And I may have told the executive director that such a policy was unacceptable. He did not take that feedback very well.

Today I work as the High Fidelity Wraparound Care Manager in Brooklyn. But my part-time office sits a mile down the road from Sagamore. My current supervisor was in Sagamore with me. She was one of the kids who I spent most of my 2 weeks with just after I was discharged from the facility. It's a joy to do this work, especially with someone who is your peer in every sense of the word. If there's a theme I keep coming back to in this testimony it's the healing power of connection. We both came to this work for the same reason, we didn't want other kids to go through what we went through. Or to put it another way, to be the adult that we needed ourselves as children.

A lot of testimony is going to focus on the harm that residential treatment programs cause, and truly even the success stories are the walking wounded. All of us here, are in our ways still attached to the institution. When residential treatment "works" it does so by screwing around with your attachments, namely by trying to sever you from your "unhealthy" attachments, and making the institution itself an attachment figure.

Good intensive in-home services, be it High Fidelity Wraparound, or Multi-Systemic Therapy, or Functional Family Therapy, or any number of other evidence-based or evidence-informed models, are built around the idea of improving the connection between a child and someone who is going to a permanent potential attachment figure, be it a parent or another caregiver.

Most congregate care programs function by trying to replace that bond, and create the unique conditions to facilitate that—Behavioral Control, Information Control, Thought Control, and Emotional Control. The same tools that domestic abusers use to control their victims. But a group care facility alone doesn't create those conditions, and a community-based provider is just as capable of grooming as a residential program is.

There's a line from the report that stuck out for me, "The warehousing of these children in RTF's only remedies society's disinterest in addressing their needs. By removing those who are inconvenient from sight, people divest themselves of the responsibility to help them". The work and value of High Fidelity Wraparound is to get the system of care, starting with the youth and family to see the value and potential of youth. It's to insist first on making the youth seen, then making the parent seen, then making the community that supports them seen and so on. It is a set of values put into practice that isn't meant to displace RTFs, but to make their use shorter and more urgent, because we still see the youth as part of that family unit and we're doing everything in our power to keep that unit together even in treatment.

As such, there is both a supply and demand side to the equation of the business of RTFs. I put as much onus on the payers who want to warehouse youth as the warehousers willing to profit off of them. Therefore here is a list of recommended actions that the Committee can take going forward to address this complex issue.

1. Clarify what is and what is not a PRTF. Medicaid dollars should not be spent on facilities that their own states don't classify as PRTFs. If a state chooses not to have a PRTF program, then the residential programs in that state should not be able to sell themselves to other states as a PRTF. Many of the facilities cited in the report would no longer be able to operate if they were properly defined as the IMDs that they are.
2. An investigation should be undertaken looking at the demand side of the residential treatment business. Which state departments send disproportionate numbers of youth to out-of-state facilities funded by Medicaid and for what reasons.
3. Place the onus of care coordination and discharge planning from residential programs on community providers. By law and by practice model intensive in-home services step away from the involvement of youth and families when they go into residential treatment for longer than 30 days. This policy reinforces the idea that RTFs are "warehouses" instead of places of active treatment. Non-clinical services built into the Medicaid per-diem such as care management and family peer support, should be offered by community providers who can continue to engage with the youth and family throughout the term of the residential intervention.

I thank the committee for all of your efforts in completing the report and in putting together the hearing. It has been the most comprehensive efforts at connecting the dots to explain the breadth of harm that this industry causes. I have provided my contact information and would gladly respond to any of the committee's inquiries.

Sincerely,

Brian Lombrowski

LETTER SUBMITTED BY TERESA LONG

June 23, 2024

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

Dear Senate Finance Committee Members,

I am writing to you from VA. Thank you for prioritizing the critical issue of Residential Treatment Facilities (RTFs).

Paid family caregivers are an integral part of a disabled individuals right for direct care, safety and respect in which they deserve that can be provided by their families who care for them and understand them the most. Paid family caregivers are extremely important as they provide direct care, protection and safety for disabled family members. They play a very important role and oftentimes are a lifeline to the disabled.

I am writing to ask you to recognize the barriers to paid family caregiving and their role in abuse and neglect in our nation's care network. Home and Community-Based Services (HCBS) current regulations (Section 1905(a)(24) of the Social Security Act, 42 CFR § 440.167, and 42 CFR § 441.105) prevent family caregivers from being paid to provide care at home. This forces many families to place their loved ones in RTFs due to the lack of affordable care options.

During the COVID–19 pandemic, 39 states allowed parents and spouses to be paid caregivers through CMS waivers. This led to better care, fewer hospitalizations, healthier homes, reduced dependency on welfare, and increased tax revenue. The National Council on Disability supports making this change permanent.

CMS officials, including Dan Tsai, have acknowledged the benefits of paid family caregivers. However, current federal regulations remain a barrier. Congress must "ban the bans" on paid family caregivers and incentivize states to adopt this model.

This change is crucial to prevent the abuse and neglect often seen in RTFs and to support families in providing safe, effective care at home.

Appreciatively,

Teresa Marie Long

LETTER SUBMITTED BY ANNA MARIE

June 23, 2024

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

Dear Senate Finance Committee Members,

I am writing to you from Ohio. Thank you for prioritizing the critical issue of Residential Treatment Facilities (RTFs).

I am one of thousands of parents and caregivers in the state who has faced the challenges raising a child who is medically complex, and developmentally delayed. Find-

ing care from the time our children are born and of age to enter into childcare centers, and up till school age when before and after school care continues to be another barrier faced.

I have been a single mother trying to balance working full time, and keeping my child who was born with a complex single ventricle heart, in daycares. Due to liability issues a lot of daycares turn our children away due to their complexity, others treat our children with negative consequences for behavior that is a symptom of their disability.

Loosing care creates a barrier for us with being able to work.

December of 2021, my son lost care in our local before and after school care due to behavioral problems. There was no opportunity for a one on one aid, no help from our county or our school district to bring someone in one on one with my son to keep him in the program.

In the program itself, they would yell and isolate my son from the group. This brought out more intense behaviors.

For 3 years, since losing care for my son I have fought and advocated with our county board of developmental disabilities; in order to become my son's paid provider. Even prior to his school age years, while my son was an infant and in and out of the ICU undergoing multiple cardiac surgeries.

Each time I inquired about being his paid provider, I was told, "No." No, because he's not 18. But someone else can, someone else who's not a family member can. I have been through countless trainings to understand autism, I've had to learn so much about my child's heart, what to look out for, what to expect for the future. Knowing our future entails another cardiac surgery however this one may lead into a transplant of his heart, lungs, kidneys. I'm not allowed thought to be paid for the amount of care, natural support that I put in daily for my son who has a chronic illness.

In our state they have become strict on provider searches, and pushing to remove parents from being the primary care provider for our children.

Our children see a revolving door of providers, and when you have a child who has a disability that relies solely on routine, this revolving door of new faces creates bigger challenges for not only our children, but our families. I've seen three providers in and out of my son's life within a span of two years, this has brought on an increase of behaviors.

I am writing to ask you to recognize the barriers to paid family caregiving and their role in abuse and neglect in our nation's care network. Home and Community-Based Services (HCBS) current regulations (Section 1905(a)(24) of the Social Security Act, 42 CFR § 440.167, and 42 CFR § 441.105) prevent family caregivers from being paid to provide care at home. This forces many families to place their loved ones in RTFs due to the lack of affordable care options.

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CMS officials, including Dan Tsai, have acknowledged the benefits of paid family caregivers. However, current federal regulations remain a barrier. Congress must "ban the bans" on paid family caregivers and incentivize states to adopt this model.

This change is crucial to prevent the abuse and neglect often seen in RTFs and to support families in providing safe, effective care at home.

Appreciatively,

Anna Marie

LETTER SUBMITTED BY TERRI MARINO

June 12, 2024

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington DC 20510–6200

I am writing to you today because my family has been forever changed. Though there is nothing we can do to remedy or change our own situation, our hope is to help bring about change for others. Our wish is to spare any other family from going through the tragedy that our family lives with EACH DAY.

Our son, Anthony, was an above average student. He grew up with a Mom and Dad and an older brother that he worshipped. Growing up, he was a cub scout, a drummer, and played soccer, baseball, hockey and football.

In 2003, we sent our son to the Academy at Ivy Ridge in Ogdensburg, NY. He was uncharacteristically not following the rules of the house. We felt he was on a dangerous path. We met with the guidance counselor at his high school (Bayport Blue Point) to figure out a solution and it was there that we first heard about (the now defunct name) WWASP—The World Wide Association of Specialty Programs. We chose The Academy at Ivy Ridge because they offered a great education, horseback riding, swimming and the grounds were beautiful. It was pricey at $3,490.00 per month. My husband, a UPS driver and myself in insurance, would have to take a second mortgage to cover the expenses for the school (and the outside seminars we were required to attend as his parents).

He spent 7½ months there. He completed his senior year and he came home on his 18th Birthday with his diploma in hand. It is important to note that a couple of years later, we received a letter from the NYS Attorney General (Eliot Spitzer) stating that the AIR diploma was invalid and should not have been issued—AIR was not a NYS accredited school. They struck deal/settlement with the school. They would enclose a check for 15% of the total tuition that was paid for each of the 112 "students" that were issued bogus diplomas. The "school" was allowed to remain open.

Once home, his life would start, then stall. This pattern continued for the next 18 years. He always was smart enough to seek professional help but the cycle of depression continued to dominate his life. He was diagnosed with "complicated PTSD." I never did comprehend this diagnosis, though I surely do now.

In spite of the struggles, he graduated University of Nevada, Las Vegas at the age of 28. His depression would rear its head, in spite of his accomplishments. He was a personal trainer (which he loved) and a job as a laborer with Local 66. Life should have been good for him but the inner struggles continued to haunt him.

One October day, he called me and asked me to come to his apartment because he needed a "Mom hug." I left immediately and upon my arrival I could see the pain he was in. He sobbed for hours though I hugged him and tried to assure him that everything would be okay.

He told me that he had been sexually assaulted at the Academy at Ivy Ridge 18 years earlier. 18 years!!!! Thoughts ran crazy through my head as I realized how long he had been carrying this trauma. He said that he had just recently told his therapist and that she and I were the only two people he had ever told. I was in total shock!

He said that he was "broken" and he was "damaged." I stayed with him for hours, did my best to comfort him, but I had never seen a human being so damaged. My ride home that night was brutal, his pleas to me, "Mom, please don't tell Dad" echoed in my head. He was so ashamed, mortified.

The next morning, he showed up at the house after calling me to tell me he was coming. He was very quiet. Eerily so. We talked for a little bit and he said he was going to leave. I asked him to stay and spend the day with us but he said he had to go. He hugged me and kissed me and I watched him walk down our driveway and get into his car.

About 45 minutes later, the siren went off. I put my head in my hands and felt a wave of panic cut through me. A few minutes later, my neighbor checked our community Facebook page and the latest news was that a train had just struck a black Sonata at the RR crossing. By the time we reached the scene he was already enroute to the hospital. It had taken the rescue crew 18 minutes to cut him out of his car. When we arrived at the hospital, he was on life support. He remained as such for 6 days (an extra 3 because they needed that time to ready his body for organ donation).

I have to tell you that in my mind I thought there was one bad apple that hurt my son. One day I recalled a past conversation that I'd had with him. He said "Mom, if you want to know how bad AIR was, check out YouTube under "WWASPS"

and "AIR." Nothing could have prepared me for what I heard in the testimonials of former "students." It wasn't ONE bad apple. And it wasn't just ONE "school" or "program." THE ABUSE WAS RAMPANT! The damage so widespread! I could not believe the extent of this abuse. Emotional, sexual, psychological, physical.

These "schools" are getting creative now and actually get licensed under "Mental Health Facility" where they can grab a share of federal funds while the mistreatment of "patients/students" continues.

I would also like you to know that there were none of the activities described earlier in my letter. In fact, "students" were not allowed to talk to each other, smile, frown, look out the window, go outside. They were strip searched, had to use the bathroom with the stall door open, could not pass gas or belch. If you haven't seen "The Program: Cons, Cults and Kidnapping" on Netflix, it perfectly depicts life at Academy at Ivy Ridge and there is actual footage of male staff beating children.

I am begging you as a grieving mother to please enact change. Please do not let the death of our son, Anthony Marino be in vain. I cannot bring him back. I cannot apologize to him and beg for his forgiveness. What I have to offer is my family's tragic story . . . one that we do not want another family to have to go through.

PLEASE HELP ENACT CHANGE. YOU HAVE THE POWER TO HELP US.

Thank you for your time.

Sincerely,

Terri, Larry, and Rich Marino
Anthony's Mom, Dad and Brother

LETTER SUBMITTED BY TODD MARLOWE

June 23, 2024

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

Dear Senate Finance Committee Members,

I am writing to you from Maine. Thank you for prioritizing the critical issue of Residential Treatment Facilities (RTFs).

Maine, like many other states, is currently grappling with a caregiver crisis that has brought significant social and financial hardships to our families.

Many parents have lost their jobs, resulting in the loss of their homes and forcing them to make difficult choices in order to make ends meet while caring for their loved ones with special needs. Those who have lost their homes now require public housing and receive food assistance, leading to a loss of self-worth and a sense of desperation among families who desire to remain productive members of our community.

During my advocacy work, I have come across numerous young adult parents of individuals with special needs who find themselves dependent on our public programs, which are not equipped to handle long-term care. These families yearn to break free from this dependency, but unfortunately, it is beyond their control.

This desperation has led some parents to reach their breaking point and leave their loved ones with special needs at emergency rooms. This last resort is socially and financially burdensome for taxpayers, as emergency room stays are extremely costly. Currently, we have a young lady with special needs who has been residing in one of our emergency rooms for 220 days and counting at $2,749 per day.

It is important to note that Maine's issue is not solely an economic one but rather a social and administrative one. While families continue to suffer, we have observed tax breaks, tax refunds, and significant deposits to our "rainy day" fund.

Personally, I have incurred significant financial losses, a reduction in future social security benefits, and suffering from caregiver burnout mostly related to sleep depri-

vation. My family then needed to move my son with his mother to another state that is able to provide adequate and quality caregiver services.

Without federal legislation that mandate all states adhere to a federal mandate. My family, as state political administrations change along with their ideologies, will be subjected to moving to yet another state that provides adequate and quality caregiver services.

The implementation of a federal mandate will have great social and financial benefits for all citizens.

I am writing to ask you to recognize the barriers to paid family caregiving and their role in abuse and neglect in our nation's care network. Home and Community-Based Services (HCBS) current regulations (Section 1905(a)(24) of the Social Security Act, 42 CFR § 440.167, and 42 CFR § 441.105) prevent family caregivers from being paid to provide care at home. This forces many families to place their loved ones in RTFs due to the lack of affordable care options.

During the COVID–19 pandemic, 39 states allowed parents and spouses to be paid caregivers through CMS waivers. This led to better care, fewer hospitalizations, healthier homes, reduced dependency on welfare, and increased tax revenue. The National Council on Disability supports making this change permanent.

CMS officials, including Dan Tsai, have acknowledged the benefits of paid family caregivers. However, current federal regulations remain a barrier. Congress must "ban the bans" on paid family caregivers and incentivize states to adopt this model.

This change is crucial to prevent the abuse and neglect often seen in RTFs and to support families in providing safe, effective care at home.

Appreciatively,

Todd Marlowe

LETTER SUBMITTED BY JILL MCCARDEL

June 23, 2024

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

Dear Senate Finance Committee Members,

I am writing to you from WA. Thank you for prioritizing the critical issue of Residential Treatment Facilities (RTFs).

Thank you for investigating the horrific care that is happening in RTF. As parents, we will do whatever we can to keep our kids at safe at home.

One way to stop HCBS from failing children and families and to eliminate barriers to paying LRI as caregivers for disabled children so that they can stay in their homes and communities with their families.

My daughter, at 2 years old, had a traumatic brain injury and went into multiple organ failure and has needed over 20 surgeries over the last 12 years. She qualifies for over 193 hours of personal care hours through HCBS and 204 hours of skilled nursing a month. When these hours are not able to be staffed, given the crisis in the labor force, I have no choice but to staff these hours unpaid, impacting my ability to work outside the home. We have never been able to have all her hours staffed at one time, and the longest an employee has stayed is 3 months because of the low wages for personal care and nursing. It becomes a position that is easy to move on from. Leaving many inconsistencies in care. This request will strengthen families and help keep children at home in their communities. Thank you for taking the time to listen.

I am writing to ask you to recognize the barriers to paid family caregiving and their role in abuse and neglect in our nation's care network. Home and Community-Based Services (HCBS) current regulations (Section 1905(a)(24) of the Social Security Act, 42 CFR § 440.167, and 42 CFR § 441.105) prevent family caregivers from being paid

to provide care at home. This forces many families to place their loved ones in RTFs due to the lack of affordable care options.

During the COVID–19 pandemic, 39 states allowed parents and spouses to be paid caregivers through CMS waivers. This led to better care, fewer hospitalizations, healthier homes, reduced dependency on welfare, and increased tax revenue. The National Council on Disability supports making this change permanent.

CMS officials, including Dan Tsai, have acknowledged the benefits of paid family caregivers. However, current federal regulations remain a barrier. Congress must "ban the bans" on paid family caregivers and incentivize states to adopt this model.

This change is crucial to prevent the abuse and neglect often seen in RTFs and to support families in providing safe, effective care at home.

Appreciatively,

Jill McCardel

LETTER SUBMITTED BY MORGAN MEADORS

June 22, 2024

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Members of the Senate,

I am writing to you today as the younger sibling of a survivor of a WWASP (Worldwide Association of Specialty Programs and Schools) institution. My brother was forcibly removed from home at 17 by two men in the dead of night. During his transport, he learned about the institution he was being sent to. Upon arrival, he immediately sensed something was terribly wrong with this so-called "school." He broke down in tears, still gripped by the transporters.

Throughout his time there, I had no contact with my brother. He wrote to our parents, pleading to come home and begging them never to send me to such a place. This plea was dismissed as manipulation, and all communication ceased. My brother missed significant milestones like prom, his senior year, graduation, and countless holidays—moments our family can never reclaim.

Six months and $20,000 later, my brother "graduated." However, after the school was shut down due to abuse allegations, the administrator, Richard Darrington, was fired for battery involving two students. Finally, after persistent efforts, the former owner, Dace Goulding, reluctantly issued his diploma, which turned out to be fraudulent. The $20,000 that my parents had set aside for college was wasted on a sheet of paper with illegitimate seals.

My brother was a teenager deeply scarred by the abandonment of two fathers and subjected to significant abuse and control from our mother. Instead of receiving love and therapeutic support from qualified professionals, he endured severe psychological and emotional abuse at the hands of staff members. Despite these setbacks, my brother earned his GED.

However, our family felt a persistent distance and resentment from him for years. It wasn't until 16 years later that we learned about his horrendous experiences at Darrington Academy. Only then did we begin to understand the depth of his trauma. We discovered not only the abuse he endured but also that he was encouraged to harm his peers, this being the only way to graduate from the program.

While my brother's story is harrowing, it is not the worst. Despite his ordeal at a TTI program, he has found success as a business owner. However, I cannot speak for his peers who suffered even worse fates, including imprisonment, death by suicide, or drug overdose.

You see, the system fails these children not only during their time in these programs but also well into adulthood. Many survivors struggle to find employment and face limited resources, often leaving them with no option but to fall into detrimental paths. When they finally escape these programs, they frequently have nowhere to turn and no family they can trust. If they speak out about their treatment, they are met with a cruel reminder of how "horrible" they were deemed to be and dismissed, making them feel responsible for their abuse. This forces survivors into

silence, just as they once were while in the program. To make matters worse, their abusers are often allowed to continue working with children, even teaching in schools, perpetuating the cycle of harm and mistrust.

To my dismay, I discovered that the former school owner, Dace Goulding, currently holds a district position and serves as a public middle school teacher at Crimson Cliffs Middle School in Utah. He has also been a long-term girls' track coach, which is deeply unsettling to me.

Parents are manipulated into believing these programs are the best option for their children, often warned that their children will die without attendance. In reality, this manipulation fosters lasting resentment and distrust, tearing families apart. Vulnerable children are taken, families are shattered, and justice is rarely served. Abusers often walk free and, in some cases, continue to work closely with children.

We must halt this and ensure these facilities can no longer operate unchecked and have stricter regulations. We owe it to survivors, families, and future generations to prevent any child from enduring such suffering again. The system must change, and we must stand by survivors, holding those responsible accountable for their actions.

Thank you for your time and consideration,

Morgan Meadors

LETTER SUBMITTED BY LINDA MOLINA

June 12, 2024

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

Dear Senate Finance Committee Members,

I am writing to you from New York State. Thank you for prioritizing the critical issue of Residential Treatment Facilities (RTFs).

I would like to invite you to read an attached letter that I first wrote over a year ago that was the catalyst to a movement in NYS for paying legally responsible adults of minors for care of their medically fragile children. I now lead a state-wide effort but despite having an active bill in the senate and assembly (NYS S8599, A9034), our plea was not louder than the forces against us and we must continue to wait for our state to correct the private duty nursing and direct support professional shortage all while going homeless, losing our life savings, and our children being forced into institutions and unable to be discharged home. IT'S UNJUST that our families must continue to advocate so hard considering what we deal with on a daily basis. If you hear from a few, please remember there are many more that despite wanting to submit comment could not because their loved ones needed them to prioritize their care in that moment. Please see my letter below.

I am writing to ask you to recognize the barriers to paid family caregiving and their role in abuse and neglect in our nation's care network. Home and Community-Based Services (HCBS) current regulations (Section 1905(a)(24) of the Social Security Act, 42 CFR § 440.167, and 42 CFR § 441.105) prevent family caregivers from being paid to provide care at home. This forces many families to place their loved ones in RTFs due to the lack of affordable care options.

During the COVID–19 pandemic, 39 states allowed parents and spouses to be paid caregivers through CMS waivers. This led to better care, fewer hospitalizations, healthier homes, reduced dependency on welfare, and increased tax revenue. The National Council on Disability supports making this change permanent.

CMS officials, including Dan Tsai, have acknowledged the benefits of paid family caregivers. However, current federal regulations remain a barrier. Congress must "ban the bans" on paid family caregivers and incentivize states to adopt this model.

This change is crucial to prevent the abuse and neglect often seen in RTFs and to support families in providing safe, effective care at home.

Appreciatively,

Linda Molina

May 2, 2024

Linda Molina, Parent
Capitol District 43

Dear State Legislators,

I am adapting a letter that initially wrote in December 2022 when first starting out advocating for this legislation (The Complex Care Act A9034/S8599). It has been a very long road but I am glad to still be able to advocate and educate on this matter as it is so very important to so many families of medically fragile children in NY. I have learned so much along the way and thus the need to adapt the letter. I am very hopeful that you will see the value of this legislation as myself and so many other New Yorkers do.

In light of the nursing shortage, parents of medically fragile children need immediate relief. In passing this legislation you can, not only improve quality of lives of the medically fragile children and their caregivers, but also reduce the burden on the taxpayers and help alleviate a critical nursing shortage. I am speaking from the unique perspective of a mother of two beautiful yet medically complex children and as a care manager for medically complex children in the State of New York.

This bill will allow New York families access to the same services already in place in several states already including Colorado, California, New Hampshire, Pennsylvania, Vermont, Arizona, Florida, New Jersey, Massachusetts, and others.

I would like to explain my thoughts on the issues as they pertain to the pediatric population and what I believe could be a win/win for all people of NYS. As the system is now in NYS, for a middle-class family with a newly diagnosed medically complex child to receive in-home support to prevent their child from being institutionalized, their options are to leave their employment (with FMLA or PFL for limited time) or their private insurance pays for custodial care private duty nursing (many do not or have limited allowance of hours—if a nurse is available). This would be a temporary solution either way before the family uses up all savings/loses homes/car etc. until they are eligible for SSI, TANF, Housing assistance. At the same time, IF the family has been made aware of waiver programs, they would start the process of applying for a Medicaid waiver (OPWDD or HCBS via CYES). This process can take 6 months before determining eligibility and obtaining Medicaid. So now the family has Medicaid and the process begins to apply for nursing or attempt to secure a non-skilled home care worker. IF a provider is available, either process could take months just to obtain approvals and set up the providers to bill.

Imagine the family is now not only struggling to pay the bills, maintain employment, and care for the daily needs of their medically complex child but also managing therapists, doctor appointments, pharmacy pick-ups, learning curve, not sleeping, obtaining durable medical equipment, gathering documentation/filling out paperwork for applications to obtain services/ submit appeals when denied (happens often), and now making calls and interviewing nurses/home care aides. All of this to maintain the child's care at home and prevent institutionalization. Remember, too that there is a new diagnosis. The family is grieving and now by necessity the family is asked to sacrifice the security of their home and their privacy which can be a huge hurdle to overcome until a level of trust is established and even then still difficult.

Many of these children are in an out of the hospital. During which time their home care providers are without employment and without income and seek to move on to a child that is more stable and not as often in the hospital. Leaving the most medically compromised children without any care at all. From personal experience, as well as, that of my families there have been multiple non-skilled providers available who ultimately leave the position or never start because of the very low wages and no benefits for what is being asked of the to do (*e.g.,* nursing tasks-such as trach care, vital signs monitoring, medications, seizure management, diapering, showering, g-tube care, etc.). Even fast food restaurants have higher wages. In these instances, we have turned to obtaining eligibility for private duty nursing. As you must know, the pay discrepancies are astronomical between a non-skilled home care aide vs private duty nurses. From $20 to $40 an hour difference to provide the exact same care to the client. As you must also know, there is a lack of private duty nursing availability so never have I witnessed a fully staffed case and the nurses who are readily available have high turnover.

The one constant in the child's life is their parent/guardian. The one person who is with them through all medical procedures, therapy sessions, hospitalizations, medical appointments and has been trained in all aspects of their care. The same person who provides all initial training to the private duty nurses on the case. The same person who by society standards is not "qualified to be paid to care for their complex child" yet is "obligated to care for the child because they are the parent." The same person who is forced to juggle employment and being a "back-up caregiver" to their child. Yes, they are asked to sign a "back-up caregiver" statement when obtaining nursing authorization. Some will say, it is your child and your responsibility, why should the state pay you with taxpayers dollars to care for your own child. I say, why would you pay a stranger to care for the child just so the parents can keep a roof over the child's head. Yet when the nurse calls out, the parent is expected to leave their jobs and risk being able to pay for a roof over that child's head (at which point if they do lose their job and end up homeless then the child would be institutionalized). Why wouldn't you pay the parents to care for their medically complex child?

Consider the benefits to the child: their health, security—allowing for them to develop higher level skills, consistency. A nurse is being reimbursed anywhere from $40 to $55 an hour to direct contract with Medicaid. A parent would be satisfied with half that amount and be able to live comfortably if the other parent is working. The benefits to the parent: reduced stress of juggling providing basic needs and caregiving = better health outcomes for the parent and less strain on medical services, perhaps allow a caregiver to leave an abusive relationship giving them autonomy, allow them to enjoy their child with they are living (as many of these medically complex children do have reduced lifespans). Don't forget the siblings of the medically complex child are affected as well (less vacations, less money for college, less opportunities to participate in sports). Financial stability for the family would alleviate those things and alleviate generations of the traumatic effects of having a medically complex child.

There are benefits to NYS as well. For every child receiving nursing services, reduce the cost by replacing 40 hours and the difference of pay between caregiver rate and nurse rate. That one nurse (in theory) then will be able to fill a shortage in another place where there is a need, perhaps allow another child in the hospital to then come home. My daughter is eligible for 96 Medicaid hours of nursing care per week. We have one consistent full-time night nurse. She fills less than 50 of those hours. We have attempted to fill the other 46 hours; however, the nurses we tried to hire did not adapt well to our family and were honestly doing more harm than good. My husband works full-time from 4.30 am to 1 pm. I work full-time with home office and travel to clients in the community.

Thankfully, my job is flexible to a point now but if we lose our full-time nurse, I would need to take leave. If I was able to be a paid caregiver for my daughter, I would be able to attend better to all her needs on the nights she is in my care. This would greatly reduce my stress and my daughters (she has high anxiety, especially with new people as she suffered from trauma from a school aide) and would decrease the cost on the state significantly. Should our regular nurse leave us, we would not be in financial ruins while waiting for another to come in to provide some respite. This would also allow me to be more active with my daughter instead of working behind a desk/driving while she is watching her tablet most of the afternoon-therefore improving our health. She has a degenerative diagnosis so it breaks my heart every day when I have to tell her I can't right now because I have to work to pay for the roof over our heads. Just advocating for this program is taking my time away from her. And this is asking for the bare minimum to make life bearable. Not even mentioning the needs of my son, who also has significant medical needs preventing him from attending school. Lastly, this legislation allows families to have access to a Registered Nurse who is familiar with their child's case.

As a care manager, I have not been able to find a pediatric visiting nurse to educate my clients on nursing tasks such as taking a manual blood pressure. When we have a question and call our pediatricians, we are sent immediately to the emergency department. Having a knowledgeable and familiar nurse to call would potentially avoid those situations.

Please, I beg that you provide immediate relief for families such as mine and those that I serve by passing this cost-neutral/cost-saving bill! Thank you for your consideration and for serving the people of NYS.

Linda Molina

LETTER SUBMITTED BY VICTORIA MOUL

June 23, 2024

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

Dear Senate Finance Committee Members,

I am writing to you from Pennsylvania. Thank you for prioritizing the critical issue of Residential Treatment Facilities (RTFs).

