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Mary Adèr, Deputy Director
Legislation, Regulations and Public Affairs
Department of Developmental Services
1215 O Street
Sacramento, CA 95814

Re: Community Crisis Homes and Enhanced Behavioral Support Homes - Proposed Regulations Notice File Number: Z2022-0524-07

Dear Ms. Adèr

Disability Rights California (DRC) submits these comments in response to the proposed regulations related to Community Crisis Homes and Enhanced Behavioral Support Homes.

DRC is California's protection and advocacy agency and the nation's largest non-profit disability rights law firm, mandated under state and federal law to protect and advance the rights of people with disabilities. 42 U.S.C. § 15001 et seq., 29 U.S.C. § 794e et seq.; 42 U.S.C. § 10801 et seq., Welf. & Inst. Code §4900 et seq. Our work includes advocating for the rights of people with disabilities to live in inclusive, integrated settings and investigating the use of abusive practices such as the inappropriate or excessive use of restraints. Disability Rights California contracts with the Department of Developmental Services (DDS) to provide clients' rights advocacy services to over 400,000 individuals served by regional centers, including children and adults placed in Community Crisis Homes and Enhanced Behavioral Support Homes.

We acknowledge and applaud DDS's commitment to developing a robust safety net to support individuals who may become involved in the criminal legal, child welfare, or behavioral health systems, or who are at risk of placement in

institutional, carceral, and other highly restrictive settings. Community Crisis Homes and Enhanced Behavioral Support Homes are a key part of this safety net. However, we fear that regulations permitting the use of restraints (along with other regulations not addressed here allowing these facilities to utilize locked doors and fences) put these homes at risk of turning into the very types of institutional placements they are designed to prevent.[1]

Our comments are primarily rooted in signifigant concerns about the use of restraints in these settings, and especially the addition of supine restraints as an acceptable "emergency intervention." Supine restraint – *a type of restraint where a person is held to the floor in a face-up position using physical pressure on their body* – creates an unacceptably high risk of asphyxiation – *the condition of being unable to breathe*. Additionally, all restraints, and especially restraints used as an extended procedure or where people are forcibly held to the ground, are harmful and traumatic to the people subjected to these practices and the staff who implement them. This is contrary to the recognition of trauma-informed care throughout the regulatory structure.

We also offer comments about additional, necessary safeguards to reduce the risk of dangerous outcomes when restraints are used, to ensure that people served have the ability to meaningfully participate in the debriefing process, and as well as other comments which we believe will bring greater consistency and clarity to the regulations.

Supine Restraints are Dangerous and Should Be Prohibited; Alternatively, *Any* Restraint that Prohibits Breathing Should Not be Allowed

> Supine restraint is the most restrictive physical restraint permitted and its (mis)use poses the greatest threat to the health and safety of the individual being restrained and to staff.
>
> -- DDS Initial Statement of Reasons, pp. 42, 43, 122

We appreciate DDS's recognition that forcibly subjecting people to supine restraints is a dangerous act. Although DDS's Initial Statement of Reasons does

[1] Restraint usage is common to institutions, but not in places people call home. Indeed, the federal Home and Community-Based Settings (HCBS) Final Rule requires all HCBS-funded settings to have home-like characteristics, which means in part that the setting ensures an individual's rights of privacy, dignity, respect, and **freedom from . . . restraint**. 42 CFR § 441.301(c)(4)(iii).

not describe why supine restraint "poses the greatest threat to the health and safety" to individuals and staff, its harmful effects are well-documented.[2] However, while DDS rightfully recognizes the risks associated with supine restraints, the regulatory solutions it presents does not adequately address these risks. For example:

1. Adding a definition of "supine restraints" to the regulatory structure may have the unintended consequence of expanding, not reducing their use.
2. Training requirements for facility administrators may reduce, but will not eliminate, risks associated with supine restraints.
3. Although the proposed changes require facilities to develop plans to systematically fade the use of supine restraints, there are no requirements for facilities to *actually* fade their use.
4. There are new requirements for facility administrators to report supine restraint usage to DDS, but no clarity or requirements about how or in what way DDS will review or act on this information.

As such, we recommend that DDS take the same approach to supine restraint that it has taken with other dangerous interventions such as prone restraint and seclusion: prohibit them.[3]

Alternatively, we recommend that DDS adopt the approach to restraint used in Health and Safety Code section 1180.4(c)(1): rather than focus on the *name* or *position* of the restraint, focus on the *action*. Under this framework, *any* physical restraint or containment technique that obstructs a person's respiratory airway or impairs the person's breathing or respiratory capacity is prohibited, which would include supine restraints where a staff member places their body weight against a person's torso.

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[2] National Review of Restraint Related Deaths of Children and Adults with Disabilities: The Lethal Consequences of Restraint, Equip for Equality Special Report, 2011, Available at: https://www.equipforequality.org/wp-content/uploads/2014/04/National-Review-of-Restraint-Related-Deaths-of-Adults-and-Children-with-Disabilities-The-Lethal-Consequences-of-Restraint.pdf; Morrison, L., P. Duryea, C. Moore, A. Nathanson-Shinn, "The Lethal Hazard of Prone Restraint: Positional Asphyxiation," Protection and Advocacy, Inc. (April 2002); Holden, J.C., et al, Cornell University RCP, 2008 Prone/Supine Perception Survey and Literature Review Comparison Study 4 (2008). Holden, J., Ph.D., "Are Supine Restraints Safer Than Prone Restraints?" Refocus: The Residential Child Care Project Newsletter 12 (2007): 4.

