August 24, 2016

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:

The Department of Developmental Services (DDS) is commended for updating their Standards to Promote Dignity 115 CMR 115. These regulations had not been updated since 1988. DDS has initiated an effort to infuse the tenants of Positive Behavior Support (PBS) into its practices.

We believe the proposed regulations will improve the quality of life and support of many individuals with Intellectual/developmental disabilities (IDD). We support:

- 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 Agencies to review the effectiveness of behavior support interventions
- Inclusion of Treatment Integrity Checks to ensure that PBSPs are being implemented as written
- The adoption of a multi-tiered system of support that is flexible for organization implementation.

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 (11) states that a "(a) PBS qualified clinician shall have training and experience in PBS and organizational strategies, shall meet all relevant state and federal licensure requirements, and have a current Massachusetts license in good standing in his or her relevant discipline" and "(b) A PBS qualified clinician serving on a leadership team under 115 CMR 5.14(5)(a)(i) or responsible for developing a PBSP for an individual shall meet the following minimum qualifications: 1. hold a master's degree in a relevant discipline such as applied behavioral analysis, psychology, or special education.

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 almost 1200 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, Koegel, et al., 2002)

Mass ABA represents over 700 behavior analysts in the Commonwealth of Massachusetts. Many of these behavior analysts work in programs serving individuals with IDD. Recently, the Commonwealth of Massachusetts passed a licensing bill for applied behavior analysts. The bill provides both standards for licensure as well as provides protections to families and individuals around the practice of applied behavior analysis. Additionally, board certified behavior analysts (BCBA) have a code of ethics that govern their practice. Consumers who feel that a BCBA involved in providing applied behavior analytic services does not behave ethically can file formal complaints with either the Massachusetts Licensing Board or the Behavior Analysis Certification Board. Allowing unlicensed professionals or those licensed professionals who do not have applied behavior analysis (ABA) as their primary scope of practice does not provide the same level of consumer protection.

We suggest since PBS is based on the principles of applied behavior analysis that the Department changes the qualifications for a "qualified clinician" to those individuals who have applied behavior analysis as their primary scope of practice and who are licensed accordingly.

Concern 2: Definition of Restrictive Procedures

Part of the definition of restrictive procedures includes: "….requires an individual to do something that they do not want to do". This wording is vague and needs to be better defined. There are many tasks (e.g., brushing teeth, bathing, working on ISP goals, leaving their bedroom, attending day program, etc.) that an individual may not want to do but are beneficial for care, safety, or instruction. Most individuals, with or without disability, do many things every day which s/he may not want to do including reporting to work on time, inhibiting the urge to disagree with a supervisor's instructions, etc. Part of the dignity afforded to adults in everyday life is the opportunity to accept or reject such requirements and affording individuals supported by DDS with this protection is consistent with the Department's direction. The concern is that there may be many instances where an individual objects to some element of the supports offered/provided and the Agency PBS Leadership Team will be overwhelmed with addressing each one. The proposed regulation requires all PBSP with restrictive interventions to be reviewed by the PBS Leadership team.

Recommendation

Further guidance may be helpful e.g., a more refined definition of what it means to "require an individual to do something s/he does not want to do" or, being clear that Agency PBS Leadership Teams will be expected to understand and prioritize different types of such objections by individuals.

Interventions involving physical prompting as an instructional procedure and used with prompt fading strategies should not require additional reviews. If every intervention using physical prompting needs to be reviewed by the Human Rights Committee(HRC) and by a PBS leadership team the amount of work required would dramatically increase for these committees and would dominate their agenda. Instead, only interventions that require physical management procedures (i.e., restraint, transports) should require additional reviews.

Concern 3: Lack of Specificity Concerning Restraints

Individuals who have had emergency restraints and are likely to need them in the future should have more specificity in their use. Without this guidance individuals with IDD are at greater risk of being subjected to restraints for low-risk behaviors under unclear circumstances or having a more intrusive restraint used.

Recommendation

We suggest that DDS specify that a Safety Plan be developed for those individuals who have had emergency restraint more than one time within a week or more than two times within a month be developed. The organization should immediately refer the individual to the appropriate PBS team in the organization for assessment and if needed the development of appropriate intervention to reduce the need for restraints. The goal of the Safety Plan is reduce both the inappropriate use of restraints and the use of more intrusive restraints.

