VERMONT
OFFICE OF THE CHILD, YOUTH, AND FAMILY ADVOCATE

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Introductory Information

- The OCYFA is an **independent, non-partisan** office that advocates for children, youth, and families in Vermont's child protection and juvenile justice systems.
- The OCYFA has statutory access to otherwise confidential records, information, and facilities.
- DCF is required to notify the OCYFA of "(1) all incidents of actual physical injury to children or youths in the custody of the Commissioner or at significant risk of such harm; and (2) instances of restraint or seclusion of any child or youth in custody of the Commissioner."[1]

Summary of Restraint and Seclusion[2]

- **Neither restraint nor seclusion have a therapeutic basis**.
- Restraint and seclusion were created as emergency interventions but have become commonplace, especially in residential care and other institutional settings.
- Restraint and seclusion injure, traumatize, and sometimes kill children.
    - One disturbing and sad example is here.
    - Another very disturbing and sad example featuring a Vermont youth is on page 11 of Warehouses of Neglect (excerpt attached below).

The Need for H.30

- **Vermont has no comprehensive data on the use of restraint and seclusion on children in foster care**. No entity—not the OCYFA, not DCF, not parents, not the legislature, not the governor, not courts, not children—knows how often Vermont children are restrained or secluded. Current law is inadequate: in the entire existence of the OCYFA, DCF has reported the restraint of just 58 children, and the seclusion of zero children.
- **Youth voice matters**. Youth have repeatedly told OCYFA staff that being restrained or even being near youth who are restrained has traumatized them, motivating them to run from treatment centers. Youth vividly remember the details of their restraints years later.
- **Restraint and seclusion data is integral to racial justice work in Vermont**. National studies show that restraint and seclusion are used disproportionately on Black and Brown children, children with disabilities, and other marginalized groups.

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[1] 33 V.S.A. § 3206(a). See also Act 129 of 2022 for full OCYFA responsibilities and duties.

[2] "Restraint, Physical: The application of physical force by one or more individuals that reduces or restricts the child/youth's freedom of movement, including an escort" … "Seclusion: (However named) is the confinement of a child/youth in a segregated room, for the purpose of preventing harm to self or others, with the child/youth's freedom to leave physically restricted. Seclusion is not a punishment. Voluntary time-out is not considered seclusion, even though the voluntary time out may occur in response to verbal direction; the child/youth is considered in seclusion if freedom to leave the segregated room is denied." (Licensing Regulations for Residential Treatment Programs in Vermont, p. 49).

- Recent news stories raise ongoing concerns about conditions of children in DCF custody.
- DCF did not include requirements for a restraint/seclusion reporting system to itself or OCYFA in its recent data system RFP.[3]
- Youth in DCF custody are restrained in multiple settings: schools, homes, hospitals, secure settings (such as Red Clover), staffing settings, and residential facilities.
- More than 13% of referrals to OCYFA in 2024 included instances of restraint and/or seclusion not reported by DCF. The OCYFA estimates that there are hundreds of additional unreported restraints and seclusions of children in DCF custody each year.
- This information is relevant not to blame or attack DCF, but to ensure that systems are keeping children safe and that policymakers are building responsive programs. We must understand how kids are treated behind closed doors, and monitor how state dollars are spent. We must ensure young people know they have a voice in their treatment. We must overcome institutional defensiveness if we are going to address these issues.

H.30 Components [Short Form]

- Pertains to children who are: 1. In DCF custody and 2. "In residential care"
    - As of April 2025, 97 out of 864 youth are in residential programs – 11%
- Four main components:
    - 1. Would add specific definitions for restraint and seclusion to 33 V.S.A. § 3206
    - 2. Would require "more consistent reporting" by residential programs
    - 3. Would require that "ongoing modifications to the Department's IT system include processes for collecting and integrating data pertaining to seclusion and restraint."
    - 4. Would require "enhanced professional development on alternatives to seclusion and restraint" for staff of residential programs serving children in DCF custody.

Legislative Suggestions

- Ban prone restraint in all settings with no exceptions.
- Require reporting within 24 hours of all incidents of restraint or seclusion of children in DCF custody to DCF, parents/guardians, attorney, GAL, educational decisionmaker or surrogate.
- Standardize reporting requirements (such as duration, modality, injuries, child response) to generate comparable data.
- Consider requiring public dashboard, updated monthly, to include restraint and seclusion data and other program info for all programs, in state and out, serving Vermont youth.
- Require legislative data on restraint and seclusion incidents at Red Clover, see Act 4 of 2025.
- Leverage expertise of current Vermont providers who employ "zero restraint" policies.

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[3] While the word "Salesforce" appears 19 times in the March 6, 2025 CCWIS RFP, the words "restraint," "seclusion," and "OCYFA" do not appear at all, despite statutory reporting requirements related to restraint and seclusion.

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 ten-question multiple-choice test on restraint and seclusion to staff.

- 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 overused 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 recommendations 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,