I am the other of special needs triplets who have complex medical care needs due to being born mico preemie. I live in Colorado and partially in Pennsylvania because 2 of my kids receive their care in Colorado and 1 in Pennsylvania as Colorado can't meet his medical needs. This is a huge burden on our family, having to travel back and forth, but I have no choice as Colorado has the best waivers, Parent CNA/PDN, and special needs services in the U.S. Pennsylvania does not offer any of these. So instead of moving permanently to PA for all 3 of my children, we have to continuously live in, and travel to both states. This is a drain on our finances, stability, and continuation of care. If the programs that are available in Colorado were uniform across the U.S., my family and others like ours would be able to move where they need to that best fits the needs of their children. My children are 12, I am afraid of what it is going to be like for us when they turn 18 if things don't change.

I am writing to ask you to recognize the barriers to paid family caregiving and their role in abuse and neglect in our nation's care network. Home and Community-Based Services (HCBS) current regulations (Section 1905(a)(24) of the Social Security Act, 42 CFR § 440.167, and 42 CFR § 441.105) prevent family caregivers from being paid to provide care at home. This forces many families to place their loved ones in RTFs due to the lack of affordable care options.

During the COVID–19 pandemic, 39 states allowed parents and spouses to be paid caregivers through CMS waivers. This led to better care, fewer hospitalizations, healthier homes, reduced dependency on welfare, and increased tax revenue. The National Council on Disability supports making this change permanent.

CMS officials, including Dan Tsai, have acknowledged the benefits of paid family caregivers. However, current federal regulations remain a barrier. Congress must "ban the bans" on paid family caregivers and incentivize states to adopt this model.

This change is crucial to prevent the abuse and neglect often seen in RTFs and to support families in providing safe, effective care at home.

Appreciatively,

Victoria Moul

NATIONAL ASSOCIATION FOR BEHAVIORAL HEALTHCARE
900 17th St., NW, Suite 400
Washington, DC 20006
202–393–6700, ext. 100

Statement of Shawn Coughlin, President & CEO

Senator Ron Wyden
Chairman
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510–6200

Senator Mike Crapo
Ranking Member
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510–6200

Re: Recent Congressional Inquiries into Youth Residential Treatment Facilities

Dear Senators Wyden and Crapo:

Following recent inquiries into youth Residential Treatment Facilities (RTFs), I send this letter on behalf of the National Association for Behavioral Healthcare to (1) clarify the definition and purpose of youth RTFs, and (2) underscore the critical need for the clinical and educational services they provide for youth with mental health and/or substance use disorders.

NABH represents behavioral healthcare systems that provide mental health and addiction treatment services across the entire continuum of care, including inpatient, residential treatment, partial hospitalization, and intensive outpatient programs, as well as other facility-based outpatient programs, including about one third of the nation's opioid treatment programs. Our members represent behavioral healthcare providers in 49 states and Washington, DC, and three of our system members participated in the recent congressional inquiries into RTFs.

If public discourse about this topic is to benefit the public good, it is vital that policymakers, the media, and providers share the same clear, informed understanding about the important role RTFs play in the behavioral healthcare continuum.

It is also important that the American public has an accurate view and clear understanding of youth RTFs when they learn about specific incidents that represent a small number of the youth who receive vital and necessary services in these facilities. These incidents are heartbreaking, unacceptable, and contrary to both the expectations and efforts from our nation's quality RTF providers. And it's imperative that worried parents, concerned teachers, and other citizens hear about the children whose lives have been greatly improved—or saved—as a result of the care and treatment RTFs provide every day.

The Role of Youth RTFs:

For children and adolescents with more serious behavioral health conditions, residential treatment settings can provide a more comprehensive array of therapies and more contact with specialized providers.

Residential treatment provides a necessary level of care for children and adolescents with significant needs, such as those at risk of hurting themselves or others or who have been diagnosed with serious behavior problems. Children and adolescents requiring this level of care often have difficulty relating successfully to others at home and in school and are at risk of dropping out of school and/or becoming involved in the criminal justice system. Psychiatric residential treatment can provide the necessary expertise and resources that the child welfare, juvenile justice, and education systems frequently lack.

The admission criteria for residential treatment reflect the severity of the behavioral health conditions treated in these settings. For residential treatment to be considered medically necessary, and covered by insurers or healthcare coverage programs, a child or adolescent must be at risk of self-injury or danger to self, physical aggression, assault, or danger to others or disruptive and destructive acts in the community.

Some of the children and adolescents who need this level of care have suffered hardships and abuse, including multiple failed community placements through child welfare programs. This experience can be traumatic and can cause increased emotional and behavioral problems.

Children and adolescents in foster care are at heightened risk of dropping out of school, at a rate of 75%, according to one study. They are also at greater risk of drug use. Rates of delinquency and arrest among these children and adolescents are also much higher.

The goal of psychiatric residential treatment is to provide care to children and adolescents with significant social and emotional needs in a non-hospital, highly structured, and therapeutic environment. These settings provide a safe place where individuals can gain stability, support, and treatment for mental health diagnoses, substance use disorders, intellectual/developmental disabilities, sexual conduct disorders, and other disabilities that require long-term treatment.

Psychiatric RTFs are Subject to Strict Oversight Requirements and Staffing Ratios:

Psychiatric residential treatment facilities provide 24-hour, therapeutically planned behavioral health interventions in a highly supervised and structured group living

and active learning environment. These healthcare settings are subject to external monitoring on validated standards and independent auditing of potential safety issues.

State agencies license and regulate these treatment settings, and nationally recognized entities such as the Joint Commission and the Commission on Accreditation of Rehabilitation Facilities, or CARF, accredit them. There are mechanisms in these settings to prevent self-harm and harm to others as well as opportunities for adolescents and staff to report their concerns.

Meanwhile, nearly every state has a required staffing ratio for this level of care that indicates how many staff are required for the number of patients being treated. In some circumstances, the number varies based upon the shift (day/evening/nights) and, in some cases, it singles out the registered nurse-to patient ratio versus the behavioral health technician-to-patient ratio. These numbers vary widely across state lines.

In addition, there are federal regulations that are applicable to the RTF programs related to using restraint and seclusion as well as emergency preparedness. The state survey agencies, on behalf of the Centers for Medicare & Medicaid Services, have been instructed to conduct a certain percentage of reviews of these regulations each year so that during the span of 5 years, each RTF is reviewed at least once. Each CEO is required to attest, on an annual basis, that his or her facility is compliant with the regulations.

Each state Medicaid plan also has requirements for this level of care that can begin with staffing or workforce make-up as well as medical record documentation standards. An RTF can have multiple contracts with state Medicaid plans, which also increases the level of oversight for each individual program through onsite and/or desk reviews to ensure compliance.

Education Services and Supports are Key Components of RTFs for Children and Adolescents:

Ensuring children and adolescents with behavioral health conditions can maintain their education is also critically important. Behavioral healthcare services in schools can improve access to treatment while providing necessary support for those with less serious mental health and substance use disorders.

Moreover, some behavioral healthcare providers have developed specialized therapeutic schools for children and adolescents who need more intensive, education-focused supports. Residential treatment settings provide education services tailored to address the needs of children and adolescents with more serious behavioral health conditions. Most of these children and adolescents have struggled in regular school settings and would not be able to succeed without the support these centers provide.

There is oversight for the educational services through national accreditation as well as state Department of Education requirements that also vary by state.

There is an Urgent and Growing Need for Youth RTFs:

Equally important to understanding the role of youth RTFs is recognizing the urgent and increasing need for them in the United States today. As this study[1] from the Manhattan Institute reports, the Substance Abuse and Mental Health Services Administration (SAMHSA) releases data every two years that detail the number of beds and the number of patients served in "residential treatment centers (RTCs) for children," which include qualified residential treatment programs, or QRTPs. Since 2010, SAMHSA reports the number of these facilities has declined 60.9%, while the number of beds has declined 66.2%. Meanwhile, the number of children served in these settings has declined even more so (77.9%) than the number of facilities or the number of beds.

As youth residential mental health treatment capacity has decreased in recent years, the demand for quality behavioral healthcare services for youth has increased. The number of children and youth in this country diagnosed with anxiety, depression, and other mental health conditions continues to rise. Between 2016 and 2020, the number of children and youth ages 3–17 years diagnosed with anxiety

[1] *https://manhattan.institute/article/the-decline-in-residential-mental-health-treatment-for-youth.*

grew by 29% and those with depression by 27%, according to data[2] from the Health Resources & Services Administration.

In addition, in 2020, suicide was the second leading cause of death for young people ages 10–14 and 25–34, according to a report[3] by the Centers for Disease Control and Prevention. And while rates of drug and alcohol use declined in youth in 2021, rates of overdose deaths rose dramatically, doubling between 2019 and 2020 and increasing another 20% in 2021.[4]

Given these sobering statistics, there is undoubtedly a critical need for youth RTFs so our nation's children and adolescents receive the appropriate and life-saving treatment in highly regulated settings with experienced staff. We would be glad to arrange a site visit with one of our system member facilities so you can see these programs firsthand. If you have any questions, please contact me directly shawn@nabh.org or 202–393–6700, ext. 100.

Thank you for your time and commitment to high-quality behavioral healthcare services for America's children and adolescents.

Sincerely,

Shawn Coughlin
President and CEO

NATIONAL ASSOCIATION OF COUNSEL FOR CHILDREN
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888–828–6222
https://naccchildlaw.org/

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510–6200

June 18, 2024

Re: Hearing on "Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions"

Dear Committee Members:

The National Association of Counsel for Children (NACC) respectfully submits this statement for the record following the June 12, 2024 hearing on youth residential treatment facilities, and the release of the related report *"Warehouses of Neglect."*[1] NACC represents a national membership community of attorneys who practice in child welfare courts, advocating on behalf of children, parents, kin and agencies. Through their daily work, they observe firsthand the many dangers inherent to these facilities and the negative impact of their overutilization, which ripples from youth, to their families, and then communities. NACC's Policy Framework,[2] which was shaped by our staff, Board, member community and lived experience Advisory Council,[3] explicitly calls to avoid such placements.

Although the harms of RTCs exist nationwide, youth are especially vulnerable if they are not represented by legal counsel.[4] ***To strengthen oversight of RTC settings, Congress must pass federal law requiring legal representation for every child and youth in foster care.*** This proposal enjoys bipartisan support, is backed by a strong body of research, is already funded by the federal government, and will help mitigate the harms of RTC placement.

Bipartisan Support—the longstanding need for legal counsel in foster care court proceedings has been championed by leaders from both parties.

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[2] *https://mchb.hrsa.gov/data-research/national-survey-childrens-health.*
[3] *https://www.cdc.gov/suicide/facts/index.html.*
[4] *https://jamanetwork.com/journals/jama/fullarticle/2790949.*
[1] *https://www.finance.senate.gov/imo/media/doc/rtf_report_warehouses_of_neglect.pdf.*
[2] *https://naccchildlaw.org/wp-content/uploads/2023/09/NACC-Policy-Framework-Final.pdf.*
[3] *https://naccchildlaw.org/national-advisory-council-on-childrens-legal-representation/.*
[4] Thirteen states currently do not guarantee legal representation for all children in foster care: Alaska, Florida, Hawaii, Idaho, Illinois, Indiana, Maine, Minnesota, New Hampshire, North Dakota, South Carolina, Texas, and Washington.

- Under former President Trump, the Department of Health and Human Services changed longstanding administrative policy[5] to open federal funding for children's and parent's attorneys and released important guidance[6] to the field to support implementation. Executive Order 13930[7] further affirmed the former administration's commitment to this issue.
- Under President Biden, HHS has continued to promote this initiative, citing it as a strategic priority.[8] As Commissioner Jones Gaston testified at the recent hearing, HHS recently finalized a regulation[9] that permanently codifies this funding for legal counsel.
- Similarly, in Congress, leaders from both parties have come together on this issue. In June 2021, the Senate HELP Committee unanimously voted in favor[10] of a proposal that would have embedded this mandate in law. The proposal had *broad national support from across the country* as well.

Backed by Research—research shows that legal representation for children and parents helps child welfare state agencies meet their mandate.

- A 2021 study from Washington State[11] found that, compared to children without attorneys, children receiving standards-based legal representation were 45% more likely to reunify, 30% less likely to change foster homes, and 65% less likely to experience unnecessary school moves. These results did not expand state costs (in fact, they may have yielded fiscal savings). This is just one of many studies[12] confirming the impressive impact of counsel for kids.
- When children achieve permanency more swiftly, they are less likely to have unnecessary, protracted stays in institutional environments. Safe reduction of a state's overall foster care population also alleviates pressure to utilize these facilities as "last resort" placements.

Funding in Place—Prior concern this reform would constitute an "unfunded mandate" is now mitigated, thanks to a recently opened Title IV–E funding stream, as well as other federal resources.

- As noted above, the U.S. Children's Bureau has granted matching funds for parent and child legal representation since 2019. The most recent available public data[13] shows that at least 26 states and 3 tribes are utilizing this opportunity (See column AG). Others have readily followed suit;[14] NACC anticipates that the next federal report will show at least 75% utilization cross states.
- In addition to Title IV-E, other federal funding streams support child welfare legal representation across the country. These include Social Services Block Grants, State Opioid Response Grants, the Victims of Crime Act, and more.[15]

Attorney Oversight of Institutional Placements—When a youth is placed in an institutional care setting, their attorney may be the only person they can rely on to report concerns, file grievances, or elevate issues to a judge's attention. Counsel for kids routinely:

- Investigate these facilities prior to placement, verifying what services are (or are not) offered, staff credentials, accreditation history, regulatory infractions, local law enforcement utilization, and more.
- Ensure fidelity to the Family First Act's court oversight requirements—including court hearings to challenge placement in RTCs when recommended over the objection of a child or their parent.
- Monitor and challenge the overutilization of psychotropic medication and other chemical and physical restraints.
- File motions or other legal tools to terminate institutional placement when conditions are unsafe, unsanitary, or contrary to a youth's best interest.

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[5] *https://acf.gov/sites/default/files/documents/cb/im2106.pdf.*
[6] *https://www.acf.hhs.gov/sites/default/files/documents/cb/technical_bulletin_faq_legal_representation.pdf.*
[7] *https://www.govinfo.gov/content/pkg/DCPD-202000472/pdf/DCPD-202000472.pdf.*
[8] *https://www.youtube.com/watch?app=desktop&v=lj3tw_hsENg.*
[9] *https://www.federalregister.gov/documents/2024/05/10/2024-09663/foster-care-legal-representation.*
[10] *https://www.congress.gov/bill/117th-congress/senate-bill/1927.*
[11] *https://www.courts.wa.gov/subsite/wsccr/docs/DCLR%20Report%202021.pdf.*
[12] *https://counselforkids.org/wp-content/uploads/2023/02/Counsel-for-Kids-Resources.pdf.*
[13] *https://acf.gov/cb/report/report/programs-expenditure-caseload-data-2021.*
[14] *https://naccchildlaw.org/wp-content/uploads/2023/03/States-Progress-Drawing-IV-E-funds-3-8-23.pdf.*
[15] *https://legalaidresources.org/wp-content/uploads/2021/05/funding-by-issue-cheat-sheet.pdf.*

I invite you to review our Policymaker's Guide to Counsel for Kids [16] and welcome the opportunity to talk more about this proposal—especially ways to move it forward through Title IV–b reauthorization in the 118th Congress. Please feel free to reach out to me using the contact information below.

Sincerely,

Allison Green, JD, CWLS
Legal Director
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The National Association of Therapeutic Schools and Programs (NATSAP) Fully Supports The Stop Institutional Child Abuse Act (SICCA)

The National Association of Therapeutic Schools and Programs *(www.natsap.org)* is fully supportive of the "Stop Institutional Child Abuse Act," (SICAA) a crucial piece of legislation that addresses and reforms the systemic issues within youth residential facilities, commonly known as the troubled teen industry.

NATSAP agrees that SICAA offers a strong step forward in Congressional oversight that will lead to a more robust, accountable, and responsible environment for youth, adolescents, and young adults seeking the appropriate treatment in accredited programs. By establishing a Federal Work Group on Youth Residential Programs and mandating a thorough study by the National Academies of Sciences, Engineering, and Medicine, the bill aims to improve data collection, implement best practices, and strengthen interagency collaboration. These measures will help prevent abuse and ensure the well-being of children in these programs, addressing long-standing issues that have plagued the field.

We urge the Senate Committee on Finance to consider the following solutions to ensure the success of this legislation:

- Improved Data Collection: Mandate comprehensive data reporting systems to track the effectiveness of youth residential programs and foster transparency and accountability.
- Implementation of Best Practices: Promote the dissemination of best practices across all youth residential facilities, addressing the needs of diverse populations, including BIPOC, LGBTQ+, and disabled youth.
- Strengthened Interagency Collaboration: Encourage communication and collaboration among federal and state agencies to optimize resource use and policy effectiveness.
- Development of Risk Assessment Tools: Create and utilize research-based risk assessment tools to prevent abuse and ensure the well-being of children in these programs.
- Educational and Training Resources: Support the development of educational resources and training for professionals involved in youth residential care, focusing on trauma-informed care and de-escalation techniques.
- Promotion of Community-Based Care: Encourage alternatives to institutional care, promoting family-based and community-centered solutions that are often more beneficial for the child's development and well-being.

Thank you, Chairman Wyden, Ranking Member Crapo, and members of the Senate Committee on Finance, for the opportunity to provide this statement. The Committee's consideration of these matters and the recommended solutions are greatly appreciated. Together, we can ensure that vulnerable youth receive the care and protection they deserve.

Sincerely,

NATSAP Board of Directors

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[16] *https://counselforkids.org/wp-content/uploads/2023/04/C4K-PolicyPaper-FINAL-DIGITAL-2.pdf.*

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The National Association of Therapeutic Schools and Programs is the largest not-for-profit membership association in the United States dedicated to residential treatment centers and has been advocating for safe, ethical, clinically informed, and data-driven treatment for youth since 1999. One of the principal goals of the association is to raise the overall standards of care, safety, and ethics in youth mental health services.

NATIONAL CHILD ABUSE COALITION
https://www.unsilenced.org/

Dear Chairman Wyden, Ranking Member Crapo, and members of the Senate Committee on Finance:

The National Child Abuse Coalition, a coalition of 28 national organizations focused on the prevention and treatment of child abuse and neglect in the United States, appreciates the opportunity to provide written comments regarding your recent hearing, *Warehouses of Neglect: How Taxpayers are Funding Systemic Abuse in Youth Residential Treatment Facilities.* The findings of the Senate Finance Committee's investigation confirm existing evidence that group placements—inclusive of shelters, group homes, and residential treatment centers, or any placement that is not in a family—do not support the well-being of youth and families. It also affirms Congressional action through the passage of the Family First Prevention Services Act of 2018 (Family First) to limit the use of group placements for children and youth in foster care and incentivize high-quality, time-limited therapeutic treatment.

Our Coalition has advocated for increased investments in community-based prevention services that can prevent children and their families from ever coming into contact with the child welfare system. It is our belief that expanding federal resources for prevention services is better for children and their families and also reduces the need for residential treatment—a theory of change embedded in Family First, which blends increased federal investments in prevention services alongside critical restrictions in group placements.

The reach of child protective services (CPS) is extensive, and even an investigation can be traumatic and cause lasting harm for families. In cases where action is taken to remove and place children into foster care, while sometimes necessary, this process can cause significant harm and should be avoided if families can be stabilized through prevention intervention. It is well documented that the trauma associated with family separation can have long-term effects on children and families' mental and emotional well-being, impacting their ability to form healthy attachments and trust relationships in the future. Furthermore, the disruption of a child's life—changing schools, losing contact with friends and extended family, and adjusting to new caregivers—adds layers of stress and uncertainty. *These adverse outcomes underscore the importance of avoiding removal whenever possible by stabilizing families earlier.* While group placements may offer immediate solutions to limited child welfare placements, as the Committee's report clearly documents, they often subject children to significant trauma that can have lasting negative effects on their mental, emotional, and developmental health—the opposite outcomes we strive to achieve.

Thus, there are critical opportunities to support families and prevent system involvement that are currently being missed. Early interventions, such as providing access to concrete and economic support, mental health services, and substance abuse treatment, can help to address the root causes of issues that might otherwise lead to CPS involvement. By investing in these prevention measures, we can help families navigate challenges before they escalate to the point of becoming entangled in the child welfare system due to a lack of access to basic supports necessary to thrive—and ultimately prevent group placements.

Additionally, we know that many adolescents enter the foster care system with unmet mental health needs, oftentimes without evidence of abuse or neglect in the household. As a result, the child welfare system has assumed the unintended role of serving as the primary behavioral health care provider for children, particularly those facing serious mental health challenges, intellectual and developmental disabilities, and trauma. This overreliance on group placement for young people even outside the intended purview of child welfare has resulted in widespread harm inflicted by these settings and compounded limited placement options for system-involved young people in need of time-limited treatment options. For children and youth who experience abuse while in residential treatment, it is important that they have ways to report the abuse and receive treatment to help them heal.

The Coalition strongly supports the development of policies that prioritize community-based mental health services and, when necessary, child welfare system responses that move away from relying on residential treatment facilities for long-term placement. Group placements are most effective as a short-term treatment intervention rather than a long-term solution. Children, especially those with behavioral health needs, thrive best under the care of a loving, consistent adult caregiver, ideally kin, and with access to high-quality medical and mental health care.

New Jersey offers a promising model to consider for strengthening the prevention continuum by strengthening mental health supports for children and youth. The state has maintained the lowest per capita rate of group placement utilization by a child welfare system and the lowest youth suicide rates in the nation by developing a comprehensive, statewide children's system of care for behavioral health, primarily funded by Medicaid but supplemented with braided funding from multiple sources and payers. This behavioral health care is universally available and not only limited to those served by child welfare, providing a blueprint for policy solutions to improve child and youth well-being, reduce the overreliance on child welfare systems as a source of behavioral health care, and decrease the use of group placement settings across the board.

Investing the time and resources to find safe alternative placements for young people when it is deemed necessary to remove them from their homes preserves family connections and provides children with a sense of stability and belonging. The costs associated with group placements—both financial and human—are significantly higher in the long run, costing 7–10 times more than family-based placements,[1] and children who experience the trauma of these environments often require more intensive and prolonged interventions. By focusing on early intervention and prevention, we can reduce the need for such placements and support the well-being of children and their families more effectively.

We offer the following recommendations for how to address the harms and challenges associated with group placements and improve outcomes for children and families. Specifically, we recommend that federal policymakers invest in community-based mental health services so that young people can access the services they need within their communities and while connected to family, without having to be placed in a group placement:

- We know that, in many cases, children and youth without histories of abuse or neglect are being placed in group placements because it is the only way they are able to access the mental health services they need. **Policies must focus on increasing access to community-based mental health services to prevent system involvement.**
- **Increase Medicaid reimbursement for community-based services and expand the scope of behavioral health services reimbursable under Medicaid.** This will help to expand continuum-of-care approaches such as the one New Jersey has pioneered.

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[1] *https://assets.website-files.com/60a6942819ce8053cefd0947/60f6b1eba474362514093f96_Away%20From%20Home%20-%20Report.pdf.*

- Research has made clear the connections between economic hardship and child welfare system involvement. Nearly 85 percent of families investigated by CPS have incomes below 200 percent of the federal poverty line, and even modest financial supports can reduce involvement with child protective services with concrete support for families to improve outcomes and limit system involvement whenever possible. **Thus, efforts to provide concrete and mental health supports for families, particularly those affected by domestic violence, would make great strides towards preventing entry into the child welfare system—including group placement.**
- Because young people of color are disproportionately represented in group placement, they are also disproportionately impacted by their lasting harm. **Any effort to prevent contact with group placement settings must include intentional efforts to target strategies that ensure equitable access to culturally responsive services and supports in families and the communities in which they live.**
- Ensure that young people have opportunities to both report, and receive healing for, abuse they experience while in residential treatment.
- **Add peer support programs as an eligible category under the Title IV–E Prevention Services.** Peer support programs offer services and support delivered by individuals who have been through similar experiences such as navigating the child welfare system. They have demonstrated efficacy due to peer supporters' unique ability to build trust with children and families. This would improve access to and engagement in community-based services for system-involved families and serve as a critical tool for augmenting the child welfare workforce.

Thank you for your commitment to children and families in America, and for your work to ensure effective and safe environments for youth and their families to thrive. We look forward to continuing to work with you in the coming months and years to improve policies to improve child and family well-being.

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Dear Chairman Wyden, Ranking Member Crapo, and Finance Committee Members, thank you for the opportunity to supplement the June 12, 2024, hearing record. The National Disability Rights Network (NDRN) respectfully submits the following statement.

I. What are the Protection and Advocacy agencies and NDRN?

The Protection and Advocacy (P&A) system is a federally mandated network of legally based agencies that advocate for and protect the rights of individuals with disabilities. Under federal law, P&As have authority to access facilities in which individuals with disabilities reside, and access relevant records. Youth residential facilities are one type of facility that a P&A can access.[1]

NDRN is the nonprofit membership organization for the federally mandated P&A Systems and the Client Assistance Programs (CAP) for individuals with disabilities. NDRN has the privilege to work with the P&A network, made up of 57 P&A organizations (which includes the U.S. territories and a P&A covering Native American Tribes in the Four Corners region) on issues that cross state lines and/or appear in multiple states, increasing the ability of the network to develop and implement systemic solutions.

After NDRN heard from multiple P&As about incidents of abuse of youth with disabilities, in 2021, NDRN published "Desperation Without Dignity" ("Desperation")[2] a report revealing widespread abuse and neglect at for-profit youth residential treatment facilities. The report provides a comprehensive review of investigations by

[1] P&A agencies are often called "Disability Rights [State Name]", but many have a different name depending on the state, and the vast majority are non-profit organizations.

[2] *See,* National Disability Rights Network *Desperation without Dignity: Conditions of Children Placed in For Profit Residential Facilities* (October 2021), *https://www.ndrn.org/resource/desperation-without-dignity/*.

P&As agencies *(https://www.ndrn.org/about/)* and others in 18 states. It examined the history of the for-profit residential treatment industry, the private funding structure that fuels it, and discussed effective evidence-based alternatives to residential placement.

The report was prompted by a series of nationwide conversations, initially brought about by a recognition of common concerns in residential facilities operated by Universal Health Services Inc. (UHS) in the Southeast.[3] Through additional investigations and inquires, it became clear that abuse and neglect was being reported at private residential facilities operated by a number of different provider companies across the U.S. While concerns about Southeastern facilities continued and intensified, the problems were not and are not limited to that region.

II. Detention Not Treatment

P&As have seen firsthand how deeply flawed the overall residential treatment model is, the pervasive nature of abuse and neglect within it, and the poor quality of services provided nationwide in treatment facilities. The current model of private residential treatment is inherently flawed. This is not a matter of a few bad actors or poorly run programs, but a foundational problem.

Our nationwide investigation into children's complaints revealed widespread concerns that included: Physical, emotional and sexual abuse; physical, medical and emotional neglect; abuse in the use of powerful psychotropic medications, and lack of appropriate treatment and education. The issues uncovered in our nationwide investigation mirror almost exactly those in the report by the Senate Finance Committee.

In short, facility providers receive federal funds to ensure specialized medical and psychiatric treatment, but what they provide is often indistinguishable from, and sometimes worse than, juvenile detention.

III. P&As as Watchdog: Nationwide Perspective

As they began to look more closely into the issues later addressed in "Desperation," P&As worked together strategically to keep their clients safe. For example, when an agency in Maine suggested moving a child to a facility in Arkansas, Disability Rights Maine staff traveled to Arkansas and participated in a joint monitoring of the facility with staff of Disability Rights Arkansas. Advocates across a number of states shared news articles and specific in-state information with one another about facilities, including those run by entities with a multi-state presence. NDRN held regular nationwide meetings and supported regional and national systemic efforts to address the issues.

In addition to the report, these efforts included media outreach, informational meetings with government actors and others, comments on proposed regulations, information sharing about alternatives to residential treatment, data mining, and work on national legislation.

IV. Paperwork Matters

We are grateful for the Senate Finance Committee report. The report is timely, thorough, and well cited. It explains clearly why the private youth residential model does not work, what alternatives exist, and why paperwork matters.

As Reagan Stanford, hearing witness from Disability Rights Arkansas, stated:

> Even with our knowledge and familiarity with the providers and state agencies generally, identifying what existed was a tedious process. Some requests were unfilled because the exact name of a document was not included, some because the facility was operating under one name and registered with Medicaid under another. Documents we did receive were often incomplete or so lacking in detail that it was impossible to make necessary connections between documents.
>
> What this process revealed was that while government agencies had substantial documentation of abuse and neglect existing at these facilities, it would be extremely difficult and time consuming for anyone that was considering placement at a particular facility to obtain this crucial information.[4]

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[3] Map of UHS Behavioral Health Facilities: UHS Locations; UHS, King of Prussia, PA, *https://uhs.com/our-locations/*.

[4] Testimony of Reagan Stanford, Disability Rights Arkansas, June 12, 2024. "Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions," *https://www.*

P&As have reported the same challenges nationwide. While staff and administrators may see logbooks and reports as busy work, they hold the key to understanding what goes on inside facilities that otherwise have little oversight. Serious restraint and seclusion incidents go unrecorded and unreported, time logs are forged, injuries and hospital visits unreported. It is extremely difficult for parents, oversight bodies, and sending agencies to determine whether facilities are safe and provide quality care to children.