The Safety Plan should be a separate document from the Behavior Support Plan document. This will help clarify the use of restraints as a method to ensure the safety of the individual and professionals and caregivers involved in the individual's care or in his/her immediate environment rather than a treatment intervention. The Safety Plan should specify observable criteria for restraint (circumstances under which restraints will be used to ensure safety), termination criteria and maximum duration, the type of restraint as approved by the specific curriculum used by the organization, data collection, and additional safeguards.

The lack of specific Safety Plan places too much responsibility on direct care staff and their judgment in emergency situations. The Safety Plan will reduce the unintended consequences of a) increased risk to the individual from the use of less restrictive procedures and may inadvertently create greater risk by waiting too long to implement a restraint, or, b) increased use of restraint by some staff as they will have to rely solely on their judgment in an emergency rather than clear and measurable criteria.

Concern 4: Functional Behavior Assessment after multiple restraints

Under the "Written Plan" section [5.14A (4) (c)] the regulations call for the completion of a functional analysis and under the "Emergency Procedures" section [5.14(17)] the proposed regulations call for a functional analysis in response to multiple restraints within a 6-month period.

Recommendation:

Mass ABA strongly recommends that the FBA is conducted *prior* to developing a behavior support plan rather than in response to emergency procedures that are used three times in a six-month period. While an FBA may be an appropriate response to increased use of emergency procedures, it is imperative that an FBA is completed and used to guide the development of the behavior support plan. Additionally, the regulations call for a functional "analysis" in these situations. While a functional analysis is generally considered more precise at identifying behavioral functions, it is important to differentiate a functional analysis from other forms of functional assessment such as descriptive analyses and indirect assessments. A functional analysis entails observing behavior while systematically manipulating environmental variables, and as such, a functional analysis requires more resources, greater behavioral expertise, and additional safeguards which many programs may not have the capacity to offer. Completing a functional behavior *assessment* should be required.

Concern 5: Prohibition of Response Cost

A response cost is a procedure in which there is a loss of a specific amount of reinforcement, contingent upon a problem behavior that results in a decrease in the future rate of that behavior. Under the proposed regulation changes this procedure would be prohibited. This would limit treatment options for behavior analysts treating severe challenging behavior. For example, under the proposed regulations it would be prohibited within a token economy for individuals to receive tokens to increase replacement behaviors

and remove a token if the individual engages in challenging behavior. Such a procedure may have significant reductive effects on problematic behavior.

Recommendation:

A response cost procedure produces moderate to rapid effects on decreasing problem behaviors and may be easily combined with other reinforcement procedures (Cooper, Heron, & Heward, 2007). All individuals have a right to effective treatment and to the most effective treatment available. When treating severe behavior that right to effective treatment may entail a fast acting but restrictive treatment to quickly reduce rates of a behavior. The use of a nonrestrictive but slower-acting treatment places an individual at greater risk, infringes upon his or her right to effective treatment, and may be considered more restrictive than the nonrestrictive intervention. Thus, in some cases of severe problem behavior, a client's right may require the immediate use of faster acting but temporarily more restrictive treatments (VanHouten et al., 1988). Instead of prohibiting response cost procedures, the regulations should classify a response cost as a Level III procedure that requires closer supervision by a licensed behavior analyst and oversight by Human Rights and Peer Review committees.

Mass ABA's parent organization, The Association for Behavior Analysis International (ABAI) supports the U.S. Supreme Court ruling that individuals have a right to treatment in certain contexts, and that many state and federal regulations and laws create such rights. Organizations and institutions should not limit the professional judgment or rights of those who are legally responsible for an individual to choose interventions that are necessary, safe, and effective. A regulation that prohibits treatment violates individuals' rights to effective treatment. The irresponsible use of certain procedures by unqualified or incompetent people should not result in policies that limit the rights of those duly qualified and responsible for an individual through the process of making informed choices (Vollmer et al., 2011).

We suggest that rather than prohibiting response cost procedures that all response cost procedures be reviewed by organizations' HRC and approved by the individual and/or guardian.

