Date of Hearing: June 25, 2024

ASSEMBLY COMMITTEE ON HUMAN SERVICES
Alex Lee, Chair
SB 1043 (Grove) – As Amended March 18, 2024

SENATE VOTE: 37-0

SUBJECT: Short-term residential therapeutic programs: dashboard: seclusion or behavioral restraints

SUMMARY: Requires facilities operating short-term therapeutic programs (STRTPs) to provide specified information to a child subject to seclusion or behavioral restraints, their foster parent, guardian, or authorized representative, and the California Department of Social Services (CDSS). Requires CDSS to post a public dashboard that is specific to STRTPs on its website, to display specified data regarding the use of seclusion or behavioral restraints. Specifically, **this bill**:

1) Provides that this act shall be known, and may be cited, as Accountability in Children's Treatment.

2) Requires a facility, in the case of an incident involving the use of seclusion or behavioral restraints in an STRTP, in conjunction with its process for a clinical and quality review and a debriefing as described in 9) in existing law below, to comply with both of the following steps:

   a) Provide a description of the incident, in both oral and written forms, to the person subject to the seclusion or behavioral restraint and, as applicable, to the person's foster parent, guardian, or other authorized representative. Requires, at a minimum, the description to contain information on all of the following:

      i) The actions taken during the incident;

      ii) The rationale for the actions;

      iii) The personnel approving the actions;

      iv) The personnel implementing the actions;

      v) The duration of the incident; and,

      vi) Whether the person is a minor or a nonminor dependent (NMD).

   b) Provide a copy of the written description referenced in a) above to CDSS, excluding any personally identifiable information of the person, personnel, or the person's foster parent, guardian, or other authorized representative.

3) Requires CDSS, by January 1, 2026, to create and post on its website, a public dashboard that is specific to STRTPs, updated quarterly, and that displays both of the following:

   a) Data collected pursuant to existing law, with regard to seclusion or behavioral restraints, as applicable to STRTPs, that includes all of the following:

i) The number of deaths that occur while persons are in seclusion or behavioral restraints, or where it is reasonable to assume that a death was proximately related to the use of seclusion or behavioral restraints;

ii) The number of serious injuries sustained by persons while in seclusion or subject to behavioral restraints;

iii) The number of serious injuries sustained by staff that occur during the use of seclusion or behavioral restraints;

iv) The number of incidents of seclusion;

v) The number of incidents of use of behavioral restraints;

vi) The duration of time spent per incident in seclusion;

vii) The duration of time spent per incident subject to behavioral restraints, and,

viii) The number of times an involuntary emergency medication is used to control behavior, as defined by the Department of State Hospitals (DSH).

b) Written descriptions collected pursuant to 2) a) above, subject to the limitations related to the inclusion of personal identifiable information.

4) Requires these provisions to be implemented to the extent they are not in conflict with any applicable federal or state privacy laws.

EXISTING LAW:

1) Defines a "short-term residential therapeutic program" to mean a non-detention, licensed community care facility (CCF), as defined in 19) below, that provides an integrated program of specialized and intensive care and supervision, services and supports, and treatment for the child or youth, when the child's or youth's case plan specifies the need for, nature of, and anticipated duration of this specialized treatment. Requires STRTPs to be organized and operated on a nonprofit basis. (Welfare and Institutions Code [WIC] § 11400(ad))

2) Requires the Department of Developmental Services (DDS) to ensure the consistent, timely, and public reporting of data it receives from regional centers pursuant to regulations as described in 26) below, regarding the use of physical restraint, chemical restraint, or both, by all regional center vendors who provide residential services or supported living services, and by long-term health care facilities and acute psychiatric hospitals serving individuals with developmental disabilities. Requires DDS to publish quarterly on its website, specified data, segregated by individual regional center vendor that provides residential services or supported living services and each individual long-term health care facility and acute psychiatric hospital that serves persons with developmental disabilities regarding the number of incidents of the use of restraints. (WIC § 4436.5)

3) Prohibits a child or nonminor who has been voluntarily placed, or as to whom a petition has been filed, or adjudged a dependent child of the juvenile court due to neglect or abuse, or an

NMD, from being placed or detained in an STRTP, group home, licensed foster family home, resource family, or certified family home or resource family of a foster family agency, with any minor adjudged a ward of the juvenile court, unless the social worker or probation officer with placement authority has determined that both of the following are true:

a) The placement setting has a program that meets the specific needs of the child or NMD being placed or detained, or, in the case of placement when no program is required by law, the home meets the specific needs of the child or nonminor; and,

b) There is a commonality of needs with the other children and NMDs in the placement setting. (WIC § 16514(c))