V. Family Contact and Transparency

Placement decisions are critically important, especially those that will last for long periods of time or occur at crisis points in a child's life—both of which are true for many residential placements. For this reason, transparency is essential. Families and placing agencies need to know exactly what a placement offers in order to ensure it is the correct fit for the child. Regular reviews are needed to ensure that a child is making appropriate progress.

Yet, as described in "Desperation," the Senate Finance Committee report and other sources, accurate information about these facilities is scant. Provider websites and marketing materials often provide only vague statements about treatment, without specifics regarding the services the facility provides, periodicity of services, conditions, and provider qualifications. In addition, reports may be incomplete or inaccurate.

Transparency is even more challenging to achieve for out-of-state parents, guardians, and placement agencies, but a great many children continue to be sent to facilities out of state.

In order to address this barrier, Disability Rights Arkansas created the Arkansas Psychiatric Residential Treatment Facility (PRTF) database. This database, organized by facility, makes available to the public incidents reported to state licensing, reports and surveys from oversight agencies, and police reports for calls related to the facility.[5] This work was funded out of the P&A's limited federal funding. Instead, facility data should be collected and reported by the responsible oversight agencies, as is the case with nursing homes.[6] Databases of this sort should be required nationwide for youth facilities.

Regular progress reviews are essential for individual children. This can be achieved with the use of "intensive care coordination." Placement reviews at regular, required intervals are necessary and must be informed by individual child data that is compared to measurable objectives, and include the input of parents, staff from the facility, and sending agency.

To supplement state and local government oversight work, the Centers for Medicare and Medicaid Services (CMS) should fund P&As in the same manner that the Social Security Administration (SSA) funds the P&As to monitor for abuse by SSA appointed representative payees.[7] Congress saw a problem in how SSA was performing the required monitoring of representative payees and determined that this critical work should be performed by the nationwide network of P&A agencies. Thus, in 2018 Congress instructed SSA to fund the P&A network to conduct much of the actual monitoring of representative payees. Following this successful model, Congress should provide sufficient funding for P&As to specifically monitor facilities providing treatment to youth with disabilities.

However, the most important oversight mechanism is regular, relaxed communication between child and family. No one will keep track of a child like loving caregivers. Most children return home to family or a prior foster family, and a successful transition to a family setting is the goal of residential placement. Parents and guardians must be actively involved in treatment planning and reviews, as well as have regular contact with children in order to ensure a smooth transition home. But most of all, a child and caregiver must be able to call each other and hear the sound of each other's voice. Treatment facilities need to be required to allow a high level of contract and involvement

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finance.senate.gov/hearings/youth-residential-treatment-facilities-examining-failures-and-evaluating-solutions.

[5] The database can be accessed at *https://disabilityrightsar.org/prtf/*.

[6] CMS Nursing home database: Nursing homes including rehab services, Provider Data Catalog, *https://data.cms.gov/provider-data/topics/nursing-homes.*

[7] Strengthening Protections for Social Security Beneficiaries Act of 2018, Pub. L. 115–165, § 101, 132 Stat 1257 (April 13, 2018); codified at 42 U.S.C. § 405(j)(6)).

VI. Alternatives

Current youth residential facilities cannot provide an adequate therapeutic and educational environment. Yet, as stated by Ms. Stanford and observed in our own work—"there is a pervasive assumption that some children need such intensive services," that they cannot be served in the community. This idea is accepted and repeated even in literature and reports that are critical of residential treatment. It is so ingrained and generally accepted that no further thought is given to what "intensive services" actually means or why such services can only be provided in a residential setting. Residential treatment is often seen as the pinnacle of treatment, the best and most intensive services a state has to offer.

As noted in her testimony, ". . . the most restrictive placements generally offer a level of care that could be replicated or surpassed on an outpatient basis." The "intensive services" that most PRTFs, acute and sub-acute programs, provide consist primarily of 50 minutes of individual therapy a week, between 1 and 4 hours of group therapy a week, between one and four family therapy sessions a month, and medication management. At most, that comes to approximately 5 hours of therapeutic services per week, which is less than is provided by many community-based models, but at a much higher price.

There are viable, fiscally responsible alternatives to residential placement. The Department of Justice's Civil Rights Division, Disability Rights Section,[8] recently issued a Letter of Findings after an investigation and found that Maine violated Title II of the Americans with Disabilities Act (ADA) when it failed to provide sufficient community-based services for youth, resulting in an overuse of institutional placements.

Disability Rights Maine, filed a complaint with the Department of Justice on behalf of a group of children with disabilities, alleging that these children cannot access needed community-based services, resulting in their institutionalization or risk of institutionalization in violation of the ADA, and the U.S. Supreme Court's decision in *Olmstead*.[9] The Department agreed, and in addition set out an exhaustive list of options within the community that could be implemented to meet the needs of children, to replace the need for residential treatment.

As long as residential treatment remains one of the only options available to many families and placement agencies, providers can rely on desperation placements as an income source and will continue to have little motivation to improve. Through NDRN's work with the P&A network, we know that these problems are not specific to any provider or any state. The conditions and systemic issues are well documented in countless reports by individual P&As, NDRN, and other sources.

Recommendations

This is a national problem that demands immediate action. NDRN recommends the following:

1. Increase investment in community-based services and supports that can help prevent the use of congregate care.
2. Require an evidence-based screening process to determine service needs and ensure that person-centered plans are fully implemented and properly informed.
3. Require meaningful outcome measures and allow payments only for models that provide active treatment and individualized services in the community.
4. De-incentivize out-of-state placements.
5. Remedy the failures of oversight that exist at all levels.
6. Create an easy to access and navigate system that accurately identifies all youth residential treatment facilities, publishes surveys conducted by state survey agencies, quality of care, and incident data to supplement and improve the Quality, Certification & Oversight Reports (QCOR) database.

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[8] With the assistance of the U.S. Attorney's Office for the District of Maine.

[9] Office of Public Affairs, "Justice Department Finds Maine in Violation of ADA For Over-Institutionalization of Children with Disabilities," United States Department of Justice, *https://www.justice.gov/opa/pr/justice-department-finds-maine-violation-ada-over-institutionalization-children-disabilities*. Findings letter can be found at *https://www.justice.gov/crt/case-document/letter-findings-state-maine. See also:* Rhode Island: Letter of Findings—State of Rhode Island *(https://www.justice.gov/crt/media/1353576/dl)* and Maryland Statement of Interest (*https://www.justice.gov/crt/media/1340986/dl).*

7. Invest in research and pilot programs to identify and validate effective treatment options.

Thank you again for this opportunity to share concerns about the status of youth residential treatment programs, as well as to offer potential solutions for improving the experience of program residents. Should you or your staff have any questions about this statement, please do not hesitate to contact Eric Buehlmann at eric.buehlmann@ndrn.org.

We look forward to working with the committee and other interested parties to address the problems, legislatively, identified in the Senate Finance Committee's report.

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Statement of Jennifer Lav and M. Geron Gadd, Senior Attorneys

The National Health Law Program (NHeLP) is a public interest law firm working to protect and advance the health rights of low income and underserved individuals. Founded in 1969, NHeLP advocates, litigates, and educates at the federal and state levels. Consistent with its mission, NHeLP works to ensure that all people in the United States have access to affordable, quality health care, including comprehensive behavioral health services. We submit the following statement as long-time advocates for children with significant mental health needs, based on our extended experience advocating for the needs of children with mental health conditions administratively, legislatively, and in the federal courts.

We appreciate the Committee's careful and thorough documentation of the overuse of residential treatment facilities, and its many devastating consequences. The conditions reported in the Committee's Staff Report reflect an ongoing failure to develop robust, community-based youth behavioral health care services. Residential treatment facilities are neither designed nor equipped to meet the needs of youth with complex behavioral health conditions, or to deliver intensive, individualized therapeutic interventions that enable youth to succeed upon discharge or avoid readmission. Overutilization of residential treatment facilities therefore deprives youth with complex behavioral health conditions of integrated, developmentally appropriate, individualized therapeutic interventions that meaningfully treat their conditions. Overutilization of residential treatment creates conditions that are ripe for neglect, abuse, and unsafe and unsanitary conditions for children the Committee has documented.

Furthermore, segregation, in and of itself, is harmful—particularly the prolonged segregation described in the Committee's report. Children do best with families, and when they cannot be with their family of origin, they should be in the least restrictive, most family-like setting.[1] The segregation of youth in residential treatment facilities separates them from their families and communities. When segregated for long periods, youth's existing coping and social skills and their behavioral health can deteriorate as a result of being separated from their families and friends. Segregation in residential treatment facilities often deprives youth of opportunities to develop their strengths and pursue age-appropriate interests, both of which can help them constructively manage their behavioral health conditions. Finally, prolonged segregation in residential treatment facilities deprives youth of the opportunity to build coping and other skills to manage their behavioral health conditions in the community-based settings in which they will eventually be expected to function successfully—at home, at school, in the community, and in the workplace. As the U.S. Department of Health and Human Services (HHS) explained in the preamble to the

[1] American Acad. of Pediatrics et al., *The Path to Well-being for Children and Youth in Foster Care Relies on Quality Family-Based Care* (Jan. 2022), *https://familyfirstact.org/resources/path-well-being-children-and-youth-foster-care-relies-quality-family-based-care-what%E2%80%99s*.

regulation implementing Section 504 of the Rehabilitation Act states, "[C]ongregate care is virtually never the most appropriate long-term placement for children."[2]

Expanding the Availability of Quality Intensive Home and Community-Based Behavioral Health Services Can Correct the Overreliance on Residential Treatment Facilities

For over 2 decades, experts have recognized the clinical benefit and cost effectiveness of intensive home and community-based services to meet the needs of youth with complex behavioral health conditions.[3] "These services enable children with complex mental health needs—many of whom have traditionally been served in restrictive settings like residential treatment centers, group homes, and psychiatric hospitals—to live in community settings and participate fully in family and community life."[4]

In many states, the array of services available to youth with complex behavioral health conditions remains woefully inadequate and often disjointed.[5] As a result, these youth frequently experience cyclical and protracted placements in residential treatment facilities that do not provide them the intensive therapeutic interventions that they need.

Focused expansion of quality intensive home and community-based Medicaid services, including (1) intensive care coordination, (2) intensive in-home behavioral services, (3) mobile crisis response and stabilization services, and (4) therapeutic foster care (also sometimes referred to as "treatment foster care"), would meaningfully address the needs of youth with complex behavioral health conditions and prevent harmful out-of-home placements in residential treatment facilities. These services are essential to a functional youth behavioral health system. Expansion of these services would work to rebalance utilization of community-based services and institutional behavioral health treatment, and with it, begin to correct the overreliance on residential treatment facilities that is so harmful for the youth trapped in them.[6]

Intensive Care Coordination. Because youth with complex behavioral health conditions typically have high needs, and need multiple services to meet those needs, intensive care coordination is essential.[7] Intensive care coordination—particularly the form of intensive care coordination specifically designed for youth with complex behavioral health conditions known as Wraparound intensive care coordination—is a critical component of an effective system of care. Wraparound intensive care coordination is a robust, comprehensive form of care coordination that involves a "team-based, collaborative process for developing and implementing individualized care plans for children and youth with complex needs and their families" that "focuses on all life domains and includes clinical interventions and formal and informal supports."[8] Wraparound intensive care coordination plans for a range of services to meet the multiple needs of youth and their families, individualizes those services, coordinates and monitors their delivery, and modifies youth's treatment plans to ad-

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[2] U.S. Dep't of Health & Human Servs., *Discrimination on the Basis of Disability in Health and Human Service Programs or Activities,* 89 Fed. Reg. 40106 (May 9, 2024), *https://www.federalregister.gov/documents/2024/05/09/2024-09237/nondiscrimination-on-the-basis-of-disability-in-programs-or-activities-receiving-federal-financial*.

[3] CMS and SAMHSA, *Informational Bulletin: Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions* (May 7, 2013), *https://www.medicaid.gov/federal-policy-guidance/downloads/cib-05-07-2013.pdf* [hereinafter "2013 Informational Bulletin"]; *see also* CMS, *Informational Bulletin: Leveraging Medicaid, CHIP, and Other Federal Programs in the Delivery of Behavioral Health Services for Children and Youth* (Aug. 18, 2022), *https://www.medicaid.gov/sites/default/files/2022-08/bhccib08182022.pdf*.

[4] CMS & SAMHSA, 2013 Informational Bulletin, *supra* note 3, at 1.

[5] Medicaid & CHIP Payment & Access Comm'n, Chapter 3: Access to Behavioral Health Services for Children and Adolescents Covered by Medicaid and CHIP, REPORT TO CONGRESS ON MEDICAID AND CHIP 105 (June 2021), *https://www.macpac.gov/wp-content/uploads/2021/06/June-2021-Report-to-Congress-on-Medicaid-and-CHIP.pdf* (noting that states have an obligation to cover these intensive home and community-based services, many children and families have difficulty accessing them).

[6] *See generally* Jocelyn Guyer et al., Manatt & The Commonwealth Fund, *Leveraging Medicaid to Support Children and Youth Living with Complex Behavioral Health Needs: Framework and Strategies* (Nov. 2023), *https://www.manatt.com/Manatt/media/Documents/Articles/The-Commonwealth-Fund-Report_2023-11_c.pdf;* Jennifer Lav & Kim Lewis, Nat'l Health Law Prog., *Children's Mental Health Services: The Right to Community-Based Care* (Aug. 2018), *https://healthlaw.org/wp-content/uploads/2018/09/NHeLP-Issue-Brief_Children%E2%80%99s-Mental-Health-Services.pdf* [hereinafter "The Right to Community-Based Care"].

[7] *Rosie D. v. Romney,* 410 F. Supp. 2d 18, 31 (D. Mass. 2006).

[8] *See* CMS & SAMHSA, 2013 *Informational Bulletin, supra* note 3, at 3; *see also* Lav & Lewis, *The Right to Community-Based Care, supra* note 6 at 12.

dress their evolving needs.[9] Intensive care coordination has long been recognized as a critical—and highly effective—service for youth with complex behavioral health conditions.[10]

Intensive In-Home Services. Intensive in-home services are highly individualized therapeutic interventions delivered to youth and families in their homes and other community settings, designed to improve youth and family functioning and prevent out-of-home placement.[11] These services offer a critical combination of individualized therapy, skills training for the youth and family or caretaker, and behavioral interventions, delivered by a team of professionals and paraprofessionals.[12] The services are tailored to address the particular and evolving needs of youth and their families in the natural environments where the challenging behaviors arise. Providers work with youth and their families to identify symptoms and triggers, develop skills needed to respond constructively to them, and build youth's capacity to effectively navigate family life, school settings, and relationships with peers and others in the community. The effectiveness of intensive in-home services to meet the needs of youth with complex behavioral health conditions and avoid residential treatment facility placements has been widely acknowledged.[13]

Mobile Crisis Response and Stabilization Services. Mobile crisis response and stabilization services (MCRSS) "are instrumental in defusing and de-escalating difficult mental health situations and preventing unnecessary out-of-home placements."[14] They are an essential component of a functioning mental health system, and can help youth experiencing acute crises avoid the need for inpatient services.[15] MCRSS are available 24/7 and can be provided anywhere youth experience crises. The service is provided by a team comprised of professionals and paraprofessionals trained in crisis intervention skills.[16] Crucially, the MCRSS team also works with the youth and family to identify potential triggers of future crises and develops strategies to effectively address those crises when they occur.[17] The effectiveness of

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[9] *Cf. Rosie D.,* 410 F. Supp. 2d at 31, 45 ("Most prominent in th[e] evidentiary landscape [at trial] was the absence of adequate recognition that the named Plaintiffs' serious emotional disturbances constitute chronic conditions that require continuous monitoring, coordination, and modification of services."), 52–53.

[10] *See, e.g.,* Jonathan R. Olson et al., *Systematic Review and Meta-Analysis: Effectiveness of Wraparound Care Coordination for Children and Adolescents,* 60(11) J. AM. ACAD. OF CHILD & ADOLESCENT PSYCHIATRY 1353–1366 (2021); Jennifer S. Coldiron, et al., *A Comprehensive Review of Wraparound Care Coordination Research, 1986–2014,* 26(5) J. OF CHILD & FAMILY STUD., 1245–1265 (2017); Oswaldo Urdapilleta, et al., IMPAQ Int'l, *National Evaluation of the Medicaid Demonstration Home and Community Based Alternatives to Psychiatric Residential Treatment Facilities* (2012); Kirsten Painter, *Outcomes for Youth with Severe Emotional Disturbance: A Repeated Measures Longitudinal Study of a Wraparound Approach of Service Delivery in Systems of Care,* 41(4) CHILD & YOUTH CARE FORUM 407 (2012).

[11] *See* CMS & SAMHSA, *2013 Informational Bulletin, supra* note 3, at 4.

[12] *Id.*

[13] CMS & SAMHSA, *2013 Informational Bulletin, supra* note 3, at 3; *see also* Eric J. Bruns et al., *Defining Quality Standards for Intensive Home-Based Behavioral Treatment Programs for Youth with Serious Emotional Disorders,* 48(6) ADMIN. AND POLICY IN MENTAL HEALTH AND MENTAL HEALTH SERVS. RESEARCH 1065–1088 (2021); Samantha Moffett et al., *Intensive Home-Based Programs for Youth with Serious Emotional Disturbances: A Comprehensive Review of Experimental Findings,* 85 CHILDREN AND YOUTH SERVS. REV. 319–25 (2018).

[14] *See* CMS & SAMHSA, *2013 Informational Bulletin, supra* note 3, at 5; *see also* SAMHSA, *National Guidelines for Child and Youth Behavioral Health Crisis Care* at 20 (2022) (best practices for mobile crisis response for youth); Jennifer Lav & Kim Lewis, Nat'l Health Law Prog., *Children's Behavioral Health Mobile Crisis Response and Stabilization Services,* National Health Law Program Issue Brief (Jan. 31, 2022), *https://healthlaw.org/wp-content/uploads/2022/02/Mobile-Response-and-Stabilization-Services-publication.pdf.*

[15] *See* Jeffery Vanderploeg et al., *Mobile Crisis Services for Children and Families: Advancing a Community-based Model in Connecticut,* 71 CHILD. & YOUTH SERVS. REV. 103 (2016) (Rapid mobile response with face-to-face crisis stabilization in the home, school, and community can improve functioning and reduce utilization of emergency departments and juvenile justice facilities); Priyanka Vakkalanka, et al., *Mobile Crisis Outreach and Emergency Department Utilization: A Propensity Score-matched Analysis,* 22 WEST J. EMERG. MED. 5 (Sept. 2, 2021) (mobile crisis outreach patients were less likely to have family and social support and yet were less likely to require hospitalization for each visit); Michael Fendrich et al., *Impact of Mobile Crisis on Emergency Department Use Among Youths with Behavioral Health Service Needs,* 70 PSYCH. SERVS. 881 (Oct. 1, 2019) (youth who received mobile crisis services had a significant reduction in odds of a subsequent behavioral health ED visit compared with youth who did not receive community-based mobile crisis services).

[16] *See* CMS & SAMHSA, *2013 Informational Bulletin, supra* note 3, at 5; SAMHSA, *National Guidelines for Child and Youth Behavioral Health Crisis Care, supra* note 14 at 20 (2022).

[17] *See* CMS & SAMHSA, *2013 Informational Bulletin, supra* note 3, at 5; SAMHSA, *National Guidelines for Child and Youth Behavioral Health Crisis Care, supra* note 14 at 22 (2022).

MCRSS to meet the acute needs of youth with complex behavioral health needs is recognized by experts and government officials alike.[18]

Therapeutic Foster Care. For youth with complex behavioral health conditions and severely impaired family relationships, or in other situations when it is not possible to provide intensive behavioral health services in the youth's family home, therapeutic foster care is a vital alternative to residential treatment facility placements.[19] Therapeutic foster care offers a clinical intervention designed to avoid a youth's placement in congregate settings, and is delivered by specially trained foster parents who help youth learn skills in a family-like environment and also work with the family or caregiver to develop skills to more effectively intervene with the youth.

Challenges Faced by Youth Who Need Intensive Home and Community-Based Behavioral Health Services

Even where states have expanded coverage of intensive home and community-based behavioral health services—including intensive care coordination, intensive in-home services, mobile crisis response and stabilization services, and therapeutic foster care—those services often are not:

- Widely available due to insufficient provider networks and wait times;[20]
- Sufficiently *intensive* due to overly-restrictive time-limits for services or infrequent service delivery;
- Provided in accordance with appropriate standards or guidelines designed to ensure their therapeutic effectiveness or provided with only some of the components required to meeting the needs of the youth receiving them;
- Provided in a highly coordinated manner;[21] or
- Accessible to children involved in child welfare and juvenile justice systems.

These deficiencies in existing services materially contribute to unnecessary—and unnecessarily prolonged—utilization of residential treatment facilities that are often a dangerous last resort for youth with complex behavioral health needs. It is essential to address these challenges.

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[18] *See, e.g.,* Melissa A. Schober et al., Nat'l Ass'n of State Mental Health Program Dirs., *A Safe Place to Be: Crisis Stabilization Services and Other Supports for Children and Youth*, Paper No. 4 in the *From Crisis to Care Technical Assistance Series* (Sept. 2022), *https://innovations.socialwork.uconn.edu/wp-content/uploads/sites/3657/2023/03/Safe-Place-to-Be_Children-Crisis-and-Supports_NASMHPD-4.pdf;* SAMHSA, *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies* 10–11 (2014), *https://store.samhsa.gov/product/crisis-services-effectiveness-cost-effectiveness-and-funding-strategies/sma14-4848?referer=from_search_result;* SAMHSA, *National Guidelines for Child and Youth Behavioral Health Crisis Care, supra* note 14.

[19] *See* Lav & Lewis, *The Right to Community-Based Care, supra* note 6 at 18–20; *see also* Laura W. Boyd, SPARC, *Therapeutic Foster Care: Exceptional Care for Complex, Trauma-Impact Youth in Foster Care* 3 (July 2013), *https://firstfocus.org/wp-content/uploads/2014/11/11-therapeutic-foster-care-exceptional-care-for-complex-trauma-impacted-youth-in-foster-care.pdf;* Phillip A. Fisher & Kathryn S. Gilliam, *Multidimensional Treatment Foster Care: An Alternative to Residential Treatment for High Risk Children and Adolescents,* 21(2) PSYCHOSOCIAL INTERVENTION 195, 196 (Aug. 2012).

[20] To fully correct the overreliance on residential treatment facilities to address the behavioral health needs of these youth, each of these services must be made available to youth whenever and wherever they need them. Although waiting lists are not permitted for EPSDT services, as a practical matter, youth often are forced to wait for services due to provider capacity. For example, if a youth needs a psychiatric or psychological evaluation before developing a community-based treatment plan, shortages of psychiatrics and psychologists can delay access to care. This insufficient service capacity can exist even in a fee-for-service environment, where enrollees are free to choose their providers, If the community as a whole has a shortage of providers and a lack of capacity to serve youth with high-end needs, then access will be challenging. These problems can be compounded when dealing with a managed care system, where enrollees have to seek care within their network.

[21] While Wraparound intensive care coordination, intensive in-home services, and mobile crisis response and stabilization services can be beneficial even when provided to youth with complex behavioral health conditions in isolation, their effectiveness is greatest when they are delivered together, as needed, in a highly coordinated manner. *See* Declaration of Richard N. Shepler, Ph.D., *A.A. v. Phillips,* Civil Action No. 19–CV–770–BAJ–SDJ (M.D. La.), ECF No. 181–1 (9/14/2023), at p. 13 (¶ 36) ("When delivered together in a highly coordinated fashion, these services robustly create the conditions necessary for children and youth with significant emotional, behavioral, and mental health needs, including youth with SED, to function safely and successfully in their homes and communities); Eric J. Bruns Expert Report, *C.K. v. Bassett,* No. 2:22–cv 01791–NJC–JMW, ECF 54–2 (11/16/2023), at 7 (youth most likely to experience positive outcomes when ICC using Wraparound, Intensive In-Home Behavior Therapy, and Mobile Crisis Services are provided in coordinated fashion at state and local levels). These and other experts have emphasized the clinical shortcomings of disjointed interventions for youth with complex behavioral health conditions.

Policy Recommendations

We wholeheartedly support the Senate Committee on Finance's recommendations in its report "Warehouses of Neglect."[22] Below are some specific policy recommendations to support the Committee's recommendation to prioritize community-based services and placements.

1. Consider financial incentives to provide services with fidelity to the model.

Some services that youth need should be delivered through practice models that have fidelity scales that allow practitioners to assess whether services are being delivered in the way that they were designed.[23] For example, Intensive Care Coordination can (and should) be delivered via High Fidelity Wraparound; and for this service, there are scales to monitor fidelity to the practice model in service delivery and indicated ways to collect data about enrollment and outcomes.[24]

For services with well-established fidelity scales and evaluation processes, states could be required to implement such evaluations and publicly share data related to the evaluations. States could be provided additional funding to develop the data systems, high fidelity monitoring, and training that is necessary to demonstrate adherence to the model and to continuously improve these services.

2. Deem Psychiatric Residential Treatment Facilities (PRTFs) "institutional placements" for purposes of 1915(c) waivers.

Because PRTFs are not considered "institutional settings" for the purposes of § 1915(c), it can be difficult to target home and community-based waivers to this population through 1915(c) waivers.[25] However, between fiscal years 2007 and 2011, CMS conducted a successful national demonstration project, the Psychiatric Residential Treatment Facilities Demonstration ("PRTF Demonstration"), authorized by the Deficit Reduction Act of 2005.[26] Through the PRTF Demonstration, youth received high fidelity wraparound services (the form of ICC discussed above), and their families received respite services, and to a lesser extent in select states, peer services. These services were targeted to youth currently in PRTFs and/or youth currently in the community but at risk of PRTF placement.[27] The PRTF Demonstration served over 4,000 youth nationally, and found that providing community-based alternatives to youth meeting the PRTF level of need improved or maintained the their functional status.[28] Youth with the highest level of need consistently showed improvement in mental health status.[29] Furthermore, the waivers were cost effective: waiver services cost only 32% of comparable services provided in PRTFs.[30]

While the EPSDT mandate requires states to cover all necessary services for youth under age 21, and each of the services discussed above fall within this mandate,

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[22] United States Senate Committee on Finance, *Warehouses of Neglect: How Taxpayers Are Funding Systemic Abuse in Residential Treatment Facilities* 6 (June 2022).

[23] *See, e.g.,* University of Washington Wraparound Evaluation & Research Team, National Wraparound Implementation Center, and the National Wraparound Initiative Webinar, *Keeping Wrap on Track: A Panel of Leaders of Large-Scale Wraparound Evaluation Projects* (April 16, 2024), *https://nwi.pdx.edu/webinars/Webinar54-keeping-wrap-on-track.pdf.*

[24] National Wraparound Initiative, National Wraparound Implementation Center, & Wraparound Evaluation and Research Team, *Guidance for Family First Prevention Services Act Evaluation Plans for High Fidelity Wraparound* (2022), *https://nwi.pdx.edu/pdf/Guidance-FFPSA-High-Fidelity-Wraparound-Updated-02-2022.pdf.*

[25] *See* 42 U.S.C. § 1396n(c)(2)(B) (permitting states to target waivers to those "entitled to medical assistance for inpatient hospital services, nursing facility services, or services in an intermediate care facility." We recognize that states have other options to target services to youth with specific needs, but such mechanisms, like 1915(i) state plan services, are underutilized. *See* Molly O'Malley Watts et al., KFF, Medicaid Home And Community-Based Services: Medicaid Home & Community-Based Services: People Served and Spending During COVID–19 (2022), *https://www.kff.org/report-section/medicaid-home-community-based-services-people-served-and-spending-during-covid-19-issue-brief/#endnote_link_548723-23* (13 states have 1915(i) state plan amendments, constituting less than 1% of all spending on HCBS, and of those, only six states use 1915(i) to target individuals with mental health disabilities).

[26] Deficit Reduction Act of 2005, Pub. L. No. 109–171, § 6063, 120 Stat. 4, 99 (2006).

[27] Oswaldo Urdapilleta et al., IMPAG International, LLC, *National Evaluation of the Medicaid Demonstration Waiver Home-and Community-Based Alternatives to Psychiatric Residential Treatment Facilities* (May 30, 2012), *https://nwi.pdx.edu/pdf/nationalevaluationPRTF.pdf.*

[28] Kathleen Sibelius, Secretary of Health and Human Services, *Report to the President and Congress: Medicaid Home and Community-Based Alternatives to Psychiatric Residential Treatment Facilities Demonstration* (July 2013), *https://www.medicaid.gov/sites/default/files/2019-12/prtf-demo-report.pdf.*

[29] *Id.*

[30] *Id.*

there are certain advantages to also utilizing a 1915(c) waiver for this population to provide services that are not otherwise covered (or coverable) as medical assistance, such as respite services. A state may also utilize a 1915(c) waiver to provide services for youth with slightly higher income levels, which can limit the harmful practice of "custody relinquishment" by families with higher incomes desperate to access community-based services for youth with complex behavioral health conditions. Last, as noted above, the fact that states have a federal obligation to cover such services does not always result in robust access to services. As the PRTF Demonstration found, use of the waiver increased participant enrollment in services and provider recruitment and enrollment.[31] Therefore, legislation that would deem a PRTF an institutional level of care for purposes of HCBS waivers may be a successful strategy to supplement essential State Plan services.

