SENATE JUDICIARY COMMITTEE
Senator Thomas Umberg, Chair
2021-2022 Regular Session

AB 2317 (Ramos)
Version: August 24, 2022
Hearing Date: August 29, 2022
Fiscal: Yes
Urgency: No
AWM

PURSUANT TO SENATE RULE 29.10(b)

SUBJECT

Children's psychiatric residential treatment facilities

DIGEST

This bill requires the State Department of Health Care Services (DHCS) to license and establish regulations for psychiatric residential treatment facilities that provide inpatient psychiatric services to individuals under 21 years of age in a nonhospital setting, as specified.

EXECUTIVE SUMMARY

Young people in the United States are experiencing a mental health crisis. In 2021, Surgeon General Vivek Murthy issued a Surgeon General's Advisory to highlight the need to address this crisis, noting that the COVID-19 pandemic exacerbated already troubling rates of mental health issues in children and youths.[1]

According to the author, sponsor, and supporters of the bill, California has a gap in its continuum of specialty mental health services for children and youth that is contributing to this crisis. Currently, children and youths covered by Medi-Cal suffering from acute crisis episodes are treated primarily in psychiatric hospitals, which are often overbooked and lack a homelike environment. This bill would establish a new category of mental health facility, the Psychiatric Residential Treatment Facility (PRTF), which would be designated to provide inpatient psychiatric services to individuals under 21 years of age in a nonhospital setting. PRTFs will be licensed and regulated by the Department of Health Care Services (DHCS). Because of the high number of foster children and youths and children and youths within the juvenile justice system likely to be admitted to PRTFs, the California Department of Social Services (CDSS) will also

---

[1] United States Department of Health and Human Services, Protecting Youth Mental Health: The U.S. Surgeon General's Advisory (Dec. 2021), *available at* https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf (all links current as of August 25, 2022).

play a role in developing certain regulations and reporting certain data to the public and the Legislature.

While there is no question that the proponents of PRTFs have only good intentions, many of the bill's opponents have noted that the history of PRTFs in other states is not encouraging—reports of patients being abused, neglected, or kept in poor conditions at PRTFs are disturbingly frequent. There is also a concern that PRTFs will be used—as they appear to be used in other states—as a replacement for home-based or community-based mental health care for parents who are unwilling to care for their children's mental health. Because these concerns are particularly acute for children under the jurisdiction of the juvenile court, such as foster children, this bill contains significant guardrails in the form of court oversight over an initial placement decision and long-term stays.

This bill was originally triple-referred to the Senate committees on Health, Judiciary, and Human Services. The referral to the Senate Human Services Committee was rescinded because of the limitations placed on committee hearings due to the ongoing health and safety risks of the COVID-19 virus, and then the author amended the bill to remove the Senate Judiciary Committee's jurisdiction in order to give the committees and stakeholders more time to work on amendments. This is therefore the first time this Committee has heard this bill. Additionally, because the newly amended bill pertains to issues within the Senate Human Services Committee's jurisdiction, this analysis contains input from that committee.

This bill is sponsored by the California Alliance for Child and Family Services and is supported by a number of child advocacy, mental health, and medical organizations. This bill is opposed by Depression and Bipolar Support Alliance California, Disability Rights California, the National Center for Youth Law, the National Health Law Program, and Youth Law Center. This bill passed out of the Senate Health Committee with a 9-0 vote, and the much narrower version of the bill passed out of the Senate Appropriations Committee with a 7-0 vote.

PROPOSED CHANGES TO THE LAW

Existing federal law:

1) Establishes requirements for inpatient psychiatric services for individuals under the age of 21 in psychiatric facilities or programs, including:
    a) That the services are provided under the direction of a physician and provided at a hospital or psychiatric facility that meets specified requirements.
    b) That the services are certified in writing to be necessary in the setting in which the services will be provided. (42 C.F.R. §§ 441.151, 483.354.)

2) Requires the certification in 1)(b) to be made by an independent team that includes a physician, that has competence in the diagnosis and treatment of mental illness, preferably in child psychiatry, and has knowledge of the individual's situation. The team must certify that:
   a) Ambulatory care resources available in the community do not meet the treatment needs of the patient.
   b) Proper treatment of the patient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
   c) The services can reasonably be expected to improve the patient's condition or prevent further regression so that the services will no longer be needed. (42 C.F.R. §§ 441.152, 441.153.)

3) Provides requirements for an order for the use of restraints or seclusion for a person under the age of 21 at a residential psychiatric facility, including the following:
   a) Orders for restraint or seclusion must be made by a physician or other specified licensed practitioner and trained in the use of emergency safety interventions. If the resident's treatment team physician is available, only they can order restraint or seclusion.
   b) The ordered restraint or seclusion must be the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff.
   c) The order may be verbal or in writing.
   d) The order must be limited to the duration of the emergency safety situation and may not exceed four hours for residents aged 18 through 21, two hours for residents aged 9 through 17, or one hour for residents below the age of nine years old. (42 C.F.R. § 483.358.)

Existing state law:

1) Establishes a state and local system of child welfare services, including foster care, for children who have been adjudged by the court to be at risk of abuse and neglect or to have been abused or neglected or wards of the court, as specified. (Welf. & Inst. Code, § 202.)

2) Establishes that the juvenile court, which has jurisdiction over:
   a) A child who is subject to, or in substantial risk of suffering, abuse or neglect. (Welf. & Inst. Code, § 300.)
   b) A child who has committed acts that trigger delinquency jurisdiction rendering the child a ward. (Welf. & Inst. Code, §§ 601, 602.)
   c) Any nonminor dependent, between the age of majority and 21 years, under specified conditions. A nonminor dependent under the jurisdiction of the juvenile court retains their legal decision-making authority as an adult, except as specified. (Welf. & Inst. Code, §§ 303, 388(e).)

3) Provides that the purpose of the juvenile court and the dependency system is to provide the maximum safety and protection for children who are currently being physically, sexually, or emotionally abused, being neglected, or being exploited, and to ensure the safety, protection, and physical and emotional well-being of children who are at risk of that harm. This safety, protection, and physical and emotional well-being may include providing a full array of social and health services to help the child and family and to prevent the reabuse of children. (Welf. & Inst. Code, § 300.2.)

4) Establishes the California Community Care Facilities Act (CCFA) and requires CDSS to administer and license community care facilities providing nonmedical services, including adult residential facilities, short-term residential therapeutic programs (STRTPs), and children's crisis residential programs. (Health & Saf. Code, div. 2, ch. 3, §§ 1500 et seq.)

