Areas of Concern and Unanswered Questions:

1. One of the main areas of concern is the proposed change of "Serious Bodily Injury" which is currently defined to an undefined term across all settings of "Serious Physical Harm (SPH)". See page 8 for further details and information.

   This policy decision has been discussed at length and there is consensus with ODHS child abuse investigators, ODHS licensors, child psychiatrist, providers, and crisis intervention trainers and frontline staff that using the plain language is the preferred policy. This has been publicly documented in testimony, the statement of intent, and the FAQs document on HB 3835.

   ODHS and SOCAC are committed to evaluating and reporting back in the implementation reports to the legislature in 2026 and 2027 if this policy has its intended effect of maintaining a high threshold, staff confidence to rely on their crisis intervention training, and there is clear understanding based on the legislative record for administrative law judges from the Office of Administrative Hearings to apply the plain language of this term.

2. Another main concern was removing "Prohibited Restraints" from the Definition of Child Abuse. See page 12 for further details and information.

Section 1: Did not get clarity that we should also be including relatives like a grandmothers or brothers in "responsible Individual"? Since they would not be considered a "responsible individual" by these definitions, they would not be investigated for abusive seclusion or abusive restraint or corporal punishment under Section 1, because those acts are limited to acts by "responsible individuals."

Oregon is the only state that does not have a defined scope in statute of who is investigated for child abuse by an agency like ODHS. There is work underway since the passage of HB 4086 (2024) for recommendations to the legislature on how jurisdiction could be established in statute.

Currently, there are two separate statutes defining child abuse in Oregon.

Investigations of child abuse under ORS 419B applies to anyone in Oregon, adults and minors, as statute is completely silent on who is investigated for child abuse under these laws.

In 2016 Oregon added ORS 418 child abuse statutes with particular child abuse definitions to apply to caregivers in CCAs. In 2017, ODDS licensed group homes, DD foster homes and Child Welfare certified foster homes were added to be under these new abuse definitions.

What happens in if the abuse is from others in contact with the child? What happens if the abuse is through another child in care or a spouse/relative of the responsible person?

When ODHS receives a child abuse allegation, they first determine if the child is a "child-in-care" (i.e., residing in or receiving services from a CCA, ODDS group home, DD foster home, or Child Welfare certified foster home).

If not, ORS 419B applies.

If the child is "in-care," then:

- Alleged perpetrators who are employees, contractors, or volunteers in these settings are investigated under both ORS 418 and/or ORS 419B.
- Alleged perpetrators outside these roles are investigated under ORS 419B alone.

Did not get clarification on how the new definition of what is not abusive seclusion allows for age-appropriate discipline or locking windows/doors during the evening in the event of an eloper.

Section 14 (2) in the -A13 was added to add clarification to address this concern:

> (2)(a) An adjudicated youth foster home or a certified foster home may not place a child in care in a restraint or involuntary seclusion.
>
> (b)(A) Notwithstanding subsection (1) of this section or paragraph (a) of this subsection, a certified foster home or a proctor foster home may, consistent with the reasonable and prudent parent standard:

(i) Temporarily restrict a child in care's freedom of movement, including by physically consoling the child in care; or

(ii) Place a child in care in involuntary seclusion as a form of age-appropriate discipline, as defined by the Department of Human Services by rule, including placing the child in care in a time-out.

(B) As used in this paragraph, 'reasonable and prudent parent standard' means the standard characterized by careful and sensible parental decisions that maintain the health, safety and best interests of a child in care while encouraging the emotional and developmental growth of the child in care.

(C) Actions taken by a certified foster home or proctor foster home consistent with this paragraph are not subject to the incident reporting requirements under ORS 418.526.

These amendments are in the -A8- sent to Chair Hartman on May 19th.

