RECOMMENDATIONS FROM THE SAFETY WORKGROUP

A Temporary Workgroup of the System of Care Advisory Council

Convened by the System of Care Advisory Council

May 2023

SAFETY WORKGROUP PARTICIPATION

The recommendations in this report were prepared for the System of Care Advisory Council (SOCAC) by the Safety Workgroup, a temporary workgroup of the SOCAC that met between March and May of 2023. Organizations that participated in the Workgroup are the following:

- Albertina Kerr
- Greater Oregon Behavioral Health Inc.
- Jasper Mountain Agency
- Looking Glass Community Services
- Morrison Child & Family Services
- NAMI Multnomah
- Oregon Community Programs
- OHSU Division of Child and Adolescent Psychiatry
- Oyen Emotional Wellness Center
- Providence Health & Services
- Rimrock Trails Treatment Services
- Trillium Family Services

Workgroup members included clinical leaders, managers and directors of programs, and psychiatrists with a range of roles. At least ten Workgroup participants identified as family members or people with lived experience in the youth system, some of whom also represented organizations, but others who were there as individuals.

State agency representatives from the Oregon Health Authority, the Oregon Department of Human Services, and the Oregon Youth Authority participated as Subject Matter Experts, rather than organizational Workgroup members.

ENDORSERS

The following organizations have reviewed and endorsed the recommendations in this report.

- Greater Oregon Behavioral Health, Inc.
- Jasper Mountain Agency
- Kaiser Permanente Northwest
- Legacy Health
- Looking Glass Community Services
- Morrison Child & Family Services
- Oregon Alliance
- Oregon Child & Family Center for Excellence
- Oregon Community Programs
- Oregon Council for Behavioral Health
- Oregon Council of Child & Adolescent Psychiatry
- Oregon Health & Sciences University
- Oyen Emotional Wellness Center
- Parrot Creek Child & Family Services
- Providence Health & Services
- Rimrock Trails Treatment Services
- Trillium Family Services

SAFETY WORKGROUP RECOMMENDATIONS
MAY 2023

INTRODUCTION

The System of Care Advisory Council (SOCAC) asked the Safety Workgroup to make recommendations to (1) improve outcomes for youth with a recent history of aggression who need residential care and to (2) ensure safety for those youth and the providers who work with them.

The Workgroup met six times between March 8th and May 10th. Participation in the Workgroup included clinical leaders, managers and directors of programs, psychiatrists with a range of roles, family members, people with lived experience in the youth system, and state agency representatives from the Oregon Health Authority (OHA), the Oregon Department of Human Services (ODHS), and the Oregon Youth Authority (OYA). Agency representatives served as Subject Matter Experts rather than organizational Workgroup participants.

The problem the Workgroup sought to address is the lack of access to a full continuum of services for youth with aggressive behaviors. Many of these youth do not move through the continuum of care and are unable to access appropriate levels of care, such as residential or subacute, due to concerns about their aggression. This may leave them in the wrong level of care without options to either move down or up the continuum. Sometimes youth with aggressive behaviors are released back to their homes and families without sufficient services. For youth who are already in the custody of the state, such as child welfare or juvenile justice, aggressive behaviors can lead to additional escalation into those systems – leading to temporary lodging, juvenile detention, or close custody rather than treatment and care.

The ability to serve youth with aggressive behaviors has been impacted significantly due to wrongful restraint investigations, most of which are unfounded or ultimately dismissed. According to data from the Office of Training, Investigations and Safety (OTIS), in 2022, out of 118 allegations of wrongful restraint in Child Caring Agencies (CCAs), 2.5% (or three) allegations were founded. Many programs will not accept youth with a recent history of aggression due to concerns about staff turnover and risk. Staff feel unable to maintain safety, and fear being investigated for abusing or neglecting youth if they make a mistake during difficult situations. Staff also are fearful when they believe they have made a correct decision to protect a youth or staff member's safety, but have put themselves at risk because the regulatory framework does not make allowances for difficult situations that aren't easily addressed.

The Workgroup's recommendations are grounded in a framework that centers trauma-informed services within a trauma-informed system (see below). The overriding goal of the recommendations is to improve care and safety of youth and the providers who work with them and to increase the system's capacity to serve these youth so they can get the care they need when they need it.

