HAVENWYCK HOSPITAL

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June 3, 2021

Michigan Department of Health and Human Services (MDHHS)
Children's Services Agency - Division of Child Welfare Licensing
Rules for Child Caring Institutions
Rule Set 2020-39 HS

Dear MDHHS,

My name is Jenifer Nyhuis and I am the Chief Executive Officer at Havenwyck Hospital. Located in Auburn Hills, Havenwyck Hospital operates a licensed child caring institution (CCI) program. Havenwyck's program offers a 30 bed male sexual impulse disorder residential program for adolescents ages 9-17. Adolescents enrolled in the program have been unable to function successfully at home, in school or in other non-specialty residential programs and require a secure, 24-hour supervised, specialized mental health setting.

Below you will find concerns expressed by my staff and me, along with suggested revisions to the proposed draft rules for child caring institutions.

- Page 3 (j): We are asking MDHHS to consider adding "sexual assault" to the definition of "emergency restraint." Because Havenwyck's CCI specifically treats adolescents with sexual impulse disorders we believe this is a necessary addition.

  The following in red is our suggested changes for MDHHS' consideration: **"Emergency restraint" means the onset of an unanticipated or severely aggressive behavior that places the youth or others at serious threat of violence, sexual assault, or injury if no immediate intervention occurs.**

- Page 29 R 400.4160: We are asking MDHHS to consider striking "as a lifesaving response." This language is concerning due to the severity of the stated threshold. The indication for emergency restraint is clearly listed and defined in the bullets under this section. It is our belief that intervention should not be withheld until lifesaving measures are needed as we strive to never reach the level of lifesaving intervention for a fellow resident or staff member. The definition for emergency restraint is sufficient and ensures the overall safety of residents and staff alike.

HAVENWYCK HOSPITAL

The following in red is our suggested changes for MDHHS' consideration: Rule 160. ~~(1) Prior to establishing a seclusion room, an institution shall obtain written approval from the department's licensing authority and the department of licensing and regulatory affairs, bureau of fire services.~~ **The use of emergency restraint ~~as a lifesaving response~~ of a youth will be limited to:**

(a) An emergency response to protect the youth or others from ~~immediate serious physical harm, as that term is defined in section 136b (1) (f) of the Michigan Penal Code, 1931 PA 328, MCL 750.136b.~~ an unanticipated or severely aggressive behavior that places the youth or others at serious threat of violence, sexual assault, or injury if no immediate intervention occurs.

(b) When all other interventions in the agency crisis prevention and intervention plan and the youth's individual safety and calming plan have been utilized but fail to protect the youth or others from ~~serious physical harm.~~ unanticipated or severely aggressive behavior that places the youth or others at serious threat of violence, sexual assault, or injury if no immediate intervention occurs.

We thank MDHHS for the opportunity to provide our public comments regarding the proposed rules for child caring institutions. We appreciate the department's time and consideration of our suggested revisions. We fully support the department's efforts towards ending all seclusion and nonemergent physical restraints in child caring institutions. Havenwyck is committed to providing compassionate and safe care to our residents as well as a safe and supportive environment for our staff who are dedicated to providing this care.

Sincerely,

HAVENWYCK HOSPITAL

Jenifer Nyhuis

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Public Comment on CCI Licensing Rule Changes - Sleeping Rooms

Dear Committee Members,

The ACLU of Michigan commends the department for thoroughly reviewing the licensing standards to create more robust support for youth within Child Caring Institutions. The ACLU has a long history of working to ensure that lesbian, gay, bisexual, transgender, & queer people belong everywhere and can live openly and authentically without discrimination, harassment, or violence. We would like to **express support for the proposed rule changes, specifically protections for youth with diverse sexual orientation, gender identity, and expression (SOGIE)** in R 400.4137 on sleeping rooms. We endorse the language as written, based on the following:

1. **The vulnerabilities of children with diverse SOGIE are well-documented, and reinforce the need for placement consistent with gender identity that prioritizes youths' views about their own safety**. Youth with diverse SOGIE often suffer harms as a consequence of rejection and social marginalization[1]. Due to pervasive rejection and bias in their homes, schools and communities, children with diverse SOGIE experience high rates of depression, suicidality, substance use, physical and sexual victimization, and homelessness. Family conflict, verbal harassment, school bullying, and physical assault constitute the harsh daily reality for too many of these young people[2]. Social conditions for transgender girls of color are particularly brutal. Child caring institutions should consider these factors related to physical and emotional safety when making placement decisions, as the rule language outlines.

2. **While children with diverse SOGIE are a particularly vulnerable population with unique developmental tasks, they also have the same inherent capacity for happiness, achievement, and healthy adjustment as other children.** Placing children with diverse SOGIE in unsafe or hostile settings exacerbates their isolation, instability, and trauma, and significantly compromises their health and opportunities. Placing them with loving, supportive adults who provide a safe atmosphere in which they can explore and develop their identities maximizes their potential to thrive and become healthy adults. **Placements that consider a youth's diverse SOGIE and prioritize youth's views about their own safety and wellbeing not only nurture children but help protect them from negative effects of living in an otherwise unaccepting society.** By adopting and implementing gender affirming policies and practices, child caring institutions promote the safety, permanency, and well-being of children with diverse SOGIE.

