Addendum 5/12/25

Chair Bowman, Vice-Chairs Pham and Drazan, members:

I am writing again to supplement my previously submitted testimony after attending the public hearing on May 12, 2025. The hearing started with Gov. Kotek stating, "I fundamentally believe we need to listen to the experts." I submit that we fundamentally need to listen to children and their families, as well as experts, who are intimately knowledgeable about *institutional child abuse*. We need to listen to survivors of institutional child abuse. We need to learn from past mistakes and be proactive in preventing child abuse and neglect. The lack of focus on *institutional child abuse* when evaluating this proposed legislation is a huge concern because that is what makes children so vulnerable in congregate care.

As an attorney for children, I am in the trenches with children, parents, and caseworkers trying to come up with solutions to Oregon's real and critical lack of mental health care options. Nobody wants children in need of serious care to be stuck in bad placements or in hotel rooms without any services at all. I believe solutions are needed, but that HB 3835-A is not a safe route to take to get there. We already learned the hard way that sending kids out of state caused harm, cost the State a lot of money paying out for civil claims, and worst of all, left children even more traumatized than before.

It does not take much googling to discover specific examples of children hurt or seriously killed while entrusted to corporations in the kid and teen residential treatment industry, including children from Oregon. Foster kids represent some of the most vulnerable populations, sometimes with no parents invested or able to keep watchful eye on their children or to advocate for them. These vulnerabilities are even more exacerbated by intersections of race, sexual and gender orientation, and disability. We heard from the mother who testified about needing to intervene to protect her 13-year-old blind and autistic son who was being mistreated out-of-state. Now imagine if that child had no mother at all.

In my role as attorney for the child, I have seen the damage that a bad congregate care facility can do to children including caregivers using seclusion and restraint against them inappropriately for disrupting in class over school work, receiving "booty juice" which is shots of strong antihistamine as chemical restraint done by injection into the buttocks, mismanagement of psychotropic medications including giving a child a different child's psych-medication, violent restraints that cause marks and left children with bloody noses, a developmentally disabled Black child with finger-print bruising on his face and neck from an improper restraint, neglect of broken bones that went weeks without proper medical

care, failing to intervene in peer-to-peer conflict resulting in a client getting a concussion, a broken nose and delayed medical care, and more. I had a client who was put in a violent hold for becoming dysregulated when they wouldn't let him call me, and the facility staff didn't want to let him cool down in his bedroom. I had a client who was shoved to the ground, belly down, while staff dug their fingers so hard into his skin that they left finger-print bruises and gave him a bloody nose. I had a client that experienced another kid in their program cut themself with glass and rub blood on the walls. I have had clients spend years and years in facilities, becoming so institutionalized that the idea of even being with a family was overwhelming that it felt unachievable to them. I have had clients spend weeks in programs without access to therapy and was told it was because the insurance hadn't changed counties yet. I have had clients forced to engage in treatment groups that were not appropriate for their diagnosis, such as attending group therapy with kids who were using hard drugs when my client was not in the program for a drug problem. This made them feel like "I'm being treated like a drug addict, but I'm not one!" I have had clients co-housed with sexually offending youth and then told they were not allowed to know anything about if or what their peers had been adjudicated for, leaving kids in the program to speculate about each other and accuse one another of all kinds of sexually problematic behavior. I have had clients retaliated for sharing information about their experiences in programs with their parents or attorney. I have had privileged attorney-client calls from clients monitored or my client was prevented from calling. I have been denied a tour of a facility that housed my client out-of-state. I have met with hundreds of survivors who shared similar experiences nation-wide in these kinds of programs.