Definition of Chemical Restraint: Why is this definition being changed from the engrossed bill? It is concerning that we would change the "or" to "and" simply because OHA has asked for it or prefers it.
The -A13, Section 1, maintains the existing statutory definition of Chemical Restraint.
This amendment is in the -A8- sent to Chair Hartman on May 19th.

Sections 8, 18, 26: Why was the definition of 'secure escort' removed from the transportation requirements, and how does the bill distinguish between an untrained adult with a car and a licensed transport provider? Are we unintentionally opening the door to unregulated, untrained transport of vulnerable children?
To address this concern, the -A13 maintains "secure escort" in statute.
This amendment is in the -A8- sent to Chair Hartman on May 19th.

Section 14(7) Having Federal Requirements supersede state requirements: I recommended removing this earlier in these discussions, as federal requirements should be the floor, not the ceiling.
The -A13 addressed this concern as it removed (7) entirely.
This amendment is in the -A8- sent to Chair Hartman on May 19th.

Sections 17, 29: If DHS can no longer impose licensing conditions or civil penalties for using prohibited restraints unless they meet the new definition of abusive restraint, aren't we limiting DHS's ability to respond to dangerous practices before they escalate into serious harm?
If a prohibited restraint is used that does not constitute an allegation of child abuse (which will be rare based on a thorough review of past cases) the provider will continue to report the use within 24 hours to licensing via an incident report. Licensing will then review and address these incidents as regulatory violations, which may include corrective actions, civil penalties, license conditions, or even suspension or revocation if necessary (see section 19 and section 27 of the -A13). The -A13 adds a requirement for providers and ODHS to report quarterly to the legislature on any prohibited restraints used by each provider (see section 32 of -A13).

These amendments are in the -A8- sent to Chair Hartman on May 19th.

Section 24: "Managers" Definition: This section defines "managers" as individuals "at the highest levels of an organization's leadership." This is concerning because this would leave out lower-level directors/managers, supervisors, etc. My reading of this is that if the supervisor/manager does not have all three responsibilities— operations, finances an overall governance of the organization—then Section 27's requirements, including ensuring that a report of child abuse is made or taking immediate steps to ensure the child's safety, would not apply to them. I also believe Section 30's prohibitions on interfering with good faith whistleblowing would not apply to the supervisor/manager. I did not get clarity on this from the proponents of this bill.

Section 27: Following the managers definition in Section 24, I needed clarification, because it seems that only a manager, as defined as those at the very top of the organization, can be held accountable for failing to take steps to ensure the child's safety and failing to report the abuse. If a supervisor at a residential facility knows about sexual abuse and doesn't act—but isn't considered a "manager" under this bill—why should DHS be barred from imposing any licensing consequence on the agency? Wouldn't this bill make it harder to hold organizations accountable for

failures in mandatory reporting or failure to act on abuse unless the neglect happens to rise all the way to the executive level?

The -A13 includes amendment to address this concern. "Agency Managers" only used in Section 27 (2)(c) and 32 (5)(e). The only time the definition of "Managers" is used is in Section 27 when the concerns reach the highest levels of leadership of an organization that ODHS **must** take a licensing action to place conditions on (like restricting admissions, requiring external auditors, etc.) or suspending or revoking a provider's license to operate a CCA. These licensing actions are necessary when there is misconduct by these high-level leaders who may only be accountable to the CCA's Board of Directors.

With lower-level supervisors that do not meet the definition of "managers", there is still recourse if these individuals fail to protect a child from abuse or neglect and fail to make a report of abuse, they would be investigated for neglect which historically leads to termination of employment. If, over the course of the investigation, OTIS finds that the failure goes higher than the supervisor, then licensing would review if a licensing action is required under Section 27.

If a lower-level supervisor does not cooperate with an investigation this in and of itself is grounds for termination of employment in a CCA. But for those in high level leadership positions where terminations would be contingent on the actions of a Board of Directors, it is appropriate for licensing to have required actions against the provider's license to ensure accountability.

