



Warehouses of Neglect:

How Taxpayers Are
Funding Systemic
Abuse in Youth
Residential
Treatment Facilities

A Senate Committee on
Finance Staff Report

| | |
|---|-----------|
| I. Executive Summary..... | 3 |
| A. Key Findings..... | 3 |
| B. Recommendations..... | 6 |
| II. Background..... | 10 |
| A. Centering Children’s Stories..... | 10 |
| B. History..... | 12 |
| a. Senate Committee on Finance Jurisdiction and Program Descriptions..... | 12 |
| b. Senate Committee on Finance Investigation..... | 14 |
| c. RTF Federal and State Oversight Efforts..... | 17 |
| C. RTF Overview..... | 21 |
| a. Population Served and General Treatment Model..... | 21 |
| b. Programs Operated by the Four Providers..... | 22 |
| c. Lack of Evidence to Support the Efficacy of This Model for Populations Served..... | 24 |
| d. The Business of RTFs..... | 25 |
| D. Report Focus, Limitations, and Next Steps..... | 31 |
| III. Investigative Findings..... | 32 |
| A. Many Children in RTFs Are Suffering Abuse During Interactions with Both Staff and Other Youth..... | 32 |
| a. Children Are at Risk of Sexual Abuse While at RTFs..... | 32 |
| i. Staff-on-Youth..... | 33 |
| Public Reporting..... | 33 |
| Documents Reviewed by the Committee..... | 37 |
| ii. Youth-on-Youth..... | 41 |
| Public Reporting..... | 41 |
| Documents Reviewed by the Committee..... | 42 |
| b. Children Often Experience Physical Abuse in RTFs..... | 44 |
| i. Staff-on-Youth..... | 44 |
| Public Reporting..... | 44 |
| Documents Reviewed by the Committee..... | 49 |
| ii. Youth-on-Youth..... | 52 |
| Public Reporting..... | 52 |
| Documents Reviewed by the Committee..... | 54 |
| c. Children Often Experience Physical Restraint, Seclusion, Chemical Restraint, and Polypharmacy in RTFs, Leading to Harm and Fatalities..... | 55 |
| i. Physical Restraint: Misuse and Harm..... | 58 |
| ii. Seclusion: Misuse and Harm..... | 66 |
| iii. Chemical Restraint & Polypharmacy: Misuse and Harm..... | 68 |
| d. Rampant Reports of Children Being Verbally Abused in RTFs..... | 74 |

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

| | |
|--|------------|
| e. Children Are Routinely Emotionally Abused in RTFs..... | 76 |
| B. RTFs Fail to Provide Home-Like Conditions to Children and Expose Them to Unsafe and Unsanitary Environments..... | 79 |
| C. Many Children in RTFs Do Not Receive Appropriate Care for Complex Behavioral and Mental Health Conditions..... | 86 |
| a. RTFs Are Intended to Meet the Needs of Children, but Often Fail to Involve the Community..... | 86 |
| b. RTFs Are Intended and Reimbursed to Offer Intensive Services, but the Committee Observed Instances of Children’s Treatment Lacking Measurable Goals..... | 89 |
| c. Treatment Plan Deficiencies Result in Children Not Receiving the Care They Need...97 | |
| d. RTFs Are Intended to Offer Brief and Intensive Services, but Children Are Trapped in These Facilities – Sometimes for Years..... | 102 |
| 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... 103 | |
| i. Some RTFs Are Routinely Understaffed..... | 104 |
| ii. RTF Employees Are Poorly Trained..... | 107 |
| iii. Children Are Harmed When Staff Abdicate Their Responsibilities, in Some Cases Resulting in Patient Deaths..... | 109 |
| iv. Understaffing and Lack of Supervision Contribute to Elopements, Which Are Critical Safety Events..... | 115 |
| f. RTFs Are Intended to Offer Intensive Services and Robust Discharge Planning, but Children Are Routinely Discharged With Subpar Planning..... | 118 |
| D. Children in RTFs Are at Risk of Incurring Long-Term Harms, Including Trauma and Death..... | 120 |
| a. Children in RTFs May Be Able to Access Self-Harm Modalities..... | 120 |
| b. Children in RTFs May Receive Substandard Education, Setting Them Up for Future Failure..... | 125 |
| IV. Conclusion..... | 127 |
| V. Appendix I: A Historical Summary of the Behavioral Health Landscape in the United States..... | 127 |
| VI. Appendix II: Exhibit List..... | 130 |

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

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 high-quality 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) investing 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.