In summary, the proposed language will enhance the wellbeing of youth with diverse SOGIE. We at The ACLU of Michigan appreciate the time and effort put into the proposed amendments and ask that you vote in support of the changes to R 400.4137.

Thank you for the opportunity to share our perspective,

Jay Kaplan, LGBT Project Staff Attorney
ACLU of Michigan

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1 Brian A. Rood, Sari L. Reisner, Francisco I. Surace, Jae A. Puckett, Meredith R. Maroney, and David W. Pantalone.Transgender Health.Dec 2016.151-164.http://doi.org/10.1089/trgh.2016.0012; Pariseau, E. M., Chevalier, L., Long, K. A., Clapham, R., Edwards-Leeper, L., & Tishelman, A. C. (2019). The relationship between family acceptance-rejection and transgender youth psychosocial functioning. *Clinical Practice in Pediatric Psychology, 7*(3), 267–277. https://doi.org/10.1037/cpp0000291

2 Higa D, Hoppe MJ, Lindhorst T, et al. Negative and Positive Factors Associated With the Well-Being of Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQ) Youth. Youth & Society. 2014;46(5):663-687. doi:10.1177/0044118X12449630

B. Brown Consulting

June 11, 2021

Via email
Department of Health and Human Services
333 South Grand Avenue, 5th Floor
Lansing, MI 48909

Re: Public Comment to Proposed DHHS CCI Administrative Rule 400.4137– Placement

Dear Committee Members,

B. Brown Consulting, LLC commends the department for thoroughly reviewing the licensing standards to create more robust support for youth within Child Caring Institutions. My name is Bernadette Brown. I'm the founder and president of B. Brown Consulting, LLC, a consulting firm that collaborates with government agencies (particularly jails, prisons, military brigs, community confinement and juvenile detention facilities), institutions and community-based organizations on the development and implementation of policies, procedures and best practices that support humane reforms within the youth and criminal justice systems. I'm also a consultant to the National PREA Resource Center (PRC). The goal of the Prison Rape Elimination Act (PREA) is to eliminate sexual abuse in all types of confinement facilities including adult prisons and jails, lockups, as well as juvenile, community, and tribal facilities. The PRC is funded via a cooperative agreement between Impact Justice in Oakland, CA and the U.S. Department of Justice's (DOJ) Bureau of Justice Assistance. As a consultant to the PRC, I developed the nation's first LGBTI (lesbian, gay, bisexual, transgender and intersex) and GNC (gender nonconforming) training curriculum for those seeking to become DOJ-certified PREA auditors.

LGBTQ and GNC youth are overrepresented in the juvenile justice system. While LGBTQ youth comprise about 7%-11% of the U.S. population[1], they account for approximately 20% of the youth in detention.[2] A shocking 57.9% of girls in detention facilities in the U.S. identify as "sexual minorities" which means that they are either lesbian, gay or bisexual (39.4%), or state that they are attracted to other girls (18.5%).[3] Data compiled by the Bureau of Justice Statistics (BJS) from the National Survey of Youth in Custody uncovered that non-heterosexual youth reported a "substantially higher" sexual victimization rate (10.3%) by other youth as compared to

[1] Estimates in studies quantifying the number of LGBTQ and GNC youth in the general population vary depending on the terms that both youth and researchers use in surveys, as well as the categories included, e.g., sexual orientation, gender identity, and/or gender expression.
[2] Irvine, A., & Aisha Canfield. (2016). *The Overrepresentation of Lesbian, Gay, Bisexual, Questioning, Gender Nonconforming and Transgender Youth Within the Child Welfare to Juvenile Justice Crossover Population*. Journal of Gender, Social Policy & the Law: Vol. 24: Iss. 2, Article, http://digitalcommons.wcl.american.edu/cgi/viewcontent.cgi?article=1679&context=jgspl.
[3] Wilson, B. D.M. Wilson, Jordan, S.P, Meyer, I. H., Flores A. R. Flores, Stemple, L., & Herman, J. L. (2017). *Disproportionality and Disparities among Sexual Minority Youth in Custody*, https://williamsinstitute.law.ucla.edu/research/safe-schools-and-youth/lgbtq-youth-disproportionately-incarcerated-in-the-u-s-juvenile-justice-system/