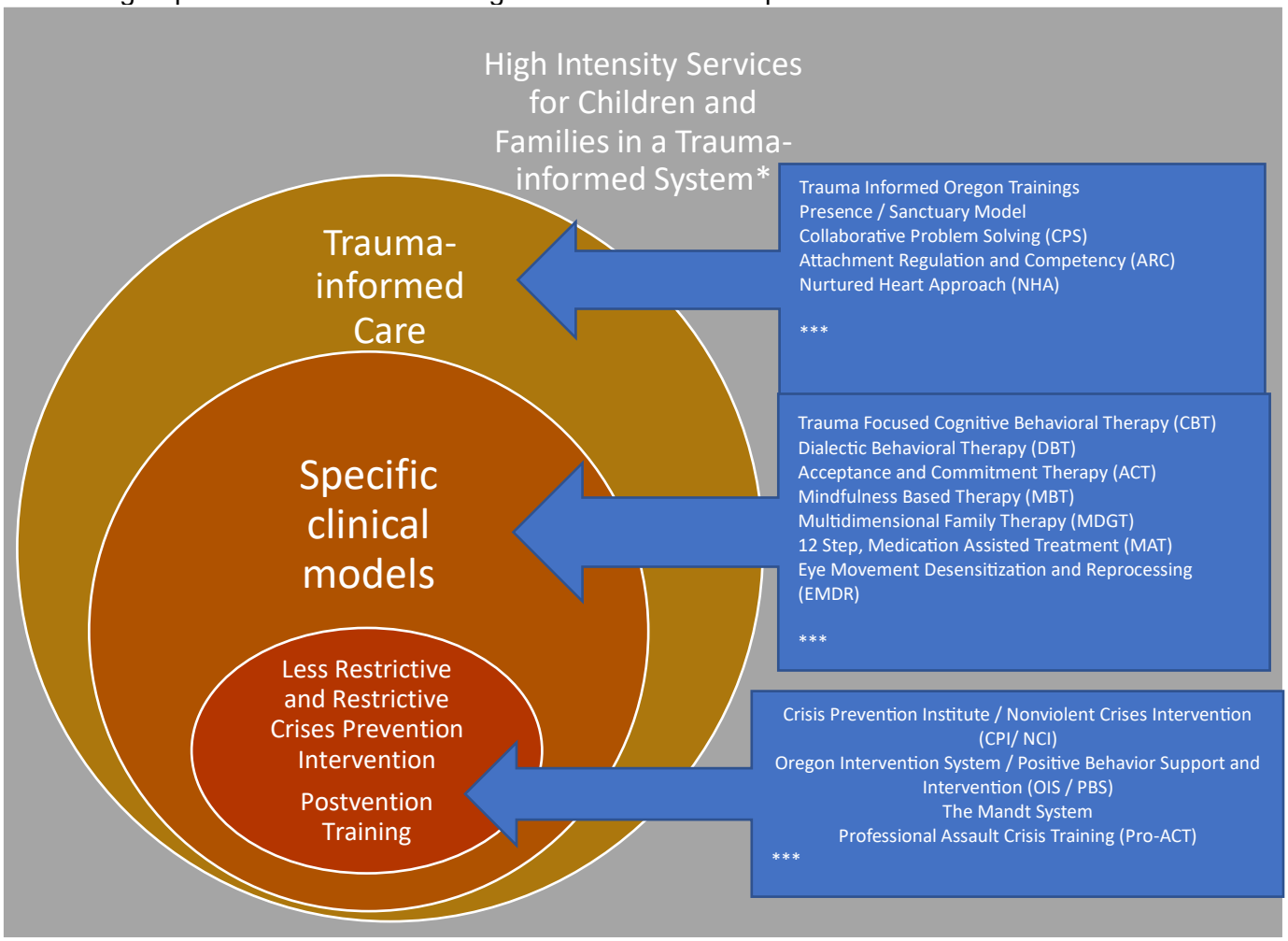
The Workgroup identified a number of the barriers to capacity, quality care and safety:

- Regulatory language and practices do not align with a trauma-informed system which is a prerequisite to successful implementation of high-quality services as well as staff and foster care retention.
- Although programs are invested in the implementation of trauma-informed care, appropriate clinical models, and crisis prevention, intervention and postvention services, they do not have the funds to implement to fidelity.
- Programs are significantly hampered by regulatory language that is not compatible with evidence-based programs, especially at the crisis intervention level.
- The behavioral health system is sometimes forced to send youth with aggressive behaviors to the juvenile corrections system, even though both systems recognize this is not the best place for them to receive treatment.

- Quality improvement practices are severely limited by the lack of retention of those who are trained to be trainers.
- The state's current punishment-oriented oversight structure does not support true quality improvement processes, open dialogue, and analysis of adverse outcomes in youth-serving behavioral health settings.

TRAUMA-INFORMED SYSTEM: THE FOUNDATION

A trauma-informed system is the critical foundation for a responsive, effective, and high-quality eco-system that serves all youth including those who have a history of aggression. Secure, well-regulated relationships can bring well-being and better health to all which is possible in trauma-informed systems. The Workgroup's recommendations are grounded in this concept.



