

May 28, 2014

Elizabeth Timm
Office of Childcare Licensing
1825 Faulkland Road
Wilmington, DE 19805

RE: DFS Proposed Residential Child Care Facility and Day Treatment Program Regulation [17 DE Reg. 1043 (May 1, 2014)]

Dear Ms. Timm:

The Governor's Advisory Council for Exceptional Citizens (GACEC) submitted extensive comments on earlier versions of this regulation in 2013. The Division of Family Services (DFS) Office of Child Care Licensing is now publishing another set of revised regulations. The existing regulations are being deleted in their entirety in favor of the new set of standards. Council has reviewed the newly proposed regulations issued by the Division of Family Services (DFS) and would like to share the following observations.

1. In §1.3, definition of "residential child care facility", psychiatric hospitals and foster homes are excluded from coverage. However, the status of a pediatric skilled nursing facility is unclear. Exceptional Care for Children in Newark is an example. The Department of Health and Social Services (DHSS) apparently licenses such facilities pursuant to Title 16 Del.C. §§1119B and 1119C. However, such facilities may also meet the DFS definition of "residential child care facility". DFS should clarify coverage or non-coverage of pediatric nursing facilities.
2. In §1.4, definition of "Administrative Hearing", the reference to "...place the facility on the enforcement actions of Warning..." is awkward language. DFS may wish to revise the reference.
3. Section 17.3 contemplates Human Rights Committee (HRC) review of "restrictive procedures" and "proper treatment". It is unclear if DFS envisions HRCs reviewing

psychotropic medications. Section 1.4, definition of “restrictive procedure”, only covers drugs which qualify as a “chemical restraint”. The definition of “chemical restraint” excludes “the planned and routine application of a prescribed psychotropic drug”. Therefore, if a child were prescribed heavy daily doses of multiple psychotropic drugs, the HRC may arguably lack jurisdiction to review. By analogy the Division of Developmental Disabilities Services (DDDS) HRCs review regularly prescribed psychotropic drugs administered in covered facilities, including co-DHSS/DFS regulated AdvoServ. DFS may wish to consider whether HRC review of psychotropic drugs excluded from the definition of “chemical restraint” merit HRC review.

4. In §1.4, definition of “Consultant”, there is a plural pronoun (their) with a singular antecedent (practitioner). Consider substituting “the practitioner’s” for “their”.

5. In §1.4, definitions of “Exclusion” and “Locked Isolation”, it is somewhat inconsistent to categorically bar the use of unlocked exclusion for kids under age six but have no equivalent limit for locked isolation. DFS may wish to consider adding a similar age standard in the definition of “locked isolation”.

6. In §1.4, the definitions of “exclusion” and “time-out technique” are not well differentiated. Placing a child in an unlocked classroom or office would fit both definitions. Section 3.12.9.3.2 reinforces the overlap by stating that “time-out” may not occur in a closet, bathroom, unfinished basement or attic. The implication is that placement in other rooms is an acceptable use of “time-out”. If a provider were considering placement of a child under age six in an unlocked room, that would be barred under the “exclusion” definition (and §17.1.2) but allowed per §3.12.9.3.3 if characterized as “time-out”.

7. A related abnormality to that described in paragraph six is that an exclusion requires “continuous” monitoring (§1.4, definition of “exclusion”; §17.5.1.1) while time-out only requires a visual check every 30 minutes (§3.12.9.3.2). If a provider wishes to avoid the continuous monitoring requirement, the provider would simply characterize placing a child in an unlocked room as “time-out”. Moreover, the implication of 30-minute checks is that “time-out” periods are extended. Clinically, a time-out should permit some time to reflect and regain self-control. A time-out should not last for hours. Children should not be left unobserved for extended periods of time. Cf. §3.12.9.3.3, time-out for children under six should not exceed one minute for each year of age.