If Congress pursues this path, safeguards must be put in place to ensure that these waivers do not in any way curtail or limit a state's EPSDT obligations or State Plan services. The Medicaid Act provides for coverage of all medically necessary services that are included within the categories of mandatory and optional services listed in δ 1905(a), regardless of whether such services are covered under the State Plan.[32] CMS has emphasized that, pursuant to EPSDT, states should not rely on waivers to provide services that can be authorized under a State Plan, but may use waivers to supplement the EPSDT benefit.[33] Thus, any waivers for PRTF levels of care should be used to help develop service structures, recruit providers, extend coverage to families with slightly higher incomes, and to supplement youth's existing entitlement.

3. Improve Access to Services by Requiring Additional Rate Analysis.

As noted above, although formal wait-lists are not permitted for State Plan services, youth often wait for services due to poor access and provider shortages. Recently, CMS finalized the Ensuring Access to Medicaid Services rule, in part to rectify this lack of access.[34] Laudably, CMS will require comparative payment rate analysis for outpatient mental health and substance use disorder services, and this analysis must measure Medicaid fee for service rates against Medicare payment rates for the same time period (and track rates for the pediatric population separately).[35] However, for various reasons, many of the services needed to serve this population of youth may not be adequately addressed in the rate analysis.[36]

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[31] Oswaldo Urdapilleta, et al., IMPAG International, LLC, *National Evaluation of the Medicaid Demonstration Waiver Home-and Community-Based Alternatives to Psychiatric Residential Treatment Facilities* 51 (May 30, 2012), *https://nwi.pdx.edu/pdf/nationalevaluationPRTF.pdf.*

[32] 42 U.S.C. § 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B); 1396d(r).

[33] *Id.;* CMS, EPSDT—A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents 26 (2014), *https://www.medicaid.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf;* ("Children under age 21 who are enrolled in an HCBS waiver program are also entitled to all EPSDT screening, diagnostic, and treatment services. Because HCBS waivers can provide services not otherwise covered under Medicaid, waivers and EPSDT can be used together to provide a comprehensive benefit for children with disabilities who would otherwise need the level of care provided in an institutional setting. . . . The HCBS waiver services essentially "wrap-around" the EPSDT benefit."). CMS, Application for a § 1915(c) Home and Community-Based Waiver [Version 3.6, January 2019] Instructions, Technical Guide and Review Criteria 131–132 (2019), *https://wms-mmdl.cms.gov/WMS/help/35/Instructions_TechnicalGuide_V3.6.pdf* ("States have an affirmative responsibility to ensure that all child waiver participants (including children who become eligible for Medicaid by virtue of their enrollment in a HCBS waiver) receive the medically necessary services that they require, including Medicaid coverable services available under EPSDT. Because the HCBS waiver can provide services not otherwise covered under Medicaid and can also be used to expand coverage to children with special health care needs, EPSDT and HCBS waivers can work well in tandem. However, a child's enrollment in an HCBS waiver cannot be used to deny, delay, or limit access to medically necessary services that are required to be available to all Medicaid-eligible children under federal EPSDT rules.").

[34] CMS, Medicaid Program; Ensuring Access to Medicaid Services, 89 Fed. Reg. 40542 (May 10, 2024).

[35] *Id.* at 40872; 42 CFR §§ 447.203(b)(2), (b)(3)(i)(B) (effective July 1, 2026).

[36] *Id.* at 40733. CMS has already stated that to narrow the analysis, it will exclude certain codes. In order to be included as a mental health service, the service must have an E/M CPT/HCPCS code that was in effect for calendar year 2023, the code must be on the Berenson-Eggers Type of Service (BETOS) code list for the same period, and it must fall into the E/M family grouping for outpatient mental health and substance use disorder services. Examples CMS gives of services that will be excluded in include peer support, psychosocial rehab, and assertive community treatment. The final list of CPT/HCPCS codes that are subject to comparative rate analysis will be published no later than July 1, 2025, and are subject to change. However, it seems likely that core services essential to support children with intensive mental health needs may not be included in this analysis.

While we appreciate that CMS has an enormous task ahead to effectively implement the Access Rule, we are concerned that payment rates for services for this population may not be adequately examined. Additional funding directed towards studying payment rates and access to the core community-based services outlined above (1) intensive care coordination, 2) intensive in-home behavioral services, 3) mobile crisis response and stabilization services, and 4) therapeutic foster care) would help inform future rulemaking to address these gaps.

Conclusion

We thank the Committee for its extensive work on behalf of youth with complex behavioral health needs, and for its steadfast commitment to improving services for these youth, and in turn, their lives. We look forward to partnering with the Committee as it continues to pursue solutions to this urgent problem.

LETTER SUBMITTED BY SASHA OATES

June 7, 2024

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

Dear Senate Finance Committee,

My name is Sasha Oates, and I am a survivor of residential treatment facilities as well as a former employee of a UHS hospital. I am testifying about the abusive and neglectful conditions I experienced in a youth residential treatment facility in response to the Senate Finance Committee's hearing titled "Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions."

I was placed in Provo Canyon School at the age of 14 due to issues with mental health and self harm. During my time there, I experienced many instances of abuse. I was sexually assaulted by a staff member, restrained in a violent manner that led to multiple injuries, isolated in a concrete room without clothing or my eyeglasses or even a bathroom, gassed by mixed cleaning chemicals that caused permanent scarring in my lungs to the point I was taken to the hospital. I was called a number, 316, instead of my name. I was dehumanized and forced to stand or sit in stress positions. I was forcibly tube-fed, one of the worst experiences of my life multiple times. I was over-medicated, including chemical restraint, and forced through conversion therapy. This treatment had a profound negative impact on me, including nightmares, chronic asthma from the scars in my lungs, severe PTSD, and a loss of self.

In addition, as one of my first jobs as an adult, I was employed as a mental health technician for a psychiatric hospital owned by UHS. At the time, I was unaware of the connection between my former placement and my then employment. I only worked there for half a year, but in that time many things stood out to me. There was a dangerous lack of staffing, for both staff and patients. Restraints were used often and de-escalation, though taught, was rarely used. I saw ignoring of medical issues and complaints, including someone going through severe withdrawal without regular nursing checks. The nursing supervisors actively discouraged mandated reporting of child abuse and I had to go around once to report something. I also felt compelled to report a sexual assault on one patient by another, and was chastised by my employers. I left when my own physical health prevented me from continuing to work, though they tried to insist on me continuing my shift despite losing consciousness and hitting my head. The lack of care applies not only to their patients, but to the entire facility.

I felt compelled to share my story to prevent any child from suffering like I have, for every child to feel safe. I want the Committee to understand the real-life consequences of inadequate care and oversight in residential treatment facilities.

To prevent these negative experiences, I believe the Senate Finance Committee should consider implementing stricter regulations and oversight of youth residential treatment facilities. This includes mandatory reporting of abuse, transparent data collection, increased staff training on trauma-informed care, regular and unannounced inspections, and ensuring that all facilities provide adequate mental health and educational services. Additionally, there should be accessible channels for residents to report abuse without fear of retaliation.

Thank you, Chair Wyden, and members of the Senate Finance Committee, for reading my testimony. I hope that my story and the stories of others like me will inspire

you to take immediate action to protect vulnerable youth in residential treatment facilities. I hope you will pass the Stop Institutional Child Abuse Act (S. 1351) and follow that legislation up with additional reform policy to ensure all youth are safe from abuse, neglect, and preventable death in youth residential treatment facilities.

Sincerely,

Sasha Oates

OMAHA NATIONAL COMMISSION FOR CHILDREN AND FAMILIES

Statement of Pat Hunt, Leonard Bickman, Ph.D., Ann Garland, Ph.D., William E. Reay, Ph.D., Barbara Huff, and Mario Scalora, Ph.D.

Subject: Response to "Warehouses of Neglect" by The Omaha National Commission for Children and Families

This Senate Report is the latest in a long line of warnings documenting the inhumane treatment children receive in institutions that are operated for the purposes of profit rather than healing. Past scholarship, beginning in 1982, by behavioral scientists like Jane Knitzer, Barbara Burns, Gary Melton, Ira Schwartz, Leonard Bickman, and Tom Dishion have identified the problems of residential treatment facilities and have advocated for alternatives. This advocacy included the lived experiences of youth and their parents.

Effective behavioral health treatments for children and families, including the development of supportive neighborhoods, schools, and related systems can be implemented and sustained. However, leadership at the state and national levels has been absent. Merely calling for tighter oversight by the very institutions who continuously permitted this tragedy to occur is shortsighted and ineffective. We must abandon the current economic model of services to our children and families that treats them as profit-making commodities, and instead value them as assets that require nurturing, resources, and the application of the latest scientific findings.

New visions and leadership are called for at this very critical period.

Respectfully Submitted for the Commission,

William E. Reay, Ph.D.
President and Chief Executive Officer
OMNI Inventive Care

Director, Omaha National Commission for Children and Families

Scholar in Residence, Saybrook University

Invited Professor of Psychology
Universidad de La Habana, Cuba

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June 23, 2024

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

Senate Finance Committee Members:

Regarding the above referenced hearing, I write to you from Idaho both as a parent of a child who is physically and developmentally disabled, and on behalf of the Pay Family Caregivers National Coalition.

Thank you for making the horrific failure of Residential Treatment Facilities (RTF) a priority to address. After reading the Committee's report, and having dealt with this broken system for 14 years, I feel it's important to note there is a systemic design flaw in HCBS that feeds the chronic RTF problem—and a simple tweak can

fix it. As parents, we dearly love our disabled children and want to care for them. Far too often, we're forced to give them up to outside institutions and RTFs simply because we cannot afford to provide that care ourselves for free. Our children often require around-the-clock care that we as parents want to lovingly provide them, however, Section 1905(a)(24) of the Social Security Act and related CFRs (such as 42 CFR §440.167 and 42 CFR §441.105) prohibit family caregivers from providing Personal Care Services to our loved ones with disabilities in our own homes. Due to workforce shortages and the unique needs of our loved ones, finding outside care providers can be impossible and many families of disabled children and adults therefore struggle to pay their bills to the point that they feel forced to sign their loved one over to care facilities. Mind you, this placement is much more expensive to the federal and state governments than paying Legally Responsible Individuals (LRI) such as parents or spouses, to provide their care at home.

Care provided by parents and spouses at home is safer and provides better outcomes that reduce overall healthcare costs. During the COVID–19 pandemic, 39 states instituted waivers through CMS that allowed parents and spouses to be paid caregivers for their disabled loved ones. This 3-year "experiment" realized these tangible benefits:

1. Families were able to bring their loved ones home from institutional settings and provide quality, in-home care at a tremendous savings to Medicaid;
2. Fewer participant hospitalizations due to better care;
3. Healthier homes requiring less mental health intervention;
4. Reduced household dependency on the public welfare and charity systems;
5. Increased payroll tax revenue into state and federal systems by compensating parent/spouse caregivers.

The National Council on Disability's report Strengthening the HCBS Ecosystem (Nov. 2022) highlights paying family caregivers as a key element to help move participants out of RTFs and into their homes stating "family caregivers should be paid, and CMS should make this a permanent to support the nation's need for a strong HCBS system."

We, Pay Family Caregivers National Coalition, have had multiple meetings with CMS administrators, Secretary Becerra's office and the Biden administration. Dan Tsai, Director of Medicaid for CMS made it clear CMS supports such change stating: "one of the silver linings of the pandemic was people seeing the impact of having paid family caregivers in the Medicaid program . . . we think it's important from a workforce standpoint, we think it's really important for care." CMS highlights the aforementioned federal regulations as the roadblock for changing the current failed model.

Medicaid is a state-federal partnership in which many elements of care are optional and at the discretion of each state. In the political world of corporate contributions, having the "option" of family caregivers is not enough. Congress must "ban the bans" on paid family caregivers and heavily incentivize the use of this effective and affordable care strategy to get every state to leverage this option over the objections and financial contributions of the RTF corporations.

This systemic flaw of HCBS is failing our families and encouraging the routine and horrific abuse of vulnerable children and adults in RTFs. Removing the federal regulatory barriers against paying family caregivers and incentivizing our country to embrace them is a key part of the solution.

Would you please review our nationwide petition regarding this and reach out to me so we can discuss this further at my phone or email above?

On behalf of my child, and our 41,000+ signers, thank you for your consideration.

Appreciatively,

Nathan Hill

Pay Family Caregivers National Coalition

Shasta Kearns Moore
Calli Ross
Mary Mac Jenkins
Linda Molina
Lindsey Sodano
Jill McCardel, MPA

LETTER SUBMITTED BY MICHELLE PEREZ

June 10, 2024

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

To whom it may concern,

Please submit the following statement into the record for the June 12, 2024 Senate Finance Hearing, Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions.

Sometimes your family isn't the one you start out with. It's the one you meet along the way. I met mine at a meeting with Jessica Grimm, director of a freshly-formed group called Bravehearts M.O.V.E. New York. They were youth just like me, who had lived what I had lived. The meeting changed my life.

My childhood was harsh. There was dysfunction and abuse. My mother spoke no English. She was powerless when they said "we are taking your daughter." I woke up and I was not at home. They tell you what to eat, when to shower, when to go to sleep. I had entered the foster care world.

From the age of 13, I lived in congregate settings, residential treatment facilities that are supposed to heal traumatized and troubled kids but often do the opposite. I was abused and mistreated. It was a dark time. I signed myself out on my 18th birthday. There were no resources for me—nobody told me about the benefits I could have received, no effort at all to help me reconnect to the world. I was hurt and depressed and slept all day. I got lucky and was assigned to Andrea, an after care worker who is like my second mom. She led me to that meeting with Bravehearts, and to my life's work as a counselor and advocate for young people threatened with or in the foster system.

I recently had the pleasure of working with Children's Rights and the amazing Rashida Abuwala (so close to my heart) as an advisor on the creation of a new report called Are You Listening? Youth Accounts of Congregate Placements in New York State. The report adds to the mounting evidence that congregate placements do more harm than good. It shines a light on a system that is hurting kids, not helping them, and offers good ideas for ending congregate placements.

One of the many reasons I participated in Are You Listening? is to lift up all of the voices that were never heard, all of the youth that were mistreated at the hands of the system. All the young people I have worked with over the years. People listened to me and that's why I am who I am today. I'm living proof that healed people heal people. But I carry the scars. Foster care is an experience that stays with you for a lifetime.

I want lawmakers to be open, to be human, to think like fathers or grandparents. What if these were your kids? You never walked in my shoes, were never homeless or hungry. So take my word for it. You have the power to make the future a little bit better for young people. If we work hand in hand to connect the empty spaces between us, we can make a lot of magic happen.

I have another reason for caring so much about this issue. His name is Jacob and he's 5 years old. My son is my beautiful blessing. I am raising him to be a light among people. There is so much that is difficult in the world. People are busy and pushing and forgetting to be human. They don't hold the door, they don't say thank you. Jacob is being raised to appreciate and respect and listen to others. I'm holding the door for others, working to ease their way. My son will do the same.

Sincerely,

Michelle Perez

LETTER SUBMITTED BY DEANDREA PETERSON

June 12, 2024

Subject: Reform for Adolescent Facilities

Attached below is a statement of concern submitted by one of my staff members before her termination as well. She asked that it be forwarded in regards to the hearing concerning residential treatment facilities, specifically UHS in Dothan, AL.

I work at a residential facility in Dothan, AL and the amount of verbal, emotional, physical, and sexual abuse at the facility needs to be investigated. They do not adhere to the staff per child ratio, they refuse children the basic rights and needs such as food, using the bathroom, outside time, and phone calls.

There are far too many unnecessary restraints with false documentation to justify the restraint and kids are retaliated against when they write a grievance. Majority of incidences are not reported to keep the numbers low.

Kids are not properly diagnosed and over medicated. Almost all of the kids have the same diagnosis and treatment is not individualized. Staff violate HIPAA by talking about other patients' information to other patients.

Staff that report things or advocate are considered a problem and targeted by administrators.

Please help!

Olivia Waters

STATEMENT SUBMITTED BY DEANDREA PETERSON

Former Director of Clinical Services of Laurel Oaks Behavioral Health Center, a UHS hospital in Dothan, Alabama

I'm so pleased that someone is intervening and reviewing the status and operations of local residential treatment facilities. I have worked with children for the duration of my professional career, and not once have I ever been terminated for speaking up for the benefit and welfare of patients or children. Sadly, during my employment, I witnessed several incidents that could have been prevented. Many of the incidents and injuries of patients and staff were due to poor training/supervision, not enough bodies for supervision, or dismissed feedback regarding concerns brought forward to our CEO.

What I witnessed in the last year was saddening and disheartening to say the least. At one point I began vehemently pointing out safety concerns and issues, which ultimately led to my termination. At different points I was pressured to take corrective action against staff members who were also reporting issues that they had observed, which were falling on deaf ears.

Despite being short staffed and other issues brought forward, our CEO instructed our director of intake not to stop intakes. At some points she would go in and accept patients herself around the director of intake, many of which had already been denied by the director of intake who did not meet our criteria for care. I began to realized our facility was finagling numbers to show specific outcomes to generating a certain amount of money no matter if we were short-staffed or how many staff members were injured, we continued to have turnover. When I brought forth solutions to rectify concerns, they were dismissed several times and it became apparent that our hospital's CEO's only focus was money.

As I became more saddened and dismayed. I started raising more concerns which generated more attention to our hospital until I was ultimately terminated for reporting (our agency not reporting) all of the incidents appropriately. The ones that I brought forward in writing were investigated, but the others that my staff verbally notated were immediately dismissed or explained away.

I know that I was terminated to be silenced about the ethical concerns I was raising. I had not received any corrective/disciplinary action in the time I had been there up until the last 30 days. In that corrective action was in the form of an employee performance improvement plan. On that plan it only had details of concerns

and issues for my department that were specifically decided and instructed by the CEO.

The dysfunction within our hospital had shown my true concern for taking the job in the first place. I had been adamantly warned by other colleagues not to accept employment there, but was initially convinced that we were trying to change the narrative, provide quality services, and be a beacon of light in our community. After a little over a year of employment, I regretfully share that I was wrong.

Sadly Laurel Oaks Behavioral Health will always have the poor reputation that it has had since my childhood in Houston county. I'm not sure who will be reading this statement, but I would like to challenge the president and any other corporate leadership to dig deeper at the virus that continues to spread.

Hire adequate CEO leadership that has a heart for the patients, families, and staff that they serve, not just obtaining money at any cost. During one credentialing visit, the last question they asked me was if I would send my children to the hospital for care, and sadly my immediate answer was no. I would never send my children to a place like this.

Respectfully,

DeAndrea D. Peterson,
Former Laurel Oaks Behavioral Health Clinical Director

LETTER SUBMITTED BY FINN POOL (RICHARDSON)

June 12, 2024

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

Dear Senate Finance Committee,

My name is Finn Pool (Richardson), and I am a youth rights advocate and survivor of abuse and trafficking in a youth residential treatment facility. I am 18 years old, and I am about to graduate high school—something that did not seem possible just a few years ago. I am finally able to come to terms with my story, use my voice, and advocate for change. I am testifying about the abusive and neglectful conditions I experienced in a youth residential treatment facility in response to the Senate Finance Committee's hearing titled "Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions."

I am your average, curious, growing teenager—who is just trying to find their way in society, but because of the trauma and abuse that I endured throughout my childhood, and my desire to live my life out loud, as a proud gay teen—I found my life forever changed.

I was kidnapped in the middle of the night, against my will, at my father's behest and unwittingly placed at Elevations RTC, located in Syracuse, Utah at 15 years old. I hadn't done anything worthy of being dragged to this place without my consent, except, my father didn't like that I was openly gay. It was clear that being sent to this nightmare facility was punishment because I wanted to live with my mom after their divorce—a choice I made as a result of the abuse I suffered at my father's hands.

When I decided that I wasn't going to take the verbal, mental, emotional, physical, and sexual abuse he doled out for another second, that was the very day he sent me away. I, for the first time, said no—I won't be hit, berated, and raped by him anymore, and it was clear that this was the consequence.

Elevations RTC is a place that purports to offer guidance, support, and relief to students of all genders, but in reality, it's a place where you are stripped bare of your basic human rights and civil liberties, and the sole goal is to do the bidding of the person who is writing the checks—in this case, my father. Their real goal was to ensure that you left as a shell of your true self, that you questioned who you were, and that you knew that full and total compliance was your only path out of this place. And I was not alone in my experience. Most of the people I knew also experienced similar things, such as being taken in the middle of the night by strangers and being told that if you ask anyone for help you'll only "make matters worse," being stripped naked, searched, and forced to use lice shampoo as if we were prisoners, or even only being allotted 15 minutes of phone use per week forcing us to choose between which loved one we wanted to call for that minimal amount of time.

Even further, during my time there, I was forced into solitary confinement on account of alleged "COVID," I was denied the right to see my Rabbi, was forced to sleep on a plastic sheet, was given a therapist who did not report my sexual assault, and frequently told that my only way out was to obey—an onslaught of emotional abuse that no 15-year-old should have to endure. This treatment had a profound negative impact on me, and the Troubled Teen Industry can't hide its impact on its prisoners. Survivors spiral into depression, drug use, and abusive relationships—then we die, and it can only be labeled as a tragedy. I can't see more people endure the same life I had to. I can't see any more believe that tomorrow isn't worth striving for. I can't sit knowing that the friends I met along the way have had their lives destroyed.

I felt compelled to share my story because I cannot stand to see more lives continue to be ruined by an unregulated "care" system and I am determined to raise awareness for all of those still stuck in the nightmare I was lucky enough to survive. I want the Committee to understand the real-life consequences of inadequate care and oversight in residential treatment facilities and I want there to be tangible action for all of us that have had to endure the suffering we had no choice but to take.

To prevent these negative experiences, I believe the Senate Finance Committee should consider implementing stricter regulations and oversight of youth residential treatment facilities. This includes mandatory reporting of abuse, transparent data collection, increased staff training on trauma-informed care, regular and unannounced inspections, and ensuring that all facilities provide adequate mental health and educational services. Additionally, there should be accessible channels for residents to report abuse without fear of retaliation.

Thank you, Chair Wyden, and members of the Senate Finance Committee, for reading my testimony. I hope that my story and the stories of others like me will inspire you to take immediate action to protect vulnerable youth in residential treatment facilities. I hope you will pass the Stop Institutional Child Abuse Act (S. 1351) and follow that legislation with additional reform policy to ensure all youth are safe from abuse, neglect, and preventable death in youth residential treatment facilities.

Sincerely,

Finn Pool (Richardson)

LETTER SUBMITTED BY SHELBY POTEET

June 23, 2024

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

Dear Senate Finance Committee Members,

I am writing to you from Kentucky. Thank you for prioritizing the critical issue of Residential Treatment Facilities (RTFs).

I am a single mother who takes care of my level 3 autistic son we are currently on a 8 year wait list in my state to get funds to pay for me to care for him without having to work a public job. This would allow me to stay home and give him all the support he needs to have a future that is independent and successful.

I am writing to ask you to recognize the barriers to paid family caregiving and their role in abuse and neglect in our nation's care network. Home and Community-Based Services (HCBS) current regulations (Section 1905(a)(24) of the Social Security Act, 42 CFR § 440.167, and 42 CFR § 441.105) prevent family caregivers from being paid to provide care at home. This forces many families to place their loved ones in RTFs due to the lack of affordable care options.

During the COVID–19 pandemic, 39 states allowed parents and spouses to be paid caregivers through CMS waivers. This led to better care, fewer hospitalizations, healthier homes, reduced dependency on welfare, and increased tax revenue. The National Council on Disability supports making this change permanent.

CMS officials, including Dan Tsai, have acknowledged the benefits of paid family caregivers. However, current federal regulations remain a barrier. Congress must "ban the bans" on paid family caregivers and incentivize states to adopt this model.

This change is crucial to prevent the abuse and neglect often seen in RTFs and to support families in providing safe, effective care at home.

Appreciatively,

Shelby Poteet

LETTER SUBMITTED BY SARAH S. POTTER

June 24, 2024

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

Dear Senate Finance Committee Members,

I am writing to you from North Carolina. Thank you for prioritizing the critical issue of Residential Treatment Facilities (RTFs).

During COVID, our family was unable to employ Direct Care Professionals to provide care for my son who has cerebral palsy. I was able to get paid during the PHE, as were many other families in similar situations. Now that they are unable to be paid for caregiving in some states, families are finding themselves in crisis. They are forced to quit their jobs to stay home to care for a loved one or be forced to place them in a RTF. Please consider the predicament this situation puts families in and how toxic it is to the health and welfare of the family.

I am writing to ask you to recognize the barriers to paid family caregiving and their role in abuse and neglect in our nation's care network. Home and Community-Based Services (HCBS) current regulations (Section 1905(a)(24) of the Social Security Act, 42 CFR § 440.167, and 42 CFR § 441.105) prevent family caregivers from being paid to provide care at home. This forces many families to place their loved ones in RTFs due to the lack of affordable care options.

During the COVID–19 pandemic, 39 states allowed parents and spouses to be paid caregivers through CMS waivers. This led to better care, fewer hospitalizations, healthier homes, reduced dependency on welfare, and increased tax revenue. The National Council on Disability supports making this change permanent.

CMS officials, including Dan Tsai, have acknowledged the benefits of paid family caregivers. However, current federal regulations remain a barrier. Congress must "ban the bans" on paid family caregivers and incentivize states to adopt this model.

This change is crucial to prevent the abuse and neglect often seen in RTFs and to support families in providing safe, effective care at home.

Appreciatively,

Sarah S. Potter

RAINN
1220 L Street, NW, Suite 500
Washington DC, 20005
https://rainn.org/

June 11, 2024

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

Dear Senate Finance Committee,

Thank you for the opportunity to provide testimony on the critical issue of abuse and neglect in youth residential treatment facilities.

As the nation's largest anti-sexual violence organization, RAINN is dedicated to advocating for safety from sexual violence and exploitation, including the most vulnerable among us: our children and youth.

The recent reports of abuse and neglect in residential treatment facilities are deeply disturbing. We cannot stay silent in the wake of accusations that these facilities, which are entrusted with the care of young individuals grappling with mental health, substance use, and behavioral challenges, have become environments of further trauma and harm.

We are alarmed by claims of inappropriate use of restraint and seclusion, chronic staffing shortages, inadequate mental health and substance use disorder services, and substandard educational provisions. We must emphasize that sexual violence, in particular, is an insidious issue within institutions, and that such abuse leaves indelible scars and compounds the already significant challenges faced by vulnerable children. These issues not only violate the trust placed in these facilities by youth and their families but also infringe upon the fundamental rights of the young people in their care.

Any exploitation, mistreatment, or abuse of youth in residential treatment facilities is abhorrent and must be addressed with the utmost urgency. We demand accountability and support for survivors of abuse, and we encourage provision of comprehensive support services for survivors within these facilities. We ask you for stringent regulations and oversight of youth residential treatment facilities, including mandatory reporting of abuse, transparent data collection, enhanced staff training in trauma-informed care, regular unannounced inspections, and assurance that all facilities offer sufficient mental health and educational services.

Furthermore, residents must have accessible and safe channels to report abuse without fear of reprisal. Ensuring that survivors have the resources they need to heal and pursue justice is critical, and we at RAINN stand ready to support the Senate Finance Committee in their efforts to ensure that these facilities serve as safe havens of healing and support, not sources of additional trauma.

Thank you, Chair Wyden, and members of the Senate Finance Committee, for your commitment to protecting our nation's youth. We look forward to working together to eradicate abuse and neglect in residential treatment facilities and promote a future where every young person can thrive in a compassionate and trauma informed environment.

Sincerely,

Stefan Turkheimer
VP of Public Policy

Karrie Delaney
Director of Federal Affairs

LETTER SUBMITTED BY ISABELLA REESE (BLANCHARD)

June 12, 2024

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

Dear Senate Finance Committee,

My name is Isabella Reese and I am a former resident of a youth residential treatment facility.

I am testifying about the abusive and neglectful conditions I experienced in a youth residential treatment facility in response to the Senate Finance Committee's hearing titled "Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions."

In June 2013, I was placed in the Village Behavioral Health Treatment Center (run by Acadia Healthcare) at the age of 15 due to depression, anxiety, self-harm, and suicidal thoughts. While at this facility, I experienced and witnessed physical, mental, and emotional abuse. Here are some examples I can recall of the abuse I experienced:

- Food was a privilege. If a patient was not behaving submissively to the staff, food would be restricted. Along the same lines: using the bathroom, contacting family members, sleeping in a bed, and sitting on furniture were also privileges.

- Children were restrained by multiple staff members at any given moment. A child simply scratching their arm could lead to being restrained and sedated. One night in particular, I witnessed 3 different girls being restrained ("for their safety"). This led to 3–4 staff members holding down each child and then giving each child a shot to sedate them.
- At the sound of the alarm to wake up in the morning, if children were not sitting up in their bed before 10 seconds, they would have water poured over their heads in their bed.
- "Wall-sits" were used as a form of punishment. We would have to sit against the wall (we did not have furniture) and perform a wall-sit for 30–60 seconds at a time. Sitting on the ground completely would lead to being physically punished.
- When coming back from an off-campus visit with my family, I was told to leave a urine sample. When I could not produce any urine, I was made to jump up and down constantly in the nurse's station until I felt like I could urinate to leave a sample.

I felt compelled to share my story to influence policy change and to raise awareness of the horrific abuse that happens at this particular facility. I want the Committee to understand the real-life consequences of inadequate care and oversight in residential treatment facilities.