Ajit Jetmalani, M.D.
Professor of Child and Adolescent Psychiatry
Oregon Health & Science University

*** Example Practices***

** The Legislature, Governor's Office, state agencies, and CCOs connect to families by providing funding, policies, oversight, resources, and access to culturally sustaining healing focused practices. A trauma-informed system does these things with flexibility, transparency, collaboration, and thoughtful investments (flexible funding, regional expectations, reasonable oversite, funding for workforce stability, etc.…)* Mandy Davis, Executive Director, Trauma Informed Oregon.

** A trauma-informed child and family service system is one in which all parties involved recognize and respond to the impact of traumatic stress on those who have contact with the system including children, caregivers, and service providers. Programs and agencies within such a system infuse and sustain*

trauma awareness, knowledge, and skills into their organizational cultures, practices, and policies. They act in collaboration with all those who are involved with the child, using the best available science, to maximize physical and psychological safety, facilitate the recovery of the child and family, and support their ability to thrive."[1]

ADDITIONAL CONSIDERATIONS

The Workgroup also outlined key ingredients for successful treatment for youth who have aggressive behaviors and need residential treatment. These components include the following:[2]

- Relationally focused and trauma informed at all levels
- State oversight of direct service and supports
- Leadership focused on improving outcomes for youth
- Workforce support and development
- Active youth and family engagement in treatment planning and system design
- Services that are:
    - Culturally and linguistically competent
    - Center diversity, equity, and inclusion
    - Data and quality driven
    - Fiscally flexible
    - Centering support for and development of permanency planning
    - Able to integrate the treatment of substance use disorder and mental illness and services for intellectual or developmental disabilities
    - Developmentally appropriate
- Financial structures and regulatory practices that align and enhance creativity and continuous quality improvement and a trauma-informed environment
- Fully integrated and supported in the continuum of care
- Physical settings are properly sized with access to nature and community when appropriate

RECOMMENDATIONS

RECOMMENDATIONS RELATED TO STATUTORY FRAMEWORK

Along with enhancing staff training, improving the regulatory framework is the Safety Workgroup's highest-priority recommendation. The Workgroup believes these regulatory changes will facilitate better outcomes for youth with aggressive behaviors and increase safety for youth and those who care for them.

⇒ **Separate child abuse statute from licensing requirements.**

The Workgroup believes licensing requirements must be rigorous to ensure quality care and safety for youth. However, licensure requirements should not exist within the child abuse investigation statutes, as is currently the case in Oregon. The Safety Workgroup recommends a clear separation in statute between licensing requirements and the investigation of potential child abuse.

⇒ **Amend statute related to child abuse to define when a restraint or seclusion is child abuse.**[3]

The Safety Workgroup recommends amending the statute related to child abuse. This revision would include identifying definitions for key terms by looking to training programs (CPI, MANDT and OIS)

---

[1] https://www.nctsn.org/trauma-informed-care/creating-trauma-informed-systems.

[2] Based on *Transforming Residential Interventions; Practical Strategies and Future Directions, 2020 and Safety Workgroup Consensus opinion.*

[3] *See Appendix D for an example of what might be included in an amended statute focused on child abuse.*

and other widely utilized, standardized, and accepted clinically based definitions, including definitions across other settings, such as statutes regulating the system that cares for individuals with intellectual or developmental disabilities. It is also important to remove the "abuse" label for mistakes in incident management where it is clear that no child abuse or neglect occurred.

In the statute, terms that need clinically based, clear, and aligned definitions include:

- Physical intervention
- Less restrictive/non-restrictive intervention
- Prohibited restraint
- Serious bodily injury/major physical contact

⇒ **Expand the permissible use of restraint to Psychiatric Residential Treatment Services (PRTS) and mental health subacute facilities when necessary for a youth's safety and care.**

The Workgroup recommends allowing limited seclusion and restraint in PRTS and subacute facilities when necessary for a youth's safety in care, based on evidence-based clinical standards and with appropriate oversight from a certifying body. Any expansion of the permissible use of seclusion or restraint must include comprehensive clinical oversight and training and demonstrated investment and implementation of trauma-informed care as an agency. For example, there could be a process that programs have to complete in order to be authorized to utilize seclusion and restraint, when necessary, clearly identifying situations where such interventions would be required for the safety of the youth in care. While providers do not want to use restraint and seclusion, it is sometimes necessary for short time periods when a youth is unable to self-regulate. The Workgroup supports adaptive, trauma-informed, physical interventions when children are at a reasonable risk of serious bodily injury to themselves, and other, less restrictive interventions would not effectively reduce the risk.

