

Person-Centered Behavioral Intervention Revised/Proposed Regulations

The Addition of 14 NYCRR Section 633.16 and Amendment of 14 NYCRR Parts 81, 624, 633 and 681

ASSESSMENT OF PUBLIC COMMENTS

OPWDD received numerous comments concerning the proposed regulations from a wide variety of sources. Specifically, OPWDD received comments from 58 not-for-profit providers of services to individuals with developmental disabilities and provider representatives, 16 self-advocates and interested family members, and 10 from other interested individuals.

I. Comments on subdivisions of Section 633.16

A. Applicability

- 1) **Comment:** One commentator inquired about having the regulation cover all individuals with disabilities in all settings, not just those certified or operated by OPWDD.

Response: OPWDD can only regulate what the legislature has given the agency authority to regulate; this includes programs operated or certified by OPWDD. The regulation is applicable to the listed services and programs as allowed. Other settings, such as hospitals, are guided by other sections of New York State Law.

- 2) **Comment:** Some commentators indicated that the regulation should be implemented more quickly. Others indicated that the time frame for implementation was too quick and should be extended.

Response: OPWDD believes that the times frames identified (e.g., providers will have a year for all behavior support plans to be in compliance with the regulation after the effective date) allow sufficient time for implementation, and that shortening the implementation time frame could create a hardship for providers.

- 3) **Comment:** There were several questions about programs that receive funding from both OPWDD and the State Education Department, and concerns about which regulations should be used to guide interventions in the event that there are differences regarding allowable behavioral interventions and supports.

Response: OPWDD will work collaboratively with the State Education Department and the relevant stakeholders to thoroughly review any potential conflicts and provide additional guidance on this issue as necessary.

- 4) **Comment:** There were several commentators who requested an extension of the ban on aversive conditioning to include individuals in out-of-state placements.

Other commentators requested that the use of aversive conditioning be allowed, in certain cases, in both in-state and out-of-state facilities.

Response: OPWDD believes that the ban on aversive conditioning is appropriate as specified in the regulation. As drafted, these regulations are applicable only to those settings set forth in paragraph 633.16(a)(1). OPWDD remains committed to serving individuals in the least restrictive environment possible, and will continue to advocate for the elimination of aversive conditioning in out-of-state placements.

B. Definitions

- 1) **Comment:** There were concerns expressed regarding the language and purpose of the Functional Behavioral Assessment (FBA).

Response: Based on the feedback received, changes have been made to the definition of the FBA.

- 2) **Comment:** Comments regarding the definition of the Behavior Plan/Human Rights Committee primarily addressed the role or function of the Committee, and the ability of some agencies to adhere to the membership requirements for this Committee.

Response: OPWDD agrees that the Committee's charge should be affirmative approval of plans rather than a "passive" sanction or lack of objection. Further, Section 633.4 addresses agencies' responsibility to ensure that rights are made known, protected, and can be exercised by individuals. These functions are not the sole responsibility of the Committee. Regarding the issue of adherence to requirements for Committee membership, OPWDD recognizes the difficulty that some agencies may have in recruiting individuals who fulfill the requirements necessary for committee membership. Therefore, agencies are encouraged to collaborate in the formation of a shared committee in the event that they are unable to meet the requirements through their own resources.

- 3) **Comment:** There was a request for OPWDD to expressly and specifically ban the utilization of any restraint techniques in a prone (facedown) position.

Response: Prone techniques are not part of the OPWDD-approved training curricula for interventions which, per this regulation, define the only intervention techniques allowable.

- 4) **Comment:** A number of commentators requested that a distinction be made regarding medication used primarily for behavior prevention, control or elimination, and medications used to treat a co-occurring diagnosed psychiatric disorder.

Response: The regulation was changed to reflect this distinction. Changes are reflected in requirements for behavior support plans or monitoring plans, the method and frequency of reviews for psychotropic medications

- 5) **Comment:** There were several requests to allow staff not employed by OPWDD to be Master Trainers of OPWDD curriculums that involve physical interventions.

