HEAL

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December 1st, 2011

Submitted via Fax To:*
House Education and Workforce Committee Members
Senate HELP Committee Members

Dear Honorable House Education and Workforce Committee and Senate HELP Committee Members:

We have created a position statement regarding HR 3126 and S. 1667: Stop Child Abuse in Residential Programs for Teens Act of 2011. Being both bills are identical, we have chosen to submit our suggestions, concerns, and questions regarding the bills in a single statement. This is that statement.

We ask that you include our position statement by reading it into the official record of all meetings (committee and sub-committee-if one is assigned), hearings, preliminary and floor votes.

We are writing as child and family advocates, families, and individuals tortured (and representing some of those killed) and defrauded by the behavior modification/residential treatment industry.

Thank you for your time and consideration.

Sincerely,

Angela Smith

Angela Smith
HEAL Coordinator

* Representatives Trey Gowdy (R-SC), Robert E. Andrews (D-NJ), and Timothy H. Bishop (D-NY) either did not have fax numbers available or the fax failed. Senators Jeff Bingaman (D-NM), Al Franken (D-MN), and Rand Paul (R-KY) did not have fax numbers available. Due to the desire to ensure every Representative and Senator that is member of a committee considering this legislation, we have e-mailed them separately with a link to this position statement.

Introduction

HEAL (www.heal-online.org) is a network of families and individuals who have been victims of fraud and abuse perpetrated by residential programs for children and teens.

We have been investigating and exposing institutionalized abuse and fraud at behavior modification programs, residential treatment centers, therapeutic boarding schools, wilderness programs, boot camps, and faith-based children's homes since 2002.

HEAL currently has eight active chapters throughout the United States and volunteers in nearly every state. Our chapters are organized by survivors of institutionalized abuse at various programs that have operated and/or are currently operating in the United States.

The remainder of the statement will identify sections of the bill(s) as written and include our concerns, suggestions, and any questions we have regarding the legislation.

As registered voters and victims of the very industry this legislation seeks to regulate, we entreat you to thoroughly review, address, and act to ensure that children, teens, and families are truly protected from fraud and abuse.

CONCERNS, SUGGESTIONS, & QUESTIONS (BY SECTION OF HR 3126 & S. 1667)

SECTION 1. SHORT TITLE.

We have no concerns, suggestions, or questions regarding this section.

SEC. 2. DEFINITIONS.

Concerns

It is a minor concern that the Assistant Secretary for Children and Families of the Department of Health and Human Services will be charged with the task of implementing the new regulations. (Sec. 2. (1))

The primary reason that this is a concern is the lack of oversight of programs currently operating with Department of Health and Human Services approval and/or recommendation that are known to engage in fraudulent and abusive practices.

For example, the Substance Abuse and Mental Health Services Administration (SAMHSA/samhsa.gov), a division of the Department of Health and Human Services, approves of and refers to the following fraudulent and/or abusive

programs (found via SAMHSA's Substance Abuse Treatment Facility Locator (http://dasis3.samhsa.gov/)):

1. Provo Canyon School in Provo, UT

Provo Canyon School has lost multiple lawsuits that included the following causes of action: civil rights violations, cruel and inhumane treatment of children, assault, battery, unlawful imprisonment, and fraud. (Source: www.heal-online.org/provocases.htm)

On June 18th, 2003, the Deseret News in Utah ran a story regarding the fact that programs like Provo Canyon School receive no oversight or regulation. In addition, the story cited Provo Canyon School as the starting place of WWASPS' founders and leadership, including Robert Lichfield and Karr Farnsworth. (Source: http://www.heal-online.org/boardschoolutah.pdf) WWASPS is currently facing a class action suit by families defrauded and children abused at its facilities. (Source: www.heal-online.org/turley.pdf)

In addition, Provo Canyon School's parent company, UHS, Inc., is currently being investigated and prosecuted by the U.S. Attorney General for defrauding Medicaid. (Source: http://www.justice.gov/opa/pr/2010/March/10-civ-219.html)