⇒ **Provide a forum for providers, OHA, ODHS, OYA and the juvenile justice system to collaborate in the best interest and outcomes of youth with severe aggression.**

Coordination and collaboration across state agencies along with providers is an important component to ensuring a trauma-informed system that adequately and safely serves youth. In particular, the behavioral health and the justice systems could work together more effectively to serve youth. This will require increased communication and coordination through a venue such as the System of Care Advisory Council.

⇒ **Amend licensing requirements to be less prescriptive while setting meaningful standards for licensing to provide oversight.**

Rather than prescribe exact times or words like "continuous," shift language to reflect best practice in training and licensure that allows providers to tailor care to each youth to keep them safe in specific circumstances.

For example, the statute currently states: *If any restraint or involuntary seclusion lasts for more than 10 minutes, the child-caring [agency] must provide adequate access to the bathroom and water at least every thirty minutes to the child in care.* Rather than set a time limit in state law, the governing rule should ensure "adequate access" to a supervised, trained individual who is regularly authorizing the restraint. This would allow providers to focus on the care and safety of the youth rather than on meeting and documenting in response to regulations that don't allow flexibility for clinical circumstances. Further, as indicated above, this type of requirement belongs in the licensure statute, not the child abuse statute.

Adjusting the regulatory framework is an important step to addressing quality, safety, and capacity. According to Mandy Davis, Executive Director of Trauma Informed Oregon, "There are many ways

policy makers can support a trauma-informed system. From the beginning policy makers can use the principles of trauma-informed care as a framework to write and review policies. Asking questions such as *does this policy hinder or promote choice for those served and the workforce? Or will this policy hinder or promote trust for those impacted by the policy.* In addition to using trauma-informed care as a lens for reviewing policies, legislators are in the position to pass policies across the life space that will have an impact on our ability to effectively prevent, mitigate, and/or reverse the impacts of trauma."

RECOMMENDATIONS RELATED TO TRAINING AND STAFFING

One of the key goals of the recommendations is to ensure staff have effective training and support so they can best care for youth with aggressive behaviors. An emphasis on training and support can eliminate fear, and make sure that mistakes, errors, and/or lack of training leads to assistance and provision of necessary resources. The science of implementation of these practices requires ongoing support as well as competency and outcome measures.

⇒ **Create an SOCAC Best Practices Committee co-led by providers, family, and youth in collaboration with agencies**. This group would:

- Review and endorse trauma-informed care and crises intervention practices (ongoing).
- Review and endorse clinical models that address the needs of youth with mental health, developmental disabilities, and/or substance use disorder (ongoing).
- Review and recommend competency and outcome measures.
- Review and recommend other innovative practices regarding care in residential facilities as well as transitions of care.
    - The state (potentially through the SOCAC) could provide financial resources for national consultation identified as training needs by the Best Practices Committee.

⇒ **Contract via the state with national training entities to achieve more cost-effective training implementation and maintenance.**

⇒ **Develop grants for programs and foster parents to engage in training, consultation, and coaching with evidence-based programs and practices endorsed by the Best Practices Committee.**

⇒ **Form a provider-led Continuous Quality Improvement (CQI) system in which residential providers can share expertise, consult with each other, and learn together in a protected space similar to medical CQI.**

In addition, OHA and SOCAC should work together to determine whether internal use of video monitoring is permissible to review high-risk events for quality improvement purposes without the requirement to edit (mask identities) and distribute.

⇒ **Create a new position description and meaningful pay differential for staff who complete "train the trainer" certification to provide real time consultation and coaching in the field as well as to promote staff retention and career advancement.**

While exact details may differ across provider agencies, this recommendation is meant to ensure opportunities for staff advancement which is key to recruitment and retention.

Recommendations Related to Creating a Culture of Continuous Quality Improvement

People who hurt children due to malice or their own emotional regulation challenges have no place as providers. That said, the ability to serve youth with aggressive behaviors has been impacted significantly due to wrongful restraint investigations, most of which are unfounded or ultimately dismissed, as indicated above. Overall, the process and frequency of investigation is traumatizing to the work force, has substantially decreased the availability of experienced clinical managers on the floor, and can aggravate distrust and erode the relationship between staff and youth.

Oregon has embraced the Family First Prevention Services Act (FFPSA) which moves away from punitive practices in protecting youth from abuse and neglect towards supporting families with added services. The same principles should apply to foster parents and residential providers in terms of shifts in tone and practice. The Just Culture Model is closely aligned with the principles of FFPSA and trauma-informed systems and would align well with the system of care model currently in implementation across Oregon.