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heterosexual youth (1.5%).[4] While BJS did not collect these data on transgender youth in detention facilities, the rates for transgender adults are extremely high: 26.8% of transgender people detained in jails and 39.9% of transgender people detained in prisons report being sexually victimized.[5] Thus, LGBTQ youth are at great risk of harassment and victimization in detention facilities. Moreover, appropriate placements for transgender and intersex youth are critical to protecting their safety and well-being, and should not solely be based on their sex assigned at birth (see also PREA Standard §115.342).[6] We also commend the language which states that placement/housing decisions may not be based on complaints of staff or other youth. These decisions are based on safety, not on any one person's personal opinion about gender identity. The DOJ's PREA Working Group also reiterated this with guidance that they issued on March 24, 2016, which states that "…a facility should not make a determination about housing for a transgender or intersex inmate based primarily on the complaints of other inmates or staff when those complaints are based on gender identity."[7]

We would like to **express support for the proposed rule changes, specifically protections for youth with diverse sexual orientation, gender identity, and expression (SOGIE)** in R 400.4137 on sleeping rooms. We endorse the language as written, based on the following:

1. **The vulnerabilities of children with diverse SOGIE are well-documented, and reinforce the need for placement consistent with gender identity that prioritizes youths' views about their own safety**. Youth with diverse SOGIE often suffer harms as a consequence of rejection and social marginalization[8]. Due to pervasive rejection and bias in their homes, schools and communities, children with diverse SOGIE experience high rates of depression, suicidality, substance use, physical and sexual victimization, and homelessness. Family conflict, verbal harassment, school bullying, and physical assault constitute the harsh daily reality for too many of these young people[9]. Social conditions for transgender girls of color are particularly brutal. Child caring institutions should consider these factors related to physical and emotional safety when making placement decisions, as the rule language outlines.

2. **While children with diverse SOGIE are a particularly vulnerable population with unique developmental tasks, they also have the same inherent capacity for happiness, achievement, and healthy adjustment as other children.** Placing children with diverse SOGIE in unsafe or hostile settings exacerbates their isolation, instability,

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[4] Beck, A. J., Cantor, D., Hartge, J., & Smith, T. (2013). *Sexual victimization in juvenile facilities reported by youth, 2012.* Washington, DC: US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, http://www.bjs.gov/content/pub/pdf/svjfry12.pdf

[5] Beck, A. J. (2014). *Sexual victimization in prisons and jails reported by inmates, 2011–12: Supplemental Tables: Prevalence of Sexual Victimization of Among Transgender Adult Inmates.* Washington, DC: US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, https://www.bjs.gov/content/pub/pdf/svpjri1112_st.pdf

[6] National PREA Resource Center, https://www.prearesourcecenter.org/implementation/prea-standards/juvenile-facility-standards.

[7] *See* National PREA Resource Center, https://www.prearesourcecenter.org/frequently-asked-questions/does-policy-houses-transgender-or-intersex-inmates-based-exclusively. Thought the language uses the term "inmate," the rule also applies to youth (residents) in juvenile facilities.

[8] Brian A. Rood, Sari L. Reisner, Francisco I. Surace, Jae A. Puckett, Meredith R. Maroney, and David W. Pantalone. Transgender Health. Dec 2016.151-164, http://doi.org/10.1089/trgh.2016.0012; Pariseau, E. M., Chevalier, L., Long, K. A., Clapham, R., Edwards-Leeper, L., & Tishelman, A. C. (2019). The relationship between family acceptance-rejection and transgender youth psychosocial functioning. Clinical Practice in Pediatric Psychology, 7(3), 267–277. https://doi.org/10.1037/cpp0000291

[9] Higa D, Hoppe MJ, Lindhorst T, et al. *Negative and Positive Factors Associated With the Well-Being of Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQ) Youth.* Youth & Society. 2014;46(5):663-687. doi:10.1177/0044118X12449630

and trauma, and significantly compromises their health and opportunities. Placing them with loving, supportive adults who provide a safe atmosphere in which they can explore and develop their identities maximizes their potential to thrive and become healthy adults. **Placements that consider a youth's diverse SOGIE and prioritize youth's views about their own safety and well-being not only nurture children but help protect them from negative effects of living in an otherwise unaccepting society.** By adopting and implementing gender affirming policies and practices, child caring institutions promote the safety, permanency, and well-being of children with diverse SOGIE.

In summary, the proposed language will enhance the well-being of youth with diverse SOGIE. We at B. Brown Consulting, LLC appreciate the time and effort put into the proposed amendments and ask that you vote in support of the changes to R 400.4137.

Thank you for the opportunity to share our perspective. Please do not hesitate to contact us with any questions.

Kindly,

Bernadette E. Brown
President

Disability Rights Michigan

June 11, 2021

Department of Health and Human Services
Attn: MDHHS-AdminRules@michigan.gov

RE: Comments by Disability Rights Michigan (DRM) to Proposed Rules for Child Caring Institutions, Rule Set #2020-39 HS

Disability Rights Michigan (DRM) is the private, nonprofit, nonpartisan protection and advocacy agency serving people with disabilities in Michigan. DRM's mission includes advocacy and monitoring of child caring institutions to address the needs of youth with disabilities in those places.