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

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. **Horrible 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.

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

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 wellbeing. 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 childrens’ 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 6:45am, staff discovered the child had escaped the facility through a window. They contacted the police at 7:10am. Hours earlier, at 4:50am, 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 childrens’ 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

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

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.

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

- 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,

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

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.

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

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

¹ APM Reports, *Youth Were Abused Here* (Sep. 28, 2020) <https://www.apmreports.org/story/2020/09/28/for-profit-sequel-facilities-children-abused>; [\[https://perma.cc/9NEH-PSW3\]](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>; [\[https://perma.cc/2Q7A-VZZX\]](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>; [\[https://perma.cc/9NEH-PSW3\]](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>; [\[https://perma.cc/2Q7A-VZZX\]](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>; [\[https://perma.cc/3HH8-VLK9\]](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>; [\[https://perma.cc/9NEH-PSW3\]](https://perma.cc/9NEH-PSW3).

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

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-homelike environments. 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 wellbeing 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

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/JS6-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-san-dwich-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-392-22023>; [https://perma.cc/HN5L-ROB3].

¹⁴ *Id.*

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

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 even begin – 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.

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).

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

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.

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.

¹⁷ 42 CFR § 440.160.

¹⁸ 42 CFR § 441.151.

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.

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

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:

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; \[https://perma.cc/5KJL-F2N3\]](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>; [\[https://perma.cc/W87M-V5PG\]](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>; [\[https://perma.cc/28DU-BFC7\]](https://perma.cc/28DU-BFC7).

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

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 seclusion²⁹), 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

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-TYGO>]; *A Chain of Private Psychiatric Hospitals Has Been Accused of Failing Vulnerable Young Patients* (Dec. 16, 2017), <https://www.buzzfeed.com/patricksmith/cygnnet-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>;

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 death of 16-year-old Cornelius Frederick following a roughly ten-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

[<https://perma.cc/U7E5-6MKE>]; 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://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 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 overlapped 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>].

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

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 “[w]eaknesses in the current federal-state regulatory structure have

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

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

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 overreliance 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

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>; [\[https://perma.cc/4EEC-TB2G\]](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>; [\[https://perma.cc/M6Y7-RDD7\]](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>; [\[https://perma.cc/96GA-J7NQ\]](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>; [\[https://perma.cc/E67X-WNWU\]](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>; [\[https://perma.cc/9EAF-LL5C\]](https://perma.cc/9EAF-LL5C).

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

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 disabilities 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*.

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/NO25-QV2K>].

⁴⁹ *Id.*

⁵⁰ *Id.*

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

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>].

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

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 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

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>; [\[https://perma.cc/7WBY-TJYC\]](https://perma.cc/7WBY-TJYC).

⁵⁶ NDRN, *Desperation Without Dignity* (Oct. 2021) https://www.ndrn.org/wp-content/uploads/2021/10/NDRN_Desperation_without_Dignity_Final.pdf; [\[https://perma.cc/MYY9-PLCT\]](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>; [\[https://perma.cc/UZ3R-TRYH\]](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>; [\[https://perma.cc/C5T2-UDCF\]](https://perma.cc/C5T2-UDCF).

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/>; [\[https://perma.cc/5WZN-7MSN\]](https://perma.cc/5WZN-7MSN).

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

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; [\[https://perma.cc/A2QW-J5DM\]](https://perma.cc/A2QW-J5DM).