⇒ **Review OTIS data on unsubstantiated allegations for minor, unintentional staff errors that do not result in harm to the youth and revise process based on findings to drive reductions in un-necessary investigations.**

⇒ **Explore opportunities to increase support to staff and proctor foster parents when an investigation is assigned.**

- Revive OTIS training on investigation process for providers and new employees.
- Ensure quality control and consistency amongst the approaches of investigators.
- Ensure OTIS oversight is implemented in trauma-informed and developmentally appropriate ways regardless of changes in leadership and personnel.
- Utilize the principles of Just Culture which facilitates open dialogue and learning in a continuous improvement environment.

Recommendations Related to Funding, Capacity and Transitions Out of Care

The Workgroup believes that the recommendations around the regulatory framework and training are the priorities to work towards better outcomes for youth, build capacity in the system, and improve safety for youth and providers. In addition, sufficient transitions out of residential care are crucial to allow youth to heal and ensure they do not need to return to residential simply because their transition was ineffective. Youth need ongoing supports after discharge.

⇒ **Change contracting and funding mechanisms.**

- Implement capacity-based system funding which incorporates an analysis of desired outcomes, necessary evidence-based models, and implementation science.
- Consider additional approaches to payment such as prioritized support and funding to develop specialized/co-occurring service array, funding for small milieu size, etc., as evidence supports.
- Increase flexibility for the step-down process to allow youth to be co-enrolled in multiple services at residential exit (e.g., opportunity to do longer home stays with access to local services, but still return to residential setting as needed).
- Create short-term access to crisis respite beds to avert the need for some residential admissions.
    - Facility-based respite would help build a healthy system. Regional differences in resources to use for building a respite system and needs for respite should be addressed by OHA in the planning and rule-making phase, so the state can support each region with appropriate guidance and resources to create a functional respite model that's culturally appropriate.

⇒ **Expand mental health and substance use disorder treatment facility capacity.**

The Workgroup believes that the current regulatory environment is a significant barrier for providers who might otherwise be willing to increase their capacity by adding additional residential beds or services. The Workgroup hopes that the recommendations provided throughout this document, if enacted, will begin to create a regulatory environment that is safe for youth who need care, supportive to the people who work with those youth, and welcoming to providers who wish to add capacity to meet the urgent need for residential services for youth in Oregon.

SUMMARY: THE URGENCY FOR CHANGE AND THE DIFFERENCE IT CAN MAKE

The statement in Appendix A is from a youth who was in treatment and is now a provider. Her experience illustrates the challenges of caring for youth who have aggressive behaviors and need residential treatment and the promise of hope and a recovery when youth have access to clinically appropriate treatment. An excerpt from her story is below:

I needed to build relationships and gain skills for self-management. I had space to learn how to correct my behaviors. I was mirroring my own physical abuse into the world, my response to feeling threatened or when I perceived someone was being aggressive to me (even verbally). Anytime that would happen, it would bring up my past trauma and my only strategies were what I had been taught – using aggressive behavior to force someone to listen. I needed space, time, skills, therapies. DBT was extremely helpful….I never once experienced a hold that was overly aggressive or used for retribution. …When aggressive behaviors happen, youth are being transported back to the time when the trauma happened. In my personal experience, safe physical intervention brought me back into my body so I could regulate. I used to go into blackout mode where I was reliving some trauma from the past, and no verbal interaction would get into my head. A touch, a hug, a weighted blanket would help me come back into my mind, and sometimes holds are a necessary part of this intervention. Some programs should be able to specialize in these types of kids with lower ratios, so other programs would have less of a risk… I know that other Black and Latino kids have not had the same good experience with residential care in Oregon and across the country– my experiences in residential worked for me and we can do this for other youth. In Oregon's residential programs, I experienced equality and equity. We were cared for and kept safe, not treated as a matter of our race or background, and I want that to be highlighted…There is so much bad in the world, but we in Oregon aren't trusting our goodness. We have so many good things here and our residential providers are okay. The bad actors are caught and removed quickly because the workers care about doing right by the kids. We have to trust that and build on it.

* * *

APPENDICES

The following appendices provide context and background for the Safety Workgroup's recommendations. Appendix A is a statement from a Workgroup participant who was a recipient of services and is now a provider. Appendix B outlines the principles adopted by the System of Care Advisory Council that served as grounding principles for the Safety Workgroup. Appendix C describes the Safety Workgroup's vision for youth who have aggressive behaviors and need residential treatment. Appendix D offers an example of how statutes could be revised to separate and clarify licensing requirements and child abuse statutes. Appendix E is a link to a report produced by NAMI Multnomah based on interviews of youth who self-identified as BIPOC.

Appendix A

Corrinne's Story, May 2023

One participant on the Safety Workgroup is a Black woman who was a youth with aggressive behaviors and received residential services in Oregon between 2010 and 2015. She is now a provider of residential services and shared her reflections on the changed regulatory environment from the time she was in care to now when she provides it. This woman's name has been changed to protect confidentiality. She will be referred to as Corrine for this narrative report.

