Senate Fiscal Agency
P. O. Box 30036
Lansing, Michigan 48909-7536

BILL ANALYSIS

Telephone: (517) 373-5383
Fax: (517) 373-1986
TDD: (517) 373-0543

Senate Bill 231 (Substitute S-1 as reported)
Senate Bill 1344 (Substitute S-2 as reported)
Sponsor: Senator Bev Hammerstrom
Committee: Health Policy

Date Completed: 10-12-04

RATIONALE

The Mental Health Code allows hospitals and other facilities to place patients and residents in seclusion under certain circumstances and according to specific procedures; for example, seclusion authorized by a physician may continue only for one hour or until a physician can examine the person, whichever is less. In 1997, an amendment to the Code included child caring institutions among the facilities that may use seclusion, since these institutions occasionally need to place a child in seclusion for the safety of the child and others. Child caring institutions, however, do not have full-time physicians on staff, which can make it difficult for them to comply with the requirement that a physician examine a child each time seclusion is used.

In 2001, the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services issued a final rule regarding the safe use of restraint and seclusion in psychiatric residential facilities that provide treatment to people younger than 21. (The HCFA now is called the Center for Medicare and Medicaid Services, or CMS.) In order to receive Medicaid funding, a child caring institution must adhere to the requirements under the final rule. (For more information on the Federal rule, and the use of restraint and seclusion, please see **BACKGROUND**, below.)

It has been suggested that provisions of the Federal rule should be incorporated into the Code so Medicaid funding could be used to treat residents of child caring institutions; reliance on restraint and seclusion in child caring institutions would be reduced; and resident and staff safety and quality of care would be improved.

CONTENT

Senate Bill 231 (S-1) would amend the Mental Health Code to prohibit a minor placed in a child caring institution from being placed or kept in seclusion, except as provided in the child care licensing Act or rules promulgated under the Act.

Senate Bill 1334 (S-2) would amend the child care licensing Act to do the following with regard to child caring institutions:

- **Prohibit the use of mechanical and chemical restraint.**
- **Allow the use of personal restraint and seclusion to ensure the safety of a minor or others in an emergency situation.**
- **Require staff to undergo continuing education and training in the use of personal restraint and seclusion, and the identification of alternate methods for preventing and defusing an emergency safety situation.**
- **Establish procedures for the use of personal restraint and seclusion, including debriefings of all situations in which personal restraint or seclusion was employed.**
- **Require an evaluation of a minor by institution staff after the implementation of personal restraint or seclusion.**

-- **Require a face-to-face assessment of a minor by a licensed practitioner if the use of personal restraint or seclusion exceeded specified time limits.**
-- **Establish documentation and record-keeping requirements.**
-- **Require the reporting of instances of death, serious injury, or attempted suicide to the Family Independence Agency (FIA) and the State-designated protection and advocacy system.**

Senate Bill 1344 is tie-barred to Senate Bill 231. The bills are described below in further detail.

Senate Bill 231 (S-1)

Under the Mental Health Code, seclusion may be used only in a hospital, center, or licensed child caring institution. ("Center" means a facility operated by the Department of Community Health (DCH) to admit individuals with developmental disabilities and provide habilitation and treatment services.) Under the bill, a minor placed in a child caring institution could not be placed or kept in seclusion except as provided in the child care licensing Act or rules promulgated under it.

(Under the child care licensing Act, "child caring institution" means a child care facility that is organized for the purpose of receiving minor children for care, maintenance, and supervision, usually on a 24-hour basis, in buildings maintained by the institution for that purpose, and operates throughout the year. An educational program may be provided, but may not be the facility's primary purpose. The term includes a maternity home for the care of unmarried mothers who are minors and an agency group home, which is described as a small child caring institution owned, leased, or rented by a licensed agency providing care for between four and 13 children. The term also includes institutions for mentally retarded or emotionally disturbed minor children. It does not include a hospital, nursing home, home for the aged, boarding school, hospital or facility operated by the State and licensed under the Mental Health Code, or an adult foster care family home or an adult foster care small group home in which a child has been placed.)

Senate Bill 1344 (S-2)

Prohibited Restraint

The bill would prohibit the use of mechanical and chemical restraint in a child caring institution that contracted with and received payment from a community mental health services program or prepaid inpatient health plan for the care, treatment, maintenance, and supervision of a minor in a child caring institution.