When children are sent out of state, they are often sent to states where corporations know they can set up shop in places with lower regulations and oversight, and where there is a culture of permission and acceptance when it comes to problematic behavior toward children. The big companies in this industry understand that setting up facilities in Utah, Missouri, Michigan, and the like will allow them to receive children from states like Oregon that have higher standards of care. In Oregon, for example, we typically do not allow chemical restraint outside of state-hospital level care, but it was regularly done to an Oregon girl who would not have been subjected that treatment here when she was sent to another state to treat her PTSD and related trauma. That facility shut down shortly after this child was returned to Oregon. Her story is available in the US Senate report here:

https://www.finance.senate.gov/imo/media/doc/rtf_report_warehouses_of_neglect.pdf

Not only do companies intentionally open facilities in low-regulation states, they also often open them in rural communities, imbedding themselves as major employers in the local economy, and becoming critical to the workforce. This allows them to continue harmful

practices when to hold them accountable means possibly putting a huge percentage of the community out of work. One such facility closure resulted in news headlines that said the closure of that particular facility caused a “devastating blow” to the town’s economy. This is one of many factors that allow institutional child abuse to go unchecked for so long.

Oregon cannot afford to keep learning the same lessons the hard way when we entrust companies in other states to provide care for Oregon’s children, especially when they do not meet the standards we have set here. A child should not be subjected to worse conditions or maltreatment because Oregon failed to develop resources within our state to meet their needs here. How many more children need to suffer before the legislature and the Department of Human Services finally allow these lessons to stick?

Some national stories should be instructional. Cornelius Frederick was a 17-year-old foster child when his child welfare agency sent him to Lakeside Academy, a Sequel facility that was licensed with the state. He was killed when several of his treatment providers restrained him to death. At least one Oregon child was placed at that facility at the time, and the family was forced to move him in the wake of Cornelius’s death. If that happened in Oregon after passing HB 3835-A, Cornelius’s likely wouldn’t have even been founded for abuse so long as the treatment providers claimed they were acting with therapeutic intent. Below is a photo of Cornelius before he died, and a picture of his treatment providers causing his death. What was Cornelius’s crime? Being a foster kid who threw a sandwich. His sentence? Death. His killers claimed to have acted in accordance with their training, and it was not until footage of the incident was released that the community demanded action and arrests were finally made. Notice the other children two tables away continuing to eat their lunch as the practice of restraint was so commonplace as to not even register. This is what institutional child abuse looks like.

Another foster child, Ja-Ceon Terry age 7, was killed in his treatment program by "positional asphyxia", aka an abusive restraint, and his death was ruled a homicide. This happened in Kentucky in a licensed program. Nobody has faced criminal charges for his death. Reports from that state reveal this facility repeatedly failed to keep children safe preceding Ja-Ceon's death, but remained open and accepting foster children. When the state calls missing a training a "technical violation" and not an actual child safety concern, I think of Ja-Ceon and why it is so important that anyone going hands-on with restraints be up-to-date on the safest way to engage that tool.

There are countless other stories of children being killed or harmed in congregate care. Oregon should absolutely not send children out of state to facilities that fail to meet Oregon's standards of care.

Further, Oregon should resist the argument that "we need to remove the fear of being investigated for child abuse in order to recruit more people to work in this industry." This is absolutely a culture problem. Perhaps Oregon should do more to support the confidence

and skills of the employees working in residential care so that when restraints and seclusions are medically necessary, employees can perform them confidently knowing their training will protect them and the children they serve. The statistics already show that most restraints, even those resulting in injuries to the child, are unfounded for abuse or closed at screening. Staff should be trained to understand that oversight is important and a review of the restraint is to be expected. Staff should also be well compensated, have good oversight and training, have reasonable schedules and staff-to-child ratios, and should represent high standards of care for working with such critical population. Abuse definitions should not be loosened to entice more people to work with vulnerable kids. Staff should be well trained, supported and confident in order to rise to the occasion.

I believe most people who choose to work with foster youth and other children in need of high levels of care are well intentioned and want kids to be safe, happy, and successful. Unfortunately, the best of intentions are irrelevant when the impact of mistakes and low standards is so harmful. We need solutions, but HB 3835-A is just not the answer. I support a more measured approach that does not loosen definitions of abuse, or make it easier to send kids to facilities out of state that do not meet Oregon's higher standards of care. I would be happy to communicate with anyone willing to spend time learning more about why I oppose HB 3836-A.