Corinne was in voluntary treatment from a young age until her mother signed custody of her over to ODHS-Child Welfare at age 13. Corrine had over 40 different placements throughout her time in foster care. Those placements include Morrison, Trillium, Farm Home, and Give Us This Day (now closed). She had a significant history of aggressive behavior, which was a catalyst for her needing residential treatment.

Corrine described that her experience in residential services included a number of restraints and seclusions. She reflected that those experiences were teaching moments for her, as she learned how to regulate her emotions and behaviors in more pro-social ways. Quotes from her story are included below:

I was in SCIP for adolescents for aggressive behavior and a therapist signed off on a seclusion plan for me. That actually worked because it was a wake-up call – people were getting hurt, they wanted to keep me safe. It was much, much better than ending up with criminal charges. I would spend 2 hours maximum in a safe seclusion room. This was a time out, not solitary confinement. I always had someone watching me through a 1-way mirror, so when you're in seclusion you know you're safe from a suicide attempt or self-harm.

I'm so grateful that I had a chance to correct my behaviors with providers who could use restraints when needed and seclusion when appropriate. I was given away to the state by my guardian. I needed to build relationships and gain skills for self-management. I had space to learn how to correct my behaviors. I was mirroring my own physical abuse into the world, my response to feeling threatened or when I perceived someone was being aggressive to me (even verbally). Anytime that would happen, it would bring up my past trauma and my only strategies were what I had been taught – using aggressive behavior to force someone to listen. I needed space, time, skills, therapies. DBT was extremely helpful.

After being in treatment for a year and a half, I felt the fatigue of that. You can feel like you'll never get out, so some kids will act out to try to get to a new setting as their only option. In residential, you get attached to your connections with workers. Knowing you're leaving is very scary, especially if you're being reunified to a family that didn't participate in the therapeutic process. These kids know they're going back to the same place that harmed them, so they lash out to stay where they feel safe (in treatment).

I never once experienced a hold that was overly aggressive or used for retribution. I did get triggered and sometimes used aggressive behaviors toward people who had set boundaries with me. Never did I feel

they retaliated or lashed out at me back. I'm not saying it can't happen, but I never saw it when I gave them every reason to do so."

Now, as a provider of residential services, Corrine has been forced to press charges against youth who have violated their safety plans by engaging in physical aggression. Quotes from her reflections on this new regulatory environment are included below:

When aggressive behaviors happen, youth are being transported back to the time when the trauma happened. In my personal experience, safe physical intervention brought me back into my body so I could regulate. I used to go into blackout mode where I was reliving some trauma from the past, and no verbal interaction would get into my head. A touch, a hug, a weighted blanket would help me come back into my mind, and sometimes holds are a necessary part of this intervention. Some programs should be able to specialize in these types of kids with lower ratios, so other programs would have less of a risk.

When I think of the providers doing this work now – would that work? What can we do to take the most aggressive kids to a few facilities who are allowed to provide the level of safety they need to provide? Right now, aggressive kids go from the hospital to OYA and end up with criminal records – that's not acceptable.

Now, we can't do holds in residential without a lot of restrictions. The result is that kids are discharged before they're treated, and more and more kids are ending up with criminal charges because we can't keep them safe – only OYA can take them. That's not fair.

They can't change the trauma they've experienced, now there's no space for them to work through this with people who know how to help them. It's just not fair.

I know that other Black and Latino kids have not had the same good experience with residential care in Oregon and across the country– my experiences in residential worked for me and we can do this for other youth. In Oregon's residential programs, I experienced equality and equity. We were cared for and kept safe, not treated as a matter of our race or background, and I want that to be highlighted.

Ten years ago, Oregon was doing the right thing for kids of color in residential. I was treated with compassion and care and respect, and it changed the person I am today. I would not be doing the work I am doing today without the treatment I got as a person in residential.
There is so much bad in the world, but we in Oregon aren't trusting our goodness. We have so many good things here and our residential providers are okay. The bad actors are caught and removed quickly because the workers care about doing right by the kids. We have to trust that and build on it.