The bill would define "mechanical restraint" as a device attached or adjacent to a minor's body that he or she cannot easily remove and that restricts freedom of movement or normal access to his or her body. The term would not include the use of a protective or adaptive device or a device primarily intended to provide anatomical support.

("Protective device" would mean an individually fabricated mechanical device or physical barrier, whose use is incorporated in the individualized written plan of service and is intended to prevent the minor from causing serious self-injury associated with documented, frequent, and unavoidable hazardous events. "Adaptive device" would mean a mechanical device incorporated in the individual plan of services that is intended to provide anatomical support or to assist the minor with adaptive skills (i.e., skills in communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work).)

The term "mechanical restraint" also would exclude the use of a mechanical device to ensure security precautions appropriate to the condition and circumstances of a minor placed in the child caring institution as a result of an order of the family division of circuit court (family court) under Section 2(a) of the juvenile code. (Under that section, the court has exclusive original jurisdiction in proceedings concerning a juvenile under age 17 who is found within the county if any of the following apply:

-- The juvenile has violated any municipal ordinance or State or Federal law.
-- The juvenile has deserted his or her home without sufficient cause, and the court finds that the juvenile has been placed or refused alternative placement,

or the juvenile and his or her parent, guardian, or custodian have exhausted or refused family counseling.
-- The juvenile is repeatedly disobedient to the reasonable and lawful commands of his or her parents, guardian, or custodian, and the court finds that court-accessed services are necessary.
-- The juvenile is repeatedly truant from, or repeatedly violates rules and regulations of, school or another learning program, and the court finds that the juvenile, his or her parent, guardian, or custodian, and school officials or learning program personnel have met on the juvenile's educational problems and educational counseling and alternative agency help have been sought.)

"Chemical restraint" would mean a drug that is administered to manage a minor's behavior in a way that reduces the safety risk to the minor or others, has the temporary effect of restricting the minor's freedom of movement, and is not a standard treatment for the minor's medical or psychiatric condition.

Required Education & Training

Within 180 days after the bill's effective date, a child caring institution would have to require its staff to have ongoing education, training, and demonstrated knowledge of all of the following:

-- Techniques to identify minors' behaviors, events, and environmental factors that could trigger emergency safety situations.
-- The safe use of personal restraint or seclusion, including the ability to recognize and respond to signs of physical distress in minors who were in or being placed in personal restraint or seclusion.
-- The use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods to prevent emergency safety situations.

A child caring institution's staff would have to be trained in the use of personal restraint or seclusion, be knowledgeable of the risks inherent in the implementation of personal restraint and seclusion, and demonstrate competency regarding personal restraint or seclusion before participating in implementation. Staff would have to demonstrate their competencies in these areas on a semiannual basis. The FIA would have to review and determine the acceptability of the child caring institution's staff education, training, knowledge, and competency requirements and the training and knowledge required of a licensed practitioner in the use of personal restraint and seclusion.

("Licensed practitioner" would mean an individual who has been trained in the use of personal restraint and seclusion, who is knowledgeable of the inherent risks in implementation, and who is a licensed physician, a certified nurse practitioner, a licensed physician's assistant, a registered nurse, a limited licensed psychologist, or a limited licensed counselor. Until July 1, 2005, the term would include a certified social worker registered under the Public Health Code. After that date, the term would include a certified or master's level social worker registered or licensed under the Code.)

"Emergency safety situation" would mean the onset of an unanticipated, severely aggressive, or destructive behavior that places the minor or others at serious threat of violence or injury if no intervention occurs and that calls for an emergency safety intervention. "Emergency safety intervention" would mean the use of personal restraint or seclusion as an immediate response to an emergency safety situation.

Limits on Restraint & Seclusion

Personal restraint or seclusion could not be imposed as a means of coercion, discipline, convenience, or retaliation by a child caring institution's staff. An order for personal restraint or seclusion could not be written as a standing order or on an as-needed basis.

Personal restraint or seclusion could not result in harm or injury to the minor and could be used only to ensure the minor's safety or the safety of others during an emergency safety situation. Personal restraint or seclusion could be used only until the emergency safety situation had ceased and the safety of the minor and of others could be ensured, even if the order for personal restraint or seclusion had not

expired. Personal restraint and seclusion of a minor could not be used simultaneously.