2. New Haven Residential Treatment Center in Lehi, UT

New Haven has engaged in false advertising. It has claimed that staff had credentials and training that it clearly did not. The evidence of this is verifiable and HEAL is processing the documents that substantiate this claim at this time. Beyond this, Utah lists New Haven School as a school that is "accredited" by the Northwest Association of Accredited Schools (NAAS). (Source: http://www.schools.utah.gov/main/INFORMATION/Educational-Directory/DOCS/2010_EducationalDirectory.aspx) NAAS has been sued as co-defendants with WWASPS. And, NAAS was also sued for misappropriating the name of a non-active accrediting agency. NAAS was forced to change names and is now NWAC. NAAS was forced to change their name to NWAC (Source: http://www.naas.org/northwestaccreditation.php?Form=NAAS.Accreditation.Report&Security=56545gthjnkuio.op06bcvghjkioophjui78jkiolp67xx&Access=345fgthybnjkmklopnaas) after a lawsuit was filed for misappropriating the name of a legitimate accreditation agency. NAAS was also a co-defendant in a lawsuit against the World Wide Association of Specialty Programs and Schools in 2006. (Case Citation: Bruce Dungan, et al. v. World Wide Association of Specialty Programs and Schools, Inc., NAAS, et al., United States District Court, Northern District of New York, July 25th, 2006) The attorneys representing the plaintiffs in this case were Hancock & Estabrook, LLP. The lawsuit was filed as a class action. Academy at Ivy Ridge was the basis of the lawsuit. NAAS "accredited"

this school. Quote: "**Ivy Ridge Academy accreditation rejected**: The Academy at Ivy Ridge will not be allowed to resume issuing high school diplomas. The State Education Department has rejected the Academy's application, according to stories Friday in St. Lawrence County newspapers and *The Watertown Times.* A letter from the State Education Department to Ivy Ridge quoted in the *Watertown Times* says, "The Department's review revealed that AIR is principally a behavior modification program and not a school..." (Source:http://www.newswatch50.com/news/local/story.aspx?content_id=AD63A1B8-8002-4DEC-801C-294F33F1698E) For complete story, see http://www.heal-online.org/declared.pdf. So, NAAS/NWAC accreditation does not provide effective assurance that the credits "earned" at New Haven are transferable. This is a serious concern.

3. Youth Care of Utah in Draper, UT

Youth Care of Utah is an Aspen Education Group program. Multiple Aspen Education Group programs have been closed due to deaths and abuse. Aspen Education Group programs that have been closed due to deaths and/or abuse include Mount Bachelor Academy (Oregon) and SageWalk (Oregon). Youth Care of Utah operates under two names to avoid association with its poor track record. The other name under which it operates is Pine Ridge Academy. The addresses for Youth Care of Utah and Pine Ridge Academy are identical. Brendan Blum died at Youth Care in 2007. (Source: www.heal-online.org/pinerid.htm)

The above three examples are not an extensive list of the problems, abuses, and concerns raised regarding the methods or standards currently upheld or required by the Department of Health and Human Services.

Federal agencies charged with enforcing regulations in various industries repeatedly fail to protect consumers and the public from fraud and abuse. In addition, there are countless examples of regulators accepting bribes or other incentives to lessen or avoid any penalties that would otherwise be applied to offenders or violators of the very regulations the regulators are charged to enforce.

Examples of this are widespread and extremely under-reported. For a brief overview of the problem, see the following websites:

http://www.ft.com/cms/s/0/382eb374-b0a7-11e0-a5a7-00144feab49a.html#axzz1aqhol9wA

http://www.lvrj.com/news/judge-to-allow-bail-for-ex-water-regulator-charged-in-bribery-scheme-121906394.html

http://www.kellogg.northwestern.edu/faculty/harstad/htm/bl.pdf (American Political Science Review, Vol. 105, No. 1 February, 2011)

The above three articles will need to suffice for brevity. It is our concern that the Department of Health and Human Services inadequately provides the oversight necessary for safeguarding children and families from fraudulent and abusive programs.

From Page 45 of CAPTA Manual (Source: http://www.acf.hhs.gov/cwpm/programs/cb/laws_policies/laws/cwpm/policy_dsp.jsp?citID=177) (Sec. 2 (3))

"For purposes of this title [42 U.S.C. 5101 et. seq.]—

(1) the term "child" means a person who has not attained the lesser of—

(A) the age of 18; or

(B) except in the case of sexual abuse, the age specified by the child protection law of the State in which the child resides;

(2) the term "child abuse and neglect" means, at a minimum, any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm;"

The above definition would appear to provide a substantial basis for determining a child has been abused and/or neglected.