Response: In order to ensure the integrity of the OPWDD-approved training curricula, all Master Trainers must be OPWDD employees.

- 6) **Comment:** A number of commentators expressed significant concerns regarding the required scope and level of the qualifications for Behavior Intervention Specialists and supervisors, and requested a possible waiver when “good faith” efforts to recruit individuals who meet specific qualifications have failed.

Response: OPWDD researched a national sample of qualifications required in this role, consulted with a number of its certified agencies, and reviewed the New York State geographic distribution statistics for several licensed professions in order to ensure an equitable and adequate qualifications framework. Additionally, a waiver based on sustained, demonstrable hardship may be requested for review and approval in individual cases by OPWDD.

- 7) **Comment:** A specific request was made to add the Consumer Advisory Board to the definition of the program planning team for individuals who are members of the Willowbrook class and fully represented by that entity.

Response: The Consumer Advisory Board (CAB) has been added to the definition of the program planning team.

- 8) **Comment:** There was a request to ban the use of Time-Out rooms.

Response: OPWDD does not encourage the use of Time-Out rooms and strongly supports reduction or elimination of Time-Out room use in individual plans whenever possible. With the promulgation of these regulations, there will be increased reporting requirements and oversight of Time-Out room use on a statewide basis in order to help achieve these goals.

- 9) **Comment:** Some of those who provided comments asked for a consistent definition/use of the term “program planning team” and its members.

Response: The definition is consistent throughout the regulations. In certain provisions, the regulation may emphasize times at which certain members of the team must be present for specific clinical activities or decisions.

C. General Provisions

- 1) **Comments:** There were concerns expressed that the regulation will be viewed as “the primary approach for addressing maladaptive behaviors” and that this could either exclude other approaches to addressing challenging behaviors, or that behavior support plans would be required for virtually all individuals with disabilities.

Response: The regulations simply state that, if a behavior support plan is necessary, certain basic requirements must be met. Those conditions or requirements are defined in these regulations.

- 2) **Comment:** There were a number of comments questioning the need for a functional assessment and behavior support plan if an individual had a psychiatric diagnosis and was being treated with medication specifically prescribed for that co-occurring diagnosed psychiatric condition.

Response: The regulations were revised to provide for the use of a modified monitoring plan for those individuals who have been prescribed psychotropic medications for diagnosed co-occurring psychiatric conditions only.

- 3) **Comment:** Several commentators agreed with the proposed regulations’ stress on the importance of function-based, proactive methods for teaching behaviors that are an alternative to target problem behaviors.

Response: OPWDD agrees with these responses.

D. Functional Behavioral Assessment

- 1) **Comment:** There were concerns expressed that the requirement of a functional behavioral assessment for every behavior support plan is ‘expensive,’ labor-intensive, and will require revisions in many agencies’ policies and procedures.

Response: Based on scientific evidence, OPWDD believes that functional behavioral assessment is critical in the development of an effective behavior support plan, as it provides a basis for both understanding the nature and function of the behavior, and helping to identify appropriate interventions. OPWDD believes that this is a reasonable requirement in the development of behavior support plans. This is also a federally-mandated (IDEA) component of behavior plan development for school-age individuals.

- 2) **Comment:** There was a request to increase the amount of time allowed for the completion of a functional assessment from 30 days to 60 days.

Response: OPWDD increased the time authorized for completion of the functional assessment to 60 days.

- 3) **Comment:** One commentator recommended adding a “brief review of the literature” to the requirements for a functional behavior assessment.

Response: While the regulations would not prevent agencies from providing literature reviews for each functional behavioral assessment, OPWDD believes that making this a universal, mandatory requirement may be unnecessarily burdensome.

- 4) **Comment:** Concern was expressed by multiple agencies that existing functional behavioral assessments would be out of compliance when the regulation is promulgated.

Response: A grace period of one year is incorporated into the regulations to allow providers to update and revise documentation to comply with the requirements of this regulation.