Personal restraint or seclusion would have to be performed in a manner that was safe, appropriate, and proportionate to the severity of the minor's behavior, chronological and developmental age, size, gender, physical condition, medical condition, psychiatric condition, and personal history, including any history of physical or sexual abuse.

Notification of Restraint & Seclusion Policy

At the time a minor was admitted to a child caring institution, it would have to do all of the following:

-- Inform the minor and his or her parents or legal guardian of the provider's policy regarding the use of personal restraint or seclusion during an emergency safety situation that could occur while the minor was under the care of the child caring institution.
-- Communicate the provider's personal restraint and seclusion policy in language that the minor or his or her parent or legal guardian could understand, including American Sign Language, if appropriate; and procure an interpreter or translator, if necessary.
-- Obtain a written acknowledgment from the minor's parent or legal guardian that he or she had been informed of the provider's policy, and file it in the minor's records.
-- Give a copy of the policy to the parent or legal guardian.

The child caring institution would not be required to inform, communicate, and obtain the written acknowledgement from a minor's parent or legal guardian if the minor were within the care and supervision of the child caring institution as a result of an order of commitment of the family court to a State institution, State agency, or otherwise, and had been adjudicated to be a dependent, neglected, or delinquent under the juvenile code, if the minor's individual case treatment plan indicated that such notice would not be in the minor's best interest.

Order & Procedures

An order for personal restraint or seclusion could be written only by a licensed practitioner. A licensed practitioner would have to order the least restrictive emergency safety intervention measure that was most likely to be effective in resolving the emergency safety situation based on consultation with staff. Consideration of less restrictive emergency intervention safety measures would have to be documented in the minor's record.

If the order for personal restraint or seclusion were verbal, it would have to be received by a child caring institution staff member who was a licensed practitioner, a social services supervisor described in R 400.4118 of the Michigan Administrative Code, a supervisor of direct care workers as described in R 400.4120 of the Michigan Administrative Code, or a licensed practical nurse. (The administrative rules set forth requirements for the education and experience of these supervisors.)

A verbal order would have to be received while child caring institution staff were initiating personal restraint or seclusion or immediately after the emergency safety situation began. The licensed practitioner would have to be available to staff for consultation, at least by telephone, throughout the personal restraint or seclusion period. He or she would have to verify the verbal order in signed, written form in the minor's record.

An order for personal restraint or seclusion would be limited to the duration of the emergency safety situation. It could not exceed four hours for a minor who was 18 or older, two hours for a minor nine to 17 years old, or one hour for a minor under age nine.

If more than two orders for personal restraint or seclusion were ordered for a minor within a 24-hour period, the director of the child caring institution or his or her designated management staff would have to be notified to determine whether additional measures should be taken to facilitate discontinuation of personal restraint or seclusion.

If personal restraint continued for less than 15 minutes or seclusion continued for less than 30 minutes from the onset of the emergency safety intervention, the child caring institution staff qualified to receive a verbal order, in consultation with the

licensed practitioner, would have to evaluate the minor's physical and psychological well-being immediately after the minor was removed from seclusion or personal restraint.

A face-to-face assessment would have to be conducted if the personal restraint continued for at least 15 minutes or if seclusion continued for at least 30 minutes from the onset of the emergency safety intervention. The assessment would have to be conducted by an individual who had been trained in the use of personal restraint and seclusion, and who was licensed as a physician, a certified nurse practitioner, a physician's assistant, or a registered nurse. The assessment would have to be conducted within one hour of the onset of the intervention and immediately after the minor was removed from personal restraint or seclusion. The assessment would have to include, at a minimum, the minor's physical and psychological status and behavior, the appropriateness of the intervention measures, and any complications resulting from the intervention.

A minor would have to be released from personal restraint or seclusion whenever the circumstances that justified its use no longer existed. Each instance of personal restraint or seclusion would require full justification for its use, and the results of the evaluation immediately following the use of personal restraint or seclusion would have to be placed in the minor's record.

Each order for personal restraint or seclusion would have to include the name of the licensed practitioner ordering the restraint or seclusion; the date and time the order was obtained; and the personal restraint or seclusion ordered, including the length of time for which the practitioner ordered its use.