The concern generated from the above definition is that such actions are already defined as abuse and the Department of Health and Human Services repeatedly fails to protect or enforce CAPTA in regards to children in both public and private programs.

HEAL understands that the intention of HR 3126 and S. 1667 is to explicitly and clearly codify regulations based on existing laws to be enforced in regards to residential programs for youth. However, we see the plan as lacking in some regards and hope you will take our concerns, suggestions, and questions into consideration.

The definition of "Covered Program" lacks coverage of many programs that appear to be the intended target of the regulations to be enacted. This is a serious concern. A "Covered Program" operates "with a focus on serving

children with—emotional, behavioral, or mental health problems or disorders; or problems with alcohol or substance abuse." (Sec. 2 (4)) Residential programs that claim to primarily be boarding schools with "specialties" dealing with certain behavioral and/or learning challenges may use the fact that they claim to primarily operate as a boarding school as opposed to a treatment environment as a loophole to avoid regulation. There are other plays on language that will assist such programs in avoiding regulation or arguing that their services fall outside the parameters of the legislation. For instance, many programs are already changing their language in claiming to be "youth development" and/or "character building/training" programs. However, they continue to use the destructive model in place at the majority of behavior modification/"troubled teen" facilities. This raises serious concerns regarding the efficacy of the legislation in regulating "Covered Programs" going forward.

In addition, many "faith-based" or "religious" homes and programs are claiming to focus on ministry, conversion, and/or instilling "Christian/Religious values" into youth enrolled in their residential homes and programs. It would appear that claiming such would rule such programs out of the scope of regulatory enforcement. Programs like Hephzibah House in Indiana, recently exposed in CNN's Anderson Cooper 360's "Ungodly Discipline" series, need to be regulated. And, the children in such programs should not be subjected to abuse in the name of God just as children in secular programs should not be subjected to abuse in the name of treatment. This is a serious concern.

The exclusion of a "hospital licensed by the State; or a foster family home that provided 24-hour substitute care for children placed away from their parents or guardians for whom the State child welfare services agency has placement and care responsibility and that is licensed and regulated by the State as a foster family home" is an additional serious concern.

For instance, the Aspen Institute of Behavioral Assessment in Syracuse, UT is an Aspen Education Group program that operates in a similar capacity to Aspen Education Group programs as Brightway Hospital operated in relation to WWASPS' programs when operating out of St. George, UT. (Source: http://wiki.fornits.com/index.php?title=Brightway_Adolescent_Hospital)

Aspen Institute for Behavioral Assessment is not listed on the "full list" of licensed hospitals in Utah. (Source: http://health.utah.gov/myhealthcare/facility.htm#boxelder) However, they are listed as a Psychiatric Hospital under Utah Stated Licensed Facility Listing by the Utah Department of Health. (Source: http://health.utah.gov/hflcra/facinfo/alpha.php?FACTYPE=012) And, the Aspen Institute for Behavioral Assessment is not licensed by the Department of Human Services. (Source:

http://www.hslic.utah.gov/db_results.asp?corp_name=Aspen&service=%&SS=%&county=%) From HEAL's research, we have found that the state of Utah may not require private mental health or psychiatric "hospitals" to be licensed. "Representatives from only four States, Alaska, Delaware, Utah, and Wisconsin, reported no provision for such licensing." (Author: Boyd E. Oviatt, Source: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1920091/pdf/pubhealthreporig00034-0047.pdf) In fact, Aspen Institute for Behavioral Health appears to be licensed with only a general business license as a foreign limited liability company in Utah. (Source: https://secure.utah.gov/bes/action/details?entity=6212094-0161)

And, Aspen Institute for Behavioral Assessment claims to be accredited by the Joint Commission. This also appears to be a false statement. Island View Residential Treatment Center is accredited by the Joint Commission (JCAHO) and claims to also provide services at Aspen Institute for Behavioral Assessment. (Source: http://www.qualitycheck.org/consumer/searchresults.aspx?nm=Aspen+Institute&ddstatelist=&st_nm=-1&st=) This shows that Island View is accredited, not Aspen Institute for Behavioral Health. Beyond this, the Joint Commission has been in repeat trouble for failure to enforce patient safety standards at programs and facilities they accredit. (Source: http://www.heal-online.org/jointcommission.pdf) There is no suggestion by the Joint Commission that Aspen Institute is ever surveyed for compliance, only that their sister facility, Island View, is so surveyed.