4) Authorizes an STRTP to accept for placement a child who meets the criteria in a) and b) and at least one of the conditions in c):

   a) The child does not require inpatient care in a licensed health facility;

   b) The child has been assessed as requiring the level of services provided in an STRTP in order to maintain the safety and well-being of the child or others due to behaviors, including those resulting from traumas, that render the child or those around the child unsafe or at risk of harm, or that prevent the effective delivery of needed services and supports provided in the child's own home or in other family settings, such as with a relative, guardian, foster family, resource family, or adoptive family. Requires the assessment to ensure the child has needs in common with other children or youth in the care of the facility, consistent with 3) above; and,

   c) The child meets at least one of the following conditions:

      i) The child has been assessed as meeting the medical necessity criteria for Medi-Cal specialty mental health services, as provided;

      ii) The child has been assessed as seriously emotionally disturbed, as defined in 7) below;

      iii) The child requires emergency placement; or,

      iv) The child has been assessed as requiring the level of services provided by the STRTP in order to meet the child's behavioral or therapeutic needs. (WIC § 11462(b)(1-3))

5) Authorizes an STRTP to have a specialized program to serve a child, including, but not limited to, the following:

   a) A commercially sexually exploited child (CSEC);

   b) A private voluntary placement, if the youth exhibits status offender behavior, the parents or other relatives feel they cannot control the child's behavior, and short-term intervention is needed to transition the child back into the home;

   c) A juvenile sex offender; or,

d) A child who is affiliated with, or impacted by, a gang. (WIC § 11462.01(b)(4))

6) Allows a CCF licensed as a group home for children to only accept for placement, and provide care and supervision to, a child assessed as seriously emotionally disturbed as long as the child does not need inpatient care in a licensed health facility, as defined. (Health and Safety Code (HSC) § 1502.45 (a)(1))

7) Defines "seriously emotionally disturbed children or adolescents" to mean minors under 18 years of age who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Further requires members of this target population to meet one or more of the following criteria:

   a) As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:

      i) The child is at risk of removal from home or has already been removed from the home; or,

      ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

   b) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder. (WIC § 5600.3.)

8) Defines the following terms to apply to the use of seclusion and behavioral restraints in facilities licensed, certified, or monitored by departments that fall within the California Health and Human Services Agency's (CalHHS) jurisdiction:

   a) "Behavioral restraint" means "mechanical restraint" or "physical restraint" used as an intervention when a person presents an immediate danger to self or to others. It does not include restraints used for medical purposes, including, but not limited to, securing an intravenous needle or immobilizing a person for a surgical procedure, or postural restraints, or devices used to prevent injury or to improve a person's mobility and independent functioning rather than to restrict movement;

   b) "Containment" means a brief physical restraint of a person for the purpose of effectively gaining quick control of a person who is aggressive or agitated or who is a danger to self or others;

   c) "Mechanical restraint" means the use of a mechanical device, material, or equipment attached or adjacent to the person's body that he or she cannot easily remove and that restricts the freedom of movement of all or part of a person's body or restricts normal access to the person's body, and that is used as a behavioral restraint;

   d) "Physical restraint" means the use of a manual hold to restrict freedom of movement of all or part of a person's body, or to restrict normal access to the person's body, and that is

used as a behavioral restraint. Physical restraint is staff-to-person physical contact in which the person unwillingly participates. Physical restraint does not include briefly holding a person without undue force in order to calm or comfort, or physical contact intended to gently assist a person in performing tasks or to guide or assist a person from one area to another; and,

e) "Seclusion" means the involuntary confinement of a person alone in a room or an area from which the person is physically prevented from leaving. Seclusion does not include a "timeout," as defined in regulations relating to facilities operated by DDS. (HSC § 1180.1(a-e))

9) Requires state hospitals operated by DSH, facilities operated by DDS, psychiatric units of general acute care hospitals (GACHs), acute psychiatric hospitals (APHs), psychiatric health facilities, psychiatric residential treatment facilities (PRTFs), crisis stabilization units (CSUs), community treatment facilities (CTFs), group homes, skilled nursing facilities (SNFs), intermediate care facilities (ICFs), CCFs, and mental health rehabilitation centers to conduct a clinical and quality review for each episode of the use of seclusion or behavioral restraints. (HSC) § 1180.5(a))

10) Requires state hospitals operated by DSH, facilities operated by DDS, psychiatric units of GACHs, APHs, psychiatric health facilities, PTRFs, CSUs, CTFs, group homes, SNFs, ICFs, CCFs, and mental health rehabilitation centers, as quickly as possible but no later than 24 hours after the use of seclusion or behavioral restraints, to conduct a debriefing regarding the incident with the person, and, if the person requests it, the person's family member, domestic partner, significant other, or authorized representative, as well as with the staff members involved in the incident, and a supervisor, to discuss how to avoid a similar incident in the future. Specifies the person's participation in the debriefing is voluntary and that the purposes of the debriefing is to do all of the following:

a) Assist the person to identify the precipitant of the incident, and suggest methods of more safely and constructively responding to the incident;

b) Assist the staff to understand the precipitants to the incident, and to develop alternative methods of helping the person avoid or cope with those incidents;

c) Help treatment team staff devise treatment interventions to address the root cause of the incident and its consequences, and to modify the treatment plan; and,

d) Help assess whether the intervention was necessary and whether it was implemented in a manner consistent with staff training and facility policies. (HSC § 1180.5(b))