The child caring institution staff would have to document the use of the personal restraint or seclusion in the minor's record. The documentation would have to be completed by the end of the shift in which the restraint or seclusion occurred. If the restraint or seclusion did not end during the shift in which it began, documentation would have to be completed during the shift in which it ended. Documentation would have to include all of the following:

-- Each order for personal restraint or seclusion.
-- The time the personal restraint or seclusion actually began and ended.
-- The time and results of the one-hour assessment.
-- The emergency safety situation that required the resident to be restrained or secluded.
-- The name of the staff involved.

The child caring institution staff trained in the use of personal restraint continually would have to assess and monitor the minor's physical and psychological well-being and the safe use of personal restraint throughout its implementation.

The institution staff trained in the use of seclusion physically would have to be present in or immediately outside the seclusion room, continually assessing, monitoring, and evaluating the minor's physical and psychological well-being. Video monitoring could not be exclusively used to meet this requirement. The staff would have to ensure that documentation of staff monitoring and observation was entered into the minor's record.

If the emergency safety intervention continued beyond the time limit of the order, staff authorized to receive verbal orders for personal restraint or seclusion immediately would have to contact the licensed practitioner to receive further instructions.

As soon as possible after the initiation of personal restraint or seclusion, the staff would have to notify the minor's parent or legal guardian, and the appropriate State or local government agency that had responsibility for the minor if he or she were under the supervision of the child caring institution as a result of an order of commitment by the family court to a State institution or otherwise. The notification, including the date and time of the notification, the name of the staff person who provided it, and the name of the person to whom the notification was reported, would have to be documented in the minor's record.

The child caring institution would not have to notify the parent or legal guardian if the minor were within the care and supervision of the institution as a result of an order of commitment of the family court to a State

institution, State agency, or otherwise, and had been adjudged to be dependent, neglected, or delinquent under the juvenile code, if the minor's individual case treatment plan indicated that such notice would not be in the minor's best interest.

Debriefing

Within 24 hours after the use of personal restraint or seclusion, staff involved in the emergency safety intervention and the minor would have to have a face-to-face debriefing session that included all staff involved in the personal restraint or seclusion, unless the presence of a particular staff member could jeopardize the minor's well-being. Other staff members and the minor's parent or legal guardian could participate in the debriefing if the child caring institution considered it appropriate.

The institution would have to conduct a debriefing in a language the minor understood. The debriefing would have to give both the minor and the staff the opportunity to discuss the circumstances resulting in the use of personal restraint or seclusion and strategies the staff, the minor, or others could use to prevent the future use of personal restraint or seclusion.

Within 24 hours after the use of personal restraint or seclusion, all child caring institution staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, would have to conduct a debriefing session that included, at a minimum, all of the following:

-- Discussion of the emergency safety situation that required personal restraint or seclusion, including a discussion of precipitating factors that led up to the situation.
-- Alternative techniques that might have prevented the use of personal restraint or seclusion.
-- The procedures, if any, for staff to implement to prevent a recurrence of the use of personal restraint or seclusion.
-- The outcome of the emergency safety intervention, including any injury that might have resulted from the use of personal restraint or seclusion.

The staff would have to document in the minor's record that both debriefing sessions took place, and include the names of staff who were present and staff who were excused, and changes to the minor's treatment plan that resulted from the debriefings.

Reporting Serious Occurrences

Each child caring institution subject to the bill would have to report each serious occurrence to the FIA, which would have to make the reports available to the designated State protection and advocacy system upon request. (Under the Mental Health Code, the Governor is required to designate an agency to implement a program for the protection and advocacy of the rights of persons with developmental disabilities and mental illness. The designated agency has the authority to pursue legal, administrative, and other appropriate remedies to protect the rights of the developmentally disabled and the mentally ill and to investigate allegations of abuse and neglect. The designated agency is independent of any State agency that provides treatment or services other than advocacy services to persons with developmental disabilities and the mentally ill. Michigan Protection and Advocacy Services is the State-designated agency.)

Serious occurrences to be reported would include a minor's death, serious injury, or suicide attempt. Staff would have to report any serious occurrence involving a minor by the close of the next business day after the occurrence. ("Serious injury" would mean any significant impairment of the minor's physical condition as determined by qualified medical personnel that resulted from an emergency safety intervention, including burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.)