- 5) **Comment:** There were comments that stressed the importance of environment and communication in understanding challenging behavior. One commentator noted how environmental factors may influence a person’s stress level, sense of personal worth, and capacity for growth.

Response: OPWDD agrees that these factors can have significant effects on behavior. These factors should always be considered, identified (if relevant), reviewed, and included as part of a full functional behavioral assessment.

E. Behavior Support Plan

- 1) **Comment:** Concern was expressed that the processes of behavior support plan development, review, and approval as described, appeared lengthy, cumbersome, and “unstructured.”

Response: OPWDD believes that the processes identified are all necessary to ensure that behavior support plans -- especially those with restrictive/intrusive interventions -- afford the necessary protections for individuals with disabilities. Agencies should create policies and procedures that reflect the required processes and structure them in ways that enable efficient completion.

- 2) **Comment:** There was concern expressed regarding how differences or conflicts between two or more agencies regarding behavioral interventions might be resolved when each agency serves the same individual in different settings or programs.

Response: Agencies are encouraged to work together cooperatively to reach appropriate resolutions to any conflicts, as consistency is most important when

providing behavioral supports and interventions. Additionally, if an individual presents different behavioral patterns in each setting, the plan for each setting should reflect what is true and relevant for the individual in that context. The regulation states that agency or program approaches to behavioral intervention should not conflict with each other, not that all agencies need to follow one plan.

F. Behavior Plan/Human Right Committee

- 1) **Comment:** There was concern expressed that the role of a Licensed Psychologist who supervises or has been involved in the development or drafting of a behavior support plans, would preclude membership on the agency's Behavior Plan /Human Rights Committee.. This could then entail having a second Licensed Psychologists or licensed clinical social worker available in order to reserve a second licensed party to function independently as a member of review Committees.

Response: If a licensed party drafted a plan that is currently being reviewed by the committee, it is necessary for that party to recuse him or herself from any contribution to or influence on the committee's opinion of such as plan. However, the licensed party does not have to be completely replaced. If a licensed party *supervised* the drafting of a plan, that person does not have to be replaced on the committee.

- 2) **Comment:** There was concern expressed that the specified membership of the Behavior Plan/Human Rights Committee was generally not qualified to review the use of psychotropic medications.

Response: OPWDD disagrees. It is accepted practice that a prescriber should identify why a medication is needed, how it should be used, and what the attendant risks and benefits are. The committee members should be able to understand this information, and the information regarding evidence of a medication's effectiveness and possible interactions or side effects, in order to form an opinion regarding the use of the medication(s) as part of the individual's plan.

- 3) **Comment:** There was a request that the facility's Nursing Supervisor should qualify as a member of the Behavior Plan/Human Rights Committee.

Response: OPWDD agrees. The Nursing Supervisor should meet the qualifications identified for those who should be members of the committee, and would be eligible to serve on the committee.

- 4) **Comment:** There was concern raised regarding the issue of HIPAA requirements and the right to privacy and confidentiality versus the proposed membership definitions for the Behavior Plan/Human Rights Committee.

Response: OPWDD believes that any HIPAA issues will be able to be addressed as they are currently addressed regarding volunteers and any employees not directly involved in providing clinical services. Further guidance will be forthcoming.

- 5) **Comment:** There was a request that the Behavior Plan/Human Rights Committee affirmatively approve plans as opposed to simply sanctioning them.

Response: The regulations have been revised to reflect this change.

- 6) **Comment:** It was suggested that OPWDD have Regional Behavior Plan/Human Rights Committees, as well as a regional Informed Consent Committee, to lessen the providers' operational burden and ensure that consistent standards and practices are being applied.

Response: An OPWDD Regional Behavior Plan/Human Rights Committee would decrease the personal connection with and knowledge of the individuals whose needs and intervention plans committee members are discussing. We recognize some of the difficulties agencies may have in fulfilling the requirements necessary for committee members. Therefore, OPWDD encourages agencies to collaborate and form interagency committees.

