



STATE OF DELAWARE
STATE COUNCIL FOR PERSONS WITH DISABILITIES

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MEMORANDUM

DATE: May 29, 2014

TO: Ms. Elizabeth Timm, DFS
Office of Child Care Licensing

FROM: Daniese McMullin-Powell, Chairperson
State Council for Persons with Disabilities

RE: 17 DE Reg. 1043 [DFS Proposed Residential Child Care & Day Treatment Program Regulation]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Services for Children, Youth and Their Families/Division of Family Services (DFS)/Office of Child Care Licensing's proposal to amend the *DELACARE: Requirements for Residential Child Care Facilities and Day Treatment Programs*. The proposed regulation was published as 17 DE Reg. 1043 in the May 1, 2014 issue of the Register of Regulations. The SCPD submitted extensive comments on earlier versions of this regulation and has the following observations on this latest version.

First, 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. DHSS ostensibly 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 may wish to clarify coverage or non-coverage of pediatric nursing facilities.

Second, 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.

Third, Section 17.3 contemplates 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 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.

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

Fifth, in §1.4, definitions of “Exclusion” and “Locked Isolation”, it is somewhat anomalous to categorically bar use of unlocked exclusion for kids under age 6 but have no equivalent limit for locked isolation. DFS may wish to consider adding a similar age standard in the definition of “locked isolation”.

Sixth, 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 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 6 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”. In general, SCPD believes that children should not be left unobserved when in “exclusion” or “time-out”.

Seventh, a related anomaly to that described in the preceding paragraph 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. Cf. §3.12.9.3.3, time-out for children under 6 should not exceed 1 minute for each year of age. In general, as noted in Par. 6, SCPD believes that children should not be left unobserved when in “exclusion” or “time-out”.

Eighth, Section 17.5.1.1 raises a similar concern. Within each two (2) 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 appear to allow sequential use of restrictive procedures resulting in extended isolation. For example, §17.5.1.1, in combination with §17.7.1.3, authorize a 2 hour locked isolation followed by a 10 minute break, another 2 hour locked isolation followed by a 10 minute break, and then a third 2 hour locked isolation. Similarly, per §§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 an aggregate of six (6) hours. Similarly, per §§17.5.1.1 and 17.9.1.4, “mechanical restraints” can be “stacked” resulting in 2 hours of mechanical restraint, followed by a

10 minute break, followed by another 2 hours of mechanical restraint. Temporal 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 to toilet or stretch. DFS may wish to consult DPBHS to assess whether the above regulations conform to contemporary clinical standards in the field. The Terry Center has converted its former seclusion room to a children’s store.

Ninth, 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 2 hours.

Tenth, 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 wherewithal. Students seeking degrees in social work, psychology, etc. may be very interested in working in an 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).

Eleventh, 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).

Twelfth, 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 S.B. 100 in 2013, it did not authorize 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 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 “loose” in authorizing restraint based on any, even minor, property destruction.

Thirteenth, Section 4.7.1 can be interpreted in two ways: a) facilities must be free of lead paint hazards if they accept kids under 6 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 6 OR with intellectual disabilities of any age OR with severe emotional disturbance of any age. SCPD suspects DFS intends the latter. SCPD recommends that the DFS regulations be more strident so there are requirements for a safe environment and requirements to remediate any lead paint hazard. In addition, the term “severely emotionally disturbed” violates Title 29 Del.C. §608 (respectful language when referring to persons with disabilities) and should be modified.

Fourteenth, in §7.0, DFS should consider adding a provision to address electronic cigarettes. See attached statement of the American Lung Association and articles describing H.B. 241 and H.B.

309.

Fifteenth, 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 is a rather ambiguous standard. When is a certification applicable? Does some in-house training suffice?

Thank you for your consideration and please contact SCPD if you have any questions or comments regarding our observations or recommendations on the proposed regulation.

cc: Ms. Vicky Kelly
Brian Hartman, Esq.
Governor’s Advisory Council for Exceptional Citizens
Developmental Disabilities Council

17reg1043 dscyf-dfs residential child care facility 5-29-14



American Lung Association Statement on E-Cigarettes

The American Lung Association is very concerned about the potential safety and health consequences of electronic cigarettes, as well as claims that they can be used to help smokers quit. There is no government oversight of these products and absent Food and Drug Administration (FDA) oversight, there is no way for the public health, medical community or consumers to know what chemicals are contained in e-cigarettes or what the short and long term health implications might be. That's why the American Lung Association has called on the Obama Administration to halt its delay and for the FDA to propose meaningful regulation of these products to protect to the public health.

The FDA has not approved e-cigarettes as a safe or effective method to help smokers quit. When smokers are ready to quit, they should call 1-800-QUIT NOW or talk with their doctors about using one of the seven FDA-approved medications proven to be safe and effective in helping smokers quit.

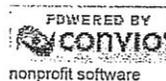
A study has estimated that there are 250 different e-cigarette brands for sale in the U.S. today. There is likely to be wide variation in the chemicals that each contain, but in initial lab tests conducted by the FDA in 2009, detectable levels of toxic cancer-causing chemicals were found, including an ingredient used in anti-freeze, in two leading brands of e-cigarettes and 18 various cartridges. That is why it is so urgent for FDA to begin its regulatory oversight of e-cigarettes, which would include ingredient disclosure by e-cigarette manufacturers to FDA.

Also unknown is what the potential harm may be to people exposed to secondhand emissions from e-cigarettes. Two initial studies have found formaldehyde, benzene and tobacco-specific nitrosamines (a carcinogen) coming from those secondhand emissions. While there is a great deal more to learn about these products, it is clear that there is much to be concerned about, especially in the absence of FDA oversight.

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