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

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

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 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

⁶³ Devereux, *Facility Information – Question 1* (Oct. 17, 2022) DEV-S_000356 at 000356-000360.

⁶⁴ *Id.*

⁶⁵ *Id.*

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/8MNO-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.

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

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 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

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

⁷³ *Id.*; see spreadsheet 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).

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).

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 seven 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

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>; [\[https://perma.cc/UF5Q-T2KP\]](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>; [\[https://perma.cc/3NTV-WYGP\]](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>; [\[https://perma.cc/UF5Q-T2KP\]](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>; [\[https://perma.cc/SUAM-7A47\]](https://perma.cc/SUAM-7A47).

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

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 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

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>].

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.pdf>; [<https://perma.cc/NG4S-OTUS>]; 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>].

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

– 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 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

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-TYGO>].

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>].

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-UMOM>].

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

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 firehose.”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*

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.

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

Dignity, cutting corners on staffing and intensive care models results in failures to treat children with evidence-based models.¹⁰⁵

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

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; [\[https://perma.cc/MYY9-PLCT\]](https://perma.cc/MYY9-PLCT).

¹⁰⁶ UHS, *About* (Accessed, Mar. 28, 2024) <https://uhs.com/about-universal-health-services/>;

[\[https://perma.cc/VQ4R-RJQT\]](https://perma.cc/VQ4R-RJQT); UHS, *Corporate Information* (accessed Mar. 28, 2024) <https://uhs.com/about-universal-health-services/corporate-information/>; [\[https://perma.cc/32B8-XFYL\]](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; [\[https://perma.cc/ZUD8-D8XS\]](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>; [\[https://perma.cc/DRF3-5MT8\]](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-uhs-behavioral-health-business/>; [\[https://perma.cc/4W77-FUEQ\]](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/>; [\[https://perma.cc/5MFL-3ADR\]](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-uhs-behavioral-health-business/>; [\[https://perma.cc/4W77-FUEQ\]](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/>; [\[https://perma.cc/5MFL-3ADR\]](https://perma.cc/5MFL-3ADR).

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

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 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,

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>].

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/38CW-45X9>].

¹¹⁷ Yahoo, *Market Cap for Acadia Healthcare Company, Inc. (ACHC)* (May 9, 2024) https://finance.yahoo.com/quote/ACHC/?guccounter=1&guce_referrer=aHR0cHM6Ly93d3cuZ29vZ2xILmNvbS8&guce_referrer_sig=A0AAAILsBTvvFi2oiiqzsLawlmX9DkcwQP-EXoGjRgh4WBE-emzFwGbv3jahgR2eg_zk3yUjNq9GtsFUsNOcD-Km5SK6eOrE2grZrVzbCgknpip30TbrRUc-lfC9a6qjdVx2TNpuhF0j5OWWCvOp_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>].

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

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

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/>; [\[https://perma.cc/KO6H-CNHL\]](https://perma.cc/KO6H-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/>; [\[https://perma.cc/JGE7-JBG5\]](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) [¹²⁶ IRS, *Tax Year 2021 Return of Organization Exempt from Income Tax \(Form 990\): Devereux Foundation* \(2021\) \[https://apps.irs.gov/pub/epostcard/cor/231390618_202206_990_2023060621384170.pdf\]\(https://apps.irs.gov/pub/epostcard/cor/231390618_202206_990_2023060621384170.pdf\); \[\\[https://perma.cc/RGP8-SHUT\\]\]\(https://perma.cc/RGP8-SHUT\); Devereux, *The Helena Devereux Foundation Tax Year 2022 990* \(2021\) \[https://apps.irs.gov/pub/epostcard/cor/300034707_202206_990_2023060621384143.pdf\]\(https://apps.irs.gov/pub/epostcard/cor/300034707_202206_990_2023060621384143.pdf\); \[\\[https://perma.cc/QEG5-QC3B\\]\]\(https://perma.cc/QEG5-QC3B\).](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].</p></div><div data-bbox=)

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_2023060621384170.pdf; [\[https://perma.cc/RGP8-SHUT\]](https://perma.cc/RGP8-SHUT).