Corrine provided the following recommendations:

- Decrease the fear of penalties for providers who need to use physical intervention or seclusion to help youth learn to regulate their behavior.
- Provide an anonymous way to report bias in residential care, overuse of holds, and unjustified holds. It could be a 'safety line' to report any concerns about your own or your child's experience in residential care. It should be included information during intake – 'here's a number you can call to report your concerns anonymously, so your youth isn't worried about retaliation for sharing a concern.' Those reports should be shared with the oversight body and reported publicly so they don't get swept under the rug. The regulatory body can prescribe training or investigations as a response.
- Increase funding for workers and youth involved in holds. Create a fund to pay for mental health days, so workers don't feel so badly about taking time off to care for themselves. *Right now, I feel guilty taking a day off because it causes so much stress on my co-workers.* For youth who witness or experience a hold, this fund could help pay for a sensory blanket or other tools to help youth learn to regulate. Think of it as a restorative justice fund – if a kid breaks a clock, they get

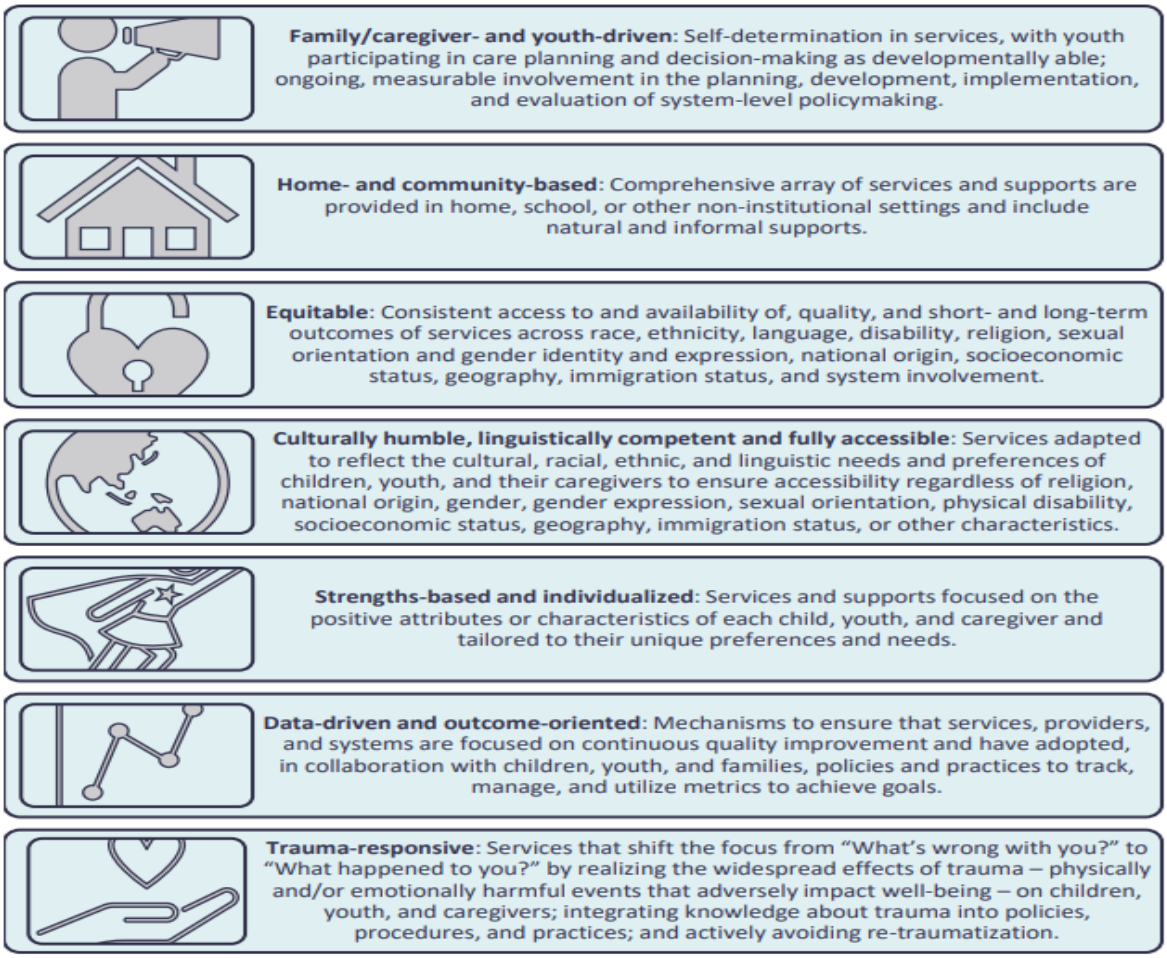
funds to pay for a new one and help the facility find a replacement, so they learn about the impact of their behaviors on others. The fund could pay for workers to support youth in volunteering in the community or beautifying the facility as a way to do repair and healing work.

- Train everyone in the facility, including youth, how to speak up if they have a concern about a hold or restraint. The MANDT system says holds can't last longer than 3 minutes. At that time, you must let go and re-engage if a youth continues aggressive behavior. For most programs, as soon as the hold starts, the youth regulates and you don't need to engage for more than a minute or two. If someone has a concern and speaks up, we can protect kids and teach them how to speak to people with power over them in respectful, meaningful ways.