5) Defines the following relevant terms under the CCFA:
   a) "Community care facility" is any facility, place, or building that is maintained and operated to provide nonmedical residential care, day treatment, adult daycare, 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 residential facility.
   b) "Residential facility" is any family home, group care facility, or similar facility determined by the department, for 24-hour nonmedical care of persons in need of personal services, supervision, or assistance essential for sustaining the activities of daily living or for the protection of the individual.
   c) "Short-term residential therapeutic program" is a residential facility operated by a public agency or private organization 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 adopted by the department. The care and supervision provided by a STRTP shall be nonmedical, except as otherwise permitted by law, and may be operated as a children's crisis residential program.
   d) "Children's crisis residential program" is a facility licensed by CDSS as a short-term residential therapeutic program and approved by DHCS, or a county mental health plan to which DHCS has delegated approval authority, to operate a children's crisis residential mental health program to serve children experiencing mental health crises as an alternative to psychiatric hospitalization. (Health & Saf. Code, § 1502.)

6) Requires DHCS, in consultation with specified agencies and stakeholders, to establish program standards and procedures for oversight, enforcement, and issuance of children's crisis residential mental health program approvals, including

provisional approvals that are effective for a period of less than one year; and for DCHS, in collaboration with CDSS and other stakeholders, to provide guidance to counties for the provision of children's crisis residential services to the extent necessary federal approvals are obtained. (Welf. & Inst. Code, § 11462.011(a), (b).)

7) Provides that a children's crisis residential program shall be used only as a diversion to admittance to a psychiatric hospital and that the length of initial authorization for admission to a children's crisis residential program shall be limited to 10 consecutive days. (Welf. & Inst. Code, § 11462.011(c).)

8) Authorizes a children's crisis residential program to accept for admission a child who meets all of the following requirements:
   a) The child is referred by a parent or guardian, physician, or licensed mental health professional, or by the representative of a public or private entity, including, but not limited to, the county probation agency or child welfare services agency with responsibility for the placement of a child in foster care, that has the right to make these decisions on behalf of a child who is in mental health crisis.
   b) The child is under 19, 20, or 21 years of age, depending on a program's licensing requirements.
   c) The child has a serious behavioral health disorder.
   d) The child requires a 24-hours-a-day, seven-days-a-week, staff-secured, unlocked treatment setting. (Welf. & Inst. Code, § 11462.011(c).)

9) Establishes the Children's Civil Commitment and Mental Health Treatment Act of 1988, which is intended to:
   a) Provide prompt evaluation and treatment of minors with mental health disorders, with particular priority given to seriously emotionally disturbed children and adolescents.
   b) Safeguard the rights to due process for minors and their families through judicial review.
   c) Provide individualized treatment, supervision, and placement services for gravely disabled minors.
   d) Prevent severe and long-term mental disabilities among minors through early identification, effective family service interventions, and public education. (Welf. & Inst. Code, div. 5, pt. 1.5, §§ 5585 et seq.)

10) Provides for the placement of a minor in a facility designated by a county and approved by DHCS for the 72-hour treatment and evaluation of minors when the minor is, as a result of a mental disorder, a danger to others or themselves or gravely disabled and authorization for voluntary treatment is not available.
   a) The facility shall make every effort to notify the minor's parent or legal guardian as soon as possible after the minor is detained.

b) "Gravely disabled minor" is defined as a minor who, as a result of a mental disorder, is unable to use the elements of life that are essential to health, safety, and development, including food, clothing, and shelter, even though provided to the minor by others. Intellectual disability, epilepsy, or other developmental disabilities, alcoholism, other drug abuse, or repeated antisocial behavior do not, by themselves, constitute a mental disorder. (Welf. & Inst. Code, §§ 5585.25, 5585.50.)

11) Provides that any minor detained under 10) shall receive a clinical evaluation provided by properly qualified professionals consisting of multidisciplinary professional analyses of the minor's medical, psychological, developmental, educational, social, financial, and legal conditions as may appear to constitute a problem, including a psychosocial evaluation of the family or living environment, or both. Every effort shall be made to involve the minor's parent or legal guardian in the clinical evaluation. (Welf. & Inst. Code, § 5585.52.)

12) Requires, if the professional conducting the evaluation in 11) determines that the minor will require additional mental health treatment, a treatment plan to be written and identify the least restrictive placement alternative in which the minor can receive the necessary treatment.
    a) The family, legal guardian, or caretaker and the minor shall be consulted and informed as to the basic recommendations for further treatment and placement requirements.
    b) Every effort shall be made to obtain the consent of the minor's parent or legal guardian prior to treatment and placement of the minor. Inability to obtain the consent of the minor's parent or legal guardian shall not preclude the involuntary treatment of a minor who is determined to be gravely disabled or a danger to themselves or others. (Welf. & Inst. Code, § 5585.53.)

13) Requires involuntary treatment under 12) to be provided in accordance with the Lanterman-Petris-Short (LPS) Act. (Welf. & Inst. Code, § 55853.)

14) Establishes the LPS Act, which provides for the involuntary detention for treatment and evaluation of people who are gravely disabled or are a danger to self or others through a series of involuntary treatment holds of increasing duration—72 hours, 14 days, then 30 days—that must be certified as medically necessary at specified intervals. (Welf. & Inst. Code, div. 5, pt. 1, §§ 5000 et seq.)

15) Authorizes a person detained for 14-day and 30-day periods of intensive treatment under the LPS Act to file a petition for habeas corpus for their release. (Welf. & Inst. Code, § 5275.)

16) Provides that a person has the right to refuse medication, including antipsychotic medication, unless they have been specifically determined to be incompetent by a court. (*Riese v. St. Mary's Hospital & Medical Center* (1987) 209 Cal.App.3d 1303, 1320.)

17) Prohibits a person detained for treatment under the LPS Act from being involuntarily administered antipsychotic medication unless a court has separately determined in a capacity hearing that the individual lacks capacity to refuse treatment. (Welf. & Inst. Code, §§ 5332-5336.)

18) Provides that the LPS Act does not limit the right of an adult to voluntarily apply for mental health services. (Welf. & Inst. Code, § 5003.)