¹²⁸ Fitch Ratings, *Fitch Affirms Devereux Corporation (PA) Revs at “A-”* (Oct.17, 2023) [¹²⁹ IRS, *Tax Year 2021 Return of Organization Exempt from Income Tax \(Form 990\): Devereux Foundation* \(2021\) \[https://apps.irs.gov/pub/epostcard/cor/231390618_202206_990_2023060621384170.pdf\]\(https://apps.irs.gov/pub/epostcard/cor/231390618_202206_990_2023060621384170.pdf\); \[\\[https://perma.cc/RGP8-SHUT\\]\]\(https://perma.cc/RGP8-SHUT\).](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].</p></div><div data-bbox=)

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

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 four years later, Acadia Montana Treatment Facility (Acadia; Montana) closed following reports of a nine-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 therein named. UHS, for example,

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, *Albuquerque 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).

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

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 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

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.

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/60a6942819ce8053cefd0947/60f6b1eba474362514093f96_Away%20From%20Home%20-%20Report.pdf; [<https://perma.cc/V56R-ZXYL>].

¹³⁷ *Id.*

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

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 four years to Provo Canyon School (UHS; Utah) and 21 times over five and a half 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]

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>].

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 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

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.

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-O7ZY>].

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-YNOD>].

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.*

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

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 Devereux [sic] [(Devereux; Georgia)] for the 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 Devereux [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

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/RZO9-PYJM>].

¹⁵⁷ *Id.*

¹⁵⁸ *Id.*

¹⁵⁹ *Id.*

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/2O5R-3XA3>].

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 two 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

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=4BB88F8C738788AC99BFD224CC0A2DDB79DDE7B88913E70CF906EEDFD2C76526FA6ABFEED34D16D7B733171ED4D4FE; [<https://perma.cc/W3HA-FF8F>].

¹⁶⁵ Devereux, *Incident ID:REDACTED Detective Arrived on Campus* (Oct. 25, 2017) DEV-S_001163 at 0001164.

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%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/2MS6-86OJ>].

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

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 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

¹⁷¹ *Id.*

¹⁷² Kentucky State Police, *Sex Offender Registry* (accessed May 26, 2024) http://kspsor.state.ky.us/Home/OffenderDetails/gqQiaqn-DO5wifnX4_0wnQ; [Permalink unavailable].

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).

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

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 eighteen 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.

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

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.

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.

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

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

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.

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

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 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

¹⁹⁵ *Id.* at 001179.

¹⁹⁶ *Id.* at 001180.

¹⁹⁷ *Id.* at 001179.

¹⁹⁸ *Id.* at 001180.

¹⁹⁹ *Id.* at 001179.

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/RZO9-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.

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

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

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

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/ZO7W-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.

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-health/>; [<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/OS42-DCCE>].

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

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/>; [\[https://perma.cc/Q5GQ-6SUV\]](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>; [\[https://perma.cc/249C-U99V\]](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/>; [\[https://perma.cc/5R89-MEV8\]](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/>; [\[https://perma.cc/5R89-MEV8\]](https://perma.cc/5R89-MEV8).

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

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.

An October 2020 investigation at Cedar Ridge Residential Treatment Services (UHS; Oklahoma) concerned an allegation that a child touched a seven-year-old on her “pee pee.”²²⁴ Investigators could not review video footage related to the incident due to the seven-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

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.*

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.

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

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 (UHS; Virginia) staffer, who pled no contest, was sentenced to one 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

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>].

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

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 6:30pm, 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 degrees²³⁴

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

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.*

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

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; 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 timeout 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

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>].

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/KTO8-O7HK>].

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

foot in his back.” The mother said her child only “got worse” at the facility.²⁴¹ The reporting details another child’s “horrific” nine 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 separate staffer from Devereux Advanced

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/employee-devereux-arrested-charged-child-abuse-battery/5896960001/>; [<https://perma.cc/DAJ4-6R4K>].