Again, Aspen Institute of Behavioral Assessment is simply one example of the problem the exclusion of hospitals licensed by the state pose in regards to effectively regulating these programs.

The second issue is with the exclusion of a foster family home. If by "foster family home" you mean actual foster homes that are family homes in which a child or children may be placed, than that may be acceptable. However, many children are placed in residential programs and some of these programs actually operate as "foster homes" or "group homes".

For instance, Utah's Child Protection Services will not investigate foster homes or residential placements where they have or the Department of Health and Human Services has placed a child.

"Utah Code Annotated §62A-4a-409(5) requires another organization to conduct child protection investigations when DCFS has a "conflict" or potential conflict of interest. The most typical conflict is a report of maltreatment in a foster home. DCFS makes the placement and, in theory, might over-identify with the child or the foster parents were we to attempt to investigate. A less typical conflict is

when the referral alleges child maltreatment by one of our employees or an employee of an agency with whom we work closely." (Source: http://www.hsdcfs.utah.gov/PDF/Weekly%20Updates/weekly061600.PDF) That report goes on to say that they hire a for-profit firm to investigate such reports and that their budget for such investigations is limited and therefore some reports simply go uninvestigated.

Obviously, the States do not always provide adequate oversight and create legal loopholes for oversight within their own laws. To eliminate oversight in regards to children placed by the State into a foster home, group home, and/or even a licensed hospital, if such is not more explicitly defined, will result in many programs in need of regulation being exempt.

Suggestions

1. Include a directive to the Department of Health and Human Services (DHHS) to review and eliminate violating programs from referral lists of DHHS departments such as SAMHSA.

2. In separate legislation, if needed, please create an oversight agency that is charged with regulating the various regulatory agencies to ensure laws are effectively enforced and opportunities for corruption are minimized.

3. Add to the definition of child abuse and neglect the language of the following New Jersey statute:

"Emotional Abuse Citation: Ann. Stat. § 9:6-8.21

Abused child or *abused or neglected child* means a child under age 18 years who is in an institution, and:

- Has been placed there inappropriately for a continued period of time with the knowledge that the placement has resulted or may continue to result in harm to the child's mental or physical well-being
- Who has been willfully isolated from ordinary social contact under circumstances that indicate emotional or social deprivation "

4. Clarify definition of "Covered Programs" and excluded programs/services. If possible, explicitly include "faith-based" programs, "youth development" programs, and "character building/training" programs to list of "Covered Programs".

5. Add a rule that all programs that may fall under the umbrella will be subject to initial review and oversight to determine whether or not the legislation is intended to regulate those programs. This should include being subjected to intense review and unannounced inspections during the first two years of

implementing the legislation for any program that provides residential care and services to children.

Questions

1. Will faith-based programs be regulated if this legislation is enacted?

2. What residential programs or services for youth will be exempt from regulation?

3. How does regulation of such programs fall outside of the current purview of DHHS authority?

SEC. 3. STANDARDS AND ENFORCEMENT.

Concerns

The concerns regarding what constitutes a "Covered Program" were covered effectively in regards to Section 2 and will not be repeated here. (Sec. 3 (1))

Federal law already prohibits child abuse and neglect through CAPTA. The concerns and/or suggestions regarding further defining child abuse and neglect were covered effectively in regards to Section 2 and will not be repeated here. (Sec. 3 (a) (1)(A))