11) Requires the facility, in the debriefing, to provide both the person and staff the opportunity to discuss the circumstances resulting in the use of seclusion or behavioral restraints, and strategies to be used by the staff, the person, or others that could prevent the future use of seclusion or behavioral restraints. (HSC § 1180.5(c))

12) Requires the facility staff to document in the person's record that the debriefing session took place and any changes to the person's treatment plan that resulted from the debriefing. (HSC § 1180.5(d))

13) Requires the CalHHS secretary to take steps to establish a system of mandatory, consistent, timely, and publicly accessible data collection regarding the use of seclusion and behavioral restraints in all psychiatric units of GACHs, acute psychiatric hospitals, psychiatric health facilities, PRTFs, crisis stabilization units, community treatment facilities, group homes, SNFs, ICFs, CCFs, and mental health rehabilitation centers that utilize seclusion and behavioral restraints. Requires, in determining a system of data collection, the CalHHS secretary to utilize existing efforts, and direct new or ongoing efforts, of associated state departments to revise or improve their data collection systems and to make recommendations for a mechanism to ensure compliance by facilities, including, but not limited to, penalties for failure to report in a timely manner. States legislative intent that data be compiled in a manner that allows for standard statistical comparison and to be maintained for each facility subject to reporting requirements for the use of seclusion and behavioral restraints. (HSC §1180.3(c)(1))

14) Requires the CalHHS secretary to develop a mechanism for making this information, as it becomes available, publicly available on the internet. Requires, for data currently being collected, this provision to be implemented as soon as it reasonably can be achieved within existing resources. Requires, as new reporting requirements are developed and result in additional data becoming available, this additional data to be included in the data publicly available on the internet. (HSC §1180.3(c)(2))

15) Requires, at the direction of the CalHHS secretary, the associated state departments to cooperate and share resources for developing uniform reporting for all facilities and requires uniform reporting of seclusion and behavioral restraint utilization information, to the extent possible, to be incorporated into existing reporting requirements for facilities, as described in 13) above. (HSC §1180.3(c)(3))

16) Requires data collected pursuant to 13) above to include all of the data described in 3) under *this bill*. (HSC §1180.3(c)(4))

17) Requires the CalHHS secretary or their designee to work with the state departments that have responsibility for oversight of the use of seclusion and behavioral restraints to review and eliminate redundancies and outdated requirements in the reporting of data on the use of seclusion and behavioral restraints in order to ensure cost-effectiveness. (HSC §1180.3(c)(5))

18) Prohibits CalHHS or any associated state department from being required to implement provisions under HSC §1180.3 (a-c) if implementation cannot be achieved within existing resources, unless additional funding for this purpose becomes available. Permits CalHHS and involved departments to incrementally implement these provisions in order to accomplish its goals within existing resources, through the use of federal or private funding, or upon the subsequent appropriation of funds by the Legislature for this purpose, or all of these. (HSC §1180.3(d))

19) Defines “community care facility” to mean any facility, place, or building that is maintained and operated to provide nonmedical residential care, day treatment, adult day care, or foster family agency services for children, adults, or children and adults, including, but not limited to, the physically handicapped, mentally impaired, incompetent persons, and abused or neglected children, and includes a “short-term residential therapeutic program,” defined as residential facility operated by a public agency or private organization and licensed by CDSS

that provides an integrated program of specialized and intensive care and supervision, services and supports, treatment, and short-term, 24-hour care and supervision to children that is trauma-informed, as defined in standards and regulations. Requires the care and supervision provided by an STRTP to be nonmedical, except as otherwise permitted by law and requires private STRTPs to be organized and operated on a nonprofit basis. Authorizes an STRTP to be operated as a children's crisis residential program. (HSC § 1502(a)(18))

20) Requires CDSS to license STRTPs pursuant to the California Community Care Facilities Act (CCF Act), and requires STRTPs to comply with all requirements that are applicable to group homes. (HSC § 1562.01(a))

21) Requires STRTPs to have national accreditation from an entity identified by CDSS and requires STRTP applicants to submit documentation of accreditation or application for accreditation with its application for licensure. Provides STRTPs up to 24 months from the date of licensure to obtain accreditation and allows CDSS to revoke an STRTP's license for failure to obtain accreditation within the specified timeframes. (HSC § 1562.01(b))

