

Person-Centered Behavioral Management
The Addition of 14 NYCRR Section 633.16 and Amendment of 14 NYCRR
Parts 81, 624, 633 and 681

ASSESSMENT OF PUBLIC COMMENTS SUMMARY

OPWDD received more than 100 comments from multiple sources, including: self-advocates, family members, agency and not-for-profit provider representatives, and public advocates. In response to the comments received, OPWDD has revised selected language, terms, and requirements contained within the original proposed regulation. Below is a summary of the comments received and OPWDD's responses. A more detailed assessment of the Public Comments received is available on the OPWDD website at www.opwdd.ny.gov.

I. Comments on specific subdivisions of Section 633.16.

A. Applicability

One comment recommended that this regulation apply to all developmentally disabled individuals receiving services in any setting, including those located outside New York State. The scope of OPWDD's regulatory authority was clarified: the legislature gives the agency authority to regulate only the programs which are operated and/or certified by OPWDD.

B. Definitions

There were a number of helpful comments received regarding suggestions for revisions to specific definitions (e.g., Functional Behavioral Assessment; membership of the program planning team, etc.). Review of the public comments resulted in some significant changes being made to the language and/or terms in the proposed regulation, including: clarifying the distinction between medication prescribed solely for the purpose of behavioral control, and medication prescribed for co-occurring diagnosed psychiatric disorders; emphasis on an active approval of behavior support plans by the Behavior Plan/Human Rights Committee; the required title, scope, and qualifications levels for Behavior Intervention Specialists and their supervisors.

C. General Provisions

In this subdivision, the primary issue focused on the question of whether there is an actual need for a functional behavioral assessment and behavior support plan for individuals who may only take medication for a co-occurring diagnosed psychiatric condition and do not display challenging behaviors. OPWDD clarified its position regarding the use and review of psychiatric medications and made changes throughout the regulation to reflect this view.

D. Functional Behavioral Assessment

Several comments supported OPWDD's requirement for a functional behavioral assessment when planning interventions to prevent, modify or control challenging behaviors. The adequacy of the required time frame for completion of these assessments was questioned; in response, OPWDD increased the time allowed for completion. Some comments expressed concern that when this regulation is implemented, existing assessments would no longer be valid, OPWDD clarified that there is a one-year grace period for update or revision of existing behavior support plans. The functional behavior assessment is the basis for developing such a plan, and is included in that grace period.

E. Behavior Support Plan

Some agencies expressed concern about a potential for conflict when more than one agency provides services for an individual in different settings. OPWDD supports a collaborative approach in these situations, and expects that agencies will reach an agreement regarding interventions, in order to provide consistency and prevent confusion in behavioral interventions for the individual.

F. Behavior Plan/Human Rights Committee (BP/HRC)

There were concerns raised regarding the qualifications, and function of the BP/HRC membership. OPWDD clarified who may serve on the BP/HRC and review plans that include medications.

G. Written Informed Consent

Although some agency representatives expressed the view that a "detailed written opinion and analysis" is unnecessary to support a determination of an individual's lack of capacity, OPWDD disagrees. It is necessary for the program planning team to document specifically which elements of capacity the individual lacks.

Agencies noted the difficulty that they often experience in obtaining written informed consent within the original proposed 30-day timeframe following a witnessed verbal consent. OPWDD extended the time frame for valid verbal consent to 45 days.

OPWDD determined that if a New York State licensed psychologist or licensed physician was a member of the individual's program planning team determining that individual's capacity, and the team was unanimous in its finding of lack of capacity, no further review was needed by an independent licensed psychologist.

H. Objections

There were concerns raised by a few agencies concerning the notification requirements, particularly with regard to notification given to the surrogate consent-givers when an individual refuses medication. Some felt it would be too burdensome to notify the consent-giver at each instance of refusal. OPWDD disagrees and believes that there are instances when immediate notification is necessary.

I. Training

There appeared to be some confusion regarding the purpose, type and documentation for training staff the proper use of restrictive/intrusive and other intervention techniques. Guidance documents and a curriculum are currently being developed to assist with this process. Further, the Quality Assurance protocols used for evaluating agencies and providers will be developed to coincide with the regulations once they are implemented.

J. Specific Interventions

1) Physical Intervention Techniques:

Several commenters expressed concern about the proposed time frame for reporting physical interventions to OPWDD, with most indicating that the time frame proposed (24 hours or by close of next business day) was too short. A number of agencies proposed alternate reporting time frames ranging from 72 hours to quarterly. After reviewing all the suggestions, OPWDD adjusted the reporting time to conform to the current reporting requirement of ADM #2012-03, which is 5 business days.