Wilderness programs, residential treatment centers, and the litany of "Covered Programs" already claim they do not withhold "essential food, water, clothing, shelter, or medical care necessary to maintain physical health, mental health, and general safety". However, many of these programs do not provide well-balanced meals and/or serve cheese sandwiches, peanut butter sandwiches, and/or water as the sole sustenance for children enrolled in the programs. And, most of these requirements include some level of subjective analysis on the part of the programs. This subjective analysis is the very basis for creating loopholes regarding meeting the minimum standards required by this legislation. And, as is quite clear, loopholes of this nature are generally exploited by the "Covered Programs". This raises serious concerns regarding the efficacy of basically encoding a law against neglect, especially when existing laws prohibiting such neglect are not effectively enforced. (Sec. 3 (a) (1)(B))

For our understanding, we have included Sec. 290jj and subsection (b)(3) below. (Source: http://uscode.house.gov/download/pls/Title_42.txt) (Sec. 3 (a) (1)(C))

"Sec. 290jj. Requirement relating to the rights of residents of certain non-medical, community-based facilities for children and youth

-STATUTE-

(a) Protection of rights

(1) In general

A public or private non-medical, community-based facility for children and youth (as defined in regulations to be promulgated by the Secretary) that receives support in any form from any program supported in whole or in part with funds appropriated under this chapter shall protect and promote the rights of each resident of the facility, including the right to be free from physical or mental abuse, corporal punishment, and any restraints or involuntary seclusions imposed for purposes of discipline or convenience.

(2) Nonapplicability

Notwithstanding this part, a facility that provides inpatient psychiatric treatment services for individuals under the age of 21, as authorized and defined in subsections (a)(16) and (h) of section 1905 of the Social Security Act [42 U.S.C. 1396d], shall comply with the requirements of part H of this subchapter.

(3) Applicability of Medicaid provisions

A non-medical, community-based facility for children and youth funded under the Medicaid program under title XIX of the Social Security Act [42 U.S.C. 1396 et seq.] shall continue to meet all existing requirements for participation in such program that are not affected by this part.

(b) Requirements

(1) In general

Physical restraints and seclusion may only be imposed on a resident of a facility described in subsection (a) of this section if -

(A) the restraints or seclusion are imposed only in emergency circumstances and only to ensure the immediate physical safety of the resident, a staff member, or others and less restrictive interventions have been determined to be ineffective; and

(B) the restraints or seclusion are imposed only by an individual trained and certified, by a State-recognized body (as defined in regulation promulgated by the Secretary) and pursuant to a process determined appropriate by the State and approved by the Secretary, in the prevention and use of physical restraint and seclusion, including the needs and behaviors of the population served, relationship building, alternatives to restraint and seclusion, de-escalation methods, avoiding power struggles, thresholds for restraints and seclusion, the physiological and psychological impact of restraint and seclusion, monitoring physical signs of distress and obtaining medical assistance, legal issues, position asphyxia, escape and evasion techniques, time limits, the process for obtaining approval for continued restraints, procedures to address problematic restraints,

documentation, processing with children, and follow-up with staff, and investigation of injuries and complaints.*

(2) Interim procedures relating to training and certification

(A) In general

Until such time as the State develops a process to assure the proper training and certification of facility personnel in the skills and competencies referred (!1) in paragraph (1)(B), the facility involved shall develop and implement an interim procedure that meets the requirements of subparagraph (B).

(B) Requirements

A procedure developed under subparagraph (A) shall -

(i) ensure that a supervisory or senior staff person with training in restraint and seclusion who is competent to conduct a face-to-face assessment (as defined in regulations promulgated by the Secretary), will assess the mental and physical well-being of the child or youth being restrained or secluded and assure that the restraint or seclusion is being done in a safe manner;**

(ii) ensure that the assessment required under clause (i) take place as soon as practicable, but in no case later than 1 hour after the initiation of the restraint or seclusion; and

(iii) ensure that the supervisory or senior staff person continues to monitor the situation for the duration of the restraint and seclusion.

(b)(3) Limitations

(A) In general

The use of a drug or medication that is used as a restraint to control behavior or restrict the resident's freedom of movement that is not a standard treatment for the resident's medical or psychiatric condition in nonmedical community-based facilities for children and youth described in subsection (a)(1) of this section is prohibited.

(B) Prohibition

The use of mechanical restraints in non-medical, community-based facilities for children and youth described in subsection (a)(1) of this section is prohibited.

