

Person-Centered Behavioral Intervention

SUMMARY OF SIGNIFICANT CHANGES IN THE OPWDD REGULATIONS – PROPOSED TO REVISED/PROPOSED

The following consists of a summary of significant changes in the Revised/Proposed regulations compared to the Proposed Regulations.

Title of Section 633.16 – changed from “Behavior Management” to “Person-Centered Behavioral Intervention.”

A. Applicability – NONE

B. Definitions

There were a number of additions, deletions and revisions made in this section. The majority were done as a result of comments that we received, and were minor. The most significant are the following (the numbers refer to the definitions in the NEW 633.16):

- #1 Approve/approving – this was revised from “sanction/sanctioning” in each instance to indicate a more affirmative approach
- #4 Behavior, challenging – this was changed from “behavior, maladaptive or inappropriate” – many commenters objected to the use of this terminology, and requested that a more person-centered term be used. The term was changed in the definition as well as throughout the entire regulation
- #10 Committee, informed consent – a phrase was added to limit the role of the committee to situations where the individual lacks capacity and does not have a surrogate available
- #15 Electric skin shock – revisions were made to this definition, but only in the terminology used to describe the use and effect of this aversive technique
- #24 Intervention, restrictive/intrusive – changes were made here specifically in subparagraph (iv) to exclude medications prescribed only for the treatment of co-occurring psychiatric disorders. This use of medication is no longer considered a restrictive/ intrusive technique, and would not be subject to the same requirements as restrictive/intrusive techniques described in this regulation. This change was made in response to multiple representations from agencies regarding the need to distinguish between the purposes of medication use.
- #27 Medication – this definition was added to describe and distinguish the purposes of medications prescribed to modify, control or prevent challenging behaviors, or for the treatment of certain co-occurring psychiatric conditions.

#29 Plan, monitoring – this definition was added to describe the type of plans required for those individuals who are prescribed psychotropic medications solely for psychiatric conditions; the requirements for the plan are outlined in further detail in paragraph 633.16(j)(5)

#32 Specialist, Behavior Intervention (BIS) – there is a change in the types of qualifications required for those who write behavior support plans which include restrictive/intrusive techniques, as well as for those who may supervise the development and drafting of such plans. The changes were made: a) to the title, to avoid confusion with the term “ABSS” used in section 679.99 to describe psychologists who provide services in Article 16 clinics; b) in response to many comments which indicated that access to staff with the original level of qualifications was extremely limited; and c) in response to agencies’ representations that they did not have the resources to hire such individuals. Additionally, the opportunity to request a “hardship” waiver was added to this section for those agencies that are unable to recruit individuals who meet all of the terms of the qualifications for those who may draft plans, or for designated supervisors, due to geographic constraints. The terms “ABSS” or “Applied Behavioral Sciences Specialist” were also replaced throughout the regulation to reflect this change.

#34 Team, program planning – a change was made to add the Consumer Advisory Board for Willowbrook class members (CAB) to the list of those included in the team for those fully represented by CAB.

C. General Provisions

- 1) Throughout the regulation, the term “behavior management” is replaced with “behavioral intervention.” Many who commented had stated that “behavior management” does not reflect a person-centered or positive approach.
- 2) A provision concerning research (paragraph 633.16(c)(12)) in the Proposed Regulations was deleted as unnecessary because adequate protections are in current OPWDD regulations in section 633.13.

D. Functional Behavioral Assessment (FBA)

- 1) The order of some of the requirements for the FBA was changed. Time frames were extended at the request of many who commented.

E. Behavior Support Plan (BP)

- 1) Changes were made to reflect the qualifications revisions made for those who can draft, and supervise the drafting, of a BSP containing restrictive/intrusive interventions;

- 2) Some requirements for BSP's were deleted and others added in this section. The reason for the changes were to avoid confusion, repetition in requirements, and in some instances, at the request of those who provided comments

F. Behavior plan/human rights committee

- 1) A change was made in the name of this committee to reflect the change in the regulation removing the term "behavior management"
- 2) The terms "sanction" or "sanctioning" was replaced with "approve" or "approving"

G. Written Informed Consent

- 1) The time for a valid verbal consent was extended from 30 days to 45 days () at the request of many who provided comments indicating that 30 days frequently is not long enough to obtain written informed consent.
- 2) If the program planning team includes a licensed psychologist or licensed physician, and the team is unanimous about capacity, a detailed written opinion must still be prepared regarding the determination of capacity. In this instance, however, the added step of seeking concurrence from a separate independent licensed psychologist or physician is not necessary. This was done at the request of commenters who thought additional concurrence was too burdensome, and unnecessary in this type of situation.

H. Objections – the only changes made here are those already made to terminology used throughout the regulation

I. Training – NONE

J. Specific Interventions

1) Physical Interventions

- a) Changes were made to subdivisions 633.16(j)(1)(vi) and (vii). The changes reflected two recognitions: first, the requests received from provider commenters who believed that the required reporting time frames were too burdensome and were unrealistic, and second, the need to provide for potential flexibility in the specific reporting details in future without requiring a change in the regulation itself. Specifically, the required 24-hour time frame for reporting to OPWDD was removed, and a more broad term substituted: "in a form and format specified by OPWDD." A revision was already necessary to allow for the *current* reporting requirement (within 5 business days) outlined in ADM #2012-03.

- b) In response to concerns about individuals' privacy and the need to maintain a sense of calm after an incident, parameters were given for visual physical inspections of an individual after a physical intervention is used.
- c) Terminology was changed to reflect previous changes throughout the regulation

2) Rights limitations

The terminology used was the only change made in this section

3) Time-Out

- a) Minor terminology changes
- b) Reporting timeframe to OPWDD was added

4) Mechanical Restraining Devices

- a) Terminology changes were made

5) Medications

- a) The requirement for semi-annual review by a separate medication review panel specifically for psychotropic medications was removed. The terms of Section 633.17 include describe an existing medication review for all medications prescribed. Many who commented thought that a separate, additional review would be difficult if additional panel was required.
- b) Psychotropic medications prescribed solely for co-occurring psychiatric conditions are not considered to be restrictive/intrusive interventions, and do not require a full FBA or BSP. Instead, a monitoring plan is required. Many commentators had stated that having to follow all the original requirements in these regulations for those who *do not* take medications solely to prevent, control or modify challenging behaviors would be extremely burdensome, and could limit the independence of those who do not require the same level of oversight.
- c) Terminology changes were made- in alignment with those listed in the subsections above.
- d) A reporting requirement for the use of emergency medication (not a planned PRN/as-needed medication) was added in line with the requirements of ADM #2012-03.