19) Permits a minor who is 12 years of age or older to consent to mental health treatment or counseling on an outpatient basis or to specified residential shelter services, including a licensed crisis resolution center, if (a) the minor is, in the opinion of the attending professional, mature enough to participate intelligently in the services and (b) the minor would either prevent a danger of serious physical or mental harm to themselves or others or is the alleged victim of incest or child abuse.
    a) A professional offering residential shelter services to the minor shall make their best efforts to notify the parent or guardian of the services.
    b) The treatment or counseling provided shall include involvement of the minor's parent or guardian unless, in the opinion of the professional person who is treating or counseling the minor, the involvement would be inappropriate. (Fam. Code, § 6924.)

20) Permits a court to authorize a minor under the jurisdiction of the juvenile court to apply, with the advice of counsel, for voluntary application for inpatient or outpatient mental health services, if the court is satisfied from the evidence before it that the minor suffers from a mental disorder which may reasonably be expected to be cured or ameliorated by a course of treatment offered by the hospital, facility or program in which the minor wishes to be placed; and that there is no other available hospital, program, or facility which might better serve the minor's medical needs and best interest. (Welf. & Inst. Code, § 6552.)

This bill:

1) Makes findings and declarations relating to the urgent need to provide alternatives to hospitals for children and youth experiencing severe mental health crises and the need for psychiatric residential facilities (PRTFs).

2) Adds PRTFs to the list of psychiatric care facilities for which DHCS must (1) provide technical assistance and training programs with the input of stakeholders, and (2) develop a system of mandatory, consistent, timely, and publicly accessible data collection regarding the use of seclusion and behavioral restraints, provided that (1)

and (2) may be implemented within existing resources or funds are specifically made available for these purposes.

3) Defines a PRTF as a health facility licensed by DHCS that is operated by a public agency or private nonprofit organization that provides inpatient psychiatric services, as described in Subpart D of Title 42 of the Code of Federal Regulations, to individuals under 21 years of age in a nonhospital setting.

4) Establishes requirements for licensure as a PRTF relating to accreditation and compliance with federal and state Medi-Cal and Medicare regulations and other laws and regulations, including:
   a) Complying with provisions requiring certification of the patient for care at the PRTF and recertification at least every 60 days.
   b) Maintaining guidelines that require, at a minimum, that all services align to trauma-informed care standards and length of stay to be determined by medical necessity for the duration of time needed to transition the patient to a less restrictive setting.
   c) Developing an individual plan of care for each patient within 72 hours after admission that is designed to achieve the patient's discharge from inpatient status at the earliest possible time and based on an individualized diagnostic evaluation.

5) Requires DHCS to set a statewide bed limit for PRTFs based on an analysis of the need for such facilities, and to notify the Legislature when the total number of beds in PRTFs statewide reaches 250 beds, 500 beds, and 750 beds.

6) Requires a PRTF to provide, by July 1 of each year, DHCS with specific data, including the total number of patients admitted, certain demographic and treatment information about the patients served, duration of stay for each patient, and certain information about the use of restraints.

7) Requires DHCS and CDSS, by January 1 of each year, to provide to the Senate and Assembly Committees on Health, Human Services, and Judiciary with a report summarizing the information provided under 6), including certain data provided on a per-facility basis, a per-county basis, and a statewide basis.

8) Requires DHCS, in consultation with CDSS and other stakeholders, to establish regulations for PRTFs, which must include the following:
   a) The requirement that therapeutic programming be provided seven days a week, including weekends and holidays, with sufficient mental health professional and paraprofessional staff to maintain an appropriate treatment setting and services, based on individual client's needs.
   b) The established number of beds in the facility shall be consistent with the individual treatment needs of the patients and consistent with requirements

requiring minors to be separated from adults, and at least 50 percent of the beds be in single-occupancy rooms.

c) The requirement that the length of stay conform to the federal Medicaid requirements for a psychiatric residential treatment facility and shall be consistent with the individual plan of care developed by the interdisciplinary team.
d) The requirement that, for a child under the jurisdiction of the juvenile court, the facility must obtain court approval for the admission of the child, and that the court must review a decision by a nonminor dependent under the jurisdiction of the juvenile court to admit themselves.
e) The requirement that PRTFs include ample physical space for accommodating individuals who provide daily emotional and physical supports to each client and for integrating family members into the day-to-day care of the youth, including at least an hour per day of time for outdoor exercise or other outdoor activities, weather permitting.
f) The requirement that a PRTF assist with the county child welfare agency's or county probation department's implementation of the patient's aftercare plan for transitioning each admitted child from the program.
g) The availability of the Patient's Bill of Rights to any patient and the right of a hearing by writ of habeas corpus by an admitted patient.
h) Requirements for the individualized plan of care.
i) Guidelines for the use of physical restraints over and above federal requirements, including notice to a patient's parent, guardian, Indian custodian, counsel, social worker, and/or probation officer, as applicable, when restraints are used.

9) Requires DHCS, on or before June 1, 2027, in consultation with CDSS, to report to the Legislature on the use of PRTFs in the state, including an evaluation of the efficacy of the facilities in treating the mental health of individuals under 21 years of age within and not within the jurisdiction of the juvenile court.

10) Requires a patient being discharged from a PRTF to be provided an aftercare plan that includes, to the extent known, matters including the nature of the illness, follow-up required, medications including side effects and dosing schedules, and the expected course of recovery.

11) Establishes an ex parte court procedure for when a parent, guardian, or Indian custodian[2] whose child under the jurisdiction of the juvenile court pursuant to Welfare and Institutions Code section 300 (Section 300) seeks to voluntarily admit the child to a PRTF, or when a child under the jurisdiction of the juvenile court pursuant to 300 seeks to voluntarily admit themselves to a PRTF under Welfare and Institutions Code section 6552 (Section 6552).

---

[2] Going forward this analysis uses "parent" to refer to a parent, guardian, or Indian custodian.