8. Section 17.5.1.1 raises a similar concern. Within each two hours of a restrictive procedure, a child is given an opportunity for 10 minutes of release. Based on the definition of “restrictive procedure”, this suggests that extended periods of mechanical restraint, locked isolation, and exclusion are acceptable norms. This section could also be interpreted to authorize a facility to limit access to a toilet to once every two hours. The structure of the DFS regulations appears to allow sequential use of restrictive procedures resulting in extended isolation. For example, §17.5.1.1, in combination with §17.7.1.3, authorizes a two hour locked isolation followed by a 10 minute break, another two hour locked isolation followed by a 10 minute break, and then a third two hour locked isolation. In a similar manner, §§17.5.1.1 and 17.6.1 and 17.6.2, “exclusions” can be “stacked” resulting in removal of a child to an unlocked room for an hour, followed by a 10 minute break, which can be repeated for a total of six hours. Similarly, per

§§17.5.1.1 and 17.9.1.4, “mechanical restraints” can be “stacked” resulting in two hours of mechanical restraint, followed by a 10 minute break, followed by another two hours of mechanical restraint. Limits on “consecutive minutes” of a restrictive procedure (e.g. §17.7.5 and 17.9.1.4) are easily circumvented by allowing short breaks for toileting or stretching. DFS may wish to consult the Division of Prevention and Behavioral Health Services (DPBHS) to assess whether the regulations noted above conform to contemporary clinical standards in the field. The Terry Center has converted its former seclusion room to a children’s store.

9. There is some “tension” between §3.12.10.1.3 and 17.5.1.1. The former section contemplates the release of a child from a restraint after no more than 15 minutes while the latter would authorize restraint for at least two hours.

10. In §3.5.5, DFS requires a “direct care worker” (who only needs a high school diploma) to be at least 21 years of age. Some states have promoted college students working as support staff in group homes and similar facilities since they generally represent a demographic group with some intellectual ability. Students seeking degrees in social work, psychology, etc. may be very interested in working in a Residential Treatment Center (RTC) or specialized child care setting for experience. However, since §3.5.5 requires a direct care worker to be 21, many college students would be categorically barred from such employment. DFS could consider either: a) reducing the age to 18; or 2) adopting a standard of at least 21 or, if the applicant is a college student, 18. DFS could also consider only allowing employment of 18-20 year old college students with a minimum number of credits in a social services field (e.g. social work; psychology).

11. In §3.12.5.5, DFS may wish to add a reference to referrals to the Pathways to Employment program for qualifying adolescents. See 17 DE Reg. 1070 (May 1, 2014).

12. There are several authorizations to use restraint to prevent destruction of property. See, e.g. §1.4, definition of “non-violent physical intervention strategies”; and §3.12.10.1.2. When the Legislature adopted Senate Bill No. 100 in 2013, it did not authorize the use of restraints in public school educational settings based on property destruction. See 14 Del.C. §4112F(b)(2). If a child is tearing paper, throwing a pencil or eraser, or ripping buttons off his/her clothes, the DFS regulation authorizes the use of physical and possibly mechanical restraint. DFS may wish to at least consider a more “restrained” authorization. For example, if the property destruction implicates a threat of bodily harm (e.g. throwing a desk or punching a wall), restraint may be justified. The DFS regulation is simply too broad in authorizing restraint based on any, even minor, property destruction.

13. Section 4.7.1 can be interpreted in two ways: a) facilities must be free of lead paint hazards if they accept kids under six who either have an intellectual disability or severe emotional disturbance; or b) facilities must be free of lead paint hazards if they accept kids under age six OR with intellectual disabilities of any age OR with severe emotional disturbance of any age. Council suspects that DFS intends the latter. Moreover, the term “severely emotionally disturbed” violates Title 29 Del.C. §608 and should be modified. However, Council feels that facilities must be free of lead paint hazards regardless of the age or intellectual or emotional disability of the child.

14. In §7.0, DFS should consider adding a provision to address electronic cigarettes. See attached statement from the American Lung Association and articles describing House Bill No. 241 and House Bill No. 309.

15. Section 3.12.10.1.4 requires persons implementing physical intervention strategies to be “specifically trained in its use...and have current certification, if applicable.” This standard is very unclear and confusing. When is a certification applicable? Does some in-house training suffice?

Thank you in advance for your time and consideration of our observations. Please feel free to contact me or Wendy Strauss should you have any questions.

Sincerely,

Terri A. Hancharick
Chairperson

TAH:kpc

Attachments