22) Requires STRTPs to maintain the program approval in good standing during its licensure and requires CDSS to track the number of licensed STRTPs that were unable to obtain a mental health program approval and provide that information to the Legislature annually as part of the state budget process. (HSC § 1562.01(c))

23) Establishes the Office of the Foster Care Ombudsperson as an autonomous entity within CDSS for the purpose of providing children who are placed in foster care with a means to resolve issues related to their care, placement, or services. (WIC § 16161)

24) Requires the Office of the Foster Care Ombudsperson to, among other things, disseminate information and provide training and technical assistance to foster youth and relevant parties on the rights of children and youth in foster care, reasonable and prudent parent standards, and the services provided by the Office; investigate and attempt to resolve complaints made by or on behalf of children placed in foster care, related to their care, placement, or services; and, have access to copies of any record of a state or local agency, and contractors with state and local agencies, that is necessary to carry out their responsibilities, and may meet or communicate with any foster child in their placement or elsewhere. (WIC §16164)

25) Requires licensees of foster family homes to provide reports to the licensing agency as required by CDSS for the following events: death of any client (regardless of cause or location); injury requiring medical treatment; unusual incidents or client absences, threatening health or safety; suspected psychological abuse of clients; suspected physical abuse of minors; and, epidemic outbreaks, poisonings, catastrophes, and fires/explosions on the premises. (California Code of Regulations Title 22 § 87061)

26) Establishes requirements for special incident reporting by vendors and long-term health care facilities. (California Code of Regulations Title 17 § 54327)

FISCAL EFFECT: According to the Senate Appropriations Committee on March 18, 2024, the California Department of Social Services (CDSS) estimates General Fund costs of $1,725,000 in the first year and $1,687,000 ongoing thereafter, for staffing and information technology costs related to data collection activities.

COMMENTS:

Background: *History of the Use of Seclusion and Restraints on Children.* SB 130 (Chesbro), Chapter 750, Statutes of 2003, required CalHHS to provide the leadership and coordination necessary to reduce the use of seclusion and behavioral restraints in facilities that are licensed, certified, or monitored by departments that fall within its jurisdiction, and also established measures to reduce the use of seclusion and behavioral restraints. AB 107 (Committee on Budget), Chapter 18, Statutes of 2017, established seclusion and behavioral restraint utilization and reporting requirements for new community-based residential models operated by DDS and required them to develop guidelines regarding the use of restraints or containment in enhanced behavioral support homes.

AB 2317 (Ramos), Chapter 589, Statutes of 2022, established requirements for an order for the use of restraints or seclusion for a person under 21 years of age at a residential psychiatric facility, and aligned with the requirements established by AB 107 regarding uniform reporting on the use of seclusion and restraints. AB 2317 also established psychiatric residential treatment facilities (PRTFs) in California. PRTFs are licensed by the California Department of Health Care Services (DHCS), which falls under the jurisdiction of CalHHS, and provide inpatient psychiatric services to individuals under 21 years of age in a non-hospital setting. PRTFs are required to report to DHCS annually regarding the number of patients subjected to restraint, the number of times each patient was subjected to restraint, and the types and duration of restraint. Additionally, DHCS and CDSS are required to annually provide a report summarizing this data, among other information, to the Senate and Assembly Committees on Health, Human Services, and Judiciary. To date, there are no PRTFs licensed in California.

However, the historical use of seclusion and restraints in these facilities has concerned many stakeholders and policymakers and there is a history of documented abuse of youth placed in these facilities in other states. According to the United States (U.S.) Government Accountability Office (GAO), "Prior GAO reports have described allegations of youth being maltreated, and sometimes killed, by staff employed at residential facilities. Many of the youth placed in residential facilities are in foster care." In response, legislation has been passed at the federal and state level to establish training standards for staff who work in these facilities with children and to require transparency in reporting these incidents. California requires that direct care staff receive eight hours of training before working unsupervised with children.

Federal regulations state that restraint and seclusion should not be used as coercion, discipline, convenience, or retaliation, and must not result in harm or injury. Seclusion and restraint are dangerous and traumatic not only to the individuals subjected to these practices, but also for the staff implementing them, according to an issue brief published by the U.S. Department of Health and Human Services' (HHS') Substance Abuse and Mental Health Services Administration. The requirements governing the use of seclusion and restraints on children in STRTPs are largely contained within the interim licensing standards that were established as a result of legislation implementing Continuum of Care Reform (CCR). CDSS is authorized to use the interim licensing standards until regulations are adopted.