12) Provides that the court procedure under 11) is as follows:
   a) The child's social worker, within 48 hours of being informed of the request, or on the next judicial day if courts are not open within 48 hours of learning of the request, must file a petition for an ex parte hearing on the request that includes specified information including the child's mental disorder, how the PRTF is likely to cure or ameliorate the disorder, why the PRTF is the least restrictive setting for care, a description of any mental health services previously provided to the child, and a statement how the child was given the opportunity to confer privately with their counsel.
   b) After receiving the petition, the court must hear the request on the next judicial day and the social worker must provide notice of the hearing under the California Rules of Court relating to ex parte procedures.
   c) At the hearing, the court shall consider evidence on a range of matters, including whether the child suffers from a mental disorder that may reasonably be expected to be cured or ameliorated by a course of treatment offered by the PRTF, whether the PRTF is the least restrictive setting for care, whether and how the social worker addressed the placement with the child's attorney, and the child's position on admission to the PRTF.
   d) The court may not continue the hearing unless the child consents to the continuance and the court determines additional evidence is necessary to support the necessary findings.
   e) The court may grant a request for admission only if it finds, by clear and convincing evidence, specific facts, including that the child suffers from a mental disorder that may reasonably be expected to be cured or ameliorated by a course of treatment offered by the PRTF, that the PRTF is the least restrictive setting for care, and that the child and parent, where appropriate, have been advised of the nature of inpatient legal services, patient's rights, and their right to contact a patient's rights advocate.
   f) In granting a request for admission, the court may make any orders necessary to ensure that the child welfare agency promptly makes all necessary arrangements to ensure that the child is discharged in a timely manner and with all services and supports in place as necessary for a successful transition into another setting.
   g) The court's order granting admission is effective until the first of the following occurs: (1) the parent, or the child if the child consented to admission under Section 6552, withdraws consent to be present at the PRTF; (2) the court finds that the child no longer suffers from a mental disorder that may reasonably be expected to be ameliorated by treatment at the facility or that the PRTF is no longer the least restrictive alternative for treatment; or (3) the court makes a superseding order.
   h) For requests made by a parent, the court must also consider whether the parent's conduct contributed to the deterioration of the child's mental disorder; if the court determines that the parent did contribute to the child's deterioration, the court shall direct the county child welfare agency to

investigate whether the child may be safely returned to the parent's custody upon discharge from the PRTF and to take appropriate action based on their findings.

13) Establishes an ex parte court procedure to review the decision of a nonminor dependent[3] under the jurisdiction of the juvenile court pursuant to Section 300 to voluntarily admit themselves to a PRTF. The procedure is substantially similar to the procedure for children set forth in 12), except for the following:
    a) The nonminor dependent's parent, guardian, or Indian custodian may not seek to admit the nonminor dependent.
    b) The nonminor dependent may admit themselves to the facility prior to the ex parte hearing.
    c) At the hearing, the court must find only whether the nonminor dependent gave knowing and intelligent consent to admission. If the court finds that the nonminor dependent did not knowingly and intelligently consent, the court shall direct the social worker to convey its findings to the PRTF and direct the facility to discharge the nonminor dependent in accordance with the nonminor dependent's aftercare plan.

14) Requires the court, for a child admitted to a PRTF pursuant to 12), to hold a hearing 60 days after the child's admission, and every 30 days thereafter, to review the child's placement in the facility based on the medical necessity of that placement. The court may hold the hearing in tandem with another statutorily required hearing if the timing coincides.

15) Requires, at a hearing under 14), the court to consider all of the following:
    a) Whether the parent or child continues to consent to the placement.
    b) Whether the child continues to suffer from a mental disorder that may reasonably be expected to be cured or ameliorated by treatment at the PRTF.
    c) Whether there continues to be no other available less restrictive setting which might better serve the child's medical needs and best interest.
    d) Whether the PRTF continues to meet its legal obligations to provide services to the child.
    e) The county child welfare agency's plan for the child and the agency's actions to implement that plan.

16) If the court finds at the hearing under 14) that the parent or child continues to consent, that the child continues to suffer from a mental disorder that may be reasonably expected to be cured or ameliorated by treatment at the PRTF, and that

[3] "Nonminor dependent" includes foster children who remain under jurisdiction of the juvenile court after reaching age of majority even if they do not meet the definition of "nonminor dependent" set forth in Welfare and Institutions Code section 11400(v).

there is no other available less restrictive setting to serve the child's medical need, the court may authorize the continued admission at the PRTF.

a) The court may hold more frequent hearings at its discretion.
b) If the child has been at the facility for over 30 days, there is a rebuttable presumption that the facility is not the least restrictive alternative to serve the child's medical need and best interest.

17) If the court finds at the hearing under 14) that the parent or child no longer consents, that the child no longer suffers from a mental disorder that may reasonably expected to be cured or ameliorated by treatment at the PRTF, or that there is another available less restrictive setting to serve the child's medical needs, the social worker must immediately work with the PRTF to arrange for the child's discharge to a different setting with the appropriate services and supports.

a) A statement from the child's attorney may be sufficient to support a finding that the child no longer consents to admission.
b) The court shall set a hearing no later than 30 days from the findings in 17) to verify that the child has been discharged; if not, the court shall issue any and all orders to effectuate the child's immediate discharge.
c) The provisions in 17) do not preclude involuntary detention of the child if the child satisfies the requirements of the Children's Civil Commitment and Mental Health Treatment Act of 1988.
d) Nothing in 17) should be interpreted to preclude a parent or child's social worker or attorney from arranging the child's discharge without a court order.
e) If the court 's determination includes a determination under 17) that the child should receive treatment in another setting or through another service, the court shall hold a hearing no later than 60 days after the child's discharge to ensure that the other services have been provided.
f) If the court determines that the PRTF failed to meet its legal obligation to the child, it may direct the social worker to engage with the PRTF to ensure the child is receiving all necessary services.
g) The court may make any orders necessary to ensure that the child welfare agency makes all necessary arrangements for the child's discharge promptly and that all services and supports are in place for the child's successful transition to a different setting, and may direct the social worker to work with the PRTF on the child's aftercare plans as appropriate.

18) Requires the court, for a nonminor dependent admitted to a PRTF, to hold a review hearing 60 days after the admission and every 30 days thereafter on the nonminor dependent's placement in the PRTF based on the medical necessity of that placement. The procedures are substantially similar to the review hearing procedures for children set forth in 14)-18), except:

a) Only the nonminor dependent's continued consent to the placement is relevant, not their parent's consent.

b) The review procedure does not prohibit a nonminor dependent from arranging their own discharge from the facility without a court order.

19) Requires a county child welfare agency, whenever a child or nonminor dependent is discharged due to revocation of consent to admission, within two days of learning of the revocation of consent, to file a petition with the court requesting an order vacating the court's order authorizing the child or nonminor dependent's admission to the PRTF. This provision does not require a court order for the discharge of a child when consent has been withdrawn.

20) Provides that, where a child or nonminor dependent has been admitted to a PRTF pursuant to the consent of a conservator, the court must review the placement at any six-month review hearing and may make any orders necessary to ensure that the child or nonminor dependent is discharged in a timely manner and with all the services and supports necessary for a successful transition to a less restrictive setting. The court may direct the social worker to work with the facility and, where appropriate, with the conservator, to ensure the child or nonminor dependent is receiving all necessary child welfare services and to develop the aftercare plan.