(C) Limitation

A non-medical, community-based facility for children and youth described in subsection (a)(1) of this section may only use seclusion when a staff member is continuously face-to-face monitoring the resident and when strong licensing or accreditation and internal controls are in place.

(c) Rule of construction

(1) In general

Nothing in this section shall be construed as prohibiting the use of restraints for medical immobilization, adaptive support, or medical protection.

(2) Current law

This part shall not be construed to affect or impede any Federal or State law or regulations that provide greater protections than this part regarding seclusion and restraint."

The concern here is that many of the "Covered Programs" claim that they only use restraint and seclusion in emergency situations and/or when less restrictive measures have been deemed ineffective by staff. However, without constant monitoring by a third-party agency, through televised filming of all areas of the facility to be regulated, ensuring that such methods are not improperly used at such programs will be improbable, if not, impossible.

We have corresponded with representatives (Sec. Kathleen Sebelius, Dir. Robin Brooks (FOIA/PA Division, Office of Inspector General), and Dir. Marilyn Dahl (Division of Acute Care Services)) from the U.S. Department of Health and Human Services (DHHS) regarding the approval process used to approve restraint and seclusion training programs. The only such guidelines identified, defined, and implemented by DHHS are those found in the "Conditions of Participation Manual" for Medicaid/Medicare approved providers. This manual can be downloaded here: http://www.cms.gov/manuals/Downloads/som107ap_a_hospitals.pdf and provides definitions of expected standards to be met. However, the system to oversee that the standards are being met is insufficient and prone to manipulation and abuse by corrupt officials and/or third-party contractors on which States, and thereby the DHHS, depend for determining provider/facility compliance.

In Dir. Dahl's responses to our inquiries, she stated:

"Title XVIII of the Social Security Act governs the Medicare program. Section 1864 of the Act provides that the Secretary of DHHS may enter into an agreement with each State for that State to evaluate compliance of health care facilities with the Medicare requirements/Conditions. All States have a Section 1864 agreement with CMS. When conducting such evaluations the State Survey Agencies must evaluate compliance with federal regulations, following federal policy and processes."

Dir. Dahl and the State Operations Manual, Chapter 8, [Source: https://www.cms.gov/manuals/downloads/som107c08.pdf] to which Dir. Dahl referred in our correspondence, states that States may rely on third-party contractors/"accreditation agencies" to determine compliance with Federal

Standards. And, it has been HEAL's experience, particularly when dealing with Utah, that the Joint Commission will refer complainants to the Department of Licensing; the Department of Licensing will refer to Child Protective Services, Accreditation Agencies, and/or Law Enforcement; and each referred to resource will continue to refer to another leaving complainants frustrated, confused, and hopeless for justice or effective redress of grievances.

Based on the language of HR 3126 and S. 1667, it does not appear that this legislation will effectively resolve the ongoing issues regarding lax oversight and enforcement of standards. As stated above, even programs that receive Medicaid; and are supposed to adhere to existing DHHS guidelines and standards; fail to do so and fail to be effectively regulated to prevent abuses this legislation intends to prevent.

An additional concern is that a supervisor or senior staff member may monitor the use of restraint or seclusion otherwise than in person. This is implied to be the case when a program has been given a timeframe in which to establish a plan for handling restraint and seclusion under the regulatory guidelines established by the Secretary of the DHHS. Such a standard creates an inherent risk of serious harm or death to children held in such an environment.

"Adaptive support" appears to be a very subjective term that allows great leeway for a "Covered Program" to determine the necessity of using restraint, seclusion, or pressure points to "encourage" compliance from a youth enrolled in the program. Such limitations may override the intent to prevent the abuse of restraint and seclusion in "Covered Programs" and this raises serious concerns. (Sec. 3 (a) (1)(C))

It is also a concern that programs do and will continue to claim that their behavior modification models are not "designed to humiliate, degrade, or undermine a child's self-respect". Positive Peer Culture/Pressure and "Confrontational Therapy" are arguably designed to identify behaviors and issues a child reportedly has difficulty identifying and though the methods may result in feelings of humiliation, degradation, and/or undermining of a child's self respect; they are not intended nor "designed" to achieve that result. The language of this section should be clarified to include that methods that result in feelings of humiliation, degradation, and/or an undermining of self-respect or that would reasonably result in such feelings by the average person if exposed to similar treatment are prohibited. This is a serious concern given the ongoing redefining and rebranding of programs that operate residential and wilderness programs. (Sec. 3 (a) (1) (D))

