

**TO:** Senate Committee on Finance; Senate Committee on Health and Welfare; House Committee on Human Services; House Committee on Health Care

**FROM:** Sandi Hoffman, Commissioner, Department for Children and Families  
Samantha Sweet, Deputy Commissioner, Department of Mental Health

**DATE:** May 12, 2026

**RE:** H.657 Restraint and Seclusion provisions

AHS continues to be very concerned about the inclusion in H. 657 of the prohibition on the use of chemical restraints for children in DCF custody in a PRTF.

The purpose of a PRTF is to provide the equivalent of hospital care in a setting that is less restrictive than a hospital. As noted in DMH's two memos of April 23 & 29, 2026, prohibiting the use of chemical restraints in a PRTF may lead to worse outcomes for children in DCF custody. Such children may end up in full-service hospitals, supervised by law enforcement and others, rather than in a PRTF, where they hold expertise in treating children with serious mental illness and where supervision is provided by staff trained in working with these high-needs children.

Federal law specifies those situations that permit state law to be more restrictive than the federal law in the use of seclusion or restraint. For instance, state law may have more protections on the length of an order for seclusion or restraint, or the time frames when a child must be seen face-to-face after the initiation of a restraint. *See* 42 C.F.R. § 482.13(e)(8) and (13), respectively. There is no such authorization for a state to limit a PRTF's ability to utilize chemical restraints, and we have been unable to identify any states that do so.

Further, such statutory limitation on such medication use may lead to results contrary to the goals of a PRTF. For instance, 42 C.F.R. § 441.154 requires a PRTF to provide active treatment that is "[d]esigned to achieve the beneficiary's discharge from inpatient status at the earliest possible time." Requiring a PRTF to utilize restraints that may be unhelpful or have been unsuccessfully utilized in the past on the child may lead to longer stays and more trauma. Children with tactile sensitivities, physical limitations or disabilities, or trauma relating to abuse or neglect may have extremely negative reactions to the imposition of physical restraints. The federal requirements for detailed plans of care for each child provides the appropriate place for any limitations on the use of medical interventions, individualized to the needs of each child based on their trauma history, their diagnoses, and their long- and short-term needs.



As with all medical care for children with mental health diagnoses, the use of chemical restraints relies, as do physical and mechanical restraints, on the judgment of physicians with extensive experience in serious mental illness and trauma response. Providing temporary, well-supervised chemical restraints when that is the most appropriate medical response, based on the informed judgment of a physician involved in the child's care at the time of the event, increases the likelihood of positive outcomes and shorter institutional stays for children in extreme distress.