G. Written Informed Consent

- 1) **Comment:** Concern was expressed regarding capacity assessments. Commentators felt that preparation of a "written opinion and detailed analysis" to be reviewed by a clinical psychologist or physician is unnecessary, and would put an additional burden on the workforce. Others felt that this was an appropriate step.

Response: If the team believes that an individual lacks capacity, it is necessary for the program planning team to document which elements of capacity an individual is lacking. However, if a licensed psychologist or physician is a member of the program planning team, the further step of having another licensed professional review the capacity determination is not necessary.

- 2) **Comment:** One commentator suggested that those who are providing informed consent should be given not only a description of benefits but also a review of the literature relative to the probability of success.

Response: OPWDD believes that providing a summary of the risks and benefits is a required component of informed consent, but providing a literature review is not necessary.

- 3) **Comment:** There was concern whether an agency can use another agency's behavior plan without obtaining additional consent or approval.

Response: The primary agency that authors the behavior support plan has the obligation to obtain and document informed consent and any required review. A different agency which may utilize such a plan in a different service setting should confirm that these requirements were met before implementing such a plan.

- 4) **Comment:** Concern was expressed regarding the role of the agency's CEO when capacity is in dispute.

Response: OPWDD believes that the role of the Executive Director/CEO is clearly defined in these regulations, and that sufficient information will be available for the Executive Director/CEO to resolve differences of opinion.

- 5) **Comment:** A concern was raised regarding the role of the licensed psychologist or physician who would review capacity determinations, and whether it is necessary for that clinician to evaluate the individual personally.

Response: These regulations do not require a personal examination when the team's opinion is unanimous, and there is not a licensed psychologist or physician as a member of the team. A personal examination is not, however, prohibited. Agencies can develop policies regarding a personal examination if they feel that this would be necessary within their circumstances.

- 6) **Comment:** There is a concern about the omission of notice to Mental Hygiene Legal Services (MHLS) when certain surrogates are asked to provide consent for behavior management interventions for individuals who lack capacity.

Response: The only notification MHLS is entitled to receive is when an informed consent committee is being utilized to obtain informed consent for an intervention plan. That requirement is reflected in the regulations as well as in Article 47 of the Mental Hygiene Law (Section 47.03).

- 7) **Comment:** Concern was expressed that there is no required notice given to the person receiving services that he or she has been deemed to lack capacity to provide (or refuse/withdraw) informed consent for restrictive/intrusive behavior support plans in all cases.

Response: The individual is part of the program planning team (as stated in paragraph 633.16(b)(32)) and would have ample opportunity to object during the capacity determination. That determination must be unanimous, or an independent psychologist or physician will make the capacity determination, which allows the individual another opportunity to object to the team's determination (see paragraph 633.16(g)(7)). OPWDD believes that this process provides sufficient notice and opportunity to object.

- 8) **Comment:** There will be a significant increase in workload if informed consent is required for all behavior support plans and interventions used.

Response: There appears to be a misconception that all behavior support plans require informed consent. This is not correct. Informed consent is only required for the use of restrictive/intrusive techniques and psychotropic medications; therefore, it would not be necessary for any plans that do not include these techniques.

- 9) **Comment:** The due process protocols more appropriately belong in Section 633.12, except when dealing with multiple refusals for medications.

Response: The regulation provides for the use of the objection process set forth in Section 633.12, except when the objection is related to restrictive/intrusive interventions. This exception is necessary due to the fact that the use of restrictive/intrusive interventions requires informed consent. As a result, these types of objections cannot be overturned through the Section 633.12 process; a court application would be necessary in these instances.

- 10) **Comment:** The regulations do not contain any guidance as to how the program planning teams will assess capacity.

Response: An accompanying handbook or guidance document will be drafted and distributed at a later date. However, program planning teams are presumably already aware of the elements required for consent capacity associated with other treatments (e.g., medical procedures).