DRM supports many of the proposed changes in the proposed regulations, including:

- planning to reduce and eliminate use of restraint and seclusion in Section 159(1);
- the immediate ban on particularly dangerous and noxious forms of restraint in Section 159(2) and 159(3);
- the May 1, 2022 ban on nonemergency restraint in Section 159(10);
- the narrowed definition of emergency restraint in Section 160; and,
- the process and May 1, 2022, ban on seclusion in Section 162.

These changes are long overdue and consistent with the recommendations from the Annie E. Casey Foundation report.

Unfortunately, the regulations do not reference or address other important Casey Foundation recommendations. Those recommendations call for broad cultural change, authentic engagement of youth and families, and disaggregated data reporting. Other than a broad staff training requirement, there are no outcome-based or transparent requirements for any of these activities in the regulations.

Disability Rights Michigan

Further, much of the success of the state's efforts to eliminate restraint and seclusion from these facilities rests on the state itself. The Casey Foundation recommends the state drive cultural change, develop and enforce contract performance standards, collect and report data, monitor and oversee performance, pre-approve outsourcing, enforce active case management, create a specialized oversight team to support change, and enforce rules (particularly with regard to repeat offenders and serious violations). The rules have no reference to these state roles as they relate to CCIs and their compliance.

The most recent report of the Dwayne B. settlement monitor highlights the inadequacy of current state corrective actions, despite over a decade of court oversight:

> The monitoring team found that [CCI corrective action plan] content and follow-up was often ineffective and deficient, lacked specificity, and did not remediate risk to children. Frequently repeated violations of a serious nature, such as physical intervention or improper restraints causing injuries, recurred despite the CAPs, and at times the CAPs did not address prevalent underlying issues that posed a serious risk of harm to children's safety. (p.29)

MDHHS acknowledged these issues in September 2020, recognizing the clear "need to expedite adverse licensing action in response to repeat non-compliance or safety violations" (p.7), but the proposed rules lack clear, transparent standards and procedures to ensure accountability and enforcement. Absent adequate state oversight, there is no assurance that a future tragedy will be prevented.

Finally, the Casey Foundation report concludes, in order to best serve youth and the community and prevent tragedy in the future, the long-term trajectory of this system is to downsize. There is no regulation in the proposed rules that governs facility size and no process for downsizing large programs.

Disability Rights Michigan

In short, while the rules have significant positive elements, they still do not address several issues of importance. The major structural deficiency this rule package does not address is the need for consistent and effective oversight and accountability by the department. Without any codified oversight, it is unclear that the positive changes proposed in this package will result in change. That must be corrected by outlining the responsibility and process by which the department will assure every licensed entity complies with the licensing rules or has its license timely revoked. This deficiency and other issues must be addressed through additional rulemaking.

Thank you for the opportunity to comment. Please contact Mark McWilliams, Director of Public Policy and Media Relations, in our Lansing office at mmcwilliams@drmich.org or (517) 487-1755 for more information.

Great Lakes Center for Autism Treatment and Research
an roi program

To: Michigan Department of Health and Human Services, Children's Service Agency, Division of Child Welfare Licensing
From: Jeana Koerber, Ph.D., BCBA-D, LBA Executive Director of Autism Services and Calvin Gage, MA, BCBA, LBA Clinical Director of Autism Services
Date: June 10, 2021
Re: Comments on proposed rules for Child Caring Institutions: Rule set 2020-39 HS

First, we commend the department for the many improvements to the rules that govern child caring institutions in the state of Michigan that are contained in the proposed rules; most notably, a focus on LGBTQ+ youth and to further ensure seclusion and restraint are only used in emergency circumstances. Unfortunately, there seems to be a disproportionate focus on youth who may reside in child caring institutions as a result of a placement in the foster care system. The proposed rules do not adequately address youth who may reside in a child caring institution due to extenuating circumstances resulting from a developmental disability. Youth may be placed in child caring institutions by community mental health entities if the facility only serves youth diagnosed with developmental disabilities. While we recognize that these facilities are not plentiful in the state of Michigan, they represent a crucial service to this population, most notably for youth with a diagnosis of Autism.

Individuals diagnosed with Autism can often engage in challenging behaviors that cause harm to themselves or others. While we recognize that our program is uniquely designed to care for individuals who engage in the most severe forms of these behaviors, there are other child caring institutions that also support youth with autism or other developmental disabilities who have challenges residing in their familial homes for a period of time. There are several proposed rules that would make it very difficult for providers, and potentially impossible for some providers, to continue to provide services to this vulnerable population of youth in Michigan. Without child caring institutions that can serve this population, these youth will be "caught" in the state's emergency rooms or psychiatric placements. Other youth may be sent out of state for the care they require, further separating them from their families. As this is already happening at an alarming rate, we cannot further limit providers' ability to provide care to this group of children.