Concern 6: Protective Equipment

There is no section of the proposed regulations that addresses protective equipment. There are numerous individuals supported by DDS who engage in self-injurious behavior as well as other individuals that are at risk during transportation due to their challenging behavior. There were no suggested regulations that address these apparent needs.

Recommendation

It is suggested that a section on protective equipment be written to address these issues. Suggested language is: "Protective equipment includes devices implemented by trained personnel or utilized by an individual that have been prescribed by an appropriate medical or related service professional and are used for the specific and approved positioning or protective purposes for which such devices were designed. Examples of such devices include: vehicle safety restraints/harness when used as intended during the transport of an individual in a moving vehicle; restraints for medical immobilization; or prescribed devices that prevent self-injury (e.g. helmets, arm limiters/splints, etc.)".

If these devices are used an FBA must be conducted and PBSP written to improve the individual's behavior. Procedures for use of protective equipment should be incorporated into the Safety Plan including clear criteria for application and removal, safeguards, oversight, and steps to fade such devices as appropriate.

Concern 7: Debriefing with the Individual after Restraint

The regulations require debriefing with an individual after being subject to a restraint. Debriefing with an individual after being subjected to a restraint may assist the individual in having a better understanding of the circumstances surrounding the restraint. In other circumstances the debriefing may actually increase the challenging behavior.

Recommendation

The reason for the debriefing should include: (a) increasing the person's understanding of his/her behavior; (b) increasing the staff's understanding of the individual's behavior; and, (c) relationship repair – holding an adult against his/her will when there is risk is a form of support but may be experienced as an assault like action.

An FBA would be helpful in determining whether a debriefing procedure has an impact on the challenging behavior. Where clinically contra-indicated a PBS team should document this outcome in the individual's PBSP and not engage in the debriefing.

Concern 8: Tiers of Support

The proposed regulations suggest there should be tiers of support but does not specify how a multi-tiered system of support should be used to improve the effectiveness and efficiency of support. Secondly, it is implied that the primary reason that individual would receive Intensive Supports would be due to the restrictiveness of the plan as all Intensive Plans are required to be reviewed by the HRC. This may be true but another reason might be due to ineffectiveness of the current interventions and the need to increase the intensity of assessment and intervention.

Recommendation

At each tier or combined tiers there should be a representative team that uses data to determine the effectiveness of the behavior support plan and quality of life interventions and suggests changes to improve its effectiveness as part of an action plan. If an organization uses targeted or intensive supports there must be a representative team for each tier. In addition to level and type of restrictive interventions, individuals receiving targeted and intensive supports should receive increased individualization and intensity of:

a) functional behavioral assessment and other specialty assessment
b) behavior support practices such as teaching the replacement behavior and reinforcement
c) treatment integrity and fidelity
d) data collection

We suggest that Intensive Plans that involve restrictiveness should be reviewed by the HRC rather than plans that are overseen by the Intensive Team. The HRC review should not be a clinical review but, instead a review of the restrictiveness of the PBSP.

Concern 8: Removal of BSP to Decrease the Use of Behavior Control Medication

The proposed regulations (5.15: Medication) do not require the development of a PBSP to improve challenging behavior when medication is being use to manage behavior.

Recommendation

We recommend that in cases where medication is used to attempt to improve problem behavior that is listed in the individual's ISP, a PBSP should be developed specifying the goals and safeguards related to such treatment including but not limited to: (a) tracking of all relevant effects of the treatment (i.e., all effects of treatment including non-goal related outcomes such as weight gain or change in sleep pattern; and (b) a regular review by the appropriate Agency/Targeted/Intensive team. Ongoing review of the progress-monitoring data on effectiveness of the PBSP should be undertaken to determine if there is still the need for medication.

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,

Joe Vedora, Ed.D., LABA, BCBA-D
President
Massachusetts Association for Behavior Analysis
184 Burbank Rd,
Sutton, MA 01590
jvedora@evergreenctr.org
617- 945-4958

Bob Putnam Ph.D., LABA, BCBA-D
President-elect
Massachusetts Association for Behavior Analysis
184 Burbank Rd,
Sutton, MA 01590
bputnam@mayinstitute.org
781-437-1207

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