The report would have to include the name of the minor, a description of the occurrence, and the child caring institution's name, street address, and telephone number. The institution would have to notify the minor's parent or legal guardian, and, if the minor were under the institution's supervision as a result of a family court order of commitment, the appropriate State or local government agency that had responsibility for the minor, as soon as possible, and not later than 24 hours after

the occurrence. Staff would have to document on the minor's record that the serious occurrence was reported to both the FIA and the State-designated protection and advocacy system. The name of the person to whom notification of the incident was reported also would have to be documented. A copy of the report would have to be maintained in the minor's record, as well as the child caring institution's incident and accident report logs.

Record-Keeping; Reporting

Each child caring institution would have to maintain a record of the incidences in which personal restraint or seclusion was used for all minors. The record would have to include all of the following information:

-- Whether personal restraint or seclusion was used.
-- The setting, unit, or location in which personal restraint or seclusion was used.
-- Staff who initiated the process.
-- The duration of each use of personal restraint or seclusion.
-- The date, time, and day of the week restraint or seclusion was initiated.
-- Whether the minor or staff sustained injuries.
-- The minor's age and gender.

Each child caring institution annually would have to submit to the FIA a report containing the aggregate data from the record of incidences for each 12-month period as directed by the FIA. The FIA would have to prepare the reporting forms, aggregate the data collected from each child caring institution, and report the data annually to each child caring institution and the State-designated protection and advocacy system.

MCL 330.1742 (S.B. 231)
Proposed MCL 722.102b-722.102e (S.B. 1344)

BACKGROUND

Use of Restraint & Seclusion

In 1999, the U.S. General Accounting Office (GAO) issued a report entitled *Improper Restraint or Seclusion Use Places People at Risk.* The GAO identified components of successful strategies states had used to reduce the use of restraint and seclusion, including clearly defined policies and principles outlining when and how restraint may be used; a strong commitment by management to the philosophy that restraint should be an emergency technique and last resort, rather than a treatment; staff training in the safe use of restraint and seclusion, and alternative intervention techniques; and oversight and monitoring.

The GAO found that the use of restraint often involved physical struggling and pressure on the chest, which can cause interruptions in breathing. Among deaths in which restraint or seclusion was identified as a factor, the causes of death were asphyxiation, strangulation, cardiac arrest or other cardiac complications, fire, smoke inhalation, drug overdoses or interactions, blunt trauma, choking, and aspiration. The GAO also found numerous examples of physical injuries, such as bruising and broken bones, and severe trauma to patients, especially among those who had been sexually abused in the past.

The use of restraint and seclusion can be harmful to facility staff, as well, according to the report. It cited several studies documenting that most assaults on staff members by patients are committed during the application of restraint or seclusion, and that most staff injuries are sustained in trying to control violent patients.

The report noted that children were subjected to the procedures at higher rates than adults, and also were at greater risk for physical injury because employees accustomed to restraining adults did not adjust the force they used accordingly.

CMS Final Rule

The final rule (42 CFR 483) imposes procedural, reporting, and training requirements regarding the use of restraint and seclusion in non-hospital psychiatric facilities serving people younger than 21. It provides that each resident has the right to be free from restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation; prohibits the simultaneous use of restraint and seclusion; and prohibits an order for restraint or seclusion from being written as a standing order or on an as-needed basis.

The rule prohibits the restraint or seclusion from resulting in harm to the patient and continuing beyond the end of the emergency safety situation. Upon admittance, incoming residents and their parents must be notified of the facility's policy regarding the use of restraint and seclusion.

Under the rule, restraint and seclusion may be ordered only by a physician or other authorized licensed practitioner trained in the use of emergency safety interventions. The physician or licensed practitioner must order the least restrictive emergency safety intervention possible under the circumstances. Within one hour of the initiation of an intervention, the physician or other practitioner must conduct a face-to-face assessment of the resident.

The rule also sets time limits for the duration of restraint or seclusion, and requires every serious occurrence (i.e., a resident's death, serious injury, or suicide attempt) to be reported to the state Medicaid agency (the FIA in Michigan), and, unless prohibited by state law, the state-designated protection and advocacy system.