- 11) **Comment:** OPWDD should establish its own regional Informed Consent Committee which provider agencies under contract with or regulated/certified by OPWDD must use. This would offer critical assurances that OPWDD would serve as the functionally independent monitor providing rigorous oversight and consistency in the utilization of best practices concerning informed consent.

Response: OPWDD believes that agencies will be able to meet the requirements for the Informed Consent Committees through active collaboration. Agencies located in the same geographic area can form a “collaborative committee” among themselves, as stated in the regulations [Subparagraph 633.16(g)(8)(ii)].

- 12) **Comment:** The expiration limit for verbal informed consent should be changed from “30 days” to “45 days,” to enable staff to obtain the required written informed consent, which is often difficult to obtain in a relatively short period of time.

Response: At the suggestion of commentators, the time limit for the validity of verbal informed consent has been revised to 45 days in the regulations, to allow more time to obtain the written statement of informed consent.

H. Objections

- 1) **Comment:** Some agencies felt that it would be too burdensome to notify the surrogate consent-givers each time that an individual refuses to take a dose of prescribed psychotropic medications.

Response: OPWDD believes that there are some instances in which immediate notification is necessary, due to the sensitivity of the situation, the individual's known potential for instability, or the potential physical consequences resulting from missed dosage. Therefore, there is a need for a set timeframe for notification. Should a surrogate consent-giver request that notifications be limited, the agency may negotiate such an agreement and provide documentation of this.

- 2) **Comment:** A commenter suggested that MHLS be notified when there is an objection to intrusive interventions and court authorization is sought to override an objection for any resident of a facility.

Response: OPWDD agrees with this comment. The regulations were revised to reflect that notification of such applications shall be provided to MHLS at the time of filing.

- 3) **Comment:** When an objection is lodged against a particular restrictive/intrusive intervention, it should not be permitted to be carried out under emergency use provisions while the court proceedings are in process, if the intervention involves physical intervention techniques (paragraph 633.16(j)(1)) or psychotropic medications (paragraph 633.16(j)(5)). Rather, the appropriate court can issue, as necessary, interim orders permitting utilization of the restrictive/intrusive intervention.

Response: It is unrealistic and impractical to require agencies to apply to the court when dealing with emergency situations. Further, the regulations contain restrictions on what types of techniques may be used when an emergency arises. The process of applying to court is not timely enough to deal with these situations. The emergency use provisions are limited to situations involving risk to health and safety.

I. Training

- 1) **Comment:** There were multiple recommendations and questions regarding what could or should be included in staff training and its documentation.

Response: OPWDD reviewed the recommendations and training documentation requirements for staff training. OPWDD Division of Quality Improvement

survey protocols will be developed to enforce regulatory compliance once the regulations are finalized.

J. Specific Interventions

1) Physical intervention techniques

- a) **Comment:** There were concerns expressed regarding the time frames for reporting physical interventions to OPWDD; a number of agencies indicated that the proposed time frames were too short. Alternative time frames were suggested, including 72 hours, monthly, quarterly summary reports, or intermittent “trend” reports.

Response: The reporting time frames for the use of specific restrictive intrusive interventions are currently subject to the requirements in place under OPWDD ADM #2012-03, effective as of July 30, 2012.

- b) **Comment:** There was also concern expressed about the time frame for completing the required inspection of individuals for injuries following a physical intervention. It was noted that the form & format for completion of the physical inspection are not specified.

Response: This issue will be addressed further in later guidance documents. The language regarding the time frame for visual inspection currently specifies that the inspection should be done “as soon as is reasonably possible.”

- c) **Comment:** There was concern expressed regarding the disallowance of physical interventions in Community Habilitation, as this could pose a safety risk if staff cannot perform physical interventions in certain circumstances.

Response: In accordance with subparagraph 633.16(j)(1)(xi) of these proposed regulations, Hourly Community Habilitation staff may use these techniques with prior authorization from OPWDD.

