April 25, 2019

From: The Massachusetts Association of Applied Behavior Analysis

To: MA Department of Developmental Services

Regarding: comments pertaining to proposed amendments to 115 CMR 2.00: Definitions and 115CMR 5.00: Standards to Promote Dignity

To Whom It May Concern:

Mass ABA represents over 1000 behavior analysts in the Commonwealth of Massachusetts. Many of these behavior analysts work in programs serving individuals with IDD. The Department of Developmental Services (DDS) is commended for updating their Standards to Promote Dignity 115 CMR 115. DDS has initiated an effort to infuse the tenants of Positive Behavior Support (PBS) into its practices.

Specifically, DDS should be commended for:

- Mandated functional behavior assessments (FBA) to inform positive behavior support plans (PBSP);
- Emphasis on evidenced-based interventions;
- Dependence on empirical data in clinical decision making;
- Establishing agency-wide PBS Leadership Teams inclusive of senior clinical and administrative staff in Organizations to review the effectiveness of behavior support interventions;
- Inclusion of Treatment Integrity Checks to ensure that PBSPs are being implemented as written and;
- The adoption of a multi-tiered system of support that is flexible for organization implementation.

Secondly, DDS has taken feedback from organizations representing individuals with IDD and these individuals and their representatives to make improvements in several areas from the previous iteration.

They include:

- Better defining restrictive practices and including research-based practices such as response cost that were prohibited and now are considered as restrictive practices;

- The introduction of a Behavior Safety Plan for situations that might require the use of restraints;
- The recommendation that a functional behavior assessment be used in development of all Positive Behavior Support Plans;
- The inclusion of transportation devices and protective equipment and;
- Limiting debriefing with an individual when it is not clinically indicated.

While the intent of the proposed changes to the 115 CMR 5.00 is admirable and many of the above changes offered by DDS are positive, Mass ABA has several concerns about the potential impact of these changes. These concerns are outlined below, and recommendations are offered.

**Concern 1: Qualified Clinicians Lack the Training and Experience to Conduct FBAs and develop PBSPs**

*Section 514 (10) states that a PBS qualified clinician shall:*

*1. be currently licensed in Massachusetts in accordance with applicable law as one of the following: a. a psychologist; b. an independent clinical social worker; c. an applied behavior analyst; d. a master's or doctorate level speech pathologist; e. a physician; f. a master's or doctorate level teacher with a certification in special education; or g. a licensed mental health counselor (LMHC); or be a doctorate level special education teacher actively teaching the topics of positive behavior support or applied behavior analysis at the college or university level;*

*2. have at least three years of training, including post graduate class work or formal training, and/or experience in function based behavioral assessment and treatment; and*

*3. have at least three years of clinical experience in the treatment of individuals with developmental disabilities.*

**Recommendation:**

PBS is clearly rooted in the field of applied behavior analysis (ABA). The Association for Positive Behavior Supports (APBS) is an international organization for the promotion of PBS with over 1500 members. APBS suggests PBS "involves promoting research-based strategies that combine **applied behavior analysis** and biomedical science with person-centered values and systems change to increase quality of life and decrease problem behaviors." (http://www.apbs.org; Carr, Dunlap, Horner, Kegel, et al., 2002). Since the only professionals, applied behavior analysts and some psychologists, have as their **scope of practice** the development and implementation of Positive Behavior Support Plans we would suggest that one of these individuals be on each Universal, Targeted, Intensive or Peer Review Team to ensure that their expertise is available to individuals served under these regulations.

**Concern 2: Definition of Timeout**

*Time Out. Time-out may be voluntary or involuntary. A voluntary time out is a self-directed or verbally prompted removal of an individual from an environment or activity to a safe or calming space. An involuntary time out is the physical removal of an individual from an environment or*

*activity to a safe or calming space over the individual's active resistance for a limited period not to exceed 15 minutes.*

*(a) Involuntary "Time out." An involuntary time-out is considered a restraint and must be reported in accordance with 115 CMR 5.11(1)(d).*

**Recommendation:**

The definition provided for "time out" is not accurate. According to Cooper, J., Heron, T. and Heard, W. (2007) Applied Behavior Analysis (second edition). Columbus, OH: Pearson Education, Inc. *Time Out* is defined as, "The contingent withdrawal of the opportunity to earn positive reinforcement or the loss of access to positive reinforcers for a specified time; a form of negative punishment." It is our recommendation that this be the definition used in the regulations.

We would suggest that the actual process of removing the individual involuntarily should be considered a restraint (e.g. *include type of hold or escort?)* not the procedure of time out itself. Thus "involuntary time out" should not be considered a restraint.

**Concern 3**

2. *Monitoring and Examination of Individuals in Emergency Restraint (Mechanical and Physical). i. 1. Staff in Attendance. Staff persons shall observe and monitor an individual in a restraint in accordance with the CPRR curriculum adopted by the provider's PBS Leadership Team. The staff person(s) observing an individual in a restraint shall be situated so the staff person is able to communicate with and see the individual at all times.*

**Recommendation:**

Please clarify that in the case where all staff persons are involved with the restraint, that a staff person involved should be situated so that they are always able to communicate with the individual.