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

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 wellbeing 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

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/>; [\[https://perma.cc/2FHF-XPMW\]](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/>; [\[https://perma.cc/9T5W-CAGE\]](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/>; [\[https://perma.cc/9T5W-CAGE\]](https://perma.cc/9T5W-CAGE).

²⁵² *Id.*

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

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 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

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.*

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.*

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

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

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.

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

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

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

²⁷⁰ UHS, *Inspection Results at Palmetto Pines* (Feb. 23, 2021) UHS-FINHELP-00011386.

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 at 00011509.

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.*

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

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 facility (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 two 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

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.

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/60a6942819ce8053cefd0947/60f6b1eba474362514093f96_Away%20From%20Home%20-%20Report.pdf; [<https://perma.cc/V56R-ZXYL>].

²⁸⁵ *Id.* at p. 36.

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 nine-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

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-MNON>].

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.*

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

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.

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

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.

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

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.

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

²⁹⁸ *Id.*

²⁹⁹ 42 U.S.C. § 483.356(a).

³⁰⁰ *Id.*

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

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 seven 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

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/>;

[\[https://perma.cc/62AQ-OZR3\]](https://perma.cc/62AQ-OZR3).

³⁰⁷ *Id.*

³⁰⁸ Acadia, *Plan of Correction* (Nov. 4, 2019) 20191011 Piney Ridge OLTC POC RESPONSE-REVISED SIGNED.

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

restraint during the physical restraint, then immediately place the child in seclusion. This 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 ten-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

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/>; [\[https://perma.cc/62AQ-OZR3\]](https://perma.cc/62AQ-OZR3).

³¹⁰ Acadia, Plan of Correction Response Attachments (Nov. 4, 2019) 20191011 Piney Ridge OLTC POC 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).

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

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 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 eight-minute restraint, staff sat on the teen’s midsection and back and he “choked on his own vomit”³²⁶ face down.

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.

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 11Alive, *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.*

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

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

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/KTO8-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.

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

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 Committee, 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

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.*

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 CRF § 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.

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

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 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

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.

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.*

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

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, “[t]wo-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

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.

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

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 Committee 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

³⁶² UHS, *Notice of Intent to Terminate SoonerCare Contract at Cedar Ridge* (Apr. 29, 2019) UHS-FINHELP-000011847.

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.*

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

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 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

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.

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.

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

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 Palmetto 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 six 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 one 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

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 at 00012136.

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 SoonerCare 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.

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

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 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 cinderblock 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

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.

⁴⁰⁰ Acadia, *Statement of Deficiencies and Plan of Correction* (Apr. 29, 2021) 20210429 Resource-4-2021 CMS 2567 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/>; [\[https://perma.cc/62AQ-QZR3\]](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/>; [\[https://perma.cc/VF6B-TFN6\]](https://perma.cc/VF6B-TFN6).

⁴⁰⁶ *Id.*

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

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 SandyPines (UHS; Florida) did not properly document the monitoring of children in seclusion. When The Florida State Agency for Health Care conducted a visit to SandyPines (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 acknowledged 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)

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 SandyPines* (Sep. 10, 2021) UHS-FINHELP-00009720 at 00009723.

⁴¹⁰ *Id.*

⁴¹¹ *Id.* at 00009724.

⁴¹² *Id.*

⁴¹³ *Id.* at 00009725.

⁴¹⁴ *Id.*

⁴¹⁵ *Id.*

⁴¹⁶ *Id.*

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

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] 1248.”⁴¹⁸ The Florida Agency for Health Care conducted a visit for SandyPines (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 any time 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

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 SandyPines* (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>.

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 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

⁴²⁶ 42 CFR 482.13(e)(1)(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 OLTC POC 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-00011285 at 00011299.