21) Provides that any information filed pursuant to 11)-20) shall not contain information that is privileged or confidential under existing state or federal law or regulation without the appropriate waiver or consent.

22) Establishes procedures for a court to review requests to admit children under the jurisdiction of the juvenile court pursuant to Welfare and Institutions Code section 601 or 602 and nonminor dependents under the supervision of a county juvenile probation department. These procedures are substantially similar to the procedures for children and nonminor dependents set forth in 11)-13) and 20), except:
   a) References to a child or nonminor dependent's social worker are generally replaced with references to a child or nonminor dependent's probation officer.
   b) References to the child welfare agency's plan for the child are generally replaced with the probation departments plan for the minor, and references to the county welfare agency are generally replaced with references to the county probation department.

23) Requires a court, for children under the jurisdiction of Welfare and Institutions Code sections 601 or 602 and nonminor dependents under the jurisdiction of a county juvenile probation department admitted to a PRTF under 22), to hold a hearing 60 days after the child or nonminor dependent's admission, and every 30 days thereafter, to review the child or nonminor dependent's placement in the facility based on the medical necessity of that placement. The procedures are substantially similar to the procedures set forth in 14)-20), except that:

a) References to a child or nonminor dependent's social worker are generally replaced with references to a child or nonminor dependent's probation officer.
b) References to the child welfare agency's plan for the child are generally replaced with the probation departments plan for the minor, and references to the county welfare agency are generally replaced with references to the county probation department.

24) Adds specifications relating to PRTF licensure and DHCS's oversight authority to the Welfare and Institutions Code. Some of the requirements are duplicative of those set forth in the Health and Safety Code at 4)-9); additional requirements include:
   a) A PRTF, for patients under the jurisdiction of the juvenile court, must:
      i. Provide the patient's counsel, social worker, and/or probation officer, as applicable, of the patient's continued stay at the facility every 30 days for the first 60 days and every 15 days thereafter.
      ii. Provide the patient with a reasonable opportunity to confer with counsel in a private setting within 48 hours of a request from the patient or counsel.
   b) DHCS must conduct an initial licensing inspection and annual licensing inspection of a PRTF.
   c) Any officer, employee, or agent of DHCS may inspect a PRTF at any time to investigate compliance, and PRTFs must furnish all information, documentation, and records requested by DHCS.
   d) A PRTF must report serious occurrences and unusual occurrences to DHCS as specified.
   e) A PRTF must report the use of restraint to DHCS, the patient's authorized representative and attorney, the patient's social worker or probation office and DSS and the county child welfare agency or probation department with responsibility for the patient if the patient is under the jurisdiction of the juvenile court, and the child's tribe if the child is an Indian child, as defined.
   f) DHCS may require a PRTF to take specified actions to correct noncompliance, may place a PRTF on probation for repeated noncompliance, and may enforce PRTF requirements through a range of administrative actions, including suspending or revoking the PRTF's license. DHCS must follow specified due process procedures in certain circumstances.
   g) The PRTF's application for licensure must specify whether it will unlocked staff-secured (i.e., entrances and exits are controlled and monitored by staff), locked (i.e., entrances and exits, including windows, are controlled with inaccessible locking mechanisms and outdoor areas are enclosed to prevent egress or ingress), or a combination of both.
   h) PRTFs shall be licensed only to serve individuals admitted prior to 21 years of age.
   i) DHCS must establish licensing requirements for homelike and age-appropriate patient rooms and common areas.

j) DHCS must establish additional licensing requirements for facilities with more than 25 beds to ensure that they establish and maintain a homelike and age-appropriate environment, as described.
k) Provides that DHCS must adopt its PRTF-related regulations by December 31, 2027, and may implement requirements through means such as information notices or similar instructions prior to that date.

25) Provides procedures for a PRTF seeking to obtain or renew a license, including the payment of a licensing fee and an application fee, the amount of which will be determined by DHCS. A license shall be subject to renewal 12 months from the date of issuance.

26) Require PRTFs to provide DHCS the information set forth in Health and Safety Code section 1250.10(c), which must not contain data that may lead to the identification of patients, as specified.

27) Provides that existing confidentiality provisions relating to medical records do not apply in certain circumstances when the records pertain to a patient under the jurisdiction of the juvenile court and the medical records are to be viewed by the patient's social worker or probation officer for purposes of ensuring that the dependent or ward receives all necessary services or referrals to transition out of a PRTF to a lower level of care.

28) Provides that existing statutes relating to applications to obtain a license from DHCS to run specified mental health facilities and the provision of community mental health services apply to PRTFs.

29) Provides that existing law relating to the provision of community mental health services and the need for 24-hour treatment at specified facilities applies to PRTFs.

30) Modifies the existing procedure by which a minor who is under the jurisdiction of the juvenile court may apply to the court for inpatient or outpatient mental health services to include applications to be admitted to PRTFs.

31) For children and nonminor dependents under the jurisdiction of the juvenile court, establishes requirements for a child or nonminor dependent's social worker or probation officer's involvement before, during, and after a child or nonminor dependent's admission to a PRTF, including requiring a plan for placement and what community-based mental health services will be available upon discharge.

32) Requires Judicial Council to develop rules and forms for the court procedures for children and nonminor dependents under the jurisdiction of the juvenile court discussed in 11)-23).

33) Incorporates chaptering-out amendments in Section 12 of the bill to avoid a chaptering conflict with AB 2144 (Ramos, 2022).

COMMENTS

1. Author's statement

According to the author:

> This bill would ensure much-needed federal funding for Children's Crisis Residential Programs to provide urgent mental health services to children in crisis. This bill seeks to maximize federal funding for these programs and ensure the availability of these critical services for youth. Not every child in mental health crisis needs to be hospitalized, yet hospitalization remains the only alternative available in California if a child temporarily cannot be safely treated at home or in their community. Alternatives to inpatient hospitalization are essential to both children experiencing a mental health crisis and their families. Children need a calming and therapeutic place near home where they can receive treatment to work through the crisis. Community-based residential mental health crisis programs can provide just that. The primary goal of these services is to stabilize and improve psychological symptoms of distress and to engage individuals in appropriate treatment to address the causes of a crisis. These services are provided in a residential home-like setting, offering the optimum environment for a child to obtain essential therapeutic help.