To prevent these negative experiences, I believe the Senate Finance Committee should consider implementing stricter regulations and oversight of youth residential treatment facilities. This includes mandatory reporting of abuse, transparent data collection, increased staff training on trauma-informed care, regular and unannounced inspections, and ensuring that all facilities provide adequate mental health and educational services. Additionally, there should be accessible channels for residents to report abuse without fear of retaliation.

The fact that this meeting even happened gives me hope for what is to come. As I mentioned earlier in my written testimony, I was sent away in June 2013. The fact that this committee has met 11 years almost to the exact date when I started to experience and witness abuse brings a complete full-circle moment for myself. In 2016, I attempted to create a conversation by leaving a Google Review on the webpage for the treatment facility and thought that was going to be the best I could do to spread awareness. I am humbled and hopeful that I have been given the privilege to write in testimony for the account of the abuse I witnessed back in 2013

Thank you, Chair Wyden, and members of the Senate Finance Committee, for reading my testimony. I hope that my story and the stories of others like me will inspire you to take immediate action to protect vulnerable youth in residential treatment facilities. I hope you will pass the Stop Institutional Child Abuse Act (S. 1351) and follow that legislation up with additional reform policy to ensure all youth are safe from abuse, neglect, and preventable death in youth residential treatment facilities.

Sincerely,

Isabella Reese (Blanchard)

LETTER SUBMITTED BY ROBERT G. REYNOLDS

June 24, 2024

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

Dear Senate Finance Committee Members,

I am writing to you from Florida. Thank you for prioritizing the critical issue of Residential Treatment Facilities (RTFs).

As a past employee of Seniors Helping Seniors, I can vouch for the necessity of support needed for stroke victims and others who have disabling conditions, and the financial, mental and emotional toll taken by employed family members who must compete in the job market while facing the challenges of these conditions.

I am writing to ask you to recognize the barriers to paid family caregiving and their role in abuse and neglect in our nation's care network. Home and Community-Based Services (HCBS) current regulations (Section 1905(a)(24) of the Social Security Act, 42 CFR § 440.167, and 42 CFR § 441.105) prevent family caregivers from being paid to provide care at home. This forces many families to place their loved ones in RTFs due to the lack of affordable care options.

During the COVID–19 pandemic, 39 states allowed parents and spouses to be paid caregivers through CMS waivers. This led to better care, fewer hospitalizations, healthier homes, reduced dependency on welfare, and increased tax revenue. The National Council on Disability supports making this change permanent.

CMS officials, including Dan Tsai, have acknowledged the benefits of paid family caregivers. However, current federal regulations remain a barrier. Congress must "ban the bans" on paid family caregivers and incentivize states to adopt this model.

This change is crucial to prevent the abuse and neglect often seen in RTFs and to support families in providing safe, effective care at home.

Appreciatively,

Robert G. Reynolds

LETTER SUBMITTED BY KATIE SCHEID

June 24, 2024

Subject: Paid parent caregivers

Dear Senate Finance Committee Members,

I am writing to you from Washington. Thank you for prioritizing the critical issue of Residential Treatment Facilities (RTFs).

Washington is a state that does not allow parents of minors to be paid caregivers for their child's Medicaid Personal Care hours. Anyone can be hired to provide these extraordinary care hours except for me, her mother. I had to leave my job in 2020 to be her full time, unpaid caregiver. We have struggled to support our family on one income ever since. My daughter was allocated these hours to support her care in the family home instead of a costly institution. Because we can't find any caregivers to hire, she is left with zero services; zero support.

I am writing to ask you to recognize the barriers to paid family caregiving and their role in abuse and neglect in our nation's care network. Home and Community-Based Services (HCBS) current regulations (Section 1905(a)(24) of the Social Security Act, 42 CFR § 440.167, and 42 CFR § 441.105) prevent family caregivers from being paid to provide care at home. This forces many families to place their loved ones in RTFs due to the lack of affordable care options.

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CMS officials, including Dan Tsai, have acknowledged the benefits of paid family caregivers. However, current federal regulations remain a barrier. Congress must "ban the bans" on paid family caregivers and incentivize states to adopt this model.

This change is crucial to prevent the abuse and neglect often seen in RTFs and to support families in providing safe, effective care at home.

Appreciatively,

Katie Scheid and my daughter Millie



LETTER SUBMITTED BY ALYSSA SINGLETARY

June 24, 2024

Subject: Paid Parent Caregiving

I am writing to you from Georgia. Thank you for prioritizing the critical issue of Residential Treatment Facilities (RTFs).

I am writing to ask you to recognize the barriers to paid family caregiving and their role in abuse and neglect in our nation's care network. Home and Community-Based Services (HCBS) current regulations (Section 1905(a)(24) of the Social Security Act, 42 CFR § 440.167, and 42 CFR § 441.105) prevent family caregivers from being paid to provide care at home. This forces many families to place their loved ones in RTFs due to the lack of affordable care options.

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CMS officials, including Dan Tsai, have acknowledged the benefits of paid family caregivers. However, current federal regulations remain a barrier. Congress must "ban the bans" on paid family caregivers and incentivize states to adopt this model.

This change is crucial to prevent the abuse and neglect often seen in RTFs and to support families in providing safe, effective care at home.

Appreciatively,

Alyssa Singletary

LETTER SUBMITTED BY MARY C. SKELLY

June 12, 2024

Re: Senate Finance Committee Hearing.

Lucia M. Skelly is a declared trafficking victim by way of abduction when she was 13, in 2018, in the counties of Broward and Miami-Dade in the State of Florida.

Lucia Skelly was ordered by Judge Stacey Ross (17th Judicial District, Broward County, in the State of Florida) to the Department of Juvenile Justice in Gainesville and Tampa, Florida "to get her help and keep her safe."

At no time did Lucia Skelly receive informed trauma care as a child trafficking victim; rather, she was beaten, raped (conviction), and attempted to un-alive herself on multiple occasions.

No organizations equipped to deal with victims of child trafficking were allowed to enter those facilities to assist in therapy.

Lucia was not afforded phone calls to discuss abuses at those facilities; rather, on one occasion she was provided a phone by staff and requested of me by text, "mom please don't report any more abuse. The girls are going to use against me and could beat me."

After her release from the Department of Juvenile Justice in Florida she was brought to New York to be close to her grandmother.

Lucia Marie Skelly was denied a timely enrollment into school (violating her rights) and the after-care plan did not readily help with her transition back into society.

Lucia would continue to struggle to perform activities of daily living, suggesting mental health instability, and was placed in Gateway program (JCAA) at the age of 15. The New York program was presented as a "secure facility" and "the only child trafficking program in the North East." Lucia was lured out of the facility by a much older youth in a matter of days and was found in Atlanta, Georgia, in a human trafficking ring.

Lucia Skelly would return to New York, at which time the Department of Social Services placed Lucia in William George Academy where she would be subjected to more physical abuse, sexual grooming by staff and peers, and brainwashing by non-medical staff; staff members' beliefs and practices included persuading Lucia, a minor child, to have an IUD implant without informed consent.

The Department of Social Services failed to reinstate Lucia Skelly's disability benefits and sued me to pay while Lucia was in DSS care, time that included residential abuse and lack of adequate care. The seizure of my assets was illegal in a second case; two times my veterans benefits were seized.

At William George Academy, Lucia Skelly struggled with depression, anxiety, suicidal ideations and attempts. Lucia was often placed in "the blue room" as a form of solitary confinement and punishment. William George Academy refused to send Lucia out for mental health evaluation and stabilization at a local hospital or an Office of Mental Health Facility.

In sworn testimony on June 23, 2020, in front of Judge Cecile Morris in the county of St. Lawrence, in the State of New York, staff at William George Academy admitted they had no staff to treat complex trauma for child trafficking.

On June 23, 2020, Lucia was denied a mental health hospitalization for stabilization but rather she was placed in the Office of Children and Family Services, Harriet Tubman Detention Center, Columbia Detention Center and eventually was moved to a boys' detention facility, Brookwood Detention Facility, "due to staffing shortages."

While at Harriet Tubman, she was tasked with preparing meals for her fellow youth, with minimal to no help from staff or peers. The companies that provided food all mentioned facilities' diets caused excessive weight gain. Lucia gained 70 pounds and was prescribed diabetes medication while still a minor child who'd been in good health before her institutionalization.

Staff at all institutions rarely provided recreation. I heard once: "You see that rec yard. Just because we have one doesn't mean we will use it."

In each of the above-mentioned facilities, Lucia Skelly was sexually groomed, observed sexual assault by staff on other youth, beaten into silence (substantiated), physically beaten by three youth and sustained head injury with no outside medical evaluation.

There are many substantiated abuse reports.

Lucia Skelly was given medications without parental consent and placed in solitary confinement as a minor (illegal).

At no time was Lucia Skelly prescribed a medication that was known to help her condition, despite my multiple attempts to discuss the same or provide clinical evidence.

Lucia was discharged from OCFS on October 13, 2021 and the Community Services Officer along with the Department of Social Services did not provide follow up care with me, her mother; rather they approved her placement with her bio-dad, who had previous arrests and incarcerations, some related to drug use. While with him, he drugged his own minor child with hard-core substances and exploited Lucia to his adult associates.

Lucia Skelly overdosed, was given Narcan, and was raped in the community, then left for dead. Law enforcement and the Department of Social Services never held bio dad accountable for anything related to Lucia.

To date, Lucia Skelly continues to struggle with mental health issues and drug addiction and has never received proper help.

I would like the opportunity to discuss this in more detail and also discuss solutions.

To view one report on Lucia's first abduction at the hands of human sex traffickers, click on the link below.

Sun Sentinel: "The Crime of Surviving" is the fourth episode of season three of the Wondery podcast "Felonious Florida: Innocence Sold." The episode is about a 13-year-old girl who goes missing from her mother's apartment and returns a week later beaten, raped, and with a rose tattoo on her neck. Within hours of her return, the police arrest her for crimes her captors forced her to commit. The episode is available to listen to on Wondery+, Apple Podcasts, and *wondery.com.*

Wondery *https://wondery.com/shows/felonious-florida/episode/5320-the-crime-of-surviving/*, episode, 5, "The Crime of Surviving—Felonious Florida:" S3 E4

Lucia is a very special young lady who has faced atrocities at a young age. "The system," no matter the state, has failed her at almost every juncture. Lucia deserves the right help and justice.

Mary C. Skelly

LETTER SUBMITTED BY OPAL D. SMITH

June 25, 2024

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

Dear Senate Finance Committee Members,

I am writing to you from Kentucky. Thank you for prioritizing the critical issue of Residential Treatment Facilities (RTFs).

I am writing to ask you to recognize the barriers to paid family caregiving and their role in abuse and neglect in our nation's care network. Home and Community-Based Services' (HCBS) current regulations (Section 1905(a)(24) of the Social Security Act, 42 CFR § 440.167, and 42 CFR § 441.105) prevent family caregivers from being paid to provide care at home. This forces many families to place their loved ones in RTFs due to the lack of affordable care options.

During the COVID–19 pandemic, 39 states allowed parents and spouses to be paid caregivers through CMS waivers. This led to better care, fewer hospitalizations, healthier homes, reduced dependency on welfare, and increased tax revenue. The National Council on Disability supports making this change permanent, and I am grateful that Kentucky is one of those states that is implementing that change. However, caring for our disabled should not be a partisan issue! Historically it has been just that in Kentucky.

Under the previous administration, attempts were under way to severely cripple our waiver system and create roadblocks for paid family caregivers. However, under our current governor, Kentucky is making headway towards expanding our HCBS waivers, both by opening more slots on the current waivers, and creating new waivers

to alleviate the extensive waiting lists for the current ones. Families worry though, that the next governor may be like the previous one, and we will be back to fighting to maintain the option of hiring family members to provide in-home care.

CMS officials, including Dan Tsai, have acknowledged the benefits of paid family caregivers. However, current federal regulations remain a barrier. Congress must "ban the bans" on paid family caregivers and incentivize states to adopt this model.

This change is crucial to prevent the abuse and neglect often seen in RTFs and to support families in providing safe, effective care at home.

Appreciatively,

Opal D. Smith

LETTER SUBMITTED BY LINDSEY SODANO

June 23, 2024

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

Dear Senate Finance Committee Members,

I am writing to you from Ohio. Thank you for prioritizing the critical issue of Residential Treatment Facilities (RTFs).

The best way to keep minor children out of residential treatment facilities, long term care facilities, and intermediate care facilities is to recognize the vital care labor of parents. Often, children like my daughter have no other choice but to be institutionalized because non-relative care workers are not interested in working with her due to her challenging behaviors, need for constant supervision, and need for hands-on direct assistance with all activities of daily living.

I am writing to ask you to recognize the barriers to paid family caregiving and their role in abuse and neglect in our nation's care network. Home and Community-Based Services (HCBS) current regulations (Section 1905(a)(24) of the Social Security Act, 42 CFR § 440.167, and 42 CFR § 441.105) prevent family caregivers from being paid to provide care at home. This forces many families to place their loved ones in RTFs due to the lack of affordable care options.

During the COVID–19 pandemic, 39 states allowed parents and spouses to be paid caregivers through CMS waivers. This led to better care, fewer hospitalizations, healthier homes, reduced dependency on welfare, and increased tax revenue. The National Council on Disability supports making this change permanent.

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Appreciatively,

Lindsey Sodano

LETTER SUBMITTED BY SONJA STEVENSON

June 23, 2024

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

Dear Senate Finance Committee Members,

I am writing to you from Oregon. Thank you for prioritizing the critical issue of Residential Treatment Facilities (RTFs).

I am writing to ask you to recognize the barriers to paid family caregiving and their role in abuse and neglect in our nation's care network. Home and Community-Based Services (HCBS) current regulations (Section 1905(a)(24) of the Social Security Act, 42 CFR § 440.167, and 42 CFR § 441.105) prevent family caregivers from being paid to provide care at home. This forces many families to place their loved ones in RTFs due to the lack of affordable care options.

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Appreciatively,

Sonja Stevenson

LETTER SUBMITTED BY TODD STEVENSON

June 23, 2024

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

Dear Senate Finance Committee Members,

I am writing to you from Oregon. Thank you for prioritizing the critical issue of Residential Treatment Facilities (RTFs).

I am writing to ask you to recognize the barriers to paid family caregiving and their role in abuse and neglect in our nation's care network. Home and Community-Based Services (HCBS) current regulations (Section 1905(a)(24) of the Social Security Act, 42 CFR § 440.167, and 42 CFR § 441.105) prevent family caregivers from being paid to provide care at home. This forces many families to place their loved ones in RTFs due to the lack of affordable care options.

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Appreciatively,

Todd Stevenson

LETTER SUBMITTED BY CYNTHIA TAYLOR

June 23, 2024

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

Dear Senate Finance Committee Members,

I am writing to you from FLORIDA. Thank you for prioritizing the critical issue of Residential Treatment Facilities (RTFs).

I am writing to ask you to recognize the barriers to paid family caregiving and their role in abuse and neglect in our nation's care network. Home and Community-Based Services (HCBS) current regulations (Section 1905(a)(24) of the Social Security Act, 42 CFR § 440.167, and 42 CFR § 441.105) prevent family caregivers from being paid to provide care at home. This forces many families to place their loved ones in RTFs due to the lack of affordable care options.

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Appreciatively,

Cynthia Taylor

THINK OF US
1400 16th Street, NW, Suite 215
Washington, DC 20036
https://www.thinkofus.org/

Statement of Sixto Cancel

Chairman Wyden, Ranking Member Crapo, and Honorable Members of the Senate Committee on Finance, thank you for holding this hearing and for the opportunity to submit written testimony. On behalf of Think of Us, I want to thank the Committee and the Senate HELP Committee for conducting this investigation and for their important work advancing the well-being of children through oversight of residential treatment facilities.

Think of Us is a research and design lab dedicated to fundamentally rearchitecting the child welfare system with the children, families, and communities that have been impacted by the system at the center of shaping what it should be. Founded and co-led by people with lived experience in foster care, Think of Us engages system-wide in participatory research, virtual support services, proximate policy, and innovative partnerships with state and local governments. Since 2020, Think of Us has engaged with over 50,000 individuals with lived experience in the system. Our recommendations are based on their invaluable insights.

In 2021, Think of Us published *Away From Home: Youth Experiences of Institutional Placements in Foster Care.*[1] The tragic death of Cornelius Frederick in a residential treatment facility (RTF) in Michigan and my brother's own story of abuse in care were the inspiration for that project. As my team considered the state of institutionalization in foster care, we recognized that though decades of research and outcomes data show the harms of unnecessary institutionalization, the voices of the children who experienced those harms were absent from the conversation. We knew so little about their actual experiences and their implications for policy and practice. We sent researchers to interview dozens of young people about their experiences in care and collect art, poetry, and artifacts. The resulting report, written in young people's own words, uses qualitative research methodologies to validate and provide context to the data and research.

Away From Home is a stark reminder of the human cost of over-institutionalization and the poor conditions and oversight of RTFs, making clear the stakes of congregate care reform. While we heard from young people who received the intensive

[1] *https://assets.website-files.com/60a6942819ce8053cefd0947/60f6b1eba474362514093f96_Away%20From%20Home%20-%20Report.pdf.*

support they needed in RTFs, many others received substandard care for their complex needs. We also heard from young people who never should have been placed in institutions in the first place. The report shares harrowing stories of abuse, neglect, and isolation. "I felt like I was in prison," one participant revealed. "They didn't care about helping us heal, just keeping us in line."

The report further validated and underscored what the bipartisan leaders of the Committee saw and acted on in the Family First Prevention Services Act of 2018 (Family First): we cannot continue the current paradigm of institutionalization as a placement and option for long-term care. We must move away from RTFs as placements and utilize intensive in-patient treatment only as a rare, high-quality time-limited, trauma-informed intervention that does not supplant family but is built to support a child's ability to heal and thrive within a family and focused on facilitating connections with family and community. Most importantly, we must focus on building the conditions wherein every child can be raised in a family.

RTFs ostensibly exist because children with complex mental and behavioral health needs require support they cannot receive in a family-based setting. However, rather than functioning as conceived, RTFs function as absorptive capacity for the placement crisis due to lack of investment across the placement continuum. Instead of functioning in a way that would help children heal, facilities that should be an option of last resort are serving as a choice of least resistance despite well-documented poor outcomes and exorbitant cost. Many youth are unnecessarily placed, sedated, and isolated, cut off from the love and stability of family. As Ms. Stanford testified, many receive substandard treatment in quantities and duration that could be better provided in a family setting.

Using RTFs as a placement option instead of a treatment is counterproductive to children's healing. Research shows that group homes and institutional placements are associated with lower graduation rates, higher rates of justice involvement, and fewer positive relationships and life skills. Children heal and develop in the context of their relationships with people who love them and separating them from those people makes it impossible for children to heal. It is imperative that we prioritize family-based treatment and, when intensive inpatient services are necessary, that maintenance and strengthening of the relationships that help children heal remain paramount.

There has been improvement on this front, and we applaud the success of states and localities that are working to reduce their reliance on congregate care. Following publication of *Away From Home,* we have worked with Indiana, New Hampshire, California, and numerous other states that seek to transition away from this practice. We know states across the country have stepped up their efforts to reduce the use of institutionalization in foster care, and we welcome the consistently declining rates of congregate placement reported each year.

The Senate Finance Committee played a crucial role in this with the bipartisan passage of Family First. The landmark law offers an opportunity to redesign the system with investment in prevention—recognizing the fundamental truth that the best way to prevent institutionalization is to prevent children from ever needing to enter foster care in the first place—and support for kin to reduce the need for unnecessary residential care. Family First offers a path forward with the Qualified Residential Treatment Program (QRTP) model. However, the bipartisan law is still in its nascent stages of implementation. A recent study [2] by the American Academy of Pediatrics and Chapin Hall found significant opportunities to support state implementation, including through improved staffing, expanded access to community-based mental health services, and effective aftercare. These are critical opportunities to better serve young people who do need time-limited treatment.

Investing in Family-based Placements

Over-reliance on RTFs is often driven by a shortage of alternatives for children with complex needs. Family-based alternatives are more developmentally and therapeutically appropriate for children, cost substantially less in the short- and long-term.

Kinship Care

In our work with states to reduce reliance on RTFs, investment in kinship care has emerged as a crucial strategy. Children placed with people who know and love them experience less trauma from family separation, maintain closer connections to their culture and community, remain with siblings, and experience better outcomes on

[2] *https://downloads.aap.org/DOFA/AAP%2050%20state%20Review%20of%20Congregate%20Care%20Reform%20Across%20America.pdf.*

nearly every measure than their peers in non-kin foster care and institutional placement. Further, kin caregivers are more likely to care for children with complex needs and to remain stable when faced with behavioral health challenges. We must focus on placing children with kin, establishing policies and practices that ensure kin are the first placement a child has in care to minimize the trauma of entering care and reduce the likelihood that children will reach an acute crisis stage.

We must also ensure we are providing appropriate and equitable support to kin caregivers. This includes offering training, financial assistance, and ongoing support, as well as increased investment in kinship navigator programs, which connect caregivers to resources and support in their communities. The Committee recognized the value of kinship navigators in Family First, making them allowable expenses for the title IV–E prevention program. Unfortunately, despite clear Congressional intent that the Clearinghouse should consider these programs differently than other title IV–E prevention interventions, they have struggled to receive approval for reimbursement, as the Clearinghouse's evidentiary requirements do not fit the realities of kinship navigation. As a result, only five program models have been approved by the Clearinghouse, which does not offer states the diversity of options necessary to meet the varied needs of communities across their jurisdiction. Most approved models were designed to meet the needs of families in urban environments, meaning states cannot serve kin in rural communities, who often face greater difficulties accessing a sparse array of services.

To ensure sufficient navigation services are available to support kinship placement, Congress should build flexibilities to allow more emerging programs to receive reimbursement and provide up-front investments in development and evaluation of kinship navigator programs, as they have through appropriations since 2018. Increasing these funds and guaranteeing them through a multi-year appropriation will allow states and tribes the funding certainty necessary to invest in the multi-year evaluations needed to ensure programs are efficient and able to meet the needs of communities that need them. In doing so, the Committee can wrap around kinship families and create the conditions for children to heal and grow.

Therapeutic Foster Care

For children with complex needs, therapeutic foster care (TFC) offers an opportunity to receive intensive intervention in a family setting. In TFC, caregivers are given specialized training and offered enhanced supports to ensure they can meet the needs of children with behavioral challenges in a stable, loving environment. States should be encouraged and incentivized to invest in therapeutic foster care, including therapeutic foster care for kin.

The Committee could address this by providing demonstration funds for TFC, including TFC models focused on kinship families, which tailor training and support to build on the inherent strengths and therapeutic potential of family bonds and to address challenges caused by family dynamics. Grants can focus on developing new models of TFC, improving existing models, and on evaluation of existing models for the purposes of quality improvement and meeting evidentiary standards for reimbursement. Further, to incentivize expansion of existing well-demonstrated TFC models, the Committee should consider increasing federal financial participation (FFP) for TFC under both Medicaid and title IV–E.

Recruitment and Retention of Foster Families

While institutional placement is meant only to be used when there is a distinct clinical need, in reality child welfare agencies also place children in RTFs when there are not enough foster homes to meet placement needs. Accordingly, the Committee should focus on strategies that support recruitment, support, and retention of foster families, such as those identified by the CHAMPS campaign.[3] When it comes to building a sufficient supply of foster family placement settings, the data are clear that retention of foster families is an even bigger barrier than recruitment. Effective foster parent retention strategies include access to crisis supports and mental health services, peer support and peer mentorship programs, and giving foster parents a dedicated staff person they can call when they need help.

Building a Community-Based Mental Health Continuum

Across the country, we face a crisis of children's mental and behavioral health, with children reporting unprecedented rates of anxiety and other problems. While this extends well beyond the foster care system, children in foster care experience this

[3] *https://bettercarenetwork.org/sites/default/files/CHAMPS-Guide-on-Foster-Parent-Recruitment-and-Retention.pdf.*

crisis more acutely because of the trauma they have experienced that brought them to the child welfare system, and the subsequent trauma of family separation and foster care.

Congress has made major investments in community-based health in schools, but community-based mental health supports are still deeply insufficient. In the absence of a more comprehensive system, foster care has become the de facto tool for dealing with children's mental and behavioral health challenges. A not-insubstantial number of young people also enter care through voluntary placement agreements, not because of any abuse or neglect but simply because their families cannot afford mental health treatment. If we had an effective community-based mental health system, we would not have a placement crisis, because children would be able to remain at home instead of ever coming into care.

Invest in Developing Community-Based Providers

Building a continuum of community-based supports to ensure children have timely access to mental health care will require incentives to develop the provider array. We need pediatric mental health providers who can deliver services focused on children in foster care in community settings. Congress should consider increasing Medicaid FFP for community-based pediatric mental health interventions focused on youth in foster care that have been shown to prevent institutionalization of children. This includes services like crisis and mobile response programs that intervene and stabilize families in times of acute stress and therapeutic foster care modalities. It should also include peer support programs for youth and kin and non-kin caregivers, which help minimize the trauma and isolation of foster care and empower caregivers with the skills and relationships needed to navigate behavioral health challenges.

We must also ensure that efforts to expand access to care come with appropriate guardrails to avoid inadvertently creating incentive for families to enter care in order to access mental health services. Think of Us has worked with loving and devoted parents who have been forced to surrender their children to the child welfare system to get them mental health services and support they need. In addition to investing in services focused on foster care, we must invest in broadly available community-based pediatric mental health services so no parent ever has to make that choice. Congress should increase Medicaid FFP for a broad array of mental health services and related interventions addressing social determinants of health to support children early before they are ever brought to the attention of child welfare.

Build the Behavioral Health Workforce

It is also vital that we expand the pediatric behavioral health workforce and ensure that they are specialized and prepared to meet the unique needs of youth in care. Congress could establish scholarships and financial incentives like loan repayment assistance that encourage people to pursue careers in behavioral health and invest in specialized training programs. Additionally, to be competitive and maintain the workforce, we must ensure that payment rates for services are sufficient to pay for the high quality of care.

Building Support for Parents and Caregivers

As we invest in expanding the availability and quality of community-based pediatric mental health care, we must also make similar investments in developing and expanding training and support for parents and caregivers of children with mental and behavioral health challenges. Caregivers need support developing the skills to understand and address challenging behavior and support and tools to cope with the difficulties of parenting children with complex needs. Peer support programs, especially, can be an effective tool for preparing parents and caregivers, as many report that managing challenging behavior can be isolating. Seeing parents and caregivers as a target population for support, not just a partner in providing support to children, can improve the care children receive and promote placement stability.

Investing in the Child Welfare Workforce

It is imperative, if we are to end over-reliance on institutional placement, that we invest in the child welfare workforce. With overburdened caseloads, caseworkers are unable to manage the complex care requirements of children in their charge. This can lead to delayed service referrals or insufficient care coordination. In our research, we heard directly from caseworkers and other agency staff who explain that, often, children who could have received treatment in a community setting are placed in institutional care because staff don't have the capacity to coordinate with community-based providers, and RTFs manage those services. This causes both negative

outcomes and preventable public expenditure that could be better deployed to appropriate services promoting well-being and permanency.

Recruitment and Training

Focusing on recruiting and training child welfare staff would reduce average caseloads and ensure youth receive better care coordination. Providing greater funding to pay for more staff and offer higher salaries could make casework competitive financially. Agencies could also be empowered to provide scholarships, student loan repayment assistance, and other financial incentives to join and remain in the workforce. States should be provided incentives to reduce their average caseload, tied to metrics related to quality of care, particularly to ensuring that you and families are actually able to access services in a timely manner.

Engaging Lived Experts in Workforce Expansion

As they expand their workforces, federal policy should require jurisdictions to engage with the community that the agency serves, so that the children and families that are meant to benefit from the child welfare system are able to inform the expansion of the workforce in ways that would benefit them. Agencies should engage with lived experts to provide input on where limited staffing resources should be placed and to direct expansion of training and professional development services, as the children and families impacted by the child welfare workforce have the clearest picture of what skills staff need in order to provide optimal care.

Until such time as the conditions are in place that residential treatment exists only as a high quality, time-limited intervention and not a placement, the following are suggestions for how to improve necessary oversight and to improve the quality of these facilities.

Improving Conditions in Institutional Settings

Some RTFs provide high-quality, intensive in-patient care in a safe, supportive environment, but both the Committee's investigation and *Away From Home* make clear this is not the norm. We encourage the Finance Committee to advance institutional care reform focused on better addressing the needs of children and establish and enforce strict requirements for providers.

Confirm Necessity of Institutional Intervention

In passage of Family First, the Committee took the powerful step of requiring independent assessment to verify the need for placement in a QRTP. In the years since passage of Family First, we have heard numerous reports of assessment tools for this purpose being used to justify placement for children who could be served in the community.

This is, in part, because assessments are carried out by individuals who do not have previous knowledge of the child. Congress should amend the independent assessment provisions of Family First to ensure the child's family and their clinicians, who have a clearer understanding of their needs than can be gleaned in a single assessment, be consulted in any decision to provide in-patient care, as well as in the regular re-assessment of the child's needs. Further, recognizing that complex behavioral needs need specific interventions, the provision should be expanded to include independent assessment that the institution in question actually has the capacity, treatment milieu, and expertise to meet the specific needs of the individual child.