- d) **Comment:** There were a few concerns raised regarding the requirement that the individual be checked for injuries following the use of physical intervention techniques.

Group Recommendations: OPWDD believes that it is important for individuals to be checked for injuries following physical interventions. The language in the regulation was modified, however, to allow these checks to be done with less potential for intrusive/negative impact on the individual.

2) Rights Limitations

- a) **Comment:** There was a comment that informed consent should be required for any and all rights limitations.

Response: OPWDD has revised the language in the regulation to reflect this expectation.

3) **Time-Out**

- a) **Comment:** There were two requests to clarify the language in the definition of time-out, in order to specify that time-out is the temporary removal of positive reinforcement.

Response: Revisions have been made to the language of the definition in response to this comment.

- b) **Comment:** Several commentators recommended banning the use of time-out.

Response: OPWDD is committed to reducing or eliminating the use of restrictive interventions, including time-out, whenever possible. Additional requirements related to the use of time-out are part of this regulation. Given the emphasis in this regulation on positive behavioral supports, and the additional reporting and oversight requirements, it is hoped that significant reductions in or elimination of the use of restrictive/intrusive interventions will result.

- c) **Comment:** There were several suggestions to further limit the maximum time allowed for an individual to stay in a time-out room. These suggestions generally recommended a 20- or 30-minute limit.

Response: The regulation sets the maximum time allowable, but it does not require that a person be placed in a time-out room for the maximum 60 continuous minutes. It is anticipated that in most situations, the time spent in this space would be much less, and is expected to be determined on an individual basis, taking into account the characteristics of the situation and the needs of the individual.

- d) **Comment:** There were different opinions and suggestions offered regarding the conditions for the required review by the program planning team when an individual is placed in a Time-Out room on five or more occasions within a 24-hour period. Different commentators suggested either higher or lower frequency thresholds for initiating the review.

Response: OPWDD believes that the present requirement is reasonable and sufficient. Agencies are not prevented by these regulations from lowering the frequency threshold for their own practice.

- e) **Comment:** It was recommended that all currently-approved Time-Out rooms be allowed to continue to be used.

Response: In response to this comment, a revision has been made to these regulations to allow for the continued use of time-out rooms that were previously approved by OPWDD prior to the promulgation of these regulations.

4) **Mechanical Restraining Devices**

- a) **Comment:** At least two parents and two agencies expressed concern that despite the prohibition of aversive conditioning, the regulations still appeared to them to permit what they considered to be harmful and abusive interventions. In one case, the terms of regulation were interpreted as permitting a hypothetical situation that would be considered equivalent to “torture.”

Response: OPWDD is promulgating regulations for behavioral interventions to set clear standards, expectations, and controls for agencies regarding the use and limitations of all interventions, including restrictive/intrusive interventions. The stated expectation is that agencies will use primarily positive behavioral approaches to reinforce positive personal and social skills, limit and control the use of restrictive interventions, and subject the rationale for and utilization of restrictive/intrusive interventions to increased internal and external scrutiny. The regulations require significant levels of oversight, approval, and informed consent prior to the implementation of any restrictive/intrusive intervention or rights limitations. With the formal approval of this regulation, OPWDD believes that the needs and rights of individuals with disabilities will be better served and protected throughout the state.

- b) **Comments:** There was a recommendation that the use of mechanical restraining devices be reviewed every 30 days by a physician instead of every 6 months, as required in the regulation.

Response: OPWDD believes that every six months is a reasonable time frame. There is nothing to prohibit agencies from conducting more frequent reviews.

- c) **Comment:** There was a request that OPWDD approval be required for the proposed use of mechanical devices that are not commercially made or designed for human use.

Response: OPWDD agrees with this condition, and clarifying language was added to the regulation.

- d) **Comment:** One commentator stated that “general practice” recommends the monitoring of an individual in a mechanic restraining device every 15 minutes rather than every 30 minutes.