In addition, there were concerns expressed regarding how soon the individual should be checked for injuries following a physical intervention. In response, the language of the regulation was modified to allow for some flexibility regarding a specific time frame, while still ensuring that the individual is checked for injuries and that medical care is provided when an injury is suspected following a physical intervention.

2) Rights Limitations:

There was a specific request for the regulations to state that informed consent is required for any and all rights limitations included in an individual's behavior support plan.

3) Time Out:

There were a number of comments regarding the use of Time Out. A few of these comments were related to a simple clarification of the definition of Time Out (that it is the temporary removal of positive reinforcement), and OPWDD modified the definition in response. Other comments were mixed. Some advocated for banning the

use of Time Out rooms or reducing the maximum amount of time allowable for usage, others specifically requested that existing Time Out rooms not be subject to the physical plant requirements set forth in the regulation. In addition, the requirement that program planning teams review Time Out room use if it is used 5 or more times in a 24-hour period generated a number of comments with both higher and lower thresholds suggested. OPWDD is committed to reducing or eliminating the use of restrictive interventions, including time out, whenever possible. The emphasis in the regulation on positive behavior supports and the increased reporting and accountability requirements will allow for greater tracking and oversight, but it would be imprudent to prohibit Time Out suddenly without possibly increasing the risk for harm. In terms of the maximum time allowable and the requirement for program planning team review, OPWDD believes that the parameters identified in the regulation are appropriate. Nonetheless, nothing would prevent agencies from setting more stringent parameters as part of their policy.

4) Mechanical Restraints:

The most prominent objection was expressed by two parents and two agencies who believe that, despite the prohibition of aversive conditioning, by this paragraph the regulations still appear to permit what they consider to be harmful, abusive interventions. In these regulations, OPWDD specifically requires informed consent, and significant levels of scrutiny, approval, oversight, limits and documentation regarding any plan that includes a restrictive or intrusive intervention, including rights restrictions. The expectation is that staff will be trained to follow plans that use primarily positive behavioral approaches. OPWDD did not agree with an observation that designating a “senior staff person” for oversight of these and other interventions would be an increased financial and staffing burden; all agencies currently have an equivalent of “senior staff.” Comments for this paragraph also included suggestions of alternatives to the required frequency for reviewing the use of these devices and specific monitoring activities when such devices are used. The current time frames for reviewing use and for monitoring conditions during actual usage conform to federal regulations. The language of the regulation was revised to require OPWDD approval of devices that are not commercially produced, or are not designed specifically for human use.

5) Medications:

There were multiple concerns and objections raised regarding the requirement of a separate consultative panel to perform a semi-annual review of psychotropic medications. In response, OPWDD has incorporated in Section 633.16 the required review as outlined in Section 633.17; the results of this review will be provided to the prescriber and to the program planning team. Questions regarding the monitoring of and notification about emergency medication use were addressed.

Finally, OPWDD recognizes that not every co-occurring psychiatric disorder for which medication is prescribed would be expressed in challenging behavior or require a behavior support plan. The regulatory requirements for behavior support plans and supportive monitoring plans were designed to provide clinical flexibility and distinction of approaches to differing circumstances and treatment needs.

II. General Comments

Concern was expressed by many of the commenters that implementation of Section 633.16 would be costly and would provide little benefit to individuals with disabilities. OPWDD believes that these regulations are needed – to enable providers to identify the true needs and potential, and protect the rights of individuals with disabilities. These regulations maintain a strong emphasis on conducting person-centered assessments, and encouraging positive behavioral supports when addressing challenging behavior. The regulations also clearly articulate the parameters regarding interventions for challenging behaviors. OPWDD believes that there will be many tangible benefits and protections for individuals with disabilities when the proposed regulations are adopted.

There were also concerns expressed that the regulation as a whole was “anachronistic,” “regressive,” and reflected a “hierarchical approach used over 20 years ago.” OPWDD notes that a regulation is not a surrogate or substitute for an agency’s policy statements and practices regarding the philosophy of care on which the agency’s approach to behavioral supports and intervention is based. A regulation simply sets forth certain standards and parameters that must be met under specific circumstances. At the basis of these regulations, there is an expectation that the individual being served, and those with whom he or she may have close personal ties and/or shared advocacy goals, will be included to the fullest extent possible in the development of services, opportunities, and behavior support or monitoring plans. Agency policies are free to eschew restrictive/intrusive interventions without penalty from OPWDD.

OPWDD would like to thank those who provided their comments and suggestions for these regulations.