Require Intensive Treatment

Think of Us commends Ms. Stanford for her testimony and affirms her assertion that the level of treatment children often receive in RTFs does not necessitate institutional care. While there are institutional providers offering truly intensive treatment, that is not the norm. RTFs should be required to provide a level and intensity of care commensurate with a need for institutional placement and should be held accountable for doing so. This treatment should be in accordance with an individualized, trauma-informed treatment plan that is focused on clinical needs, always with a goal of return to family and community. In addition to requiring this of providers receiving federal funding, Congress should require the Department of Health and Human Services to provide comprehensive guidance and technical assistance to states on establishing customized treatment plans for youth with complex needs.

Center Family in Institutional Care

Children heal, develop, and thrive in the context of their families, and if they cannot safely remain within a family and need in-patient treatment, family should be central to the care that they receive. This means that the child's family should be closely involved throughout the course of the child's time in care. Institutions should be

required to implement family team decision making, wherein youth and family voice are central to the creation of the child's individualized treatment plan. We further agree with Ms. Manley, who testified that a child's family should be granted access to the child at any time, both to ensure that the child remains connected and that the family can ensure conditions within the facility are sufficient.

Focus on Return to Community

In interviews we conducted for *Away From Home,* youth repeatedly reported that placement in institutional settings made them feel isolated and that they had no way out because life in institutions was so restrictive and so different from life in the community. Many reported struggling and feeling unprepared when they returned to family settings or aged out of care. Accordingly, it is crucial that RTFs strive to create normalcy for children in their care, allowing them to have access to extracurricular activities and connections with their family. Discharge planning for every child should begin on the first day of care, and RTFs should have effective financing mechanisms to ensure access to seamless transition care, such as case management providers within the community, so that the therapeutic benefit of residential treatment continues through the return to family.

RTFs should be required to provide support to the child's family as well, to ensure they are ready to meet the child's needs and able to adapt to managing challenging behaviors. This support should continue once the child has returned to the community, to ensure stability and help children re-acclimate to less restrictive environments.

Professionalize the RTF Workforce

The Committee's report, *Away From Home,* and the American Academy of Pediatrics report made clear that staffing in RTFs is insufficient to meet the needs of children in care and is a key quality improvement need. As a result, instances of abuse that should be prevented go unchecked and children are not provided the level of clinical treatment needed. RTFs must be held strictly accountable for meeting staffing ratios, but staffing needs in RTFs extend beyond staff size. RTFs must ensure the workforce is professionalized, well-trained, and supported to provide the level of care that is needed. A workforce development plan is needed to support staff and improve pay so RTFs can attract and retain employees of a sufficient caliber. To effectively meet the needs of youth with complex trauma, staff need to be sufficiently and regularly trained and credentialed to provide care that meets clinical standards.

Improving Oversight of Institutional Care

Expand Oversight Capacity

This investigation made clear that regular and routine oversight of all RTFs receiving federal funds is necessary, and Congress should provide sufficient funds to oversight entities, such as Protection and Advocacy Agencies, to do this oversight. While all facilities should receive oversight, it is essential that reviews be conducted in response to any adverse event at the facility where they occurred and any other facility owned by the parent company. At a minimum, any fatality in a child welfare institution should require an external post hoc review to understand why it happened and address the underlying causes at the individual facility and across the network. Similar reviews should be conducted for other sentinel events such as elopement, sexual abuse, or inappropriate use of seclusion and restraint.

Establish Time Limits for FFP

Understanding that the negative impacts of institutionalization compound as children spend longer periods outside of family and community settings, Congress should implement a process to establish time limits for FFP for any residential treatment facility. Time limits should be determined by medical professionals and child development experts and should be based on age, developmental stage, and clinical presentations and prognoses, with flexible and regularly re-evaluated guidelines.

Create Oversight Standards for Psychotropics

The Committee's findings about use of psychotropics confirm the long-held understanding that psychotropics are dramatically overused in institutional settings to enforce compliance. It's important that states have protocols in place for monitoring psychotropic medications use, for informed consent from youth, and for assurances that use of psychotropic medication complies with professional practice guidelines. Understanding that psychotropics are often used as a crutch to manage behavior in lieu of effective treatment to address underlying trauma, this must be coupled with

expansion of non-pharmaceutical treatment. Use of psychotropics should be evaluated in the context of other services provided to the child.

Establish Uniform Federal Restraint and Seclusion Standards

The Committee's findings on seclusion and restraint were particularly concerning, especially those in contravention of state and federal laws and those that were not documented. Congress must establish and enforce uniform federal standards related to restraint and seclusion at any facility receiving federal funding. At a minimum, the standards for any facility should correspond to those currently required for PRTFs. Additionally, for any institutions receiving federal funding, strict documentation and reporting requirements for any use of restraint or seclusion should be mandated, with harsh penalties for fraud or failure to report.

Require Public Data Reporting

All facilities receiving federal funding should be required to publicly report on measures related to safety and efficacy of programs, including uses of restraint and seclusion, instances of abuse, rates of successful return to community, length of aftercare provided, average length of stay, staff-child ratios, and measures that indicate the intensity of interventions provided, such as average weekly hours of clinical intervention for children in care. Additionally, RTFs should be required to report on metrics related to the specific target populations they are meant to serve. For instance, an RTF specialized in treating children with problematic sexual behaviors should be required to report on metrics of whether incidence of those behaviors has changed.

Performance and Outcome-based Monitoring

To ensure federal investment in institutional treatment sees results, Congress should establish a system for monitoring the performance and outcomes of these facilities by initiating a process to generate quality measures and benchmarks against which RTFs are evaluated. Medical and child development professionals should be engaged to determine what are the most appropriate metrics and benchmarks to ensure that RTFs are meeting their stated purpose of time-limited, intensive in-patient treatment in service to family. Rankings of providers based on these quality metrics should be published and regularly updated.

Create a Private Right of Action

The findings of the Committee's investigation made clear that children are experiencing serious harms in institutional care, often in clear contravention of state and federal laws. This highlights a clear need for a private right of action for youth, as was included in early drafts of Family First, to allow them to receive relief and restitution. At minimum, this should extend to instances of abuse, of unnecessary institutional placement, of excessive length of stay incommensurate with clinical need, and of failure to provide sufficient clinical care.

Maintain Medicaid Protections Against Inappropriate Institutionalization

The Committee's report made clear that the harms of institutionalization are worse in larger facilities. Think of Us is concerned by efforts to undermine oversight of QRTPs by exempting them from Medicaid's Institutions for Mental Diseases (IMD) exclusion. We strongly oppose the Ensuring Medicaid Continuity for Children in Foster Care Act (S. 3196), which would weaken oversight and prioritize institutionalization over community-based mental health care, undermining the progress of Family First. We reject a paradigm in which children in foster care are placed in facilities deemed impermissible for any other child. In-patient treatment should be provided in the most family-like setting possible. There is no clinical reason for large-scale institutionalization and no evidence that children are better off in facilities that are larger than 16 beds. Exempting QRTPs from the IMD exclusion would have no tangible benefit for children in care and would amount to a massive wealth transfer to institutional facilities.

A better system is possible. As we hold the industry accountable for past abuses, we must recognize that the most egregious actors are not representative of the whole system. We have seen group home providers shift toward in-home services and providers offering high-quality intensive inpatient services with a focus on returning to the community. We must also create a path forward for providers willing to embrace a new family-centered approach.

We are grateful to the Committee for conducting this important investigation, which we hope will be a catalyst for greater focus on oversight of these facilities and improved conditions within them. We urge the Committee to focus on building the con-

ditions for high-quality community-based mental health care and for every child to grow up in a family.

Most importantly, we are grateful to the survivors whose resilience and courage have shone a light on a system that failed them. Only by listening to their voices and honoring their strength can we build something better. We know what works and what to do; we just need the policy reforms and investments that make it possible at scale.

Think of Us stands ready to support Congress in helping to shape this better future. If you have any further questions, please contact Steven Olender, Senior Advisor for Policy Innovation at steven@thinkofus.org.

LETTER SUBMITTED BY MARIA M. TIROLY

June 24, 2024

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

Dear Senate Finance Committee Members,

I am writing to you from Pennsylvania. Thank you for prioritizing the critical issue of Residential Treatment Facilities (RTFs).

I have direct experience working with individuals with disabilities and have witnessed abuse first hand in residential facilities at the hands of uncaring providers who prioritize profit over disability rights, and I am also a woman diagnosed with disabilities myself who has been the victim of abuse and violence and can relate to how individuals with disabilities feel to be powerless and helpless against the harm inflicted by those who are meant to protect us and will do anything in my power to advocate for disability rights.

I am writing to ask you to recognize the barriers to paid family caregiving and their role in abuse and neglect in our nation's care network. Home and Community-Based Services (HCBS) current regulations (Section 1905(a)(24) of the Social Security Act, 42 CFR § 440.167, and 42 CFR § 441.105) prevent family caregivers from being paid to provide care at home. This forces many families to place their loved ones in RTFs due to the lack of affordable care options.

During the COVID–19 pandemic, 39 states allowed parents and spouses to be paid caregivers through CMS waivers. This led to better care, fewer hospitalizations, healthier homes, reduced dependency on welfare, and increased tax revenue. The National Council on Disability supports making this change permanent.

CMS officials, including Dan Tsai, have acknowledged the benefits of paid family caregivers. However, current federal regulations remain a barrier. Congress must "ban the bans" on paid family caregivers and incentivize states to adopt this model.

This change is crucial to prevent the abuse and neglect often seen in RTFs and to support families in providing safe, effective care at home.

Appreciatively,

Maria M. Tiroly

LETTER SUBMITTED BY LISA TSCHUDI

June 23, 2024

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

Dear Senate Finance Committee Members,

I am writing to you from Oregon. Thank you for prioritizing the critical issue of Residential Treatment Facilities (RTFs).

I am the parent of a young lady with IDD. When she was very young, I vigorously sought preschools and daycares and could not find any that would accept her—none. Public school is in session about half the days of the year, and not as late as the typical work schedule for paid employment. My daughter still as an adult cannot safely be left alone without supervision.

Medicaid home and community based services were just expanded when my daughter was about 13, after which we had a lot of experiences having difficulty finding employees for all the hours we needed and with call-outs or no shows when we did schedule them. I pursued employee recruitment, and I provided orientation, scheduling and supervision to those we did find. Not being eligible to work those paid jobs myself, even as my daughter grew into her teens I therefore was never able to find any way to receive any income outside of relying on my husband's salary, despite my massive expenditures of time and energy while meeting my daughter's care needs. I was reliant on my husband.

I was frequently complimented on the quality of the job I did and my daughter has in fact grown up to be a confident, really delightful young lady who is stable medically. In order to get her to this point, I drove on 6 hour trips multiple times yearly to see specialists, watchful each time that she might require immediate medical care while in transit. In between those trips, I took her to other local specialists. I sought out and implemented directions from the medical providers, calculated meal plans, researched food content carefully and measured all of her food to the nearest gram for the ketogenic diet as prescribed by her dietician and neurologist for epilepsy.

I drove my daughter to physical, occupational and speech therapies on a weekly basis. I sat in IEP meetings for school and meaningfully advocated for my daughter to attend our neighborhood high school instead of one 30 minutes away where I didn't feel her needs were being met. I bathed her, got her dressed including specialized orthotic gear that is complicated to put on, learned to understand her unique way of communicating, programmed and worked with her on AAC devices. I sought accessible social opportunities and ordinary childhood experiences for my daughter to enjoy.

I supported her involvement with playdates, assisted her to walk around parks (including as she got to be 12 years old and older), and to communicate at the library. I provided transportation to an acting class which led to her having an incredible opportunity in a professional theater production. I supported her involvement in that play. I did the above and more daily, without reliable breaks.

I made the appointments, filled out the many, many lengthy forms and kept the calendar for all of it. All while we very much struggled to pay my family's bills on my husband's income alone, and I struggled with the emotional repercussions of being told repeatedly, directly and indirectly, that everything I was doing was not working. My daughter and I have been very fortunate that we never reached the excruciating level of unmet need at home such that we would seek placement for her in an RTF, but I am very aware of the delicately tenuous nature of the life we lived. I can imagine if a few things were slightly different, we might have sought such a placement.

I am writing to ask you to recognize the barriers to paid family caregiving and their role in abuse and neglect in our nation's care network. Home and Community-Based Services (HCBS) current regulations (Section 1905(a)(24) of the Social Security Act, 42 CFR § 440.167, and 42 CFR § 441.105) prevent family caregivers from being paid to provide care at home. This forces many families to place their loved ones in RTFs due to the lack of affordable care options.

During the COVID–19 pandemic, 39 states allowed parents and spouses to be paid caregivers through CMS waivers. This led to better care, fewer hospitalizations, healthier homes, reduced dependency on welfare, and increased tax revenue. The National Council on Disability supports making this change permanent.

CMS officials, including Dan Tsai, have acknowledged the benefits of paid family caregivers. However, current federal regulations remain a barrier. Congress must "ban the bans" on paid family caregivers and incentivize states to adopt this model.

This change is crucial to prevent the abuse and neglect often seen in RTFs and to support families in providing safe, effective care at home.

Appreciatively,

Lisa Tschudi

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Youth Residential Treatment Facilities:
Examining Failures and Evaluating Solutions

Universal Health Services, Inc. ("UHS" or the "Company")[1] submits this statement for the record of the June 12, 2024 Senate Committee on Finance ("SFC" or "Committee") hearing titled "Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions." UHS appreciates the Committee's focus on Residential Treatment Facilities ("RTFs"), how they are regulated and ensuring a safe environment for the residents.

We regret that, in spite of our cooperation with the Committee throughout the course of a 2-year investigation of RTFs,[2] the report is incomplete and misleading and provides an inaccurate depiction of the care and treatment provided at UHS RTFs, as well as the safety of the residents at those facilities. While we recognize the importance of the Committee's work in this area and share its concern over any incidents at any RTFs that cause harm to residents, the Committee's report does not present an accurate picture of UHS RTFs. Further it fails to recognize the thousands of children helped by our facilities over the years; children whose lives have been greatly enhanced as a result of their stay and the treatment they received at one of our RTFs.

Our network of subsidiary facilities serving this challenging juvenile population aims to provide high-quality, compassionate, effective treatment and care to each and every individual served. UHS RTFs offer behavioral and mental health services, academic instruction and life-skills training to help residents reach their therapeutic and academic goals, then successfully step-down to outpatient treatment or community-based care. This care setting comes at a time when these youth need intervention, redirecting them from counterproductive and dangerous behaviors. Many individuals are prepared to rejoin and be successful in their schools and communities as a direct result of the care and education they received at a UHS RTF.

We are proud of the positive clinical outcomes consistently achieved by our RTFs, the strong ties that we have developed and maintained with the communities we serve, and our good standing with the regulatory and administrative entities that oversee us. Our Behavioral Health Division resources along with facility leadership and staff work tirelessly to ensure we uphold the high standards we set for ourselves. Any deviation from our high standards is one too many. Additionally, we value the review and feedback of our regulators and seek to continuously improve when opportunities are identified.

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[1] UHS is a registered trademark of UHS of Delaware, Inc., the administrative services company for Universal Health Services, Inc. and a wholly owned subsidiary of Universal Health Services, Inc. Universal Health Services, Inc. is a holding company and operates through its subsidiaries including its administrative services company, UHS of Delaware, Inc. All healthcare and management operations are conducted by subsidiaries of Universal Health Services, Inc. Any reference to "UHS" or "UHS facilities" or "UHS RTFs" in this document relates to healthcare or management operations of the subsidiaries of Universal Health Services, Inc., including UHS of Delaware, Inc. For ease of reference only, we may use the term "UHS" or "UHS RTFs" in this document, but such use does not diminish the individual operational responsibilities of the subsidiary facilities. The terms "we," "us," "our" or "the company" in such context similarly refer to the operations of the subsidiaries of Universal Health Services, Inc., including UHS of Delaware, Inc. Further, any reference to employees, staff or UHS employees refers to employees of subsidiaries of Universal Health Services, Inc.

[2] UHS has continuously cooperated with the Committee over the course of its investigation. UHS has voluntarily made nine separate productions, totaling more than 12,000 pages of documents, relating to numerous requests for information regarding the policies, practices and clinical operations of UHS RTFs and provided multiple briefings to Committee staff to answer questions following these voluntary productions. In addition, UHS' senior leaders have spent hundreds of hours responding to the Committee's requests, including a culminating meeting with Committee staff that lasted more than 4½ hours. At every step of the investigation, UHS has provided thorough and transparent responses to every question posed by Committee staff. Despite this good-faith cooperation, the Committee's report is unfortunately riddled with misleading and incomplete allegations of substandard care.

We dispute the contention of the report and at the hearing that UHS places financial gain over resident treatment and safety. The care and safety of our residents is our top priority. UHS does not sacrifice those elements for financial benefit.

We would welcome the opportunity to work with the Senate Committee on Finance as well as other committees of jurisdiction on the development of potential legislation for the nation's RTF programs.

UHS Response to the Committee Report

We acknowledge that there have been incidents over the years at some of our facilities where residents have suffered harm. Such incidents are unacceptable and are contrary to the goals and expectations of our facilities. Any harm perpetrated by any staff member is unacceptable, not tolerated and directly contradicts the expectations of employment, the extensive training provided as well as the policies, procedures, and protocols of the facility.

Per UHS' policies and practices, allegations from individuals and survey findings from regulators are promptly investigated and, when appropriate, action is taken. Deviation from our high standards is not tolerated, and in most cases, noncompliant behavior by staff results in termination, along with an action plan to drive continuous improvement (*e.g.,* retraining, refinement of protocols, changes to future hiring practices, etc.).

That being said, the Committee Report is incomplete, misleading and provides an inaccurate depiction of the care and treatment at UHS RTFs as well as the safety of the environment at the facilities. None of the Committee staff involved in the investigation of this matter visited any UHS RTF despite being invited prior to publication of the report.

We are deeply committed to providing young people with effective treatment, compassionate care, and a nurturing environment, but are well aware that no organization, including our own, is perfect. We are always looking to improve the care and safety of the patients entrusted to us, which is why the incomplete and misleading Committee Report represents such a missed opportunity to actually improve patient care.

The following attempts to address and respond to the major themes and issues raised in the Committee Report relating to UHS RTFs. Due to space limitations of this submission per Committee rules, we will not address each and every matter, incident or survey cited in the report.[3]

Regulatory/Accreditation Surveys

The Committee Report cites various regulatory and accreditation surveys of UHS RTFs over several years. All healthcare facilities are subject to surveys (essentially inspections) by state and federal regulatory agencies as well as accreditation bodies in the ordinary course. The job of every regulator conducting a survey is to identify areas for improvement at a facility and UHS RTFs greatly benefit from their careful review. The Committee Report assumes that the existence of a report and all allegations and findings therein are evidence of deficient care—they are not.

Merely aggregating survey findings across 59 facilities over a multi-year period without regard to severity does not equate to a finding of poor quality of care at those facilities or across the UHS RTF spectrum. Further, the report references many TJC surveys but does not indicate that with each report where issues were referenced, the facility remedied those and maintained full accreditation. The same is true of state licensing and other regulatory reviews received by the Committee. No corresponding plan of correction is mentioned in the report, nor is any resolution of the identified issues mentioned.

All UHS RTFs are fully accredited by either The Joint Commission (TJC) or the Commission on Accreditation of Rehabilitation Facilities (CARF) and are in good standing with all regulatory agencies. All 59 facilities are Medicaid providers for in-state residents as well as out-of-state residents. Each Medicaid plan has its own requirements which vary from state to state. Additionally, all facilities are in compliance with the Federal Regulations (42 CFR §§ 483.350–483.376) governing restraint and seclusion as well as emergency preparedness at

[3] Our complete response can be found at *https://uhs.com/rtf/*.

RTFs. Further, all 59 UHS RTFs are in good standing with their licensing bodies in their respective states.[4]

As one example of a misguided attempt to impugn the regulatory compliance of one of UHS' RTFs, the Committee Report references a letter received by a Division VP of UHS indicating that there were incomplete behavioral treatment plans and crisis plans for children at the facility. It failed to mention that the facility "continues to MEET the family first requirements for QRTP (Qualified Residential Treatment Program) and did not require a plan of correction." That same letter closes with "DCFS [Department of Children and Family Services] is grateful for your partnership in our collective efforts to improve outcomes for Illinois' most vulnerable children and families." This is an example of failing to provide full context to a regulatory matter and drawing an erroneous conclusion based upon an incomplete review of the document.

Notwithstanding, we view all external agency and accrediting surveys as an opportunity to enhance the quality of care at our facilities as well as improve our operations. In addition, we have engaged our own external consultants at times to assess our facilities and provide recommendations on quality enhancement initiatives and to improve regulatory compliance.

Staff Incidents

The Committee Report cites isolated incidents over a several-year period of inappropriate sexual contact between staff and residents. To be clear—UHS' position is that one substantiated case of sexual relations or assault as well as any physical abuse by a staff member towards a patient is one too many. UHS has a zero-tolerance policy for such behavior and those incidents have no place in any treatment facility. In all of the instances cited in the report where the allegations were substantiated, those staff members were ultimately terminated.[5] Notwithstanding, context to these incidents is also relevant when viewing UHS as whole in relation to the safety of our RTFs. The Committee Report referenced five incidents at three facilities over a 6-year period (2017–2022) of inappropriate sexual contact with residents while at the facility. During that 6-year period, UHS RTFs treated approximately 19,000 patients spanning approximately 7 million patient days. Internal data for the past 4 years on these types of incidents establishes that the patient risk rate[6] for this type of harm was 0.003.[7] Again, while even one such incident is one too many and UHS' expectations are zero, such a risk rate does not equate to the narrative of a pervasive problem and/or an unsafe environment for residents at our facilities.

As to the incidents of staff physically harming residents at any of our facilities, the report once again identified a small number of isolated incidents to create the narrative of unsafe environments at UHS RTFs without any context as to the number

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[4] As of the time of submitting this response, Benchmark Behavioral Health in Utah is currently under a Conditional License but is expected to be returned to full license standing by the end of June 2024. Benchmark has had three visits by their state agency in the last few months and there have been no identified concerns raised.

[5] The report incorrectly highlights one matter at Cedar Ridge where a staff member was alleged to be engaging in sexual activity with a resident, but the facility transferred the staff to another unit in lieu of termination. This reference is incomplete and inaccurate. The facts of this matter are more complex. A staff member at Cedar Ridge initially thought there may be boundary issues involving the alleged staff member and reported that to facility management. However, there were no allegations of inappropriate sexual contact between the staff member and resident, and no evidence to support such behavior at that time. Notwithstanding, despite the lack of evidence present at that point in time, the facility transferred the employee to another unit pending a fuller investigation and re-trained and re-educated the employee regarding the facility policies on therapeutic boundaries. Subsequently, information became known to the facility that there may have been inappropriate sexual contact between the staff member and resident. At that point, Cedar Ridge immediately contacted the Oklahoma Health Care Authority who conducted an investigation which substantiated the allegations. The facility then immediately terminated the employee and notified law enforcement. This occurred over a course of 2 days. The Committee Report completely failed to include this context.

[6] The patient/resident risk rate is the percentage of patients that encounter this type of conduct or incident during a time period. If the resident risk rate is .003, that equates to .003% of all patients at UHS RTFs encountering this conduct. Conversely, 99.997% of the residents at UHS RTFs during this time period did not encounter or experience such an event. The same is true for other patient/resident risk rates referenced in this response.

[7] Some of these sexual encounters between staff and patients happened outside of the facility after the resident was discharged. Our incident tracking process does not separate the two as such contact and conduct violates our policies and procedures and the training our staff receive on boundary issues with residents (present and former). However, the rate of sexual contact among residents under our care would be even lower if we were to only account for contact within the facility.

of patients treated across the UHS RTF spectrum during that time. Over the past 3 years, based upon the number of patients treated during this time period, the patient risk rate of physical harm from staff was 0.015. Again, while even one such incident is too many and UHS' goals and expectations are zero, such a risk rate does not equate to the narrative of an unsafe environment for residents at our facilities due to staff harm since 99.985% of our residents across the UHS RTF continuum never encounter this conduct.

As referenced, through its Patient Safety Organization (PSO) process, UHS tracks the number of serious incidents per year where our staff has acted in a manner inconsistent with our training, policies and procedures, and protocols with respect to interactions with residents that result in harm. With almost 13,000 employees working at various UHS RTFs, the average annual rate of staff involved with serious incidents with patients is 0.005% of the staff. In all these instances, disciplinary action was taken, including and up to, immediate termination dependent on the circumstances and actions involved. Once again, our expectations are that there should be **zero** incidents. However, this data contravenes the false narrative, depicted in the Committee Report, that UHS RTFs are unsafe environments for our residents based upon staff interactions. In fact, this data supports the efforts of UHS to hire, train and evaluate our employees' actions in accordance with our expectations for the safety and well-being of our residents.

As described and provided in detail to the Committee staff during the course of their investigation, UHS facilities utilize an extensive hiring and training regimen for all employees—especially those that will interact directly with our residents. All employees go through screening prior to hiring that includes background checks by a third party. Every new employee undergoes a minimum of 40 hours of initial training. This training includes therapeutic boundaries with patients, physical management techniques, patient observation rounding and verbal de-escalation, to name a few. Employees in training will then be proctored on the patient care floor for a period of time before they are allowed to work independently with the residents. There is annual training required for all employees on a myriad of quality, clinical and resident safety issues.

Patient-on-Patient Abuse

The Committee Report attempts to portray pervasive patient-on-patient violence (sexual and physical) based on incidents cited in the report over several years. Once again, greater context will provide a more accurate picture of the state of the patient environment at UHS RTFs. Over the past 5 years, the average rate of patient-on-patient incidents resulting in serious harm across the UHS RTF spectrum was 0.1 per 1,000 patient days. Further, when assessing from a resident risk rate, the resident risk rate for significant physical harm was 0.01. The resident risk rate for sexual contact or acting out was 0.027.[8]

To be clear, even one substantiated incident is one too many. All UHS RTFs have protocols and practices in place to minimize the chance of sexual encounters or assaults between residents. We acknowledge that when the protocols and safety measures put in place are not followed by our staff, these types of isolated and unfortunate incidents can occur. Further, when an incident is reported and investigated, the facility promptly acts to remediate any deficiencies and enact measures to prevent recurrence. The primary focus, in the event of an allegation, is patient safety and protection against any harm. While there are not national benchmarks for this type of conduct, we believe that our rate would compare favorably to similar RTFs in similar locations treating a similar patient population. This is an area where greater data reporting may be of benefit to the industry, our residents and their families.

Restraints and Seclusion

The Committee Report inaccurately depicts UHS RTFs as overutilizing restraint and seclusion techniques to manage residents. This, again, is an incomplete and misleading characterization of the usage of restraint and seclusion at UHS RTFs. The report also references instances of improper restraint techniques being used. In fact, in UHS RTFs, restraint and seclusion are only for limited circumstances when a resident is in danger of harming themselves or others and in need of greater sup-

[8] UHS includes both consensual sexual activity as well as non-consensual activity in its data without distinction. While consensual activity between residents is inappropriate and efforts are taken to prevent such conduct, the rate of non-consensual sexual activity would be even lower that the 0.027% rate referenced above if the data were segregated.

port. In those circumstances, the use of each intervention is carefully monitored and documented.

The restraint usage at issue is staff members physically holding or restricting a resident's movement in order to help the resident regain self-control when they are dysregulated and are a danger to themselves or others. *To be clear, UHS does not use mechanical restraints.* While UHS RTFs focus extensively on reducing and minimizing the use of restraints, it is necessary at times to utilize these techniques to protect the patients. As stated, if our staff is found to have utilized inappropriate restraint techniques or utilized restraint in inappropriate circumstances, disciplinary action will be taken, including immediate termination, if warranted. Re-training may also be provided as appropriate.

UHS RTFs have comprehensive policies and procedures regarding the use of restraints and seclusion. Consistent with federal guidelines allowing restraint and seclusion at RTFs in certain circumstances (42 CFR §§ 483.350–483.376), UHS has standardized policies and procedures in place pertaining to restraint and seclusion practices, which are required at each UHS RTF. Some individual states have additional regulations that govern these procedures that are implemented by the facilities as well.

Consistent with these policies and other applicable regulations, we require a number of trainings on restraint and seclusion to relevant staff as needed. Training includes instruction on verbal de-escalation and physical management techniques, ongoing monitoring of the patient's health and safety, and properly choosing the least restrictive intervention among many others. UHS policy requires clinical and nursing staff, upon hire (and semi-annually thereafter), to receive mandatory training on the proper use and monitoring of physical and chemical restraints and seclusion. The training includes an 8-hour training class on verbal de-escalation techniques, followed by a 6–8 hour class on physical management techniques. Direct care staff are required to be certified in a nationally recognized physical management program and show evidence of competency related to application of restraints, and the monitoring, assessment and care of a resident in restraint or seclusion. In order to minimize the use of restraint/seclusion, staff involved in the use of restraint/seclusion must demonstrate an understanding of the causes of threatening behaviors, the impact of staff behaviors, the use de-escalation techniques, the signs of physical and emotional distress during restraint usage, including first aid techniques, and the processes for challenging inappropriate restraint interventions.