2. This bill authorizes DHCS to license and oversee PRTFs for children and youths under 21 years of age

This bill creates the PRTF license category in the state and tasks DHCS, sometimes with the assistance of CDSS, with licensing and overseeing PRTFs in the state. PRTFs will also be governed by specific federal regulations for this category of facility; the relationship between PRTFs and federal regulations is discussed more thoroughly in the Senate Health Committee's analysis of this bill, which is incorporated here by reference. Part 4 of this analysis includes a comment from the Senate Human Services Committee which provides useful background on prior attempts to establish inpatient psychiatric facilities for children and youths in the state.

At a broad level, PRTFs will be inpatient residential facilities intended to treat children and youths experiencing mental health crises in a nonhospital setting. A patient must be voluntarily admitted to a PRTF, though in the case of most minors, voluntary consent

can be given by their parents. Nonminor dependents and foster children specifically seeking court permission[4] will be able to consent to their own admission. Patients will be provided with an individualized treatment plan within 72 hours of admission, and the plan must be reviewed and updated as needed at least every 10 days. DHCS, working with CDSS and stakeholders, will develop regulations to ensure a homelike setting; facilities must have at least 50 percent of beds in single-occupancy rooms and provide at least an hour a day of outdoor exercise or other outdoor activities. PRTFs may be locked and they may also restrain or seclude patients. DHCS will devise its own regulations relating to restraints and seclusion, but federal regulations authorize up to four hours of restraint or seclusion for patients aged 18 through 21, up two hours for patients aged 9 through 17, and up to one hour for patients below the age of nine years old.[5]

Opponents of the bill have expressed concern that there is no cap on the length of stay at a PRTF. They argue that, because PRTFs are intended to provide acute crisis care and achieve the patient's discharge from inpatient status at the earliest possible time, an open-ended duration of stay runs contrary to the purpose of the PRTFs. According to the author and sponsor, however, any durational cap is inconsistent with the federal regulations requiring stays to be based on medical necessity. Instead, this bill includes a requirement that a PRTF obtain recertification for the stay every 60 days, consistent with the federal regulations governing recertification.[6]

Opponents also object more generally that the bill reflects a policy choice to adopt PRTFs—which, by definition, remove patients from their support networks—rather than invest in intensive home and community-based mental health services that are just as effective as PRTFs. As Part 4 of this analysis explains in more detail, the state has taken meaningful steps in the last decade to improve mental health care for foster children, and this bill could reflect a reversion to more a restrictive and institutional approach to care.

3. <u>This bill creates court oversight for the children and nondependent minors admitted to PRTFs</u>

Last year, the Legislature passed a bill from this author to establish PRTFs that relied solely on medical professionals' determination of whether a patient's admission or continued stay was "medically necessary" to protect against overly long stays or parents admitting children who would be better served in less-restrictive care settings.[7] Governor Newsom vetoed that bill in part because it lacked safeguards to ensure children did not remain in PRTFs any longer than necessary.[8] Accordingly, this bill

[4] Welf. & Inst. Code, § 6552.
[5] 42 C.F.R. § 483.358.
[6] *See* 42 C.F.R. § 456.60.
[7] AB 226 (Ramos, 2021).
[8] Governor's veto message to Assem. on Assem. Bill. 226 (2021-2022 Reg. Sess.).

contains an array of safeguards, particularly for children and youths under the jurisdiction of the juvenile court.

The key safeguard set forth in the bill is the judicial oversight provided for children and nonminor dependents under the jurisdiction of the juvenile court under both Welfare and Institutions Code section 300 and sections 601 and 602. For such children under the age of 18, the court must give its approval before a parent admits their child to a PRTF; the bill establishes an ex parte hearing proceeding to ensure that the admission is not delayed any longer than necessary. Nonminor dependents in the foster system or under the supervision of a county probation officer can admit themselves to a facility before obtaining court approval—consistent with the fact that nonminor dependents are over 18 and can legally consent to their own care—but the admission must be reviewed by a court on an expedited basis to ensure that the consent was given voluntarily (e.g., not as the result of coercion or threats from a family member or roommate). The court at these proceedings should inquire about the child or nonminor dependent's feelings about the placement and ensure they were given an opportunity to confer with counsel. If the court finds that a child's parent contributed to the mental health crisis necessitating admission, the court may make orders necessary to ensure the child's wellbeing after they are discharged.

Once a child or nonminor dependent has been admitted to a PRTF, the court must review the placement for medical necessity after the first 60 days and every 30 days thereafter. The PRTF must also provide a child or nonminor dependent's counsel, social worker, and/or probation officer, as applicable, with notice of the child or nonminor dependent's continued stay at the PRTF every 30 days for the first 60 days and every 15 days thereafter to try to keep children in these placements from falling through the cracks. Nothing in the bill requires a court order before the child or nonminor dependent can be discharged; if the patient is ready to be stepped down or consent is withdrawn, the child or nonminor dependent can be discharged and the social worker or probation officer need only notify the court of that event. If, however, a court determines at a review hearing that there is no longer medical necessity for the placement, the court may order a social worker or probation officer to arrange the discharge at the earliest possible time.

Certain stakeholders have expressed concerns that the protective procedures set forth above are overly onerous. In light of the nationwide history with PRTFs, however, these measures seem entirely prudent. Several recent reports have documented numerous instances of abuse and neglect in PRTFs, including staffing shortages, lack of appropriate treatment options, and the inappropriate use and lack of reporting of restraint and seclusion.[9] In July of this year, United States Senators Patty Murray and

---

[9] *E.g.*, United States Government Accountability Office, Child Welfare: HHS Should Facilitate Information Sharing Between States to Help Prevent and Address Maltreatment in Residential Facilities (Jan. 2022), *available at* https://www.gao.gov/assets/gao-22-104670.pdf; National Disability Rights Network, Report: Desperation Without Dignity (Oct. 2021), *available at* https://www.ndrn.org/wp-

Ron Wyden sent letters to four companies that operate PRTFs and other residential facilities demanding information on the facilities' practices following reports of abuse and neglect.[10] So while there is no question that children in this state need better access to mental health care in times of crisis, the circumstances surrounding PRTFs warrant caution.

In addition to the procedural safeguards, the bill contains an annual reporting requirement so that the Legislature will be able to monitor the implementation of this bill. The information to be provided includes per-facility and statewide data on the number of patients admitted, length of stay, demographic information about the patients, and the use of restraints and seclusion, with some data tallied for patients under juvenile court jurisdiction and patients not under juvenile court jurisdiction. DHCS is also tasked with informing select committees (including this one) when the statewide number of beds in PRTFs reach 250, 500, and 750. With this information, the Legislature will be able to determine whether the procedural protections in the bill can be eased or whether additional protections are necessary.