Response: The requirement for monitoring an individual every 30 minutes is the maximum allowable time between checks, as stated in Federal regulation. Agency staff may want /could be encouraged to check more frequently, depending on the person and the situation.

- e) **Comment:** There was a suggestion to create a separate regulatory provision regarding required documentation related to the use of mechanical restraints, including an individual’s behavior, checks on physical condition and needs, and specific care offered and provided.

Response: OPWDD does not feel that it is necessary to create a separate provision in the regulation to address these aspects of monitoring. This recommendation will be reviewed for inclusion in the planned guidance documents.

- f) **Comment:** One commentator expressed concern that designating a senior staff person for oversight of this and other interventions would entail an increased financial and staffing burden. This designation was envisioned as requiring a new job title and job description, increasing wages, and having an effect on shift staffing, as well.

Response: All agencies currently have some equivalent of ‘senior staff’ within their organizational hierarchy. OPWDD does not believe that this will cause an additional financial burden or require the creation of new positions.

5) **Medications**

- a) **Comment:** There were numerous concerns and objections regarding the requirement that a separate consultative panel would review the use and effects of psychiatric medications on a semi-annual basis.

Response: A Medication Regimen Review is already a requirement in Section 633.17. In response to the numerous concerns, OPWDD has incorporated the proposed required reviews of psychiatric medications into the existing review requirement in Section 633.17. This required review is referenced in the text of these regulations, and should be performed as specified in Sections 633.16 and 633.17.

- b) **Comment:** There was a question regarding how OPWDD will monitor/audit for compliance regarding the emergency use of medication.

Response: Once these regulations are promulgated, OPWDD’s Division of Quality Improvement will revise survey protocols to incorporate the new requirements set forth in Section 633.16, in order enforce regulatory compliance.

- c) **Comments:** There was concern expressed that there was no requirement for notification to the surrogate provider of consent when psychiatric medication is used in an emergency.

Response: The regulations currently reflect that notification is required.

- d) **Comment:** Agencies should not have to draft behavior support plans for individuals who are prescribed medications for a psychiatric diagnosis but have no challenging behaviors to prevent them from living with an appropriate degree of independence in their chosen setting.

Response: OPWDD recognizes that psychiatric medications can be important in the treatment of identified co-occurring psychiatric disorders, and that every co-occurring disorder is not universally expressed in challenging behaviors. The regulations and regulatory requirements regarding behavior support and monitoring plans have been modified to reflect this.

II. General Comments

A. Time Frames

- 1) **Comment:** Concern was expressed that reporting requirements for the use of restrictive intrusive interventions would impose a burden on agencies.

Response: OPWDD recognizes that, although timely reporting is important, the original time frames can be modified and extended to help ease the burden on agencies.

- 2) **Comment:** Concerns were raised that when a restrictive intrusive intervention is used in an emergency situation, OPWDD would be notified before the family, guardian, or advocate.

Response: OPWDD has adjusted the notification time frames. Families are to receive notification within 2 business days and OPWDD within 5 business days.

- 3) **Comment:** One commenter stated that the new requirement to report the use of all restrictive physical interventions to OPWDD would require agencies to evaluate the use of each technique, which is a positive thing.

Response: OPWDD agrees with this comment.

B. Fiscal Impact/Workload Issues

- 1) **Comment:** Some commentators expressed concern about the possible financial impact associated with implementation of these regulations.

Response: OPWDD has worked closely with agencies to try to minimize the financial impact of the regulations, and this effort is reflected in changes made in the revised proposed regulations.

- 2) **Comment:** Concern was expressed regarding the geographic availability of licensed psychologists to provide supervision.

Response: OPWDD has reviewed the qualifications and geographic distribution statistics for several licensed professions in New York State. OPWDD has consequently expanded the list of qualified supervisors, and included language regarding a possible waiver of this requirement where there is a sustained, demonstrated hardship regarding access to qualified BIS or supervisory staff.

- 3) **Comment:** Some agencies stated that there will be additional costs to pay unemployment benefits to the employees who would have to be laid off because they no longer met qualification under this proposed regulation.