Appendix B

Principles adopted by the System of Care Advisory Council that served as grounding principles for the Safety Workgroup

Figure 1: Systems of Care Values in Service Planning and Provision. Adapted from Stroul, B.A., Blau, G.M., & Larsen, J. (2021). The Evolution of the System of Care Approach. Baltimore: The Institute for Innovation and Implementation.



Appendix C

Vision

The Safety Workgroup's vision for youth who have aggressive behaviors and need residential treatment is as follows:

- Extensive evaluation so services are appropriate
- Expedience in identifying and beginning appropriate residential treatment program
- A safe, reliable, and stable residential treatment program
- An overall environment that is conducive to healing, including the physical facility
- Provision of appropriate strengths-based and individualized services
- Youth and family voice/choice are centered and youth and families are participating in leadership and oversight as well as employed by agencies
- Families are intimately involved in the care of their child
- Services end at the appropriate time, accompanied by solid transition services/plans
- Staff are supported, consistent and stable, and find joy in their work
- Programs, policies, services, support to staff, and messaging to youth are trauma informed

Appendix D

RELATED TO RECOMMENDATION TO SEPARATE THE LICENSURE REQUIREMENTS FROM CHILD ABUSE STATUTE AND CLARIFY DEFINITION OF CHILD ABUSE

⇒ **Amend statute to define when a restraint or seclusion is child abuse.**

Below is an example of a revised child abuse statute that is separate from the licensing statute.

Amend ORS 418.257(1)(i) to include:
(i) Use of prohibited restraint.
(j) Use of prohibited seclusion.

Further define the following:
"Restraint" means a physical intervention that impacts a child's liberty of movement.

- *The Safety Workgroup recommends identifying a definition of "physical intervention" by looking to training programs (CPI, MANDT and OIS) and other widely utilized, standardized, and accepted, clinically based definitions, including definitions across other settings, such as IDD statutes.*

"Less restrictive/nonrestrictive intervention" means…

- *The Safety Workgroup recommends identifying a definition of either "less restrictive" or "nonrestrictive intervention" by looking to training programs (CPI, MANDT and OIS) and other widely utilized, standardized, and accepted, clinically based definitions.*

"Prohibited restraint" means [insert definition of restraint] and any of the following:

(a) The use of restraint was a form of discipline, punishment, retaliation, or for convenience.
(b) The use of restraint was not justified as there was no imminent risk of serious bodily injury to the child or others.
(c) Excessive force was used during a restraint.
(d) A drug or medication was administered to a child to control behavior or restrict freedom of movement.
(e) A device was used to restrict the movement of a child or the movement or normal function of a portion of the body of a child.
(f) The child was held face down on the floor in a prone restraint.
(g) A child is held face up on the floor in a supine restraint. A supine restraint is permissible when used by a secure children's inpatient treatment program or secure adolescent inpatient treatment program.
(h) A solid object, including the ground, a wall or the floor, was intentionally used to impede a child's movement and was not necessary to gain control of a weapon.
(i) The restraint placed, or created a risk of placing, pressure on a child's neck or throat.
(j) The restraint placed, or created a risk of placing, pressure on a child's mouth and was not necessary for the purpose of extracting a body part from a bite.
(k) The restraint impeded, or creates a risk of impeding, a child's breathing.
(l) The restraint involved the intentional placement of a hand, foot, elbow, knee or any object on a child's neck, throat, genitals or other intimate parts.
(m) The restraint caused pressure to be placed, or creates a risk of causing pressure to be placed, on a child's stomach, chest, joints, throat or back by a knee, foot, or elbow.
(n) The restraint's primary purpose was to inflict pain.

- *The Safety Workgroup recommends a review of where (g) and (h) are permitted and the clinical oversight and training that must accompany any expansion*.

“Seclusion” means the confinement of a child in care alone in a room or an enclosed space from which the child in care is prevented from leaving by any means.

"Prohibited seclusion" means the confinement of a child alone in a room or an enclosed space from which the child is prevented from leaving by any means, when:
(I) The use of seclusion was a form of discipline, punishment, retaliation, or for convenience.
(II) The use of seclusion was not justified as there was no imminent risk of serious bodily injury to the child or others. Serious bodily injury means

“Serious bodily injury/Major physical contact means…

- *The Safety Workgroup recommends identifying a definition of “serious bodily injury or major physical contact” by looking to training programs (CPI, MANDT and OIS) and other widely utilized, standardized, and accepted, clinically based definitions. The threshold has to be reasonable - the current definition seems overly restrictive. OIS has potentially helpful language that should be researched.*

Appendix E
Improving Psychiatric Residential Treatment Services for BIPOC Youth in Oregon, NAMI Multnomah, August 2022.