4. Comment from the Senate Human Services Committee, including background on recent legislative efforts to improve mental health care services for foster children and youth

This bill was originally referred to the Senate Human Services Committee as the third committee of referral, but the referral was rescinded due to COVID-19-related bill limits. The recent amendments address many significant issues within the jurisdiction of the Senate Human Services Committee. The Senate Human Services Committee has therefore provided the following comments, which include useful context for this bill:

This bill seeks to address what the sponsors see as a gap within the continuum of crisis care available to all of California's youth, including foster youth. Since the Human Services Committee's jurisdiction focuses on the child welfare system, this comment focuses on resources available to foster youth. Aside from emergency hospitalization, California has few crisis diversion programs for adolescents and limited options for children in a mental health crisis currently available. In an attempt to address this need, AB 501 (Ridley-Thomas, Chapter 704, Statutes of 2017) expanded the definition of STRTP to include a children's crisis residential program (CCRP) to be used as a diversion from psychiatric hospitalization and created a new facility licensure category for CCRPs. AB 501 was follow up to AB 741 (Williams, 2016) which would have

content/uploads/2021/10/NDRN_Desperation_without_Dignity_Final.pdf; United States Government Accountability Office, Residential Treatment Programs: Concerns Regarding Abuse and Death in Certain Programs for Troubled Youth (Oct. 10, 2007), *available at* https://www.gao.gov/assets/gao-08-146t.pdf;
[10] U.S. Committee on Health, Education, Labor & Pensions, Press Release, Murry, Wyden Demand Answers on Mistreatment at Youth Residential Treatment Facilities (Jul. 22, 2022), https://www.help.senate.gov/chair/newsroom/press/murray-wyden-demand-answers-on-mistreatment-at-youth-residential-treatment-facilities.

expanded the definition of a STRTP to include a CCRP to be used as a diversion from psychiatric hospitalization with time limited stays. AB 501 was vetoed by the governor.

Both bills were introduced in response to a 2015 paper published by six mental health advocacy organizations that noted the lack of crisis options available for children and teens results in untreated mental health issues, which worsen over time. This paper, entitled "Kids in Crisis: California's Failure to Provide Appropriate Services for Youth Experiencing a Mental Health Crisis," described California's system as inconsistent statewide with many families turning to local hospital emergency rooms for help. The paper, which was published by a workgroup led by the California Council of Community Mental Health Agencies, advocated for the creation of community-based crisis facilities for children and youth, stating "the emergency room should be the last resort for a child in crisis."

There have been a variety of recent legislative efforts to better address the crisis mental health needs of foster youth. This includes AB 2083 (Cooley, Chapter 815, Statutes of 2018), which requires each county to develop a memorandum of understanding (MOU) to describe the roles and responsibilities of certain entities that serve youth in foster care who have experienced severe trauma in an effort to break down silos between state departments responsible for serving this population, as well as entities at the more local level, including county mental health plans, behavioral health service providers, and county child welfare departments. Additionally, AB 2083 requires the California Health and Human Services Agency (CHHS) and the Superintendent of Public Instruction to establish a joint interagency resolution team to implement and review aspects of the MOU. The Legislature has also funded the Family Urgent Response System through the state's budget to create on-demand support for foster youth and caregivers through a crisis hotline and in person mobile response units.

Most recently, the Legislature, through last year's budget, and associated human services trailer bill language, created the Children's Crisis Continuum Pilot (CCCP) Program. The CCCP Program is a five-year pilot program that seeks to address the increased prevalence of youth mental health issues and increase the availability of competent care settings for children with intensive needs in California's child welfare system. Through the CCCP Program, participating counties, or a collaboration of counties that share regional proximity, are provided with structure and funding to establish a full continuum of crisis services that includes an array of residential and community based options. This program attempts to create a series of step down services for youth who may need higher levels of crisis intervention, moving them back to family and community based settings as quickly as possible.

Counties were supposed to submit proposals to participate in the CCCP by January 31, 2022, with CDSS dispersing funding to selected counties by March 31, 2022. However, the rollout of this pilot program is still in process, with the request for proposals only recently released. AB 2786 (Stone, 2022) would have extended the application and grant

funding disbursement deadline, as well as the program's sunset date, by one year. AB 2786 would have also expanded the CCCP beyond foster youth by including youth who meet the eligibility requirements to enroll in the Medi-Cal program and who meet medical necessity standards for the care components offered through the CCCP Program. Such an expansion would have allowed the state to deliver different models of short-term stabilization treatments for acute crisis outside of the child welfare system, possibly negating the need for PRTFs. AB 2786 was held in the Senate Health Committee.

Despite these recent and ongoing efforts to build out the continuum of crisis care available to California's foster youth, the sponsors of this bill continue to believe that California's continuum of crisis care for youth is inadequate. The sponsors suggest that PRTFs will fill a necessary gap in that continuum. In the Senate Human Services Committee analysis of AB 226 (Ramos, 2021), the Committee raised concerns that allowing the use of PRTFs in California for foster youth may be counter to the state's ongoing Continuum of Care Reform efforts by creating another avenue by which youth may spend long periods of time in institutional settings, instead of being cared for in the least restrictive family-based placement available to them. Additional safeguards are included in AB 2317 in an attempt to address those concerns, including requirements for notice of the child or youth's placement to be provided to their counsel, upon request, and mandatory court review hearings after the initial 60 day placement and every thirty days thereafter for all foster youth placed within a PRTF. Additionally, AB 2317 includes ongoing recertification requirements every 60 days for all youth receiving residential treatment in a PRTF, requiring the child or youth be reevaluated to ensure they continue to meet the medical necessity requirements.

Human Services Committee staff notes these additional guardrails should address some of the concerns raised in the Committee's analysis of AB 226. However, Committee staff also remains sensitive to the concerns raised by those stakeholders in opposition to this bill and the potential infringement of foster youth's rights that may result from long-term stays in such restrictive settings. As amended, this bill requires annual reporting of multiple data points by DHCS and CDSS to the Legislature, including, but not limited to: the number of patients admitted to each PRTF and the number of patients under the jurisdiction of the juvenile court; the number of patients subjected to restraint and details of that restraint; demographic data about the patients, such as age, race or ethnicity, gender, sexual orientation, and gender identity; types of community-based services provided to patients; the average and median lengths of stay; the types of placements patients were discharged to; and, the number of intensive services foster care homes, enhanced intensive services foster care homes, and other family-based treatment settings, and other less restrictive placement settings available around the state by county. It will be up to the Legislature to utilize this required reporting to exercise oversight of the implementation and use of PRTFs in California to ensure these facilities are being used appropriately.