The rule requires facility staff to have ongoing education and training, and demonstrate knowledge, in identification of factors that may trigger emergency safety situations, the use of nonphysical intervention skills, and the safe use of restraint and seclusion. Additionally, staff must be certified in the use of cardiopulmonary resuscitation.

ARGUMENTS

(Please note: The arguments contained in this analysis originate from sources outside the Senate Fiscal Agency. The Senate Fiscal Agency neither supports nor opposes legislation.)

Supporting Argument

The bills would improve safety for residents and staff, as well as the quality of care children receive in child caring institutions that contract with a community mental health services program or prepaid inpatient health plan. Although the use of seclusion and all forms of restraint once were considered acceptable methods to control disobedient children, there is a growing consensus that these procedures sometimes do more harm than good, and should be implemented only by trained personnel and only when a clear threat is posed to residents and staff.

Due to a statewide trend toward the deinstitutionalization of mental health patients, child caring centers are treating greater numbers of children with more severe emotional disorders or disabilities than in the past. Some people believe that the use of seclusion or restraint sends a conflicting message to the troubled children who have been placed in what is supposed to be a safe, therapeutic environment. Often, a child who previously experienced neglect or abuse feels threatened by the implementation of seclusion or restraint and only becomes more aggressive. If facility staff had more training in de-escalating a potential emergency safety situation before restraint or seclusion became necessary, presumably residents would be more trusting of staff and more open to treatment. This, in turn, would help child caring institutions avoid the need for a licensed practitioner to conduct a face-to-face exam, a requirement that child caring institutions have difficulty meeting.

Undoubtedly, residents of child caring institutions sometimes behave in ways that endanger themselves, other children, and workers. Implementation of seclusion or restraint, however, can be dangerous, or even deadly, for residents and staff. A person can suffocate when restrained in certain positions. In some cases, restricting movement might interfere with the way a person's body metabolizes medication he or she is taking, endangering his or her life. When it becomes necessary to restrain a person physically, or place him or her in a room alone, it is imperative that the treatment be done by trained staff who know which techniques should be avoided due to the potential for injury or death, and can recognize signs that a person is in physical distress.

In situations in which a child's behavior endangered his or her own safety or that of others, the bills would ensure that the child was restrained or secluded safely and appropriately. Senate Bill 1344 (S-2) incorporates many of the key provisions of the Federal rule, including the prohibition against employing restraint or seclusion except as an emergency safety intervention, the requirement that the procedures be ordered only by a health professional trained

in their use and inherent risks, parental notification requirements, time limits, debriefings, and reporting requirements. Furthermore, Senate Bill 1344 (S-2) would prohibit the use of mechanical and chemical restraint, and allow only the use of personal restraint.

The reporting and record-keeping requirements under the bill also would help improve resident and staff safety. According to the GAO report described above, the lack of a comprehensive reporting system for deaths and injuries in which restraint or seclusion was a factor prevented the true scope of the problem from being known. Under the bill, in addition to reporting serious occurrences to the FIA and Michigan Protection and Advocacy, a child caring institution would have to keep a record of all uses of personal restraint and seclusion, and submit an annual report to the FIA. This would help child caring institutions to discover patterns in their use of personal restraint and seclusion, and the circumstances that lead to emergency safety situations; and identify aspects of their policies and procedures that need to be improved.

As updated by the bills, Michigan's policy regarding the use of restraint and seclusion on minors would reflect an increasingly accepted philosophy that health care workers should not employ either of those procedures as a treatment, but only as a last resort in a potentially dangerous situation. The bills should lead to a reduction in the need for restraint and seclusion, and ensure that this population of vulnerable children received appropriate treatment in an environment that would protect their safety and dignity.

Legislative Analyst: Julie Koval

FISCAL IMPACT

Senate Bill 231 (S-1)

The bill would have no fiscal impact on State or local government.

Senate Bill 1344 (S-2)

The bill would have an indeterminate impact on the Family Independence Agency. The State licenses approximately 300 child caring institutions, of which 10% are institutions serving children receiving community mental health services that would be affected by the bill. The requirements for reporting, developing and preparing report forms, collecting data, and preparing reports would result in some administrative costs; the amount cannot be determined at this time.

Fiscal Analyst: Steve Angelotti
Constance Cole

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