These amendments are in the -A8- sent to Chair Hartman on May 19th.

Section 32(3)(b): I never received clarity on how this changes the way investigations are recorded, and the type of information received. This feels as though there could be a loophole on the current requirements to investigate prohibited restraints now that HB 3835 removes prohibited restraints. Will we be able to see and reference past incident reports, review training records, reasonable efforts etc. I have come to learn how crucial it is to understand the history of incidents to better evaluate whether a child in care's plan is appropriate.

If a prohibited restraint is used that does not constitute an allegation of child abuse (which will be rare based on a thorough review if previous cases) the provider will continue to be required to report the use of any prohibited restraint within 24 hours to licensing via an incident report. Licensing reviews all incident reports to ensure compliance with licensing regulations including monitoring trends and reviewing training records, etc. There are no identified concerns by ODHS licensing entities that there is a loophole being created. Should an incident report include information that indicates abusive restraint was used, ODHS licensing would be required to forward that information to OTIS to be screened for an investigation.

Sections 32-33: Why are we removing the longstanding right of a child's parents and attorneys to receive copies of records and documents during child abuse cases?

Parent's and attorneys still have access to copies of written records and documents regarding a child abuse investigation as well as child abuse investigation reports. Sections 32 and 33 have no impact on that right. The bill only addresses review of video recordings, and has no impact on existing access to documents, written reports, or other non-video materials relating to the incident.

During one of our last conversations, it was stated that this was to get the "providers" to turn their cameras back on because they are concerned with the information getting out. Besides it being a concern that these providers can "choose" when and where to turn off their cameras, if they have nothing to hide, I see nothing wrong with requiring the cameras to be on.

As has been documented in the FAQs to HB 3835, section 15 concerns access to recordings (photo, audio, video) related to restraint or seclusion. Legal parties in dependency cases maintain discovery rights to these records. For youth not in the custody of Child Welfare, this section clarifies statutory consent requirements for sharing such recordings with parents, guardians, or attorneys, respecting privacy and consent of an 18-year-old. The amendments in HB 3835 improve the balance of transparency and the youth's right to privacy.

Out of State Placements: My first concern was learning that the state just finished a years-long lawsuit over its handling of out-of-state placements, and a Neutral Expert has been hired to review the practices of ODHS and report back in July 2025. I believe it would be responsible to wait to review his recommendations after his findings.

Since the proponents were not interested in waiting, I was adamant that we add a sunset clause to the new provisions in allowing out of state placements. I can empathize with the need for services now, but this should not be looked at as the permanent solution. Instead, ODHS and all interested parties should be focusing on investing in services for Oregonians and bringing the services directly to the children in care. The focus should remain on a strategic plan on increasing the number of therapeutic resource families in Oregon, increasing training opportunities for next of kin, and developing the services identified as gaps in care for Oregon children. Ultimately, they did not agree on a sunset.

Behavioral health is an essential component of healthcare, and the national trend is moving toward a more regionalized healthcare model. In this context, imposing a sunset on out-of-state behavioral health services for youth in the custody of child welfare is inappropriate. Youth in Child Welfare custody will continue to have behavioral healthcare needs that can be best treated by specialty providers out of state, just as children with hard-to-treat cancers or other medical conditions have access to.

There is broad consensus and significant ongoing work aimed at expanding behavioral health services and capacity within Oregon to better serve these youth. The analysis SOCAC will conduct under HB 3835 on the circumstances and types of care received by children placed out of state will be instrumental in identifying gaps in Oregon's current system. These findings will help shape strategic efforts to build a more robust, comprehensive behavioral health system that meets the needs of all children in state custody.

Section 36 (3)(i): I just want to confirm here that by adding "as defined in ORS 161.015," this has added a higher threshold definition for "Serious Physical Injury." Would a child-caring agency not need to report if Serious Physical Harm?