⁴³⁴ *Id.*

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

Public reports document concerns regarding overreliance on chemical restraint and failure to employ proper de-escalation techniques. Independent oversight authorities and firsthand 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 three months at Provo 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 five-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

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-OZR3>].

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>].

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>].

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

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

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>; [\[https://perma.cc/L2V6-VDQU\]](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; [\[https://perma.cc/XH3C-VZTG\]](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/>; [\[https://perma.cc/HD3L-L9WR\]](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/>; [\[https://perma.cc/62AO-OZR3\]](https://perma.cc/62AO-OZR3).

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, 20210) 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.

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

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.

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 x 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

⁴⁵² *Id.*

⁴⁵³ *Id.* at 00012210.

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 at 00011735.

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 facilities 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, nonprofit, 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.

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-GOHD>].

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.

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

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/>; [\[https://perma.cc/69WS-YQVB\]](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; [\[https://perma.cc/VS6R-ZXYL\]](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; [\[https://perma.cc/MYY9-PLCT\]](https://perma.cc/MYY9-PLCT).

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

“[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 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

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.*

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.

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 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

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 AR DHS 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/60a6942819ce8053cefd0947/60f6b1eba474362514093f96_Away%20From%20Home%20-%20Report.pdf; [<https://perma.cc/VS6R-ZXYL>].

⁴⁸⁷ *Id.* at p. 39.

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=prmo-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.

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

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

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)

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

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

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 two hours on campus, and allows a library book; Level 3 increases family visitation to three 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 four 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

<https://www.northcarolinahealthnews.org/2022/11/30/parents-allege-11-year-old-sexually-assaulted-in-nc-psychiatric-hospital/>; [<https://perma.cc/Q5GO-6SUV>].

⁴⁹⁷ Acadia, CHAPTER 10 Consumer Rights (07.22) at p. 45.

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.

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. Children 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,

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/60a6942819ce8053cefd0947/60f6b1eba474362514093f96_Away%20From%20Home%20-%20Report.pdf; [<https://perma.cc/V56R-ZXYL>].

⁵⁰³ *Id.* at p. 29, 62.

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

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

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.

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

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 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

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.

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.”

WAREHOUSES OF NEGLECT:

HOW TAXPAYERS ARE FUNDING SYSTEMIC ABUSE IN YOUTH RESIDENTIAL TREATMENT FACILITIES

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 trading food, but they don’t feed us much.”⁵¹⁹ A South Carolina Department of Health and Environmental Control investigation of Palmetto Summerville Behavioral Health (UHS; South Carolina) found “food [was] not being prepared properly and the

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.

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.

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

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.

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

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 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

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.

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.

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

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 ten 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

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-willow-springs-childrens-hospital-fined-outbreak-riots-coronavirus/5240400002/>; [<https://perma.cc/MV6V-8E2Z>].

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

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.*

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

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 consents 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

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.

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.

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

Children (ICPC) is meant to govern which oversight entity is responsible for an out-of-state child's wellbeing; 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 four 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 Gelsler 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

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

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).

WAREHOUSES OF NEGLECT:

HOW TAXPAYERS ARE FUNDING SYSTEMIC ABUSE IN YOUTH RESIDENTIAL TREATMENT FACILITIES

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 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

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.

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.

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

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 Hills Youth Center (UHS; Utah) all treatment plans

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.

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

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 ten or more pounds in the previous three 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), eight of 43 children “could not explain what the help was

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.

that they were receiving”⁵⁹⁴ and ten 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 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

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.

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/aijan/prtfgeneralrequirementsandconditionsofparticipation.pdf>; [<https://perma.cc/DJS9-TDVT>].

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

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 that adjusted for the child’s changing

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 4-9-18–4-12-18* (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 0011021.

⁶¹¹ UHS, *Department of Behavioral Health and Developmental Services Corrective Action Plan: Harbor Point Behavioral Health Center* (May 2, 2019) UHS-FINHELP-00010303.

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

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

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.

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

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; 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,

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.*

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).