The Community Care Facility Act. The CCF Act contains provisions for various community-based housing options to create a new community-based care system for adults and children who require additional supervision and support. These care facilities provide nonmedical services to individuals with disabilities, seniors, children in foster care, families who need early child

education, and those with severe behavioral, emotional, or mental health disorders. CDSS is responsible for licensing facilities across programs and ensures regulatory compliance and enforcement when necessary with a mission to promote the health, safety, and quality of life of each person in community care through the administration of an effective collaborative regulatory enforcement system.

Within CDSS, the Community Care Licensing Division, Children's Residential Program, licenses several categories of children's CCFs, typically those in the child welfare system. These facilities provide 24-hour care and supervision for minors, from birth through 17 years of age, and nonminor dependents 18 to 20 years of age. According to the CDSS website, the Children's Residential Program's mission is to protect and improve the lives of all youth who reside in a CCF through the administration of a transparent licensing system that is collaborative, fair, and supportive of families. Some of the facilities include crisis nurseries; adoption agencies; foster family agencies; licensed foster family homes; small family homes; group homes; and STRTPs. Although they vary in care and supervision level, these facilities are all licensed by CDSS.

Short-Term Residential Therapeutic Programs. STRTPs were established in 2017 as a new CCF to provide short-term, 24-hour nonmedical care and supervision to children and offer mental health interventions to stabilize, support, and transition youth with high-level mental health needs to lower levels of care using trauma-informed, culturally relevant services. This licensing category was established to align mental health policy with the state's efforts to reduce the use of congregate care settings as part of CCR. The use of residential facilities as placements for youth in foster care has declined over the course of 20 years, according to data from HHS. Residential facilities were listed as the most recent placement for about 101,000 youth in foster care in 2002. By 2022, the most recent year of available data, that number had dropped to about 34,000 youth. As of June 12, 2024, there were 339 licensed STRTPs in California with a capacity to serve 2,605 children. Currently, there are 1,182 child welfare placements and 317 probation placements for a total of 1,499 youth residing in STRTPs.

As part of CCR, group homes were replaced with STRTPs in order to serve a more specialized population of mostly foster youth up to 20 years of age whose challenging behaviors and significant emotional and developmental needs created barriers to placement in family-based care. According to a February 2021 report published by the California Alliance of Child and Family Services regarding STRTP Policy and Practice Recommendations, the STRTP is often described as one step below psychiatric hospitalization and that residents in STRTPs can present behavior that includes attempts to harm themselves and others including violent assaults on peers and adults. However, there are also complaint investigation reports listed by facility that detail incidents where children have been injured by staff, sometimes requiring hospital emergency room visits for a broken wrist or personal rights violations where reports of staff physically restraining a child and knocking them down on the ground have been substantiated. A January 2022 GAO report entitled, *Child Welfare: HHS Should Facilitate Information Sharing between States to Help Prevent and Address Maltreatment in Residential Facilities*, reviewed this issue as a result of several incidents of youth being maltreated by staff employed at residential facilities which were reported in the media. Some of these youth were in the child welfare system and some had special needs. Because states oversee these facilities, and often contract with private providers to operate them, the GAO states that little information is publicly available about incidents of maltreatment in federally funded residential facilities for youth. The report found that, "Differing interpretations of what constitutes maltreatment may result in facilities over- or under-reporting incidents, thereby complicating states' data collection efforts, according to state officials and other stakeholders. In

response, selected states have taken steps to make it easier for residential facility staff to determine what types of incidents they should report, such as by providing facilities with technical assistance on states' legal reporting requirements."

Out-of-State Facilities. Prior to 2022, when certain children were in need of behavioral health services that could not be met in California facilities, children were placed in out-of-state facilities that had been certified by CDSS once the court had reviewed the necessary assessments, technical assistance efforts, or recommendations, and found that in-state facilities or programs were unavailable or inadequate to meet the needs of the child.

However, in April 2020, staff members at a CDSS-certified Michigan facility for foster youth restrained 16-year-old Cornelius Frederick for 12 minutes in response to him throwing a sandwich at another boy in the cafeteria of the residential facility where he had been placed. Reports of the incident allege that two staff members laid across Cornelius' torso. He was in cardiac arrest when the paramedics arrived and died in a hospital two days later. His death was ruled a homicide, the result of asphyxiation. According to an NBC News report, "California's Department of Social Services documented at least seven violations in the two years before Cornelius died, including concerns with 'types of physical intervention possibly being utilized'."
In May of 2020, CDSS reviewed the operations of all certified out-of-state facilities and found significant licensing violations and in December 2020, decertified the out-of-state facilities, and returned all youth placed in those facilities back to California. Subsequently, the Legislature passed AB 153 (Committee on Budget), Chapter 86, Statutes of 2021, a budget trailer bill, which phased out the use of out-of-state residential facilities by child welfare and probation departments, removing all foster children from out-of-state facilities as of July 1, 2022.