When youth are placed in a child caring institution through a community mental health placement, facilities are required to follow the Michigan Mental Health Code and rules set forth through MDHHS Behavioral Health and Developmental Disabilities Standards. Child caring institutions are also required to follow Act 116 of 1973 for Child Care Organizations. We implore the authors of the rules to cross-reference the documents linked at the end of this document to

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ensure that definitions are consistent and to collaborate with the Behavioral Health and Developmental Disabilities department at MDHHS lead by director, Allen Jansen. This will ensure providers are not placed in a situation of either following Act 116 or the MDHHS Behavioral Health and Developmental Disabilities Standards at the risk of violating a child caring institution licensing rule, or vice versa. For ease, rules that we have identified as areas of conflict with Act 116, or the MDHHS Behavioral Health and Developmental Disabilities Standards are detailed below.

We have also noted other rules, that while written with positive intent, may be quite difficult for providers to comply with. We have noted those rules and potential barriers to implementation in a separate section below.

We appreciate the time and effort the authors of the proposed rules have already invested in this process. We are confident that our comments will be taken seriously and implemented in these rules so we can ensure a strong provider network for our most vulnerable children with developmental disabilities. If any further information or insight would be helpful, we are happy to discuss or provide additional input into this important endeavor. Our contact information is provided below.

References:

Act 116:
http://www.legislature.mi.gov/(S(eame3rjt143yvpz1401ihdve))/mileg.aspx?page=GetObject&objectname=mcl-act-116-of-1973

MDHHS Behavioral Health and Developmental Disabilities Standards:
https://www.michigan.gov/documents/mdhhs/Technical_Requirement_for_Behavior_Treatment_Plans_702787_7.pdf

Contact Information:

Jeana Koerber, Ph.D., BCBA-D, LBA - Executive Director of Autism Services
jkoerber@resopp.org or 269-250-8242

Calvin Gage, MA, BCBA, LBA - Clinical Director of Autism Services
cgage@resopp.org or 269-250-8249

Rules that are in conflict with Act 116 or MDHHS Behavioral Health and Developmental Disabilities Standards:

Rule number	Wording	Conflict
4101(J)	"Emergency Restraint" means the onset of an unanticipated or severely aggressive behavior that places the youth or others at serious threat of violence or injury if no immediate intervention occurs	In Act 116.7229(D) this is defined as an emergency safety situation. In the MDHHS standards this is listed as emergency interventions, for which one is physical management. Under physical management in the MDHHS standards, this is the language “Physical management shall only be used on an emergency basis when the situation places the individual or others at imminent risk of serious physical harm. To ensure the safety of each consumer and staff, each agency shall designate emergency physical management techniques to be utilized during emergency situations.”
4101(S)	“Mechanical restraint” means a device, materials, or equipment attached or adjacent to the youth’s body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body.	Act 116 722.122B(G) does not define mechanical restraint in this manner, nor do the MDHHS behavioral health and developmental disabilities standards. Both Act 116 and MDHHS have an exclusion for the use of devices used for protective equipment and anatomical support.
4101(W)	Personal restraint means the application of physical force without the use of a device, that restricts the free movement of a youth's body	In Act 116 722.122B(H) does not define personal restraint in this manner. Act 116 has an exclusionary list of items that do not meet the definition of personal restraint that are omitted here. MDHHS standards discuss this under physical management which is defined as “A technique used by staff as an emergency intervention to restrict the movement of a recipient by direct physical contact to prevent the recipient from seriously harming himself, herself, or others. NOTE: Physical management shall only be used on an emergency basis when the situation places the individual or others at imminent risk of serious physical harm. To ensure the safety of each consumer and staff, each

		agency shall designate emergency physical management techniques to be utilized during emergency situations”
4101 (2)	A term defined in the act has the same meaning when used in these rules	This statement again justifies that the definitions in this document should match the definitions in Act 116
4157a	Rule 157. (1) An child caring institution shall implement a behavioral and calming plan that includes all the following: (a) Development of agency-based crisis prevention and intervention strategies that are strength-based and non-coercive. The plan will be used to support staff development and assist youth in self-regulation and social skills. An agency plan will include all the following: (i) On-site, sensory-based interventions that will be made available to youth. (ii) A physical environment that promotes comfort and healing. (iii) Access to a youth’s support team, which may include peer support. (iv) Youth engagement with family. (v) In the absence of family, developing a community of support for youth. (vi) Opportunities to teach youth dispute resolution, conflict mediation, and negotiation skills. (vii) Staff awareness and inclusion in each youth’s behavior and calming plan that is updated regularly, as needed.	This is stating that the agency has a behavioral and calming plan that covers all individuals. This goes against person centered planning and individualized plan of service. Behavior and calming plans should be individualized per the youth. MDHHS Behavioral Health and Developmental Disabilities Administration already has established guidelines for what should be included in behavior treatment plans with a focus on evidence-based practices. Some of the listed interventions may not be considered evidence-based practice depending on a youth’s diagnosis (e.g. sensory-based interventions). We advocate that the language found in the MDHHS Behavioral Health and Developmental Disabilities standards for behavior treatment review committees Revision FY17 be mirrored in these rules. This will ensure that the most appropriate evidence-based interventions are used for the individual served based on their functional behavioral assessment and diagnosis.