Response: OPWDD has revised and expanded the qualifications structure, and has allowed for retention of existing staff to minimize the potential for fiscal impact.

- 4) **Comment:** Concern was expressed that implementation of the regulation would be costly and would provide little benefit to individuals with disabilities.

Response: 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. These 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.

C. Miscellaneous Comments

- 1) **Comment:** Several commentators agreed with the proposed regulations' stress on the importance of creating and maintaining function-based, proactive intervention approaches that include the identification, teaching, and positive encouragement of behaviors that are an alternative to target problem behaviors.

Response: OPWDD agrees with these sentiments.

- 2) **Comment:** One commentator expressed concern that the regulations allow procedures that are “punitive” and “abusive” to be used on people with developmental disabilities.

Response: OPWDD does not actively encourage the use of any restrictive or intrusive intervention. However, OPWDD recognizes that a small number of individuals with disabilities may exhibit extremely destructive behaviors, such as physical aggression and self inflicted injury, which do not respond to positive supports alone and necessitate other, more restrictive interventions to protect the health, safety, and welfare of the individual and those around them. By setting clear parameters around the use of restrictive/intrusive interventions, any inappropriate applications would be considered abuse and reported as such.

- 3) **Comment:** One commenter stated that the regulations would reinforce the need to be pro-active when dealing with behaviors, and will demonstrate to staff the need to avoid power struggles that never end positively. These emphases on alternate, positive procedures can lead to increased growth and satisfaction among individuals served, and greater skills levels and satisfaction among staff members.

Response: OPWDD agrees with this statement.

- 4) **Comment:** Some of those providing comments applaud the strong, clear, and consistent restrictions on the use of restrictive physical interventions and restraints.

Response: OPWDD agrees with these sentiments.

- 5) **Comment:** One commenter suggested that the terminology “maladaptive/inappropriate” used to describe behaviors is outdated, and should be changed to “challenging” in an effort to use non-judgmental language.

Response: OPWDD agreed and changed the terminology.

- 6) **Comment:** There were some comments suggesting that OPWDD work in concert with NYS Education Department (SED) to ensure consistency in the application of behavior management.

Response: It is suggested that if the regulations are in conflict and the individual receives funding from SED, then the SED regulations should prevail. If they receive money exclusively from OPWDD, then Section 633.16 should prevail. It is not currently possible to have identical regulations for differing agencies.

- 7) **Comment:** One commenter stated that less proscriptive regulations, along with guidance or best practices documents, would better allow agencies to develop and

implement policies for behavior management that could be more individualized for the people we support.

Response: Based on its extensive knowledge of agencies' current practices statewide, OPWDD believes that regulations which combine both prescriptive and proscriptive components are necessary.

- 8) **Comment:** One commentator indicated that the proposed regulations are exemplary and speak to the progressive movement away from external physical, psychological, and chemical restraints within the field of developmental disabilities.

Response: OPWDD appreciates the comment.

- 9) **Comment:** Several commentators objected to specific terms in the language used in the initial draft regulations, including the use of phrases such as "behavior management," and "maladaptive behavior."

Response: OPWDD used this opportunity to review the document's premises and language in light of these concerns and of its own mission and vision. Revisions were made to these regulations to better reflect the person-centered nature of our best practice expectations, and the concerns expressed in these comments.

- 10) **Comment:** There were some concerns expressed that the regulation as a whole was "anachronistic," "regressive," and reflected a "hierarchical approach used over 20 years ago."

Response: 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.

- 11) **Comment:** Some agencies noted and expressed appreciation for the clarity and completeness of the regulation's definitions, especially with regard to the information & clarifications regarding the use of medications. There was also positive support for a perceived effort on OPWDD's part to develop & implement uniform practices & procedures regarding behavioral intervention that incorporate principles of both positive behavioral support and the generally proactive/preventative approach embodied in the regulations.

Response: OPWDD agrees and appreciates this comment.