It is a concern that other forms of domestic violence, physical assault, or battery are not included in the terms that would preclude individuals from being allowed to work with children. (Sec. 3 (a) (1) (J))

We will address any concerns and/or questions regarding section 7 and/or section 114(b)(1) of the Child Abuse Prevention and Treatment Act in the discussion of section 7 below. (Sec. 3. (a) (1) (N))

It is a serious concern that the Department of Health and Human Services is allowed 60 days to complete an investigation into any violation of Sec. 3 (a)(1). 60 days is long enough to move, transfer, or otherwise make unavailable witnesses, victims, and perpetrators. And, such has been the status quo for this particular industry, so that is exactly what will likely occur. (Sec. 3. (b) (1) (A-C))

It is a serious concern that credible complaints of abuse at any of the covered programs may begin up to 30 days after receipt of the complaint. As stated above, this long of a delay from complaint receipt to investigation will likely result in loss of witnesses, victims, perpetrators, and/or evidence. (Sec. 3. (d) (3))

Suggestions

1. Define essential food, water, clothing, shelter, and medical care. Specifically, create dietary guidelines to which programs must adhere. And, create clothing and shelter guidelines in a relative table that includes climate/location variables. In addition, include standards and guidelines for requiring medical attention.

2. Explicitly define "emergency situation(s)" that would mandate the use of restraint and/or seclusion.

3. Require installation of video surveillance in all areas where staff may be in the presence of children. Require video surveillance to be accessible by DHHS through closed-circuit satellite monitors.

4. Require in-person supervision by supervisory and/or senior staff in any incident where restraint or seclusion is deemed necessary. This should be included as a requirement even during interim periods of adjustment by the "Covered Programs" to new regulations/requirements.

5. The use of restraint and/or seclusion for the purposes of "adaptive support" should be clearly defined and/or abolished (i.e. not included as permissible) by the legislation.

6. Positive Peer Culture/Pressure and "Confrontational Therapy" are arguably designed to identify behaviors and issues a child reportedly has difficulty identifying and though the methods may result in feelings of humiliation, degradation, and/or undermining of a child's self respect; they are not intended nor "designed" to achieve that result. The language of this section should be clarified to include that methods that result in feelings of humiliation, degradation, and/or an undermining of self-respect, or that would reasonably result in such feelings in the average person if exposed to similar treatment, be prohibited. (Sec. 3 (a) (1) (D))

7. Individuals convicted of domestic violence, assault, or battery against another should be prohibited from working with minors in a residential setting. If not, then such individuals should have a limit on the allotted time between the conviction and their employment in such facility. For example, banning an individual convicted of domestic violence, assault, or battery from working with children in a residential setting for 10 years following such conviction.

8. It may be fair that investigations be concluded within 60 days. However, such investigations should begin within 7 days of receiving a credible report, if not sooner.

9. Create a victim's relief/assistance fund with a portion of the fines collected from offending/violating programs.

10. Change language from "best practices" to "best evidence-based practices". (Sec. 3 (c) (1) (B))

11. Require programs to post publicly and accessibly to all children enrolled their rights as guaranteed under this legislation. Such should include telephone numbers to any hotlines and be placed near all accessible phones provided for the use of children enrolled.

Questions

What is meant by "reasonable access" to a telephone? (Sec. 3 (a) (1) (E))

Who will perform the on-site investigation of a report of child abuse? (Sec. 3 (a) (1) (N) (i))

What actions will be taken to guard against corruption of those assigned to investigate abuses and/or enforce the law? (Sec. 3 (b) (2))

SEC. 4. ENFORCEMENT BY THE ATTORNEY GENERAL

Concerns

We have no concerns regarding granting the authority to investigate and/or prosecute offending programs to the Attorney General.