Emergency Intervention Plans. Due to the high incidence of children in STRTPs with reported complex care needs, the interim licensing standards for STRTPs outline the requirements for each facility's emergency intervention plan when challenging incidents occur. The current version of STRTP interim licensing standards require the plan to be trauma-informed, culturally relevant, appropriate for the age, size, emotional, behavioral and developmental level of the children and account for their particular traumas, including CSEC. The plan must include de-escalation and harm reduction techniques and must be submitted to, and approved by CDSS, prior to implementation.

For each type of emergency intervention, the plan is required to include specified information, including the following:

- A description of each emergency intervention technique, including manual restraints, to be used and in what types of situations they will be used;
- Maximum time limits for each emergency intervention technique, not to exceed specified maximum time limits;
- In what situations each emergency intervention technique is not to be used;
- A statement specifying what emergency interventions will never be used;
- A description of the circumstances and the types of behaviors that may require the use of emergency intervention;

- Procedures for determining and using age and size appropriate emergency intervention techniques;

- A description of how the assessments for each child, which includes the needs and services plan, will be used to inform the licensee's emergency intervention plan;

- The manual restraint plan is to be included as a component of the emergency intervention plan. If the facility will use, or it is reasonably foreseeable that the facility will use, manual restraints, the plan must include the following:

    - Procedures for ensuring a child's safety when a manual restraint is being used including, but not limited to, the titles of staff responsible for checking the child's breathing and circulation and the job titles or names of the administrator's designee(s) who will be authorized to extend the restraint time;

    - Procedures for determining when a medical examination is needed during a manual restraint;

    - Procedures for ensuring that the amount of time a child is restrained is limited to the amount of time when the child is presenting an immediate danger to themselves or others and that the restraints will not cause injury to the child. Such procedures must include provisions that ensure the following:

        - A child does not remain in a manual restraint for more than 15 consecutive minutes, unless written approval to continue the restraint after the initial 15 minutes is obtained from the administrator or administrator's designee.

        - Written approval to continue a manual restraint beyond 15 consecutive minutes must be documented in the child's record.

        - A child does not remain in a manual restraint for more than 30 consecutive minutes in a 24-hour period unless the child is still presenting a danger to self or others and written approval to continue the restraint after the initial 30 minutes is obtained from the administrator or administrator's designee and the facility social work staff.

Debriefing and Review of Manual Restraint Use. Existing law requires STRTPs, as quickly as possible but no later than 24 hours after the use of seclusion or behavioral restraints, to conduct a debriefing regarding the incident with the person, and, if the person requests it, the child's family member, domestic partner, significant other, or authorized representative, as well as with the staff members involved in the incident, and a supervisor, to discuss how to avoid a similar incident in the future. The child's participation in the debriefing is voluntary.

The interim licensing standards also detail a process for a debriefing and review of manual restraint use and requires an administrator to offer a debriefing to the child involved with the use of manual restraint. If the child chooses to attend the debriefing, the debriefing process is required to be facilitated in a trauma-informed manner and is required to include the following individuals, at a minimum:

- The child who was manually restrained;

- The child's authorized representative, if applicable;

- The mental health head of service and the administrator or their designee; and,

- Other individuals requested by the child, such as the child's attorney or support person chosen by the child.

This bill would require the facility to provide a description of the incident, in both oral and written forms to the child subject to the seclusion or behavioral restraint in conjunction with the existing debriefing process. The facility would also be required to submit the written description of the incident to CDSS to be posted on their website, with any personally identifiable information redacted.

Incident Reports. According to the interim licensing standards, each use of manual restraints must be reported to CDSS and the child's authorized representative by telephone no later than the next working day following the incident. A written incident report must be submitted to CDSS within seven days, as required by California Code of Regulations, Title 22, Section 80061.

Incident reports documenting the use of manual restraints must include the following:

- Date and time of other manual restraints involving the same child in the past 24 hours;

- A description of the child's behavior that required the use of manual restraints, and description of the precipitating factors which led to the intervention**;**

- Description of what manual restraints were used, and how long the child was restrained;

- Description of what non-physical interventions, trauma-informed practices, or de-escalation techniques were utilized prior to the restraint and an explanation of why more restrictive interventions were necessary;

- Description of any injuries sustained by the child or facility personnel, including what type of medical treatment was sought, where the child was taken, and an explanation if medical treatment was not sought for injuries;

- Name(s) of facility personnel who conducted the manual restraint;

- Name(s) of facility personnel who witnessed the child's behavior and the restraint;

- The child's verbal response and physical appearance, including a description of any injuries at the completion of the restraint;

- If it is determined by the post incident review that facility personnel did not attempt to prevent the manual restraint, staff need to provide a description of what action should have been taken by facility personnel to prevent the manual restraint incident. If law enforcement was involved, a detailed description of the events involving the law enforcement contact, including a police report number if available; and,

- Documentation that the child's authorized representative has been notified of the incident.