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

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 five 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 kind of psychological treatment, it was psychological mistreatment, and they knew it.”⁶³²

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.

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>].

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

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

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>].

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

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 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 Debar (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

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-MNON>].

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/Q5GO-6SUY>].

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.

⁶⁴¹ *Id.*

⁶⁴² *Id.*

⁶⁴³ *Id.*

⁶⁴⁴ *Id.*

⁶⁴⁵ Notes from Vivant Behavioral Health Briefing (May 22, 2024) (on file with Committee).

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

documented to be in therapy and in other activities at the same time.⁶⁴⁶ In another report, the facility also failed, in six 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 ‘seventeen-year-old versus an eleven-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 four 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 five 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

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.*

three-months reviewed.⁶⁵⁷ The Committee also reviewed documents related to Medication Administration Records at Copper Hills Youth Center (UHS; Utah) which found that six 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.”

⁶⁵⁷ *Id.* at 00008926-00008927.

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.

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.

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 eight and half 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 six 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 two years). In 2022, every UHS facility had a max LOS longer than four months, with 40 having a max LOS longer than one year. Of these 40, eight facilities had a max LOS longer than three years. The facilities with the longest max LOS in 2022 were Havenwyck Hospital (UHS; Michigan; 2220 days, or just over six years),

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/>; [\[https://perma.cc/KUO2-NJKT\]](https://perma.cc/KUO2-NJKT); UHS, Natchez Trace Youth Academy, *Info on Calls, Visits & More*: “Stays are typically three to nine months long” (accessed June 1, 2024) <https://natcheztraceyouthacademy.com/admissions/frequently-asked-questions/>; [\[https://perma.cc/8DR5-SQNR\]](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/>; [\[https://perma.cc/M5TW-HME7\]](https://perma.cc/M5TW-HME7); Devereux Advanced Behavioral Health, *Residential Treatment Center FAQs*: “A child’s average length of stay is approximately four to six months” https://www.devereux.org/site/SPageServer/?NONCE_TOKEN=CC5162714A1ECFAEDAAA578A74807973&page_name=az_rtc_faq; [\[https://perma.cc/V7OK-BXCE\]](https://perma.cc/V7OK-BXCE).

⁶⁶⁶ Devereux, *Agency Spreadsheet* (modified May 25, 2024) DEV-S_000436.

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

Foundations Behavioral Health (UHS; Pennsylvania; 2115 days, more than five and a half years), and The Hughes Center (UHS; Virginia; 1710 days, more than four and a half years).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 overstated. Children are supervised by staff who are ill-equipped to address their complex behavioral health needs

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 may be a statistical anomaly. At the time of production, Vivant had only been in operation for ten 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.

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

and, in some cases, children interact with staff who actually pose a direct threat to their wellbeing. 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

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/>; [\[https://perma.cc/4GMW-DJYG\]](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/>; [\[https://perma.cc/YXT4-KRLV\]](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-routineVisit.

⁶⁷⁶ Acadia, *Indiana Department of Child Services To: [REDACTED] CEO, Resource Treatment Center* (Mar. 29, 2022) 20220329 Resource-Referral hold letter-DCS Licensing.

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

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 three years for related issues and that the facility was not complying with the terms of a previous 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

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 SoonerCare Contract at Cedar Ridge* (Apr. 29, 2019) UHS-FINHELP-00011847.

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.

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

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

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

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 Sandy Pines 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: Sandy Pines* (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/2022/10/04/patient-escapes-and-damage-reported-at-north-star-youth-psychiatric-hospital-over-the-weekend/>; [<https://perma.cc/3OBU-JWJB>].

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

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

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>].

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

(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 fingerprints. 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 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 five 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 onboarding, 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

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 at 00009153; 00009158.

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 at 00008737.

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.

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 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

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>].

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

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 wellbeing 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 6:30am, [the child] was in his room sleeping.”⁷¹⁴ According to public reports, the child was killed at 4:50am, over an hour and a half earlier⁷¹⁵ 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 “6:45am, [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 7:10am.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

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.