4157c	(c) Development of an individualized behavioral and calming plan for each youth that includes: (i) Safety and calming strategies unique for each youth, including options for support tools. (ii) Utilizes trauma responsiveness and best practices. (iii) A youth-centered prevention plan incorporating input and ideas from the youth and family. (iv) Strength-based and non-coercive crisis prevention and intervention strategies that will be used to assist a youth in self-regulation and social skills. (v) Options for fresh air, movement, and exercise.	Again, the MDHHS document linked above already contains criteria for developing a behavior plan. We propose that these two documents be linked. Even if youth are not receiving services through the community mental health (CMH) provider while they reside in the CCI, oftentimes when they return to the community, they are served through CMH programs. Continuity in the guidelines for behavior plan development is crucial for continued progress when the youth returns to a community placement.
4159(5)	In the event a restraint occurs, must be [...] done in a manner that is consistent with the youth's treatment plan.	The MDHHS guidelines do not allow for restraint to be written into treatment plans as this would not be considered emergency use if it is planned.
4159(6)	If a personal or mechanical restraint is used, staff must use the permitted methods of personal and mechanical restraint, appropriate techniques for use of restraints, and the child caring institution must provide guidance to staff in deciding what level of restraint to use if that becomes necessary.	Again, this would not be allowed per the MDHHS guidelines. Staff must use the least restrictive technique that would safely address the situation. This may include the reactive strategies but reactive strategies cannot include physical management.

4160(a)	Emergency restraint.The use of emergency restraint as a lifesaving response of a youth will be limited to: (a) An emergency response to protect the youth or others from immediate serious physical harm, as that term is defined in section 136b(1)(f) of the Michigan Penal Code, 1931 PA 328, MCL 750.136b. (b) When all other interventions in the agency crisis prevention and intervention plan and the youth's individual safety and calming plan have been utilized but fail to protect the youth or others from serious physical harm. (c) The emergency restraint must not last longer than needed to end the threat of serious physical harm. (d) Staff must continuously monitor the youth's breathing and other signs of physical distress and take appropriate action to ensure adequate respiration, circulation, and overall well-being. (e) The youth must be released immediately when an emergency health situation occurs or a situation that presents physical distress occurs during the restraint. Staff must obtain immediate medical treatment for the youth.	The penal code referenced here references child abuse. This would indicate you could only use emergency restraint if the danger was to another child. That is not consistent with Act 116, the MDHHS guidelines, or the definitions provided earlier in these proposed rules.

Rules that may pose challenges to providers during implementation of the rules:

Rule number	Wording	Barrier to Implementation
4133	Rule 133. A child under 10 years of age may not remain in a child caring institution for more than 30 days, unless this stay is documented to be in the best interest of the child.	Youth who have autism typically benefit from earlier intervention. If their behavior is already severe enough at age 8 to warrant out of home treatment, it will only increase intensity. Limiting the age range for these youth may actually increase the length of stay in out of home placements then reduce them.
4142(2e)	(e) Dispensing medication, including methods for dispensing medication when the youth will be off site, for example, all-day outings, parenting time, and court appearances. Prescription medication, including dietary supplements, or individual, special medical procedures must be given, taken, or applied only as prescribed by a licensed physician or dentist.	In emergency situations often physician assistants (PA) or nurse practitioners are writing prescriptions. During routine visits, our youth are also often being seen at a family health center so a licensed physician is often not writing prescriptions. We propose the language be written in a way to include these professionals.
4147(C)	(3) [Dental] Reexamination must be provided at least every 6 months unless greater frequency is indicated.	Insurance companies will not authorize a visit less than every 6 months unless medically indicated. Using a 6 month timeline does not give providers time to schedule an appointment. For 12 month appointments, a 14 month timeline is given to allow time to schedule the appointment in line with insurance regulations. We propose the 6 month timeline be changed to 8 months to give providers scheduling time.
4149(3)	A CCI must provide any special diet that has been prescribed by a licensed physician	Same issue as indicated in rule 4142(2e). Many dietary needs come from a PA or another profession that isn't specifically a licensed