According to CDSS, once an incident report is received from an STRTP, a licensing program analyst (LPA) triages with a manager to determine if an investigation is warranted based on the appearance or potential use of an improper restraint. There are no criteria in statute or regulations for when an incident must be investigated. CDSS reports that there is no uniform guiding policy for LPAs to make that determination either. CDSS does not collect data on how often an incident report is the basis for an investigation.

Lack of Transparency: Seclusion and Restraint Data. The incident reports are stored on an in internal CDSS network server and are not publicly available. CDSS reported to the Committee that after a hand count, in 2023, there were roughly 3,000 incidents of restraint or seclusion in licensed STRTPs. However, there was no further data shared due to their current process.

Seclusion and behavioral restraints are used in other state-licensed facilities. The use of restraints and their appropriateness has come up several times in the Legislature in the last decade. Ultimately, they are permitted in limited circumstances and with the expectation data on the use is made available. Specifically, SB 130 (Chesbro) states legislative intent that publicly accessible data regarding the use of seclusion and behavioral restraints in all psychiatric units of GACHs, acute psychiatric hospitals, psychiatric health facilities, PRTFs, crisis stabilization units, group homes, SNFs, ICFs, CCFs, and mental health rehabilitation centers should be compiled in a manner that allows for standard statistical comparison and maintained for each facility. As reported by the Author after several attempts at accessing this data in the last six-months, to date, CDSS has not provided this data for STRTPs, which are under the CCF licensing category.

DDS, DSH, and DHCS, all departments under CalHHS, currently publish quarterly data regarding the use of restraints, which is posted on their respective websites. It is unclear why CDSS is not currently sharing similar information.

Current law established under SB 130 (Chesbro) requires the CalHHS secretary to take steps to establish a system of mandatory, consistent, timely, and publicly accessible data collection regarding the use of seclusion and behavioral restraints in the facilities mentioned above. SB 130 also requires the CalHHS secretary to develop a mechanism for making information, as it becomes available, publicly available on the internet, and for data currently being collected, to be available as soon as it reasonably can be achieved within existing resources. At the direction of the CalHHS secretary, the departments are required to cooperate and share resources for developing uniform reporting for all facilities and requires uniform reporting of seclusion and behavioral restraint utilization information, to the extent possible, to be incorporated into existing reporting requirements for facilities.

Author's Statement: According to the Author, "California has been at the forefront in strengthening youth in congregate care laws. [This bill] is a children's protection measure that will create more accountability in in how children in these facilities are treated. When it comes to our children's health and wellness we should only accept the highest level of transparency in these areas of care. [This bill] will create more transparency at the Department of Social Services by requiring the Department to create a dashboard on their website to publish the use of restraints and seclusion rooms in Short-Term Residential Therapeutic Programs (STRTPs)."

Equity Implications: Youth who are referred to an STRTP have complex care needs and are overwhelmingly represented by foster youth. According to the data provided by the Catalyst Center covering May 18, 2020, to May 29, 2024, there were 279 total requests for placements or service referrals, and of that number, 242 unique youth, of which 45% are CSEC, transgender or

non-binary, or have substance use factors and the plurality, (75%) of requests were initiated by child welfare. Because these youth arrive to these facilities in a particularly vulnerable state, it is imperative that their well-being and safety is protected along with that of the staff who are charged with addressing the needs of youth who can sometimes present with difficult behavior. While there is a robust process laid out in statute, regulations, and interim licensing standards regarding the use of seclusion and restraints in STRTPs, there is little known about how often these incidents take place, how often and why they are investigated, and whether the youth agree with the characterizations and outcomes of the investigations. This lack of transparency makes it difficult to gauge whether restraints are being applied in a disproportionate manner.

Policy Considerations: As noted above, the overwhelming majority of STRTP residents (75%), are foster youth. While the Legislature has allowed the use of seclusion and restraints in residential facilities that serve children, the Legislature also codified provisions requiring CalHHS to reduce their use in departments that fall within its jurisdiction. Advocates and policymakers do recognize there are limited circumstances where it is appropriate to utilize restraints to protect the residents' and staffs' well-being and to prevent youth from injuring themselves or others or running away under dangerous conditions. However, without being able to access the data that indicates the frequency of their use, or without having criteria for when an incident is investigated, there is no way to conduct the statistical comparison for the use of seclusion and behavioral restraints for each facility and to ensure restraints are being properly used in the limited circumstances. Without the data on their use, there is no way to measure reductions.