Suggestions

1. It is unclear whether or not this would be the correct section to include information on extending the statute of limitations as was included in the 2005 version of this bill. Regardless, we do recommend that the statute of limitations be extended for victims of institutionalized abuse. Due to the trauma caused by the practices at such programs, we believe the statute of limitations should be extended to a minimum of 20 years. And, our preference would be to eliminate the statute of limitations due to the psychological trauma caused by the practices of many of these programs and the necessity for justice to allow for those harmed to be secure in mind and body before pursuing legal action. We ask for the longest extension of the statute of limitations practicable to be included in this legislation.

Questions

We have no questions regarding Section 4.

SEC. 5. REPORT.

We have no concerns, suggestions, or questions regarding Section 5.

SEC. 6. AUTHORIZATION FOR APPROPRIATIONS

We have no concerns, suggestions, or questions regarding Section 6.

(SEC. 7. ADDITIONAL ELIGIBILITY REQUIREMENTS FOR GRANTS TO STATES TO PREVENT CHILD ABUSE AND NEGLECT AT RESIDENTIAL PROGRAMS.

Concerns

We have no concerns regarding Section 7.

Suggestions

We have no suggestions regarding Section 7.

Questions

What will be the consequences for States that refuse to participate?

Can the Commerce Clause be used to stop States, who refuse to adopt the regulations set forth in this bill, from being allowed to have "Covered Programs" in those States accept children from other States?

SEC. 114. ADDITIONAL ELIGIBILITY REQUIREMENTS FOR GRANTS TO STATES TO PREVENT CHILD ABUSE AND NEGLECT AT RESIDENTIAL PROGRAMS.

Concerns

It is a serious concern that States are given 30 days to notify DHHS regarding any investigation regarding abuse at a "Covered Program". Such gives too long a delay for DHHS to investigate in the event of abuse and such was discussed in the concerns listed above in the discussion of Section 3. (Sec. 114 (b) (3))

Suggestions

1. The unannounced inspections should be defined clearly to include access to all areas in which children are present, permitted, or placed while enrolled. It should also specifically allow access to interview any child enrolled without supervision by program staff. (Sec. 114 (b) (2) (C))

2. The DHHS should be required to place a DHHS liaison in every State agency providing oversight of the industry. This should be for the purposes of guaranteeing enforcement and assisting the State in following the federal guidelines/regulations proposed by this legislation. (Sec. 114 (b) (6) (A-B))

Questions

Will States be allowed to receive grant money prior to enforcing and/or adopting the regulations as set forth in this legislation?

If States that receive grant money fail to develop, enact, and/or enforce policies and procedures within three years, what will be the penalty? (i.e. Will they have to refund the grant money if they fail to abide by the requirements of the legislation?) (Sec. 114 (b) (1))

What will happen to States that fail to comply with the regulations? (Sec. 114 (d) (1))

SEC. 8 STUDY AND REPORT ON OUTCOMES IN COVERED PROGRAMS

Concerns

We have no concerns regarding this study and believe it will be of benefit to obtaining legitimate data regarding the efficacy of the "Covered Programs".

Suggestions

1. We suggest that agencies and experts utilized be from outside the industry that comprises the "Covered Programs". Agencies and experts consulted should be from the fields of law, mental health, and social work.

Questions

How will this data be used by the Committee on Education and the Workforce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate?

General Concerns

Institutionalizing a minor who has committed no crime in a residential facility without due process of law appears to violate the minors' liberty interests. This legislation does not protect the liberty interests of minors. Such institutionalization is a civil rights violation and has been so determined by the federal courts. (Source: www.heal-online.org/provocases.htm)

Many of the "Covered Programs" violate child labor laws and force/coerce children to provide uncompensated (slave) labor for the program. This issue is not effectively addressed by this legislation.

Many of the "Covered Programs" use deceptive marketing practices. This includes claiming credentials for staff that are non-existent. This is a serious concern.

General Suggestions

1. Parents should be barred from enrolling a child in an out-of-state residential facility without due process of law.

2. Parents should be barred from enrolling a child in any residential facility without due process of law.

3. Parents should be forced to participate in any and all activities to which their child is subjected.

4. Ban "Covered Programs" from using enrolled children as staff and/or free labor for themselves or their business associates.

5. Include in directives to the DHHS that they must verify the credentials of all "Covered Programs"' staff with proper professional licensing agencies.