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

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 “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.

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.

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.*

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 want justice for her, I just want her story told. And I want – I never want this to happen again to anyone.”⁷³⁵

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-mid-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.alaskanewssource.com/2023/01/12/its-just-damn-roller-coaster-its-freaking-nightmare-alaskan-mother-wants-justice-after-daughters-death-treatment-center-outside/>; [<https://perma.cc/JH8N-KMD7>].

⁷³⁵ *Id.*

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

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 p.m, 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 six-year-old with autism was found walking alone on the road after leaving Laurel Heights Hospital (UHS; Georgia) just three 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

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>; [\[https://perma.cc/6CCU-6WBH\]](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/>; [\[https://perma.cc/O5GO-6SUV\]](https://perma.cc/O5GO-6SUV).

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

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 students 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

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-dfac-behavioral-health-hospital-scratches/85-41b24b6e-a90e-4761-bd66-e5489e66b759>; [<https://perma.cc/3LFI-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.*

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.*

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 with autism ran away from Devereux – Rutland (Devereux; Massachusetts). The child was found barefoot at a gas station. The same child ran away, again, two 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

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.

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>].

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

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 six 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

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-MNON>].

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 knife point 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>].

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

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 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 ten 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

⁷⁶⁵ News Channel 5, *Armed Teen Runaways Captured in Perry County* (Feb. 23, 2018) <https://www.newschannel5.com/news/armed-teen-runaways-captured-in-perry-county/>; [\[https://perma.cc/Y9N4-7269\]](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>; [\[https://perma.cc/5F5T-RYYC\]](https://perma.cc/5F5T-RYYC).

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/>; [\[https://perma.cc/KJM8-KMKM\]](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/>; [\[https://perma.cc/2JW6-6HO8\]](https://perma.cc/2JW6-6HO8).

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/>; [\[https://perma.cc/3OBU-JWJB\]](https://perma.cc/3OBU-JWJB).

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

Arkansas police five 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 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.

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/4UUO-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.*

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

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

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.

(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 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)

⁷⁸⁶ UHS, *Alabama Department of Mental Health – Programmatic Findings: Hill Crest Behavioral Health Services* (May 22-23, 2019) UHS-FINHELP-00009384 at 00009389.

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/00002224/>; [<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-00009639 at 0009651.

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

“sustained self-inflicted injuries at the facility...[and] died six 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 risk on 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;

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-facility-sequel-tsi-son-died-suicide-escape-livi-rna45729>; [<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.

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

Florida) found the facility did not demonstrate use 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 cut her 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

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 L.L.C.* (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.*

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 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

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.

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.*

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

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

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.*

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

and self-harm were reported to the state’s Office of Licensing.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

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., PutnamHornstein, 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>].

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

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 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 nine-years-old, were learning about the Holocaust by watching *The Pianist*.

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>; [\[https://perma.cc/N8EA-RJE7\]](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.

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.

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

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

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.*

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

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 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

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.

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>].

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

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 three 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.

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) ISBN 0938008064, 9780938008064.

⁸⁴⁹ *Id.* at p. ix.

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]
- 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 MillcreekofArkansas 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.** AcadianaTreatmentCenter [No Redactions Required]
- Appendix 33.** CovePREP [No Redactions Required]

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

Appendix 34. LittleCreekBehavioralHealth [No Redactions Required]

Appendix 35. MillCreekBehavioralHealth [No Redactions Required]

Appendix 36. MillCreekMagee [No Redactions Required]

Appendix 37. MillCreekPontotoc [No Redactions Required]

Appendix 38. PineyRidgeTreatmentCenter [No Redactions Required]

Appendix 39. ResourceTreatmentCenter [No Redactions Required]

Appendix 40. SUWSCarolinas [No Redactions Required]

Appendix 41. VillageBehavioralHealth [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]

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

- 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]

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

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| 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] |

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

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| 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

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| 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] |

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

- 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]