While we acknowledge there are instances when inappropriate restraint techniques are utilized (sometimes resulting in harm to a resident), the Committee Report presents a false narrative that such incidents are commonplace at UHS RTFs. The reality is that such incidents are rare. Through its PSO, UHS tracks the use of restraints as a mechanism to enhance our clinical operations and reduce their utilization. We provided data to the Committee staff on restraint usage at the RTFs in accordance with the Patient Safety Quality Improvement Act (PSQIA). In describing this data, the Committee Report made misleading and unsubstantiated claims and failed to provide the larger context for the data. The Committee Report stated that in 2022 there were 35 facilities with "double digit" restraint rates as if to indicate that was excessive. However, there is no nationally established standard or rate at which restraint usage per 1,000 patient days is deemed excessive at RTFs. Based upon our years of experience in the industry, our internal benchmark rate for restraint usage is 16 per 1,000 patient days. The average restraint rate for all UHS RTFs for 2022 was 15.63—below the benchmark. In 2022, 39 of the 59 facilities (66%) had restraint rates below that benchmark. Further, 44 out of 59 facilities (75%) had restraint usage rates below 20 in 2022.

Additionally, UHS has undertaken a concerted effort over the past few years to significantly reduce the usage of restraints in our facilities. In fact, for 2022, 36 out of the 59 RTFs referenced by the report saw a decrease in restraint rate/usage (some being substantial decreases). UHS has utilized an evidence-based approach to overall restraint use by adopting the principles developed by the National Association of State Mental Health Program Directors' (NASMHPD) Six Core Strategies for Reducing Seclusion and Restraint Use©. By implementing to these guiding principles throughout the UHS Behavioral Health Division, we have seen significant results.

The use of medication as restraint (commonly referred to as chemical restraint) is governed by the same set of rules as physical restraints (holds) and seclusion. All medications, regardless of their use, are ordered by a physician or a nurse practitioner. When less-restrictive interventions do not support the patient in regaining

self-control, medications may be an option to assist. There are states that do not allow the utilization of medication as restraint and UHS facilities comply with that requirement. UHS RTFs have policies and procedures regarding the use of chemical restraints to ensure appropriate utilization, management and oversight.[9] As with other restraints, chemical restraints are never to be used as a form of punishment or for staff convenience. In any circumstance where lack of compliance is identified, the RTF creates a plan of correction and resolves the concern.

The seclusion data we provided the Committee staff is even more compelling. The Committee Report merely states that in 2022 one UHS RTF had a seclusion rate of 12.63 per 1,000 patient days with no other context around this statement. **However, the report does indicate that 36 of the 59 RTFs (61%) had a seclusion rate of 0.** What the report failed to mention was that of the remaining 23 facilities, 13 had a rate of less than 1. That means 83% of UHS RTFs had a seclusion usage rate of less than 1 per 1,000 patient days.

While UHS is focused on reducing seclusion usage, it is a necessary intervention utilized to protect residents and to help them regain composure and emotional control. Staff are trained never to use seclusion as a punishment or for staff convenience. The requirements for staff monitoring of a patient in restraint and/or seclusion are significant which is counter to any suggestion that seclusion is utilized to address staffing concerns.

There are variances amongst the facilities as to the usage of restraints and/or seclusion. The variances are due to the patient populations at those facilities and the mental health pathologies of those residents as opposed to failures of the staff or lack of appropriate policies and procedures at the facilities.

This is an area where greater industry benchmarks may help establish standardized rate targets to assist all RTFs in reducing and managing restraint and seclusion usage. A national metric exists for restraint and seclusion utilization in inpatient psychiatric settings, however it does not exist for the RTF level of care. UHS would support efforts in identifying an appropriate metric that would provide greater understanding of its utilization. Currently, there is no reliable way to interpret the utilization of restraint and seclusion across RTFs without insights such as patient populations, among others. As the Committee Report is written, it provides the reader with information that is meaningless without this appropriate context.

Many of the issues raised in the report by the Committee staff around restraints dealt with documentation failures as opposed to improper use of restraints. As will be addressed in more detail below, documentation errors or omissions do not indicate the appropriate treatment was not rendered or that protocols were not followed.

Suicide and Ligature Risk

The report describes survey citations around suicide risk assessment documentation, protocols and ligature risks.[10] The Committee Report once again attempts to create a false narrative that UHS RTFs fail to take appropriate clinical and environmental actions to prevent suicides in our facilities. As part of the review of each facility's physical environment, a ligature risk assessment is completed and issues are addressed based upon that assessment. Our staff are trained on assessing ligature risks and notifying the appropriate individuals to remove such risks when identified.

The Committee Report also references certain instances where surveyors have pointed out ligature risks. In each of those circumstances, the facility promptly mitigated those risks—sometimes while the surveyors were on site. Further, as was described to the Committee staff, we have environmental services staff at all facilities who constantly assess and remediate anything in the facility that could reasonably present a ligature risk.

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[9] The report inaccurately states that during an interview with UHS Leadership, we stated that we believed there were circumstances in which it might be necessary to both chemically restrain and seclude a resident. That is not an accurate representation of the interview nor a statement made by UHS Leadership. Committee staff asked whether there were circumstances where it would be necessary to use a chemical restraint in conjunction with a **physical restraint,** to which we replied there would and which is allowed by federal regulations. We were not asked about chemical restraint in conjunction **with seclusion** as the report incorrectly states. As such, the statement in the report attributed to UHS Leadership on this issue is inaccurate.

[10] Ligature is defined as "a thing used for tying or binding something tightly" and in this circumstance largely means tied to a fixed point in a physical environment.

Patients are assessed regularly throughout the course of their care at an RTF. Those residents who are assessed as a high suicide risk should not be treated in an RTF setting. Those individuals require a higher level of care and should be in an acute inpatient facility. Notwithstanding, our RTF facilities have policies and procedures to assess suicide risk in our patients as well as interventions and safety measures to prevent suicides in the facility. We also provide training to all staff on assessing suicidality and maintaining vigilance in looking for any signs of suicidal behavior or ideation via the use of standardized industry developed and endorsed tools. As mentioned in our prior responses and our interview with Committee staff, one additional intervention at all UHS facilities is the 15-minute observation checks done 24-hours a day, 7 days a week for all residents, regardless of assessed suicide risk.

The Committee Report mainly references documentation errors or omissions regarding suicide assessments which does not mean that our residents are in an unsafe environment.

Staffing

The report attempts to create the false narrative that UHS RTFs are systemically understaffed. UHS RTFs comply with all state regulations that provide for specific staffing ratios. In addition, in those states that do not have required ratios, UHS RTFs ensure that staffing numbers meet the requirements for effective treatment and a safe environment. Our facilities utilize a multi-level assessment process that takes into account a large number of clinical and operational factors to determine appropriate staffing levels. These staffing levels are then regularly and routinely reassessed and updated to ensure the appropriate staffing levels are utilized. We acknowledge that due to sudden and unforeseen circumstances, staffing numbers may be below ratio or less than what a facility staffing plan requires for a limited time period on a particular unit. This can happen when there are unexpected call-outs by staff without giving sufficient time for the facility to fill the vacancy. We have processes in place to limit the occurrence of those situations, including closing beds or stopping admissions to ensure that the staff available can provide the necessary care and ensure a safe environment for each resident. However, there is no systemic or endemic understaffing at UHS RTFs.

Medical Record Documentation

Many of the survey issues noted in the Committee Report involve medical record documentation errors or omissions by facility personnel on a variety of issues. First, it is not uncommon for all health care providers and facilities to have documentation lapses, errors and omissions. Second, while there may be omissions in various aspects of the medical records, that does not mean that the appropriate treatment, intervention or care was not provided. The report attempts to aggregate documentation errors and omissions in medical records at select facilities to improperly draw conclusions regarding the quality of care or patient safety at those facilities. While we acknowledge the failure of technical record documentation at some of the facilities referenced in the report, we dispute the narrative of deficient care or safety due to record errors or omissions.

The Committee Report discusses treatment interventions as missing or incomplete as reflected in the medical records. While we acknowledge documentation errors and omissions at selected facilities, we dispute the narrative that our residents are not getting the requisite level of care during their treatment stay from admission through discharge.

UHS spends significant effort and resources training our staff on proper and thorough medical record documentation. We also conduct regular audits of medical records to ensure compliance with record-keeping requirements, including those required for documentation of the use of restraint and seclusion. UHS has also begun implementing electronic medical records (EMR) at our facilities. With respect to the RTFs, we have installed EMR systems at 15 facilities to date, with more planned. We are confident that this investment will enhance the quality and completeness of our medical record documentation to fully reflect the care and treatment provided.

Length of Stay

Length of stay at a UHS RTF is dependent on a number of factors and ultimately determined by the attending physician in consultation with the treatment team. Length of stay is a metric that is clinical in nature and focuses on the individual needs of each patient meeting appropriate medical necessity criteria. In addition, others outside the treatment team are also involved in length of stay determinations

including family members, guardians, social workers and outside clinicians who will oversee the patient's transition back into the community.

Each RTF has a different average length of stay that is driven by the patient population served. There are occasions where there are not resources available in the child's home state for follow up care and there is no other location that can safely treat the child. At no time would a UHS RTF discharge a patient without a discharge plan in place. On average, the length of stay at our RTFs for children and adolescents is 137 days and has been fairly steady across the last several years. There are outliers based upon clinical presentation and program structure. The Committee requested the minimum and maximum length of stay, which is not a standard metric used in this industry, and it did not request information about the corresponding circumstances that would explain the lengths of stay for those patients.

Education

The Committee Report incorrectly states that UHS RTFs failed to provide adequate and appropriate education to our residents. UHS facilities' educational services teams are committed to preparing every learner for a successful transition back to their traditional school setting and post-secondary opportunities.

- UHS partners with the appropriate state and local education agencies to thoughtfully plan and allocate educational resources at our RTFs. Educational services may be provided by a local education agency (LEA), or by a charter school or non-public school authorized to operate by the state.
- Programs typically use state-specific curriculum frameworks, designed to offer transferable course credit and grades and to meet the special education needs of children with individualized education plans (IEPs).
- UHS facilities comply with all applicable state education requirements for compliance reviews and are staffed by credentialed teachers as well as non-licensed support staff as required by the individualized needs of each school program.
- Many of our academic programs are nationally accredited by Cognia, one of the nation's leading accreditation bodies for K–12 education.
- The "UHS Best in Class Academic Accountability System" measures and reports on academic achievement at UHS RTFs for continuous performance improvement. This system consists of a set of national education standards, an annual school improvement plan and outcome measurement tools.

In the 2023–2024 school year, UHS academic programs had more than 138 students complete their high school requirements; almost 30% are headed to post-secondary school, while others plan to enter the workforce.

Grievance Reporting

The Committee raised concerns that staff and patients failed to report their concerns due to fear of retribution. UHS employees who want to report a problem or concern about inappropriate or unethical actions, not related to fraud, are encouraged to submit their concern through the Compliance Hotline (which can be done anonymously) or reach out to their supervisors, to management, to Facility Compliance Officers, or the UHS Compliance Office. UHS prohibits any form of retaliation against anyone who reports, in good faith, potential acts of misconduct or wrongdoing. For employees, anyone retaliating against someone for expressing a concern is subject to disciplinary action.

Patients are also able to report their concerns via the UHS Compliance Hotline/platform. In addition, patients are able to submit complaints or grievances to their Patient Advocate—which is the way most patients report concerns. Patients and families are provided information at the time of admission on how to report concerns internally to the facility and externally to all of the appropriate authorities.

Conclusion

We acknowledge that there have been incidents over the years at some of our facilities where residents have suffered harm. These unfortunate, isolated incidents are completely at odds with our deep commitment to provide a safe and therapeutic environment as well as inconsistent with the policies, procedures, protocols and training for our facilities. There is no place for any conduct that is inconsistent with the high standards we set for ourselves in our facilities and we remain committed to ensuring such events are reduced with a goal of zero.

Notwithstanding, and as stated numerous times above, the Committee Report paints an inaccurate, incomplete and misguided picture of the quality of care and safety at UHS RTFs. The report also wholly fails to recognize the thousands of ado-

lescents that have been successfully treated in our facilities over the years whose lives have been dramatically enhanced and quite possibly saved as a result of the care provided. The incidents and references cited in the report are not representative of the hard work of our dedicated staff whose only mission is to improve the lives of the residents they care for.

UHS remains committed to ensuring that the youth who require this level of care have safe and high-quality options that provide hope and recovery. This work is challenging, and it is a high calling, one that each member of our UHS team takes very seriously. Our facility staff are dedicated to the mission of taking care of youth and work tirelessly to ensure that each resident is treated with dignity in a safe environment. Patients come to us after a broad variety of negative experiences—they need very specialized care and treatment. Incidents of staff failing to follow our training, policies, procedures and protocols are an extreme exception and not the norm. Patient and family success stories are our motivation. We have been providing behavioral health care for more than 40 years and our consistent goal is to continue to be a valued resource in each individual community.

STATEMENT SUBMITTED BY ANNALISA WEBB

June 12, 2024

Youth Residential Treatment Facilities:
Examining Failures and Evaluating Solutions

Family Treatment Cooperative (FTC) 1997–1998, at 14 years of age

My name is Anna Webb. In 1997 I was enrolled in the Idaho Department of Health and Welfare's Region VI Family Treatment Cooperative (FTC), which was part of School District 25 . FTC existed under the State Governorship of Philip E. Batt, Director Linda L. Caballero, and Regional Director Nick Arambarri.

There I was abused in plain sight by educators, mental health professionals and my parents, funded with tax payer dollars and the blessing of the local government.

My Journey to Family Treatment Cooperative (FTC) began with an infection misdiagnosed as mental illness

At age 7, I developed an autoimmune response to a streptococcal infection, known as PANDAS. Similar to how rheumatic fever affects the heart, this infection caused my immune system to attack my brain, resulting in a rapid onset of obsessive-compulsive disorder (OCD). Almost overnight, I was plagued by relentless and terrifying thoughts, impulses and behaviors. Alongside OCD, the immune system's misguided attack on my brain led to developing several disabilities, including sensory processing disorder, dysgraphia, motor control issues, and communication and attention problems.

Back then, the understanding of PANDAS was in its infancy. Like many PANDAS children, I was prescribed Zoloft for COD and stimulants for ADD. Unfortunately, I had a bad reaction to these drugs that led to bipolar misdiagnosis. Consequently, I was heavily medicated for bipolar disorder, suffering horrific side effects that led to severe agitation, suicidal impulses, terrifying thoughts, and self harm. My supposed mental illness was blamed for these drug side effect.

I was hospitalized out of state twice for self harm because Idaho had limited resources to provide necessary mental health services to its youth. During these hospital stays, they adjusted my medications and had me attend groups to learn coping skills. However, new medications caused androgenic illnesses and psychiatric symptoms. I was treated respectfully at this hospital aside from the abusive use of the 12 step program for mental illness (its my understanding that its malpractice when used this way). Unfortunately, the medications exacerbated my symptoms, making it difficult to use these skills effectively when I got home.

Due to heavy drugging, untreated illness, and the lack of necessary rehabilitation for my acquired learning disabilities, I fell behind my peers both socially and academically. My condition worsened as treating my so-called mental illness took priority over everything else, overshadowing the real issues: diagnosed autoimmune disease, complex trauma, learning disabilities, and trouble at home. As my condition continued to deteriorate, my parents said they couldn't afford to send me back to the hospital. They told me there was a new program in town my teacher recommended, which led to my enrollment at Family Treatment Cooperative.

What I Was Told About Family Treatment Cooperative

I was told FTC was a new experimental, all-in-one school program that included a psychiatrist, one-on-one therapy, family and group therapy, special education, small classrooms, and field trips. The program had a heavy focus on behavior modification. I would attend school during the day and the program would be enforced at by my parents. All family members were expected to participate. The plan was for me to attend FTC and then reintegrate back into regular school after completing the program.

FTC had direct ties to the Department of Health and Welfare and District 25. It was like a part of the district but separate from the main schools. It also seemed like FTC operated in more than one town, but without more info, I can only speculate.

My Theories on How FTC Came to Be

Theory 1: Jeff D/SED Connection: FTC was created to fulfill the requirements of the Jeff D lawsuit. If this is true, it represents a tragic irony where a lawsuit meant to prevent abuse buy providing better care for youth, resulted in a program that perpetuated it.

Theory 2: Collaboration with the Troubled Teen Industry: FTC was part of a collaboration with the troubled teen industry—possibly hiring program directors with tax payer dollars. While the program heavily focused on behaviorism, it also incorporated tactics similar to those used by the Syn anon cult.

What Happened to Me at FTC

I assumed FTC would be a legitimate education/mental health program, like the hospital in Utah. I expected the same standard of care. I wanted to get well and was eager to start, but it didn't take long to realize something was wrong. The following are a few things I experienced at FTC:

- Our every move word and action was closely policed and rewarded or punished. We had rules hanging on the wall under categories like Authority problem and Lying problem with definitions of what constitutes a rule infraction. Do what you are told: get points. Break a rule lose points. Lose all your points and sit in time out like a small child in front of peers.
- I was exploited for labor—we were taken to my psychologists house on the Indian reservation to pick beans from her massive garden. We were told it was "volunteering." I thought it was weird but didn't realize how messed up this was until I learned how physical labor is common in troubled teen programs like in the Netflix documentary, the Program, Where some incarcerated teen girls were used for free childcare for program admins.
- My psychologist told me the religion I was raised in was fake.
- My psychologist encouraged me to "do certain sexual acts." I politely told her what she was saying made me uncomfortable. She wouldn't stop. When my politeness wore off and I tried to defend my boundaries they would punish me by taking away fake dollars that bore the face of the programs president we could use to buy snacks and toys provided in this token economy.
- I was bullied into accepting a bipolar misdiagnosis and taking an obscene amount of drugs that sedated me and caused me to gain weight. I was ultimately blamed and judged for my failure to maintain a healthy weight.
- My many diagnosed illnesses were treated as fake and ultimately I and my parents were blamed for my lack of success in the program. I had multiple undiagnosed chronic illnesses, a failed gallbladder, and suffered many more illnesses from the large amount of drugs.
- I was mocked for wanting to do cognitive behavioral therapy (CBT) instead of this program to manage my OCD. CBT is a recommended modality for PANDAS to help manage intrusive thoughts and compulsions. I learned what I could from library books on my own when therapy I needed was not provided.
- They showed us disturbing movies like What's Eating Gilbert Grape and At Play in the Fields of the Lord.
- Attack therapy: In group therapy private painful experiences were used to attack us in front of the peers and other staff. Nothing was sacred—a friend's molestation weaponized against her. I attempted suicide to escape this program when begging my parents to remove me proved futile. FTC had their hooks too deep in them and they ignored anything bad I said about the program. My parents, also participants as enforces, reported everything to my psychologist. I was forced to go to school the next day where my suicide attempt was used to attack me with in front of my peers in group. In my previous school I had been

ridiculed for being suicidal by classmates. Now adults were using it to humiliate me.

- Abuse at FTC meant I had no one to turn to when I was sexually assaulted; if I told my parents they would tell my psychologist and church leadership. My SA would have ammunition to use against me in group and church leadership would demanded I prove I was blameless in the assault. I knew of women who were publicly shamed and even excommunicated for being assaulted. I had already been ostracized and shunned by my religious community for having the problems I did. Not wanting to go through worse humiliation I kept my mouth shut.

After being dragged to school following a suicide attempt, it became clear that the only way out of the program was death. I felt like I had to kill my soul by no longer resisting. Severely ill and unable to defend myself, I caved. I convinced myself that playing along wouldn't change me, but it did. I exchanged my soul for any shred of kindness I could get while my health deteriorated.

I learned that's all they wanted—to break me. They did nothing to build me back up after.

Consequences of My Year at FTC:

Not long after FTC I would be diagnosed with gallbladder failure, one of the many "fake illnesses" I was supposedly using to avoid following rules.

Without addressing any of my learning disabilities health issues, trauma from the program they dumped me back in regular school. I lasted 2 weeks before dropping out.

The consequences of the abuse I endured has made me unemployable. I continue to suffer from complex trauma and crippling flashbacks. I can never work with a mental health professionals again.

Being conditioned to accept abuse led to abusive relationships as an adult, as well as medical mistreatment and assaults which I obediently and quietly complied with.

I lost more friends and was too messed up and sick to make new ones. I understandably developed a fear of humans from being abused by people I was raised to trust—parents, educators, therapists, and doctors—all funded by taxpayer money, while good people did nothing. From painful firsthand experience and decades of psychology research, I learned that this behavior isn't a bug in humanity; it's a feature.

People will put social hierarchy before what is right, and predators will always find a way to get to their prey. Anyone who falls outside the norm of society can be abused "for their own good." People will prioritize social hierarchy over what is right, and predators will always find a way to get their prey.

What happened to my relationship with my family after FTC

I never got my parents back. Our relationship never recovered. Like many parents who enroll their kids in TTI programs, they refused to talk about it afterward, cutting off any chance for us to heal. They never apologized and were able to move on with their lives. I was told to "get over it." I had complex trauma and an undeveloped brain, making it impossible for me to just move on. After the things they complied with from FTC, it was clear my parents weren't safe. FTC never ended: they unwittingly kept some of the FTC tactics in their parenting repertoire . . . I was forced to fight any connection with them out of self-preservation. I can't describe the pain having to intentionally cut off feelings for your parents as a teen who needed their love and more than ever.

The abuse, unaddressed trauma, poly-drugging, and health problems that led to my placement in this program contributed to the depression that resulted in electroshock treatment (ECT) at age 17. ECT caused brain damage that left me severely disabled. Since most doctors refuse to believe that ECT causes brain damage, I was unable to access rehabilitation. As a result, I was trapped in the broken relationship with my parents for decades.

I now face an uncertain future as I suffer neurological decline from ECT I received in part because of the what FTC did to my life.

What I know of FTC's end

My speech therapist told me the founders were in prison because a child died in their care. I've been unable to find out any more information. I noticed that FTC abuses seemed to be an open secret among mental health professionals and educators. Any person I told who was in education and mental health looked horrified

when I mentioned previous enrollment. This was a surprise as I worked with several therapists after and they refused to engage in any talk about the abuse I endured there.

Cynthia Aldana, the psychologist who abused me and my peers, still practices in Southeast Idaho.

Decades trapped in silence

FTC didn't have a formal code of silence like other programs—they controlled our parents, so it wasn't needed. However, I still suffered under an informal one. None of my friends understood or wanted to hear about it, and my family refused to talk about it. If they did, it was only to remind me what a problem I was.

I also worked with several therapists afterward, but they refused to discuss the abuse I endured there. As a result, I have suffered in silence for decades, unable to process the trauma and heal because who could I possibly trust? Abuse by mental health and medical professionals end after the program—if anything I was at greater risk because of FTC's abuse.

The fact that the TTI issue is only now being addressed by the U.S. Government after millions if not billions of taxpayer dollars and countless lives and families been destroyed speaks to this. Politicians wives (Nancy Reagan, Ann Romney) have celebrated the TTI and some have even profited off if it (Mitt Romney, Bain Capital).

Idaho Youth

Little has changed for Idaho's youth since my time at FTC. Children are still being sent out of state due to a lack of resources, while the state remains hospitable to the troubled teen industry. Vulnerable young people like I was now face a new threat: the age limit for electroconvulsive therapy (ECT) has been lowered.

This spring, Senator Abbey Lee advocated for a bill that would allow ECT for children and teens. I fear that distressed children, like I was, are now at risk of being given electroshock at younger ages, sometimes by force, in abusive institutional settings. I've seen adults in mental hospitals and group homes subjected to forced ECT, and now, I fear the same risk extends to children in the troubled teen industry.

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Idaho Youth

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LETTER SUBMITTED BY AMBER WEISE

June 23, 2024

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

Dear Senate Finance Committee Members,

I am writing to you from Wisconsin. Thank you for prioritizing the critical issue of Residential Treatment Facilities (RTFs).

I live with a rare neuromuscular disease called Spinal Muscular Atrophy type 2. I require 24/7 assistance with activities of daily living. My husband is the only reliable caregiver I can retain. We cannot live in states that do not allow family caregivers to be paid for their work because I would be forced to be institutionalized. I was raised by a single father who was overwhelmed with the stress of having a full-time job on top of being my caregiver. Our whole family suffered as a result.

I am writing to ask you to recognize the barriers to paid family caregiving and their role in abuse and neglect in our nation's care network. Home and Community-Based Services (HCBS) current regulations (Section 1905(a)(24) of the Social Security Act, 42 CFR § 440.167, and 42 CFR § 441.105) prevent family caregivers from being paid to provide care at home. This forces many families to place their loved ones in RTFs due to the lack of affordable care options.

During the COVID–19 pandemic, 39 states allowed parents and spouses to be paid caregivers through CMS waivers. This led to better care, fewer hospitalizations, healthier homes, reduced dependency on welfare, and increased tax revenue. The National Council on Disability supports making this change permanent.

CMS officials, including Dan Tsai, have acknowledged the benefits of paid family caregivers. However, current federal regulations remain a barrier. Congress must "ban the bans" on paid family caregivers and incentivize states to adopt this model.

This change is crucial to prevent the abuse and neglect often seen in RTFs and to support families in providing safe, effective care at home.

Appreciatively,

Amber Weise

LETTER SUBMITTED BY DEVIN WEISE

June 23, 2024

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

Dear Senate Finance Committee Members,

I am writing to you from Wisconsin. Thank you for prioritizing the critical issue of Residential Treatment Facilities (RTFs).

My wife lives with a rare neuromuscular disease called Spinal Muscular Atrophy type 2. She requires 24/7 assistance with activities of daily living. I am the only reliable caregiver she can retain. Although I love caring for her, I cannot physically be in two places at once perform two attention requiring jobs at once. When I work another job, it takes me away from her, leaving her in dangerous situations without care. We cannot live in states that do not allow family caregivers to be paid for their work because she would be forced to be institutionalized. My wife was raised by a single father who was overwhelmed with the stress of having a full-time job on top of being her caregiver. Their whole family suffered as a result.

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This change is crucial to prevent the abuse and neglect often seen in RTFs and to support families in providing safe, effective care at home.

Appreciatively,

Devin Weise

LETTER SUBMITTED BY SABRINA K. YOUNG

June 7, 2024

U.S. Senate
Committee on Finance

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

Dear Senate Finance Committee,

My name is Sabrina Young, and I am a survivor of the adoption system, and the Troubled Teen Industry specifically, "Charity Haven Girls Home," "Victory Acres Girls Home," "Bethel Academy," "The Rebekah Home for Girls," "New Beginnings Girls Academy," and "Reclamation Ranch." I am testifying about the abusive and neglectful conditions I experienced in these youth residential treatment facilities in response to the Senate Finance Committee's hearing titled "Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions."

I was placed in Charity Haven when I was 11 and then transferred after 3 months by Charity Haven to Bethel Boys and Girls Academy at the age of 12. A year later, I went home for 3 months, during which my adoptive mother, Mary, died. A week later, I came home from school and found my bags packed by my Aunt, who said I was to return to Bethel Girls Academy; I was 13 at that time. I remained at Bethel for a year and then was transferred by Bethel Staff to Charity Haven's sister school, Victory Acres. Due to the abuse allegations, Victory Acres was shut down 6 months later, so I was picked up by my Aunt and driven back to Charity Haven. Afterward, I was taken to my next program, The Rebekah Home for Girls, which has a long history of abuse allegations and battles with Texas regulators. I was then sent to Rebekah Homes' new facility known as New Beginnings Girls Academy, where I was sleep deprived and my right to attend school and shower privileges were revoked for months on end. I was then transferred to Reclamation Ranch in Tennessee and then relocated to Alabama before it was eventually shut down after a raid.

I was sent away because my adoptive family was abusive and exploitative toward me and my three siblings. As soon as we started to talk about what home life was like, my adoptive mother found it was easier to get rid of us all. I was sexually abused when I was 10, and I started to wet the bed. My adoptive mother made me sleep in the urine-soaked sheets and rubbed my face in them. I wasn't allowed to shower and often went to school smelling like urine. She sent me to go live with my Aunt who just didn't want the responsibility of taking care of me. Yet it didn't prevent her from claiming me on her taxes the entire time I was in the programs. When I was 15, she died, passing the guardianship to her mother, who did the same thing: she kept me in the programs until I turned 18.

I attended more programs than most people ever do, and I was severely abused in each and every one of them. During my time there, I experienced significant incidents of abuse, neglect, and mistreatment. I could easily fill an entire book with all of the abuses I suffered—as a matter of fact, I am in the process of writing my book *(Dear Renisha)* on this very subject. I am an author, and there are so many more authors out there with books detailing the abuses we suffered in these facilities (I would be happy to provide books upon request of the committee).

At different times, I was beaten, sexually abused, starved, force-fed, and locked in an isolation room for months as they played preaching sermons and music through the speakers. I was forced to do ridiculous amounts of calisthenics and work long hours of manual labor, often until I passed out. I was forced to hold other girls down, duct tape them, and watch both girls and boys get beaten. I was even forced to beat other girls at the direction of the staff. I suffered from the inappropriate use of restraints, unnecessary and highly invasive strip searches, a lack of adequate mental and medical health services, poor nutrition, and copious amounts of other psychological and physical abuse. This treatment had a profound negative impact on me, including complex PTSD, loss of trust in caregivers, poor education, and many other personal issues.

However, it's not just me who was affected by this program; this experience has also affected the next generation of my family. We tend to raise our own children the way we were raised, and I constantly have to fight the urge to do what was done to me. I refuse to give my children the same abusive upbringing that I had, but I know for many survivors, the cycle of abuse still continues.

No child should ever have to endure the things that I went through. I have spent years paying for a therapist to help me heal from the trauma that these programs inflicted on me. I refuse to let my pain affect my loved ones, so I am constantly reaching out to others to help ensure I don't pass it on. Most former troubled teen survivors don't have these resources, and that scares me.