It is correct that "serious physical injury" as defined in ORS 161.015 is a more severe injury that what may be considered serious physical harm as defined by plain language. Section 36 (3)(i) pertains specifically to out of state Oregon licensed child caring agencies, to require immediate notification for this level of injury in comparison to what would be reported within 24 hours in a standard incident report to ODHS.

Section 36(7)(b): This states that children placed under this subsection 7 are not subject to subsection (5), which states "A department child welfare services employee must accompany a child who is placed in an out-of-state child-caring agency any time the child is transported to an initial out-of-state placement, any time the child is moved to a new placement and any time the child is moved by secure transport." While I understood that it was not realistic to keep this whole provision, I firmly believe that ODHS or a close caregiver, like a CASA, resource parent, or attorney, must accompany a child on initial placement. This was not clear and was not answered.

This concern is addressed in Section 36 (9)(c) of the -A13.

This amendment is in the -A8 sent to Chair Hartman on May 19th.

Section 36(7)(b) also states that children placed under subsection 7 are not subject to subsection (4), which includes protections for youth with I/DD. These protections are crucial, and language should be added to clarify that these children have the same rights that align significantly with their rights in the State of Oregon.

This concern is addressed in Section 36 (9)(e) of the -A13.

This amendment is in the -A8 sent to Chair Hartman on May 19th.

Section 36(9)(c): I believe that we need to specify that someone from Oregon (CASA, ODHS, resource parent, etc.) will visit the child. I understand that ODHS used to contract with third-party caseworkers to conduct these visits, and they would not provide the best service to our youth.

This concern is addressed in Section 36 (9)(d) of the -A13.

This amendment is in the -A8 sent to Chair Hartman on May 19th.

Section 36(9)(d): There is nothing wrong with ensuring the child understands their rights and how to report. However, it should clearly state that when a youth reports certain types of abuse, then an ODHS employee will visit them in person within 72 hours. This should be called out.

This concern is addressed in Section 36 (9)(g) of the -A13.

This amendment is in the -A8 sent to Chair Hartman on May 19th.

Section 36b: This updates the timeframe of reports to 6 months after receiving a quarterly report and adds a new yearly report from SOCAC that provides only a summary to the legislature. We, the legislature, should receive hard data and be able to review it. The reports should include an analysis of not just the "appropriateness of the placement exceptions" as stated in the bill, but also an analysis of the gaps in care and a strategic plan for increasing care in Oregon. What are we doing to bring care to kids and training and education to families, instead of sending kids to care? (5)(a) makes it so that records received by SOCAC are not subject to public records requests. I understand the need for some of a vulnerable youth's information, including information that could identify them, to remain confidential. However, every other detail about why a child was placed out of state is crucial to legislative oversight.

To improve understanding of the requirements in this legislation the following document was created on Out-of-State Transparency and Accountability. It includes that ODHS government relations will email Bi-Partisan Legislative leadership prior to or as soon as possible after placement.
Then on a monthly basis, ODHS must update a public website as currently required by ORS 419B.335 regarding children in the custody of Child Welfare who have been placed or sent to treatment out of state.

In addition to immediate notification to SOCAC, ODHS must also submit quarterly narrative reports to the System of Care Advisory Council describing the circumstances justifying the exception to an in-state or out-of-state placement.

The System of Care Advisory Council must submit quarterly reports to committees of the Legislative Assembly related to human services and behavioral health on their analysis of the appropriateness of the placement exceptions and of the trends reflected in the quarterly report.

The System of Care Advisory Council must also submit a report to committees of the Legislative Assembly related to human services and behavioral health annually before September 15 of each year, summarizing the quarterly reports received from the department in the previous four quarters. The summary must include the System of Care Advisory Council's summary of quarterly reports from the previous four quarters, analysis of appropriateness of placement exceptions, and trends in out-of-state placements to inform legislature of gaps in Oregon's capacity.