		physician
4150	Rule 150. (1) Child caring institution staff must contact the youth's parent or legal guardian, the licensing authority, and the caseworker within 12 hours, and provide a written report to the same parties within 24 hours of any of the following: (a) Any accident, illness, or mental health crisis that requires emergency medical attention, hospitalization, or both. (b) Attempts at self-inflicted harm or harm to others that causes injury. (c) Attempted absent without leave or escape from the institution. (d) Incidents or allegations of sexual abuse or other forms of sexual misconduct. (e) Behaviors that result in contacting law enforcement. (f) Any use of prohibited methods of discipline under R 400.4158. (g) Any use of lockdown procedure under R 400.4165. (2) The death of a resident youth to the parent/ or legal guardian, responsible referring agency, and the licensing authority as soon as possible must be reported immediately to the parent/legal guardian or next of kin, law enforcement, the licensing authority, and the referring agency. Child caring institution staff must provide a written report to the same parties within 24 hours.	All of our youth in care have several attempts at self-inflicted harm or harm to others per day. The same can be stated with attempts to leave as youth with autism display a high level of elopement. This places an unnecessary burden on providers as they would not be in care if they were not attempting to hurt themselves or others. We propose that this is addended to "incidents" in b and c instead of "attempts"
4155(h)	Permanency plan and steps that will be taken to achieve permanency	Many of our youth are coming from their homes and plan to return home. This seems like a more appropriate statement for the foster care contract than the CCI rules

PENRICKTON CENTER FOR BLIND CHILDREN

June 11, 2021

Michigan Department of Health and Human Services
Attn: MDHHS-AdminRules@michigna.gov
MDHHS South Grand Building
333 South Grand River Avenue, 5th Floor
Lansing, MI 48909

RE: Proposed Rules for Child Caring Institutions Rule Set 2020-39 HS
LICENSE # CI820201363

Penrickton Center for Blind Children established in 1952, serves blind, multi-disabled children ages one through twelve. All of our children are legally blind with at least one additional disability. Most of children have multiple disabilities including seizures, cerebral palsy, brain damage, autism, hearing impairments and developmental delay. All services are provided to private families at no charge. Penrickton Center does not contract with the Michigan Department of Health and Human Services. Please note that Penrickton Center is supported solely through private donations.

Following are my comments on the proposed rule for Child Caring Institutions. Typeface in black are current rules, red are proposed changes.

Sincerely,

Kurt M. Sebaly, M.Ed.
Executive Director

26530 Eureka Road / Taylor / MI / 48180
(734) 946-7500 / Fax (734) 946-6707 / www.penrickton.org

Rule 400.4147 Dental Care

(1) ~~A licensee~~ **Child caring institution staff** ~~shall~~ **must** provide for and document dental examinations and treatment for each ~~resident3~~ **youth 1** year~~s~~ of age and older.

(2) A dental examination within~~12~~ **3** months prior to admission ~~shall~~ **must** be documented or there ~~shall~~ **must** be an examination not later than 90 calendar days following admission.

(3) Reexamination ~~shall~~ **must** be provided at least every ~~14~~ **6** months unless greater frequency is indicated.

Rule (1) The requirement that a child must have a dental examination and treatment at age 1 is not practical. Many children do not even have teeth at age 1; therefore the rule should remain, beginning dental exams at age 3.
Rule (3) This rule places a substantial financial burden on families that do not have insurance for this service. In addition, children with multiple disabilities often need to be under anesthesia to complete any dental exam or work, which adds additional costs. There must be a grace period to ensure insurance will cover the cost of all appointments. The current rule as stated "at least every 14 months" is adequate. The time period should remain the same, or allow the youth's physician to make an exception.

Rule 400.4150 Incident Reporting

(1) ~~Any of the following incidents resulting in serious injury of a resident or illness requiring inpatient hospitalization, shall be reported, but not more than 24 hours after the incident~~.
Child caring institution staff must contact the youth's parent or legal guardian, the licensing authority, and the caseworker within 12 hours, and provide a written report to the same parties within 24 hours of any of the following:

(a) Any accident, illness, or mental health crisis that requires emergency medical attention, hospitalization, or both.

(b) Attempts at self-inflicted harm or harm to others that causes injury.

Our issue is specifically with (a) and (b). Penrickton Center has children who engage in self-injurious behaviors including scratching, biting, and head banging to themselves and others. Our programming focuses on reducing these behaviors. Due to our children's cognitive impairments – it may take years to resolve these behaviors. This rule would mandate, for example, that every time a child scratches him/herself we must notify our Licensing Consultant. Currently, Penrickton Center notifies a parent of all injuries, including self-injurious behaviors.

Notifying our Licensing Consultant each time a child engages in self-injurious or aggressive behaviors is unreasonable. Our Licensing Consultant would be contacted weekly and on multiple occasions. Our Licensing Consultant and Penrickton Center staff can spend our precious time in a more productive manner addressing the needs of our children and families. A more practical approach would be to keep the current rule as written adding (a), (c), (d), (e), (f) and (g) or the addition of the word "serious" injury in (b).

Rule 400.4101 Definitions

(x) "Seclusion" means the involuntary placement of a youth in a room alone, where the youth is prevented from exiting by any means, including the physical presence of a staff person if that staff person's presence prevents the youth from exiting the room.

Penrickton Center has a concern with the definition of seclusion. Penrickton Center has no desire to use a seclusion room for our children. However, due to the developmental disabilities of our youth, our children on occasion act aggressively toward other youth. In an attempt to de-escalate behaviors, we frequently redirect child to a room offering appropriate activities and stimulation, calming the child and channeling activity to constructive acts not aggressive acts.