I felt compelled to share my story to help spread awareness, prevent future abuse, highlight the severe shortcomings in these facilities, influence policy change, raise awareness of how the adoption and foster care system dumps children into this industry, and seek accountability for what these programs do to children. I want the Committee to understand the real-life consequences of inadequate care and the consequences of insufficient oversight in residential treatment facilities.

Approximately, over one-third of the Troubled Teen Industry is made up of foster kids and rejected adoptees. It shouldn't be this easy to get rid of a child that already comes from a displaced and dysfunctional environment.

As a Direct Support Professional in the state of Ohio, I have realized in my 15-year career that there is more oversight and rights within the developmental disability community than there is in the Troubled Teen Industry. The history between the two is very similar when it comes to institutionalized abuse in facilities. But we still haven't found solutions to this in the Troubled Teen Industry. This has to change.

To prevent these negative experiences, I believe the Senate Finance Committee should consider implementing stricter regulations and oversight of youth residential treatment facilities. This needs to include mandatory reporting of abuse, transparent data collection, mandatory State and National background screenings for all employees, ensuring that only qualified professionals work in these facilities, increased staff training on trauma-informed care, regular and unannounced inspections, and ensuring that all facilities provide adequate mental health and educational services, create an abuser registry for facilities found guilty of abuse, neglect, or as recent events have shown us, even death of children in their care. Additionally, there should be accessible channels for residents to report abuse without fear of retaliation.

Thank you, Chair Wyden and members of the Senate Finance Committee, for reading my testimony. I hope that my story and the stories of others like me will inspire you to take immediate action to protect vulnerable youth in residential treatment facilities. I hope you will pass the Stop Institutional Child Abuse Act (S. 1351) and follow that legislation with additional reform policies to ensure all youth are safe from abuse, neglect, and preventable death in these treatment facilities.

Sincerely,

Sabrina K. Young

Attachments:

Provided below is the link to Ohio Department of Developmental Disabilities to help give an example of the oversight implemented within DD community to prevent abuse and exploitation, *https://dodd.ohio.gov/forms-and-rules*.

Provided below is additional information within these links regarding the programs I attended and the mistreatment we suffered including previous lawsuits against the facilities.

http://www.heal-online.org/bethelsuits.htm

https://www.nytimes.com/1979/05/22/archives/texas-demands-that-preacher-shut-girls-home-linked-to-abuse-im.html

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YOUTH LAW CENTER
832 Folsom Street, #700
San Francisco, CA 94107

Statement of Jenny Pokempner

Thank you for the opportunity to provide testimony on this important topic. The Youth Law Center ("YLC") is a national organization based in California, founded in 1978, that advocates to transform the foster care and juvenile justice systems so that children and youth can thrive. Through legal, legislative, and policy advocacy, YLC works to advance the rights of young people who come into contact with the juvenile justice and child welfare systems and to strengthen the supports available to them so they can transition successfully to adulthood and thrive. Key to young people thriving is growing up with family in the community. One of Youth Law Center's initiatives is the Quality Parenting Initiative (QPI). This systems change approach is designed to ensure that young people in foster care receive excellent parenting from their caregivers and centers the need of youth for strong and nurturing relationships. QPI has been implemented in over 80 jurisdictions across 10 states and is committed to developing the supports that youth need to be raised and supported in their communities by their families and supportive adults.

The topic of this hearing is so critical to the work of Youth Law Center because of the high number of young people in the juvenile justice and child welfare system who end up in residential treatment facilities (RTFs) and other group care settings. While research, experts and the powerful voices of young people repeatedly tell us that these institutional placements tend to not meet their treatment needs and put them at risk for abuse and further trauma, we continue to fall back on their use as an answer to the challenges our child welfare and behavioral health systems are facing. Even with well intentioned staff, institutions just cannot provide the care and relationships that family can. We cannot give up on the goal of having young people with family and cannot give up on advancing policy and law that makes it possible to support youth in family based settings. While the issues raised at the hearing impact more young people than just those in foster care and the juvenile justice system, our comments will focus on these youth, however, we believe responses to meet the needs of these young people will also serve all youth at risk of institutionalization.

This testimony will focus on the three following recommendations:

- Congress Should Take Action to Actively Support the Development of Treatment and Supports for Children and Youth in the Community to Provide Alternatives to Residential Care
- Congress Should Reject Proposals that Result in the Increase of Institutional and Residential Care Such as S. 3196
- As We Work to Develop Services to Support Community Based Care and Treatment, Congress Should Greatly Increase Oversight and Accountability for Group and Institutional Care

A. Congress Should Take Action to Actively Support the Development of Treatment and Supports for Children and Youth in the Community

The Family First Prevention Services Act (FFPSA) took critical steps to impose financial disincentives to group care, *but it did not create any incentives to create alternatives to group and residential care.* Federal leadership and investment is needed to successfully complete what FFPSA started. Below are several actions Congress can take to incentivize and support the development of alternatives to RTFs and group care.

1. Fund a Core Array of Services and Supports for Caregivers and Youth through Title IV–E that Will Provide Meaningful Alternatives to Institutional Care

Retaining excellent caregivers—kin and non-kin—is critical to supporting youth in their communities and avoiding the need for higher levels of care. Caregivers have clearly told us for many years that they need more support. When they are well supported by the child welfare agency and related systems, they are able to support children and youth in their own communities, including youth with higher levels of need. Currently, many do not feel they have the support they need—this accounts for caregivers opting out of fostering and kinship caregiving or never beginning in the first place. Caregivers have told us that they need the following: peer support (mentoring, coaching, assessment, crisis intervention, advice, referrals, and related support services), reliable respite care, training, crisis support, youth development activities, individual and family counseling and behavioral health services, and child care.

Law should be developed that makes these core supports a central part of the Title IV–E program and made available to all caregivers. States should be required to develop a core set of supports for caregivers that reflects what the caregivers have identified as in need and that the agency has identified to correspond to the needs of system involved young people. Legislation should provide IV–E reimbursement for a percentage of these services and supports to incentivize their provision, which have been shown to improve placement stability as well as caregiver retention. When caregivers can rely on and easily access these supports, they have the confidence and resources to care for children and youth even those with higher levels of need who may otherwise end up in residential care or group homes.

2. Require the Administration for Children and Families (ACF) and the Centers for Medicare Medicaid Services (CMS) to Develop Detailed Guidance on How Child Welfare and Juvenile Justice Systems Can Best Leverage Medicaid to Enhance the Community Based Behavioral Health Service Array

We have seen innovative work in states that has resulted in responsive behavioral health systems that better support caregivers who want to provide care to children in the community through Medicaid Waivers and other options. Youth and families report behavioral health services not being adequate and not being accessible: young people need more high quality and varied services and services must be available when they are needed. Many youth end up in residential care because we do not have the right services for them and their caregivers are not able to access the right services at the time they are needed.

Medicaid allows states to apply for several types of waivers that allow, among other things, demonstration projects, flexibility to provide home and community based services, and flexibility in the delivery of services through managed care organizations. For many states this has led to the development of a mental health and behavioral health service array that provides much more support to youth and their caregivers in the home and community. These are continuums of services that are much more expansive and varied than what most youth currently have access to and they are much more easy to access than many services currently are. For exam-

ple, through a Medicaid Demonstration Waiver California is making the following services available to system involved young people in need with few barriers: Intensive Care Coordination, Targeted Case Management Services, Therapeutic Behavioral Services, Intensive Home Based Services, Crisis Intervention Services. This waiver also has allowed managed care organizations to provide young people with an array of interventions that young people and caregivers have requested: the provision of peer support, art therapy, and access to healing enrichment activities. There are excellent examples from other states as well.

This excellent work that helps keep youth in their homes and communities could be the norm for states rather than the exception if federal action is taken. Congress should develop incentives for states that opt for waivers that expand their community based mental health service array and for waivers that center the involvement of youth and families in their development.

This excellent work could also be replicated in more states if the Centers for Medicare and Medicaid Services (CMS) and the Administration for Children, Youth and Families (ACF) provide targeted and detailed guidance that is directed at state Medicaid agencies and Child Welfare and Juvenile Justice Agencies so they have a road map for creating these robust service array. We recommend guidance in the following three areas:

Area 1: Guidance on Expanding Peer Support Services through Medicaid

There is great consensus on the benefit of peer support in the delivery of behavioral services. Young people in and from foster care and the juvenile justice system have identified high quality peer support services as an effective and important service that supports their treatment and wellness. While there has been consensus on the value and effectiveness of this service and CMS has provided some guidance [1] on how Medicaid can be used to fund peer support, young people in and from foster care and juvenile justice have limited access to this critical service.

To expand access to peer support services for youth in and from foster care and juvenile justice system, we ask that legislation include a provision that CMS issue joining guidance with ACF on the various ways states can leverage Medicaid to provide peer support to youth with experience in foster care and the juvenile justice systems and examples of best practices. Guidance should include:

- The different ways states may choose to deliver peer support services through several Medicaid funding authorities including, but not limited to, the state plan rehabilitative services option, and Section 1915(b) or 1915(c) waivers.
- The flexible ways that services can be delivered.
- The flexibilities states have to provide the service without a diagnosis.
- Ways to provide training and credentialing that streamline service access and maintain quality.

Guidance should also include recommendations on how young people can be included in developing peer support.

Area 2: Guidance on Use of Medicaid to Fund Services that Support Wellness and Address Trauma for Youth in Foster Care

Young people in and from foster care and the juvenile justice systems experience high rates of trauma and behavioral health challenges. Not only do they face barriers to access traditional services like talk therapy, they face limited access to services and activities that complement more traditional behavioral health services and promote wellness and resilience. Examples of activities include, but are not limited to: yoga, recreational activities, equine therapy, etc.

To expand access to peer support services for youth in and from foster care and juvenile justice system, we ask the legislation require that guidance be developed on how states can use the rehabilitative services and in lieu of options as well as other avenues provided by Medicaid to fund these types of services as well as strategies for streamlining the process to allow an array of health care practitioners to provide services. Guidance should also describe how to improve access to these and other more traditional mental health services by removing medical necessity requirements as discussed in recent CMS guidance.[2]

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[1] *https://www.medicaid.gov/federal-policy-guidance/downloads/SMD081507A.pdf.*
[2] *https://www.medicaid.gov/federal-policy-guidance/downloads/bhccib08182022.pdf.*

Guidance should also include the ways that Medicaid funded crisis response can be used to prevent system involvement, help youth in the child welfare system stabilize their placements, and connect youth with community based treatment and support.

Area 3: Guidance on Use of Medicaid to Improve Care Coordination for Youth in and Leaving Foster Care

Care coordination across youth service systems and between youth and adult serving systems continues to be a challenge especially for youth in the foster care and juvenile justice systems who may touch multiple systems and not have the support of a caregiver or parent to ensure coordination. The harm to a youth, especially a youth who is aging out of foster care, when system coordination does not occur can be significant. Critical insurance coverage, treatment, and care can be interrupted or lost. This happens far too often in the child welfare system.

To address this problem we recommend that CMS and CCF provide joint guidance on how Medicaid can be used to improve care coordination and access, including, but not limited to the use of Health Care Homes, specialized case management and rehabilitative services. Ensure that guidance includes how this coordination can be maintained as a youth transitions from child to adult systems and should be aligned with the child welfare transition plan.

3. Support the Foster Youth Mental Act, Which Would Create A National Navigation Program and Invest in a More Comprehensive Behavioral Health Array for Youth and Families

The Foster Youth Mental Health Act, S. 2836, is a bill that would expand and enhance the community based continuum of behavioral health care and supports to youth and families. Passing this bill would be an investment in the types of services that do keep young people out of residential and institutional care. The bill would create a national navigation program to support the mental health and well-being of foster youth and former foster youth. This navigation program would serve current and former foster youth, their caregivers, families, and parents. It would help them navigate and connect youth and caregivers with behavioral health services and other concrete resources that families need to support young people. Importantly, the navigation program would be "staffed by youth who were formerly in foster care and individuals with expertise in helping young people navigate and access service to treat and support their mental health and well-being, insurance coverage and renewal, housing, childcare, skills training and education, extracurricular activities, and other critical services for young people with experience in foster care."

In addition to the development of this navigation program, the bill requires states to expand their health care oversight plan for youth in foster care "to ensure states have in place key components of a comprehensive children's mental health system, including prevention, early intervention, and treatment." Among other things, this system must include:

- The use of peer specialists; training of caseworkers on connecting young people with therapeutic supports; therapeutic supports and community-based resources that are appropriate for the needs of youth (including meaningful extracurricular activities and wellness support); processes to address privacy concerns; and planning for continuity of care.
- Protocols for assisting youth access all available mental health services and supports, and community-based resources, such as parenting classes, community-provided financial and in-kind material support, behavioral health care, and community engagement opportunities.
- That the case plan for a youth who needs treatment includes documentation that options for treatment have been discussed with the youth and a plan for delivery of treatments has been made.
- Procedures for continuity of care if the youth experienced a placement move.
- That the transition plan for youth leaving the foster care system at age 18 or older includes a plan for continuity of care.

If passed, this bill would create a baseline and foundation for the type of behavioral health care infrastructure that all young people and caregivers across the country need to be able to provide meaningful care and support in the community. Providing this foundation still allows for state flexibility and innovation in the exact components of their service array, but ensures that all youth and families have access to what is needed to stay in the community.

B. Congress Should Reject Proposals that Result in the Increase of the Use of Institutional and Residential Care Such as S. 3196

We urge Congress to remain steadfast in its commitment to make all efforts to keep children in their communities and in family based care. Defaulting to seeing beds and institutions as a response can be too easy, especially when for profit entities are well funded and staffed to make these beds and facilities immediately available. We ask that you remember the youth, advocates, parents, and social workers who do not have the same resources, funding and attention, but have the experience, expertise, and research that clearly shows that residential care harms children and youth and puts them at risk for an array of poor outcomes. For these reasons, we ask that you oppose any actions that would take us backwards and increase the use of group and institutional care rather than supporting youth in families. We believe that the Ensuring Medicaid Continuity for Children in Foster Care Act (S. 3196) would be an investment in institutional care rather than children and families. We are concerned that this bill would undermine implementation of FFPSA. The Medicaid IMD exclusion prohibits the federal government from providing federal Medicaid funds to states for services rendered to Medicaid enrollees who are patients in certain large facilities (*i.e.,* with more than 16 beds) that primarily provide mental health and substance use disorder treatment services. One of the reasons the IMD exclusion was created was to incentivize state investment in community-based services, with an understanding that large, restrictive institutions were counterproductive in mental health treatment. Creating a broad federal exemption *just for children in foster care* could have significant unintended consequences that lead to children and youth languishing in massive congregate care facilities. If more institutional beds are funded, they will be filled whether or not they are the appropriate placement for the child. But, if you remain firm in refusing to make further federal investments in institutional care and take action to incentivize the development of community based alternatives, you will see them grow and children and their families will greatly benefit.

C. As We Work to Develop Services to Support Community Based Care, Congress Should Increase Oversight and Accountability for Group and Institutional Care

Children and youth in the child welfare system should be placed in family based care in the community. It is clear that young people do best in family and deserve to have their needs met in the community rather than institutions that, in large part, are not providing effective treatment and put youth at great risk of harm.

As we work towards developing more community based services and supports for youth and families, it is the case that young people remain in residential and institutional care. Because this is the case, there must be increased oversight of these facilities and there must be more avenues for children and youth to file complaints and resources and entities that have the capacity to quickly respond and address these complaints.

We recommend that Congress convene multi-system experts to develop a concrete and comprehensive proposal for oversight of all residential and institutional settings that serve children and youth and accept federal funds. Oversight should include warning systems that flag facilities for more scrutiny when certain factors are present, for example when they house large numbers of systems involved youth; when they have youth with long lengths of stay; when they receive frequent complaints. The oversight system must prioritize the interest of children and be willing to take decisive action to keep young people safe.

We recommend that a federal Ombuds Office be developed that is well staffed and able to provide independent and effective advocacy for young people who face abuse, maltreatment, and poor treatment and care in residential and institutional care. This office could follow existing state models as well as be modeled on our national Protection and Advocacy system. To be effective, the office or system that is developed would need to reflect and be responsive to the unique developmental needs of youth and young adults and the unique barriers that youth face in accessing help when they are in residential care.

Thank you for the opportunity to submit this testimony for consideration. The Youth Law Center is ready and able to work with you to develop and advance solutions that will provide support for youth and families in the community.

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Statement of Patrick Lawler, Chief Executive Officer

Dear Chairman Wyden, Ranking Member Crapo, and Members of the Committee,

On behalf of Youth Villages, we thank Chairman Wyden, Ranking Member Crapo, and members of the Senate Finance Committee for the opportunity to submit a statement for the record. We commend the Committee for its ongoing commitment to uplifting young people and families nationwide.

Youth Villages' long-term vision is to ensure that all children and families receive the intensive in-home services they need, when they need them. At Youth Villages, this vision drives our efforts to address the complex challenges faced by young people experiencing mental and behavioral health challenges. With over 36 years of experience as a service provider, our development of evidence-based models and cross-system collaboration across over 100 locations, and 26 states and the District of Columbia, Youth Villages understands the crisis facing young people with mental and behavioral health challenges, including existing gaps in access to appropriate services compounded by a lack of cross-agency collaboration to diversify and coordinate available funding streams to support this population.

Young people and families across the nation experience varied levels of access to critical mental and behavioral health services, leaving many unsupported in times of crisis. Service gaps are particularly pronounced for at-risk populations and in rural areas, where many children experiencing mental and behavioral health challenges lack access to needed resources that would assist them in overcoming adverse experiences.

At Youth Villages, we wholeheartedly believe that children are best served in their homes and communities. Children and families experiencing emotional and behavioral health challenges often encounter highly complex obstacles that require collaborative, multi-level interventions involving multiple stakeholders. At Youth Villages, we understand there are seldom simple, one-size-fits-all solutions to complex issues. Our comments do not suggest that our solutions are the sole answer to these complexities. Instead, our comments below are informed by our years of experience using codified, evidence-based models; supporting jurisdictions nationwide with sustained funding and new infrastructure; and assessing out-of-home treatment structures to determine the best ways to help young people and families live successfully.

Addressing Youth with Higher-Level Needs

The nationwide failure to address the lack of appropriate first placements for older children and those with higher level needs has exacerbated a crisis that existed long before the pandemic. States have moved towards deinstitutionalizing congregate settings across foster care and juvenile justice systems and failed to adequately identify alternative placements for children and youth with complex behavioral health challenges. For adolescents with complex needs, this tends to be a time when their mental and behavioral health challenges are intense and persistent. Similarly, older youth with complex trauma and experiences of maltreatment require placements that can account for their higher-level needs and pave the way to safety and stability. Further, in many areas, a lack of community alternatives or agency resources often compound this crisis, leading to more challenges to securing appropriate placements for young people in a timely manner. The youth mental health crisis in America is a major contributor to the increase in the severity of the behavioral health problem impacting our youth, particularly for those in foster care. Although the number of children and youth entering foster care has declined since 2016, there is a steady increase of the number of youth being placed into the child welfare system to receive services.

Common reasons for out-of-home placements across the country include: behavior problems, including impulsivity, problem sexual behavior, or poor problem-solving or anger management skills; trauma from abandonment, neglect, and physical or sexual abuse; depression, low self-esteem, self-harming behaviors, or suicidal thoughts; conflicts with parents, school, or juvenile court systems; running away; drug or alcohol abuse; or problem sexual behaviors. Each of these complex behavioral challenges impact placement decisions surrounding each young person. Although progress has been made in recent years to focus on family-like settings for youth and set stand-

ards for qualified residential treatment programs (QRTPS) as established by the Family First Prevention Services Act (Family First/FFPSA), state and the federal governments find that these reforms have intensified the current crisis leading to youth with high acuity needs falling through the cracks.

On the other hand, Family First holds promise for financing evidence-based prevention services to strengthen families and prevent children and youth from entering the foster care system. We think it's important that the Title IV–E Clearinghouse include programs to help prevent youth from entering foster care in the first place and re-entering foster care, and older youth in extended care states from re-entering foster care. At the same time, we know transition-age youth fare better with the support of extended foster care. To achieve population-level impact, some recommendations that we submitted in our written testimony for the Senate Committee on Finance hearing, The Family First Prevention Services Act: Successes, Roadblocks, and Opportunities for Improvement, include:

- Congress should encourage a broad and inclusive "candidacy of care" definition to include families in need of after care services by including post-reunification, post-adoption, and kinship care after a youth has been placed in the home.
- Increase flexibility in state Medicaid matching rate at 90 percent compared to the current law at 50 percent, allowing states to spend half of their annual spending on evidence-based programs (EBPs) rated well supported or supported, approved by the Title IV–E Clearinghouse, and allow states to spend 15 percent on a new category of unproven programs that have evaluation ratings on the California Evidence-Based Clearinghouse (CEBC).

Invest in Intensive In-Home Services to Avoid Unnecessary Out-of-Home Placements for Youth

Youth Villages' Intercept® program, a comprehensive, in-home services model rated "Well-supported" by the Title IV–E Prevention Services Clearinghouse, serves families at a critical crossroads to reduce out-of-home placements and accelerate permanency for children by up to 53 percent. As highlighted during the hearing, community-based support and services such as Intercept® are critical resources through which the trajectory of a young person's life can significantly improve in the long term.

Many jurisdictions are seeking a broad-based, highly adaptable program such as Intercept that is proven to be highly effective at preventing a diversity of youth from being removed from their homes and placed into foster care. Intercept's versatile scope is core to its capacity to serve children from birth to age 18 who are involved in child welfare, adolescent mental health, or juvenile justice systems. Intercept specialists work alongside parents or caregivers to provide direction and support in all systems surrounding the child. Specialists work collaboratively with every member of the family, typically for a period lasting 4 to 9 months, to address potential concerns in the young person's community or social system.

Youth Villages Family Intervention Specialists work intensively with families in their homes three times per week, providing 24/7 crisis support for families. The integrated, trauma-informed Intercept model is designed to meet families at a critical crossroad and provide support and behavioral health interventions that keep households together and change the direction of a child's life by reducing the need for out-of-home placements, such as foster care or residential treatment facilities. The Intercept model involves highly trained specialists working directly with a child and their family to develop behavioral management, problem-solving, and family coping mechanisms to support their self-sufficiency and long-term thriving. While receiving services, Intercept families are fully supported in locating and connecting to community resources to ensure their progress is sustained to inform the ultimate goal of family preservation and reunification.

Although Youth Villages believes that Intercept is a leading child welfare service solution, it is one critical part of a much broader effort that is required to ensure children and families with complex needs live successfully. Youth Villages believes that a full array of high-quality services is best suited to ensure young people, families, and jurisdictions have access to supports and preventative services that divert youth from entering care and, for those who enter the foster care system, reduce the amount of time they spend in care. Across the country, states are in different stages of shifting toward prevention services. Those states that have invested in prevention may offer multiple intensive, in-home services; but typically, they still have critical gaps that leave certain sub-populations underserved (*e.g.,* those in rural geographies, or those with certain intellectual and developmental disabilities). To have

population-level impact, states must invest in systems-change infrastructure that facilitates a shift toward a prevention mindset.

Building a Systems-Change Infrastructure

Medicaid is the largest payer for behavioral health services for children and youth with serious emotional disturbances. Yet, there continues to be a gap in the available services and families who either cannot access or pay for the needed services for their children's behavioral or emotional issues, forcing many youth to be served through child welfare services. Child-serving systems must use multiple funding streams to achieve optimal impact. Public-private partnerships with child welfare systems are vital for maximizing the impact of child welfare funding for service coordination and wrap-around services. Youth Villages aims to work alongside jurisdictions to transform their systems to reorient toward prevention services, especially for jurisdictions seeking solutions to instances of unnecessary out-of-home placements for a broad range of youth. These efforts require cross-agency collaboration to deliver a comprehensive system of care in states.

Furthermore, accessing services should not be dictated by subpopulations when most evidence-based services, including Intercept, can be funded by child welfare, mental health, and human services. Restricting funding streams like Title IV–E and Medicaid inhibits many states from scaling prevention services and investing in family-centered approaches to care. To move from theory to change, a comprehensive care infrastructure will require cross-agency collaboration and the integration of multiple federal funding streams. Congress has had an increased focus on addressing the behavioral health needs of adults and children in the United States; however, that legislation does not always translate to success at the state level.

One of the main challenges is the basis of the existing system of billing on an individual going to a provider and being billed in 15-minute increments. This does not work for evidence-based programs like Intercept, which provides services on a more frequent basis through costs outside of the visit, such as the cost to travel to rural locations or for intervention planning. Per diem rates make more sense, but state Medicaid agencies are struggling to identify how to fit this into the existing system. One way of addressing this concern is encouraging CMS to provide state Medicaid Directors with evidence-based suggestions for implementation. We recommend that Congress clearly define intensive, home-based services and encourage evidence-based guidance be provided to state Medicaid agencies by the Centers for Medicare and Medicaid Services (CMS).

Youth Villages maintains our steadfast commitment to ensuring young people remain safe and supported in their homes and communities. We reiterate our gratitude for Chairman Wyden, Ranking Member Crapo, and the Committee at large for the opportunity to use our expertise to inform our feedback for the record. Thank you for your efforts to advocate on behalf of young people and families across the nation. For additional information, please contact Shaquita Ogletree, Director of Federal Policy at Shaquita.Ogletree@youthvillages.org.

LETTER SUBMITTED BY ANN YURCEK

June 23, 2024

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Re: Youth Residential Treatment Facilities: Examining Failures and Evaluating Solutions

Dear Senate Finance Committee Members,

I am writing to you from Wisconsin. Thank you for prioritizing the critical issue of Residential Treatment Facilities (RTFs).

My husband and I have adopted 6 children with special needs from the foster care system. Our biological daughter born in 1989 was born with a severe form of Noonan Syndrome—24/7 nursing care keeping her alive against the odds. I have seen firsthand the neglect, abuse and the trauma of institutional care can have on children. With raising our kids, we have found that families have little support for some of the most vulnerable children. One state child welfare official told me that

the state does not make good parents. A child needs someone who cares deeply and can watch out for them not just for childhood, but for their lives.

I have given up 34 years caring for my biological daughter, 28 years caring for 5 siblings with fetal alcohol syndrome and trauma history and now our youngest, an amazing young boy who they said would never do anything. He proves the systems wrong all the time. The system had to be trusted with my adopted daughter who landed in a state hospital and an RTF at 13 due to her intellectual disability and fetal alcohol syndrome along with years of trauma. I saw abuse, neglect and kids who were given up to get care and had no one. I fought for my daughter and retained custody and watched over her the best I could from afar. But systems didn't listen and blamed her trauma for her challenges. She had underlying medical issues that could have been corrected and she lost her life due to unmanaged renal failure. Blamed for her behaviors that had real life medical causes, that a simple surgery removal of a pituitary tumor could have changed the course of her life. I will never trust an RTF, care facility or the state with another of my children again.

As a veteran parent of children/adults with medical complexity and technology dependence, since COVID–19, the medical system is in stress, delayed appointments and surgeries, communication failures. Few understand children and adults with neurodevelopmental disorders and blamed for their prenatal exposures, genetic disorders, trauma histories, there is absolutely no facility to help these children across the country. We go on doing what we can to help kids who society made promises of help when removed from their parents, only to be told to give them back to get care paid for. This is not right. One cannot trust our kids' care without total oversight.

Support is rare and the help for help in the homes virtually non-existent. The system is failing us. I am mom, nurse, PT, OT, speech therapist, respiratory therapist, CNA, PCA, medical transport, pharmacist, special education teacher, assistive technology consultant, hearing intervenor, teacher of the visually impaired, and so much more. But I am told I am just a mom. When my sib set was younger, the state paid for day care for working parents. I was told that I was not working, I was just a mom to 11, 6 with special needs in the early 2000s. I had three level III, two level II kids from foster care. And my medically fragile daughter. Four of these kids had to have eyes on them at all times. It was exhausting.

Waiver lists years long. We left that state for a state where we could find hope and help. Approaching retirement I have given up earning a living and retirement supports, because I have given my life to caring for very complex and vulnerable children. The mom who spends 24/7 keeping my son safe, breathing and learning. Saving the state thousands of dollars for now for a child who is defying the odds. A former foster care child. I have done it 6 times over.

I am writing to ask you to recognize the barriers to paid family caregiving and their role in abuse and neglect in our nation's care network. Home and Community-Based Services (HCBS) current regulations (Section 1905(a)(24) of the Social Security Act, 42 CFR § 440.167, and 42 CFR § 441.105) prevent family caregivers from being paid to provide care at home. This forces many families to place their loved ones in RTFs due to the lack of affordable care options.

During the COVID–19 pandemic, 39 states allowed parents and spouses to be paid caregivers through CMS waivers. This led to better care, fewer hospitalizations, healthier homes, reduced dependency on welfare, and increased tax revenue. The National Council on Disability supports making this change permanent. For our family the isolation of the pandemic is never going to be over. A facility will kill two of our children as they are immune compromised.

CMS officials, including Dan Tsai, have acknowledged the benefits of paid family caregivers. However, current federal regulations remain a barrier. Congress must "ban the bans" on paid family caregivers and incentivize states to adopt this model. This change is crucial to prevent the abuse and neglect often seen in RTFs and to support families in providing safe, effective care at home.

Appreciatively,

Ann Yurcek

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