6. Arguments in support

According to the National Association of Social Workers – California Chapter, writing in support:

> AB 2317 is aimed at addressing a critical component missing in the continuum of specialty medical services and youth in California – children's crisis residential services. This legislation seeks to add a new licensing category in state statute, the Psychiatric Residential Treatment Facility. This legislation would ensure that counties and their community-based providers have the ability to develop crisis residential programs with an appropriate licensing category, and ensure children and youth can access mental health services that are responsive to their individual needs and strengths in a timely manner. The creation of the licensing category is consistent with Med-Cal Early Periodic Screening Diagnosis and Treatment (EPSDT) Specialty Mental Health Services (SMHS) program standards.
>
> There is no question that a full continuum of care for children and youth is needed, and the lack of a licensing component for children's crisis residential programming is preventing the development of this much-needed program. While crisis residential services are still acute in nature, they are provided in a less restrictive environment, and would be a more appropriate alternative for children who don't necessarily require the level of care that an acute inpatient hospitalization provides.

7. Arguments in opposition

According to Cal Voices, Depression and Bipolar Support Alliance California, Disability Rights California, the National Center for Youth Law, the National Health Law Program, the National Center for Youth Law, and Youth Law Center, writing in opposition:

> AB 2317 creates PRTFs which are among the most restrictive secured institutional settings that can be utilized to treat children with mental health conditions using Medicaid funds. For children and youth in foster care, this reliance on Medicaid rather than foster care bypasses the protections required by the federal Families First Prevention Services Act and the state's Continuum of Care Reform. California does not need to rush to create another treatment facility that removes children from their support networks and costs tens of millions of dollars every year. Instead, the state must invest in legally required intensive home and community-based mental health services that have been shown to be just as effective but cost only a fraction of PRTFs. Such home and community based services further enable children and use to be treated in the most integrated setting, as required by the Americans With

> Disabilities Act and affirmed by the landmark United States Supreme Court *Olmstead* decision[11]…
>
> [T]he bill particularly harms children in foster care, who will be placed in these institutions at disproportionate rates and for long periods of time, detrimentally impacting their development and connections. Foster youth have already experienced trauma and instability and will face additional challenged with permanency and transitioning to adulthood if placed in PRTFs, rather than supported in their homes and communities. While recent amendments attempt to provide some checks and balances on the overutilization or length of stay of foster youth in these facilities, it still provides no actual limits.

SUPPORT

California Alliance for Child and Family Services (sponsor)
A Greater Hope
Aspiranet
California Association of Alcohol and Drug Program Executives
California Association of Social Rehabilitation Agencies
California Children's Hospital Association
California Children's Trust
California Council of Community Behavioral Health Agencies
Chief Probation Officers of California
Childhelp
Children's Health of Orange County
Children's Receiving Home of Sacramento
County Behavioral Health Directors Association
County Welfare Directors Association of California
Didi Hirsch Mental Health Services
Family Care Network, Inc.
First Tee Silicon Valley
Fred Finch Youth & Family Services
Healthier Kids Foundation
Hillsides
JobTrain
National Alliance on Mental Illness-California
National Association of Social Workers
Pacific Clinics
Pacific Juvenile Justice Center
SAGA Foundation
San Bernardino County Department of Behavioral Health
San Bernardino County Board of Supervisors

---

[11] *Olmstead v. L.C.* 527 U.S. 581 (1999).

San Diego Center for Children
SEIU California
Seneca Family of Agencies
Sierra Vista Child & Family Services
Steinberg Institute
Sycamores
Warrior Canine Connection
Youth Transportation Association

OPPOSITION

Cal Voices
Depression and Bipolar Support Alliance California
Disability Rights California
National Center for Youth Law
National Health Law Program
National Center for Youth Law
Youth Law Center

RELATED LEGISLATION

Pending Legislation:

AB 2786 (Stone, 2022) extends the application and grant period for the Children's Crisis Continuum Pilot and extends the sunset provision by one year. AB 2786 is pending before the Senate Health Committee.

AB 1051 (Bennett, 2021) prohibits presumptive transfer from applying to foster youth placed in a group home or a short-term residential therapeutic program outside of the county of original jurisdiction, unless an exception is invoked, as specified; establishes contracting options and notification requirements for county mental health plans and specialty mental health services providers; and requires the Department of Health Care Services and the California Department of Social Services to collect and make available certain data related to the presumptive transfer of foster youth. AB 1051 is pending on the Senate Floor.

Prior Legislation:

AB 226 (Ramos, 2021) was similar to this bill insofar as it reclassified children's crisis residential programs as children's crisis psychiatric residential treatment facilities and transferred licensing responsibility to DHCS in order to address the same lack of treatment options addressed by this bill. AB 226 was vetoed by Governor Gavin Newsom, whose veto message stated that the bill eliminated a service the state is required to provide under Medi-Cal, did not appropriately identify the roles of DHCS

and other entities in the program, and did not provide adequate safeguards to ensure children are not in the facilities longer than necessary.

AB 2083 (Cooley, Ch. 815, Stats. 2018) requires each county to develop a memorandum of understanding (MOU) to describe the roles and responsibilities certain entities that serve youth in foster care who have experienced severe trauma, and instructed the Secretary of California Health and Human Services and the Superintendent of Public Instruction to establish a joint interagency resolution team to implement and review aspects of the MOU.

AB 501 (Ridley-Thomas, Ch. 704, Stats. 2017) expanded the definition of a short-term residential treatment center (STRTC) to include a children's crisis residential center (CCRC) to be used as a diversion from psychiatric hospitalization and creates a new facility licensure category for CCRCs, and made related changes.

AB 741 (Williams, 2016) was substantially similar to AB 501 (Ridley-Thomas, Ch. 704, Stats. 2017) and limited a stay at a STRTC to 10 consecutive days and no more than 20 total days within a six-month period. AB was vetoed by Governor Brown, who stated that the bill’s restrictions on facility size and length of stay were not consistent with rules and would jeopardize funding.

PRIOR VOTES:

Senate Appropriations Committee (Ayes 7, Noes 0)
Senate Health Committee (Ayes 9, Noes 0)
Assembly Floor (Ayes 74, Noes 0)
Assembly Appropriations Committee (Ayes 16, Noes 0)
Assembly Health Committee (Ayes 14, Noes 0)

****