[3] Prone restraint is a prohibited emergency intervention where a person is held to the floor in a face-down position using physical pressure on their body is a prohibited emergency intervention. 17 CCR §§ 59010.1; 59060.1. Seclusion is the involuntary confinement of a consumer alone in a room or an area from which the consumer is physically prevented from leaving. *Id*.

Trauma-Informed Care Means Working to Eliminate the Use of Restraints

> A trauma-informed approach to care is based on the recognition that many behaviors and responses expressed by [people] are directly related to traumatic experiences that often cause mental health, substance abuse, and physical health concerns. For many [people], treatment facilities perpetuate traumatic experiences through invasive, coercive, or forced treatment that exacerbates feelings of threat, violation, shame, and powerlessness. The use of seclusion and restraint is considered coercive and is often retraumatizing.
>
> -- Promoting Alternatives to the Use of Seclusion and Restraint, U.S. Dept. of Health and Human Services, March 2020, https://www.samhsa.gov/sites/default/files/topics/trauma_and_violence/seclusion-restraints-1.pdf

We welcome DDS's focus on trauma-informed care throughout these regulations and the related efforts in the regulatory scheme to limit the use of restraints. However, the prevention and reduction of permissible restraints should not be the singular goal of trauma-informed care. Restraints *are* trauma. *Eliminating* restraint is a trauma-informed practice.

The regulations are a good start. For example, the proposed regulations require Individualized Emergency Intervention Plans to "include a description of the plan to systematically fade the use and inclusion of supine restraint in the Individualized Emergency Intervention Plan" and for facilities to submit those plans to DDS. *See* proposed regulation at 17 CCR §§ 59010(d)(11), 59060(d)(11). But two important elements are missing from these regulations:

1. A plan to fade the use and inclusion of supine restraint does not actually ensure that supine restraints will be faded. Nor do the regulations provide clarity about what DDS will do with the information it receives, or if it will ensure that the facility follows the fading plan.

2. The department has an opportunity to embrace trauma-informed care by similarly requiring Individualized Emergency Intervention Plans to include a plan to systematically fade the use of *all* restraints, not just supine restraints.

DDS, in its initial statement of reasons, discussed how the inclusion of trauma-informed care exemplifies the importance and foundation for this model of care. We look forward to working with DDS to achieve this vision.

Additional Clarity is Needed to Ensure People Served Understand How They Can Participate in the "Debriefing Process"

The addition of a "debriefing process" following the use of a physical restraint is a necessary for all the reasons DDS described in its initial statement of reasons. We also agree that the person served should be an essential part of the debriefing. However, the regulations do not clearly outline how and under what circumstances the person can participate in this process, or the implications if they are experiencing trauma that prevents their ability to atttend a debriefing session under the prescribed timelines. For example:

1. The facility must conduct a debriefing no later than 24 hours after each use of restraint. The debriefing "shall include" the consumer "unless the consumer voluntarily declines." 17 CCR §§ 59010.4, 59060.4. This standard is problematic and inconsistent with principles of trauma-informed care. For example, if the person does not want to participate because they are too traumatized, or because they cannot or will not be in the same room as the staff who restrained them, that is not the same thing as saying they don't want to participate in the debriefing.

   We recommend that if the consumer does not want to or is unable to participate in the debriefing directly/in-person, the facility be required to make every effort to at least obtain the consumer's input in some alternative manner (e.g. through a separate interview/written report or via Zoom, where possible) before a refusal to participate can be considered truly voluntary.

2. The regulations also require that the debriefing "include individuals requested by the consumer." 17 CCR §§ 59010.4, 59060.4. However, they lack necessary clarity about the circumstances under which a a debriefing may proceed without the participation of this person. On the one hand, the language says the debrief "shall" include such individuals, but on the other hand, goes on to say such individuals "are not required to attend."

   Similarly, the regulations state that the debriefing "may also include the clients' rights advocate and a regional center representative with approval

from the consumer." *Id.* But they lack clarity about what triggers an invitation to the debriefing meeting and who holds the authority to make the request.

3. Lastly, the amendment making "any individual(s) deemed necessary by the consumer . . . " an *optional* instead of *required* member of the "Individual Behavior Supports Team" is wholly inconsistent with person-centered planning and trauma-informed care. *See* 17 CCR §§ 59000(a)(28), 59050(a)(27). More troublingly, it also has the impact of removing essential protections in the aftermath of a restraint. For example, without the presence of individuals *deemed necessary* by the consumer, the narrative of "what happened" will exclusively be told from the perspective of the facility or by the staff who did the restraining. Making individuals *deemed necessary* by the consumer an optional member of the team may also chill the ability of people from outside the facility to observe, first-hand, signs of trauma or injury or support the person experiencing trauma. The proposed amendment should not go forward.