Section 37(3)(d): I did not get clarity on why this is changing. This entire conversation has been about allowing children in care to go out of state if it is medically necessary. So why change this to "services or treatment"? This seems too broad.

These terms are intentionally used as they are in alignment with Medicaid terminology.

Section 37(4): I did not get clarity on adding in reporting on youth in adult settings. SOCAC should also be reporting on this as well.

This concern is addressed in the -A13 under section 36b (3).

This amendment is in the -A8 sent to Chair Hartman on May 19th.

Section 37(9): Because we are being told out of state placements are only going to be used if medically necessary, I believe we need to be very clear who exactly is going to approve these exceptions.

Section 37 (9) is about exceptions for in-state placements not out-of-state exceptions.

(9)(a) requires approval from the Director of Child Welfare or their designee for approvals of the exceptions described in subsections (3)(k) and (5)(b) and exceptions under subsection (3)(k) must also be approved by the Medicaid Director or their designee. This language was in the introduced version of HB 3835.

We understand there have been concerns about the 'or their designee' portion of that language. This terminology is frequently used to allow for interim directors, such as the role currently occupied by Rolanda Garcia at ODHS-CW, to be legally allowed to assume this responsibility as would be necessary for continuing functionality of this law. Please note, the term is singular – designee, not designees – which indicates that only 1 person may be designated to fulfill this role at CW or Medicaid, preventing the designation of this responsibility to district managers, CCO behavioral health directors or other lower level, less accountable decision makers.

Section 39: I appreciate adding back the website and monthly updates. However, I will call attention to the information they want to remove. I believe this data is crucial for legislative oversight. Also, I have asked for the narrative report to also be sent to the appropriate legislative committees, but it is still not referenced in this new amendment.

The information removed from public online reporting is demographic information including but not limited to age, gender or gender identity, race, ethnicity, tribal status and, if disclosed by the child or ward, sexual orientation as well as the number of children or wards the department currently has placed in out-of-state facilities who have autism, intellectual disabilities or developmental disabilities. No such publication is required for other children on OHP who are receiving Medicaid treatment and services outside of Oregon. Online publication of this identifying information is particularly concerning for the confidentiality of these youth but in many circumstances would pose a safety concern for youth who have experienced domestic violence or commercial sexual exploitation (sex trafficking). It is more appropriate for the SOCAC to be provided this level of information for their analysis and reporting to the legislature without tying specifical placement locations and the identifying demographics of a child.

Section 41: This section exempts people who are over 18 and living in foster homes from background checks if the department placed them there. I did not get clarity on whether saying "placed in the household by the department" means that the department placed them there before they turned 18. I feel like we need to be clearer on whether they were a ward, already in a foster home, if a new child is coming into care with them, etc.

Sections 40 and 41 were removed with the -A13 as SB 944 was passed in the legislature to address these concerns and was signed by the Governor on 6/11/2025.

Section 47: I proposed changing this from two reports to four because of the immense changes; I believe more than two reports are necessary to see if any adjustments are needed. My suggestion was that the final report be delivered on September 15, 2029.

We welcome the legislature to consider if this is necessary after evaluating the results of the two required reports that will encompass over two years of data.

Section 48: This should be changed Oct 1, 2025. The quarterly reports in Section 36b (3) are by ODHS to SOCAC and are used by SOCAC to report to the legislature starting Sept 1, 2026. ODHS should start sending these quarterly reports to SOCAC as soon as possible because this bill has an emergency clause. SOCAC has several reports to analyze when reporting to the legislature, and they need time to examine these reports before the report to the legislature is due.

This amendment is reflected in the -A13 and was sent to Chair Hartman on May 19th with the -A8.

New Question on -A5 Section 23: Why are we still removing (L) and (m)? If we are leaving school settings alone shouldn't this stay in? Taking this out seems to put us in a situation where there will be two different standards between CPS and APS.

This amendment is reflected in the -A13 and was sent to Chair Hartman on May 19th with the -A8.