**Concern 4: Timelines of restraint briefings**

*5:11 (B) Individuals who are subject to a restraint shall participate in a separate debriefing with trained staff persons who did not participate in administering the restraint in order to support the individual and to mitigate distress that may result after experiencing a restraint. In the event the debriefing is clinically contraindicated, the PBS qualified clinician shall document the reason why the debriefing cannot take place in the PBSP.*

*Restraint debriefings described in 115 CMR 5.11(1)(a)(1)(iii)(A) of this section shall be completed within 72 hours after the time the restraint occurred. The restraint debriefing described in subparagraph 115 CMR 5.11(1)(a.)(1)(c)(B) of this section shall be completed within 24 hours after the time the restraint occurred.*

**Recommendation:**

These timelines could be problematic for residential programs since only staff involved in the restraint may be those on duty. In some residential situations a restraint occurring over a weekend could potentially involve all the employees working in that home. We are suggesting that the timeframes be changed to read "1- business day" (for staff persons involved in a restraint) and "3-business days" for debriefing of the individual involved in the restraint (where "business days" are defined as M-F excluding official state holidays).

**Concern 5: Maladaptive behavior**
Use of the term "*maladaptive behavior*"

**Recommendation:**
We suggest that the term "*maladaptive behavior*" be changed to "*problem behavior*".

**Concern 6:**

ii. *The restraint form shall be retained in the individual's record.*

**Recommendation:**

It is understandable that some organizations are between paper and electronic systems. The current regulation does not seem to allow for the electronic retention of restraint records in the HCSIS system. We would recommend the regulation read "restraint forms will be retained in the individual's paper record or in the individual's electronic record in HCSIS."

**Concern 7: Broader definition of PBS**

*514: (1) PBS emphasizes the use of positive behavior approaches and recognizes that behavior is often an individual's response or reaction to the environment and the need to communicate his or her preferences and wants to others. Therefore, PBS focuses on environmental modifications and antecedents.*

**Recommendation:**

We would suggest an expansion of this statement

Therefore, PBS focuses on environmental modifications and antecedents, active teaching of replacement behaviors and reinforcement for replacement and desired behaviors.

**Concern 8: Determination of whether written Targeted PBSP needs to be written**

*5. Notwithstanding anything contained in 115 CMR 5.14(5), providers may develop individualized, targeted supports unique to an individual but that do not meet the criteria for the Targeted Tier of Support set forth in 115 CMR 5.14(5)(b)(2). Such individualized or "targeted supports" must be expressed in written guidelines, but do not require an abbreviated or informal functional behavior assessment and do not require a PBSP. An example of an individualized or targeted support would be a unique approach to transitions to avoid the development of a problem behavior.*

(*8) Positive Behavior Support Plans.*

*(a) A written PBSP is required for Targeted or Intensive Supports. The PBSP must be designed and written by a PBS qualified clinician. A PBSP should include the elements consistent with guidance provided by the Department. The PBSP should describe procedures for preventing a problem from occurring and ongoing monitoring of individuals to ensure treatment integrity.*

**Recommendation:**

Based on the above information it is our understanding that generic guidelines, that are not individualized, do not require a Targeted PBSP. Please clarify in the regulations.

**Concern 9:**

*Medication used to manage or treat behavioral symptoms shall be administered subject to the requirements of 115 CMR 5.15. (a) Medication used to manage or treat behavior symptoms shall be administered in accordance with the recommendations of the ISP team and referenced in the ISP, contained in a medication treatment plan referencing the individual's Targeted or Intensive PBSP and subject to regular review by the provider's Targeted or Intensive PBS Team.*

*(b) The medication treatment plan shall contain at least the following: 1. a description of the behavioral symptoms to be managed or treated; 2. information concerning the common risks and side effects of the medication, procedures to minimize such risks, and description of clinical indications that might require suspension or termination of the drug therapy; 3. monitoring data pertaining to the target behavior, including goals, and target behavior prior to and subsequent to the administration of the medication(s), such that the individual's clinical course may be evaluated; 4. data tracking of all relevant effects of the treatment with the medication(s), including secondary effects such as weight gain or loss and changes in sleep patterns.*

**Recommendation:**

All medication administration should follow the physician's and/nurse practioner's orders. The ISP team should ensure that these orders are followed. Would the medical professionals provide the team with a description of the "behavioral symptoms to be managed or treated"? We highly support the DDS's effort in both tracking the target behavior as well as side effects of the medication. Given that this a major task we would recommend that DDS suggest to their ISP teams that this be one of each individual's ISP objective. If this is not considered an ISP goal then monitoring of the target behaviors should not be undertaken.

**Concern 10:**

*Response blocking or physically preventing a maladaptive behavior from occurring that typically requires a visible motor response*

**Recommendation:**

Response blocking as defined above is often considered a least restrictive practice and is taught in approved physical management course, Safety-Care™. With the term visible motor response (staff or individual?), an example would be standing in front of a TV to prevent property destruction from occurring, or perhaps a staff blocking an individual from engaging in self harm but does not restrict freedom of movement. We would suggest that response blocking be removed from restrictive procedures.

We appreciate the opportunity to provide feedback to DDS on these proposed regulations and hope you consider these suggestions to improve individuals supported by DDS overall quality of life. Please feel free to contact us if you would like to discuss any of these issues further.

Sincerely,

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