<u>Additional Safeguards are Needed to Reduce the Risk of Injury or Death When Restraints are Used</u>

Restraints are dangerous interventions that can result in severe injury or death. For this reason, we support the strong oversight mechanisms in the regulations before, during, and after restraints are used. We offer the following suggestions to further minimize restraint-related risks.

1. 17 CCR §§ 59010.2(c)(3); 59060(c)(3): For restraint usage over 15 consecutive minutes, the proposed regulations require "the person who approves continuation of the physical restraint" to "observe the consumer's behavior while the consumer is being restrained to determine whether continued use of physical restraint is justified." We recommend DDS use the more stringent requirments of Health and Safety Code section 1180.4(i), which requires "face-to-face human observation" under specified conditions.

2. 17 CCR §§59010.2(e); 59060(e): For restraint usage over 30 consecutive minutes, the proposed regulations require visual checks "to ensure the consumer is not injured, that consumer's personal needs are being met, and that the continued use of the physical restraint is justified." Visual observation alone is not enough to identify injury or harm. At this point (and any point beyond 15 minutes), we recommend that the person's vitals also be checked.

We also question how and under what circumstances a person could pose an *imminent* danger for over 30 consecutive minutes, letalone be forcibly restrained by staff for such an extended period of time.

3. 17 CCR §§ 59010.2(f),(g),(h); 59060(f),(g),(h): Additional, escalating layers of approval are necessary for restraint usage over 60 minutes, all the way up to 2 *consecutive* hours. This is not enough. Restraint usage for this amount of time must be strictly prohibited.

   Health and Safey Code section 1180.4(h) prohibits restraints as an extended procedure, defined as anything over 15 consecutive minutes. We acknowledge that Health and Safey Code section 1180.4(h) also gave DDS the authority to adopt regulations that authorize exceptions to the 15-minute maximum set forth in statute. However, these regulations — *which authorize the use of restraint as an extended procedure for 8 times the statutory maximum* — cannot be read as consistent with the underlying statute or what the legislature intended when it gave DDS this regulatory authority.

<u>Additional Safeguards Are Needed to Prevent Short-Term Community Crisis Homes from Becoming “Long-Term” Placements</u>

The proposed regulations require transition planning to begin as soon as an individual is placed in a community crisis home. There are also regulatory limits on the length of stay an individual can be placed in this setting: 18 months if the person is placed in an adult Community Crisis Home; 12 months for Crisis Homes for children. Beyond that, any additional day(s) must be approved by the DDS and reviewed monthly thereafter. 17 CCR § 59009.5.

However, there are no clear standards in the regulations that detail how and whether DDS can exercise its discretion to approve *or* reject an extension. This creates the ability for DDS to potentially approve placements indefinitely, which runs counter to the statute’s emphasis on “*time-limited* objectives and a plan to transition the consumer to his or her prior residence or an alternative community-based residential setting. . .” Welf. & Inst. Code § 4698.1(a)(2). We recommend amendments that create a higher level of “scrunity” for subsequent extentions that exceed a certain period of time, such as 6 or 9 months. This could come in the form of additional requirements that different approaches or interventions be attempted, or new assessments be tried.

The Use of Law Enforcement as an “Community Emergency Service” Should be Prohibited

The proposed regulations define “Community Emergency Services” as “law enforcement, crisis teams, or intensive transition services.” 17 CCR §§ 59000(a)(11); 59009.5(a)(10). They also permit facilities to call law enforcement when an incident escalates beyond what they think they can control and permit facilities to define for themselves the criteria that would necessitate law enforcement involvement. 17 CCR §§ 59002 (a)(7)(D)(4); 59052(a)(7)(D)(4).

The use of law enforcement as an *affirmative* emergency service should be prohibited. Law enforcement does not have the requisite expertise to respond to people with intellectual and developmental disabilities in crisis. But more broadly, for too many disabled people and people of color, law enforcement brings trauma instead of safety, betrayal instead of justice. Encounters with law enforcement also have dire consequences, including the death of the person served.[4] Between one-third and one-half of all police use of force incidents involve a person with a disability.[5]

We recommend that the regulations specify that facilities must make every effort to avoid bringing residents in crisis into contact with law enforcement. Facilities should instead employ all their expertise in de-escalation and utilize alternative crisis response teams where available.

Thank you for the opportunity to submit these comments. If you have any questions or would like to further discuss, please reach out to William Leiner at william.leiner@disabilityrightsca.org or (510) 267-1237.

[4] *See* DRC’s report on the death of Nikolai Landry, a service recipient killed by police in the backyard of his group home, *available at*: https://www.disabilityrightsca.org/latest-news/the-anderson-police-departments-shooting-of-nikolai-landry-a-person-living-with-a

[5] David M. Perry & Lawrence Carter-Long, The Ruderman White Paper On Media Coverage of Law Enforcement Use of Force and Disability, Ruderman Family Foundation 7 (March, 2016), *available at*: https://rudermanfoundation.org/wp-content/uploads/2017/08/MediaStudy-PoliceDisability_final-final.pdf.