The provisions of this bill seek to address a lack of transparency when it comes to the use of seclusion and restraints in STRTPs, by requiring CDSS to post data about these incidents on an STRTP-specific website. While this is a laudable goal, and it is appropriate to access aggregated data regarding the use of restraints and seclusion in STRTPs after the fact, there are no provisions related the needs of the youth who are subject to the inappropriate use of restraints and seclusions in these facilities in real time.

Should this bill move forward, the author may wish to consider ways to also address instances where youth are currently being subject to the improper use of seclusion and restraints in STRTPs.

The existing process outlined in the interim licensing standards requires an incident report to be filed with CDSS for each instance of the use of seclusion and restraints, but leaves the determination of whether to conduct an investigation to the discretion of the LPA. The incident reports are not publicly available.

Should this bill move forward, the author may wish to consider establishing criteria for when an investigation is conducted after an incident report has been made regarding the use of seclusion and restraints in an STRTP.

This bill establishes a process for a facility to follow in the case involving the use of seclusion or behavioral restraints in an STRTP, in conjunction with its process for a clinical and quality review and a debriefing, but does not specifically include a process or appoint a neutral third party for the child who was subject to the restraint and seclusion, to provide input in the incident report or any subsequent investigation, nor does it establish a timeline for the process.

Should this bill move forward, the author may wish to consider placing a deadline on when the facility must comply with this process and include a youth-centered procedure that specifically includes the youth perspective in the investigation.

Proposed Committee Amendments:

The Committee proposes amendments to address policy considerations stated above to do the following:

- Require CDSS to investigate all incidents of seclusion and restraints in STRTPs that are reported.

- Require the Office of the Foster Care Ombudsperson to collect a statement about the incident from the child subject to the seclusion or behavioral restraint, to be included in the completed investigation report.

- Require completed investigation reports regarding the use of seclusion and restraints, specific to STRTPs, to be displayed on CDSS' website and updated bi-annually.

- Require STRTPs, in the case of an incident involving the use of seclusion or behavioral restraints, when providing a copy to CDSS, to also include a description of the type the placement the youth falls under, and the type of personnel implementing the actions within 7 days.

- Require CDSS to display data on the number and types of licensing administrative actions taken against an STRTP or individual associated to STRTP for the improper use of seclusion or behavioral restraints.

- Technical amendments to correctly cite this act as "The Accountability in Children's Treatment Act," strike the term "public dashboard" and replace with "data."

RELATED AND PRIOR LEGISLATION:

AB 2317 (Ramos), Chapter 589, Statutes of 2022, see comments above.

AB 226 (Ramos) of 2021, would have eliminated Children's Crisis Residential Programs (CCRPs) under the purview of CDSS and instead create Children's Crisis Psychiatric Residential Treatment Facilities under the purview of DHCS, to provide intensive mental health care for children, including those in foster care. *AB 226 was vetoed by Governor Newsom.*

AB 107 (Committee on Budget), Chapter 18, Statutes of 2017, see comments above.

AB 501 (Ridley-Thomas), Chapter 704, Statutes of 2017, expanded the definition of STRTP to include CCRPs to be used as diversion from psychiatric hospitalization and created a new facility licensure category for CCRPs, and made related changes.

AB 741 (Williams) of 2016, would have expanded the definition of an STRTP to include a CCRP to be used as a diversion from psychiatric hospitalization with limited time stays. *AB 741 was vetoed by Governor Brown.*

AB 1997 (Mark Stone), Chapter 612, Statutes of 2016, adopted changes to further facilitate implementation of CCR provisions established by AB 403 including modifications of the resource family approval process, required payment of basic rate to all families regardless of approval process, and altered requirements for mental health certification of STRTPs.

AB 403 (Mark Stone), Chapter 773, Statues of 2015, established STRTPs as a new CCF category, among other provisions related to the implementation of CCR.

AB 918 (Mark Stone), Chapter 340, Statutes of 2015, required the Secretary of CalHHS to establish a system of mandatory, consistent, timely, and publicly accessible data collection related to data on seclusion and restraint in community facilities serving aged and developmentally disabled persons. Required DDS to publish on its website the number of incidents of physical and chemical restraint in community facilities, as specified. Further requires community facilities to report every death or serious injury of a person in seclusion or in physical or chemical restraint no later than the close of business day following the death or serious injury.

SB 130 (Chesbro), Chapter 750, Statutes of 2003, see comments above.

REGISTERED SUPPORT / OPPOSITION:

Support

11:11 Media Impact (Sponsor)
11:11 Media
Ambika Law
Anti-Recidivism Coalition
Boys and Girls Club of Kern County
Children's Law Center of California
Disability Rights California
Educate. Advocate.
Institutional Child Abuse Prevention & Advocacy Network
Kern County Network for Children
Lives in the Balance
National Center for Lesbian Rights
Steinberg Institute
The Mission At Kern County
Unsilenced

Opposition

None on file.

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