Again, because of the cognitive impairments of our children, they may initially focus on wanting to run out of the room. We prefer to have the option to physically stand in the room with the child, and redirecting them away from the door, back to the activities in the room. This action is viewed as seclusion, and we are prevented from using this technique. Our only option is to allow the child to leave the room, which can escalate behaviors and eventually force the use of **"emergency restraint."** The definition of seclusion should be changed, or an exception should be made to allow staff to redirect a small child, or child with cognitive disabilities away from a door – without this being viewed as seclusion.

Public Comment to Proposed DHHS CCI Administrative Rule – Placement

Dear Licensing Rules Administrative Committee,

Michigan Center for Youth Justice (MCYJ) commends the department for thoroughly reviewing the licensing standards to create more robust support for youth within Child Caring Institutions. The Michigan Center for Youth Justice (MCYJ) is a non-profit organization dedicated to advancing policies and practices that reduce confinement and support trauma-informed, racially equitable, socio-economically and culturally responsive, community-based solutions for Michigan's justice-involved children, youth and young adults. We would like to **express support for the proposed rule changes, specifically protections for youth with diverse sexual orientation, gender identity, and expression (SOGIE)** in R 400.4137 on sleeping rooms. We endorse the language as written, based on the following:

1. **The vulnerabilities of children with diverse SOGIE are well-documented, and reinforce the need for placement consistent with gender identity that prioritizes youths' views about their own safety**. Youth with diverse SOGIE often suffer harms as a consequence of rejection and social marginalization[1]. Due to pervasive rejection and bias in their homes, schools and communities, children with diverse SOGIE experience high rates of depression, suicidality, substance use, physical and sexual victimization, and homelessness. Family conflict, verbal harassment, school bullying, and physical assault constitute the harsh daily reality for too many of these young people[2]. Social conditions for transgender girls of color are particularly brutal. Child caring institutions should consider these factors related to physical and emotional safety when making placement decisions, as the rule language outlines.

2. **While children with diverse SOGIE are a particularly vulnerable population with unique developmental tasks, they also have the same inherent capacity for happiness, achievement, and healthy adjustment as other children.** Placing children with diverse SOGIE in unsafe or hostile settings exacerbates their isolation, instability, and trauma, and significantly compromises their health and opportunities. Placing them with loving, supportive adults who provide a safe atmosphere in which they can explore and develop their identities maximizes their potential to thrive and become healthy adults. **Placements that consider a youth's diverse SOGIE and prioritize youth's views about their own safety and wellbeing not only nurture children but help protect them from negative effects of living in an otherwise unaccepting society.** By adopting and implementing gender affirming policies and practices, child caring institutions promote the safety, permanency, and well-being of children with diverse SOGIE.

In summary, the proposed language will enhance the wellbeing of youth with diverse SOGIE. We at MCYJ appreciate the time and effort put into the proposed amendments and ask that you vote in support of the changes to R 400.4137.

Thank you for the opportunity to share our perspective,

Jason Smith, Executive Director

MCYJ
MICHIGAN CENTER for YOUTH JUSTICE

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1 Brian A. Rood, Sari L. Reisner, Francisco I. Surace, Jae A. Puckett, Meredith R. Maroney, and David W. Pantalone.Transgender Health.Dec 2016.151-164.http://doi.org/10.1089/trgh.2016.0012; Pariseau, E. M., Chevalier, L., Long, K. A., Clapham, R., Edwards-Leeper, L., & Tishelman, A. C. (2019). The relationship between family acceptance-rejection and transgender youth psychosocial functioning. *Clinical Practice in Pediatric Psychology,* 7(3), 267–277. https://doi.org/10.1037/cpp0000291

2 Higa D, Hoppe MJ, Lindhorst T, et al. Negative and Positive Factors Associated With the Well-Being of Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQ) Youth. Youth & Society. 2014;46(5):663-687. doi:10.1177/0044118X12449630

~~Placement personnel shall not automatically house youth according to their sex assigned at birth~~.

(1) The presumption ~~shall be that~~ **for** ~~transgender and gender non-conforming (TGNC)~~ **diverse SOGIE** youth **is that they** are placed consistent**ly** with their gender identity. In addition to the information relevant to placement of all youth, ~~personnel~~ **the child caring institution must** ~~shall~~ consider:

(a) The physical and emotional safety of ~~TGNC~~ **diverse SOGIE** youth and prioritize the youth's views about their own safety.

(b) Any recommendations from the youth's ~~regular health care~~ **professional service provider team** about the impact of potential placements on the youth's health and wellbeing.

(2) ~~Personnel~~ **Child caring institutions may** ~~shall~~ not base housing decisions on the complaints of ~~personnel~~ **staff** or other youth when those complaints are based on the youth's gender identity or gender expression.