Protection of Individuals Receiving Services in Facilities Operated and/or Certified by OPWDD

Amendments to 14 NYCRR Part 633.16
Proposed Regulations

Effective Date: Upon Adoption

- **Existing 14 NYCRR Part 633.16 is retitled as follows:**

Protection of Individuals Receiving Services in Facilities Operated and/or Certified by [OMRDD] OPWDD

- **Existing paragraph 633.16(a)(1) is amended to read as follows:**

(1) This section applies to:
- (i) all residential facilities certified or operated by OPWDD, including family care homes;
- (ii) all facilities certified by OPWDD, except:
  - (a) free standing respite, except as described in section 635-10.5(h) of this Title;
  - (b) clinic treatment facilities (see Part 679 of this Title); and
  - (c) diagnostic and research clinics (see Part 676 of this Title);
- (iii) day habilitation services (whether or not provided in a certified facility);
- (iv) prevocational services (whether or not provided in a certified facility); and
- (v) community habilitation [(both hourly and Phase II)].

- **Existing paragraphs 633.16(a)(4), (5) and (6) are deleted.**

- **Existing subdivision 633.16(b) is amended as follows:**

(2) *Assessment, functional behavior[al]*. A process intended to: identify and operationally describe challenging behavior(s); identify the function(s) or purpose(s) for challenging behavior; and to identify the specific environmental stimuli or conditions that are maintaining the challenging behavior(s). (See subdivision (d) of this section.)

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Note: New material is underlined and deleted material is in [brackets].

(9) Blocking pad. See pad, blocking

(10) Clothing, modified (for use). Clothing that does not restrict free movement, but is designed or used to decrease or prevent challenging behavior (e.g., jumpsuit, leotard, or custom-designed clothing such as shirts or pants made of non-shreddable cloth) by limiting or preventing access to a portion or portions of a person's body or by using material that cannot easily be ripped, torn or shredded. "Modified" refers to modified use of clothing such that it is clothing that is being used for a specific reason related to challenging behavior. Modified clothing is considered a type of mechanical restraint.

(11[9]) *Committee, behavior plan/human rights*. A committee which has the responsibility to protect the rights of persons whose behavior support plans incorporate the use of any restrictive/intrusive intervention and/or limitation on a person's rights in order to prevent, manage, and/or control challenging behavior, and which exercises this responsibility through the process of reviewing and approving proposed behavior support plans.

(12[0]) *Committee, informed consent*. A committee which has the authority to give informed consent for:

(i) a behavior support plan incorporating the use of any restrictive/intrusive intervention and/or the use of medication to treat a co-occurring diagnosed psychiatric disorder;[,]

(ii) [or for] the short-term use of medication with no behavior support plan;[,] or

(iii) the use of medications or interventions used as part of Medical Immobilization/Protective Stabilization (MIPS) and Sedation for Medical/Dental Appointments, when the individual lacks capacity to consent and there is no other authorized surrogate available (except for a court). (See subdivision (g) of this section.)

(13[1]) *Conditioning, aversive*. The contingent application of a physical stimulus or device to a person's body or senses in order to modify or change behavior. Such a stimulus or device must be reasonably considered to be uncomfortable, painful, or noxious to the person when applied. Examples of such stimuli may include, but are not limited to: water and other mists or sprays, noxious odors (*e.g.*, ammonia), noxious tastes (*e.g.*, hot sauce), corporal punishment (*e.g.*, slapping, spanking, hitting, or pinching), air blasts, blindfolds, white noise helmets, and electric skin shock (see paragraph (17[15]) of this subdivision).

(14[2]) *Conflict of interest*. See Interest, conflict of.

(15[3]) *Consent, informed.*

Note: New material is underlined and deleted material is in [brackets].

(16[4]) *Device, mechanical restraining*. Any physical apparatus or equipment placed on or worn by the individual and used to limit or control challenging behavior, that does not meet the definition of modified clothing (see paragraph (10) of this subdivision). This apparatus or equipment cannot be easily removed by the person and may restrict the free movement, or normal functioning, or normal access to a portion or portions of a person's body, or may totally immobilize a person. (See paragraph (j)(4) of this section for requirements specific to the use of mechanical restraining devices.)

(17[5]) *Electric skin shock*. The application to a person's body of an electronic skin shock device in an effort to modify or change behavior. Such a device is reasonably considered to be uncomfortable, painful, or noxious to the person when applied. This definition is not applicable to the use of electroconvulsive therapy provided in a hospital setting and used as a treatment for specific psychiatric disorders.

(18[6]) *Emergency*. A term that describes a situation posing an immediate health or safety risk to the person or to others that is unexpected, unforeseen, or unanticipated, and for which procedures have not been specified in a person's behavior support plan to address how the staff is to handle the emergent situation.

(19[7]) *Functional behavior[al] assessment*. See assessment, functional behavior[al].

(20[18]) *Guardian*. A party appointed by a court of competent jurisdiction to make or assist a person to make personal and/or financial decisions in situations in which the person is deemed not to have capacity to make those decisions.

(21[19]) *Immobilize, totally*. The complete curbing of the movement of both arms and both legs, and/or torso through the use of (but not limited to):

(22[0]) *Instructor*. A party employed by OPWDD, or by an agency certified or authorized by OPWDD, who has been approved to teach a curriculum approved by OPWDD on the use of positive behavioral approaches, strategies and/or supports and physical intervention techniques.

(23[1]) *Instructor-trainer*. A party employed by OPWDD, or by an agency certified or authorized by OPWDD, who has been approved to teach a curriculum approved by OPWDD on the use of positive behavioral approaches, strategies and/or supports and physical intervention techniques and further certified by OPWDD to train, mentor and certify new Instructors in the teaching and implementation of the training curriculum. An instructor trainer also reviews and/or approves modified physical intervention techniques as necessary.

(24[2]) *Interest, conflict of*. Any real or perceived financial, personal or other interest, which may impede the impartial discharge of the party's duties.

Note: New material is underlined and deleted material is in [brackets].

(25[3]) *Intervention, physical*. Those intervention techniques, or the adaptations of such, that either include hands-on techniques that deflect, protect from, or release hits, kicks or grabs by persons receiving services toward others in their environment, or holds of limited duration that may reduce, limit, or restrict an individual's freedom of movement in order to interrupt or control challenging behavior that is posing an immediate health or safety risk to the person or to others. (See paragraph (j)(1) of this section for requirements specific to the use of physical intervention techniques.) There are three categories of physical intervention techniques:

(i) protective techniques, which include blocks, deflection strategies and grab releases;

(ii) intermediate techniques, which include holds and escorts/removals intended to maintain a person in a standing or seated position to reduce or limit movement, to maintain health and safety, and/or to remove a person from an unsafe location or situation; and

(iii) restrictive techniques, which include holds that restrict freedom of movement in order to interrupt or control behavior that is posing an immediate health or safety risk to the person or to others and involve taking a person from a standing position to the floor and holding the person on the floor.

(26[4]) *Intervention, restrictive/intrusive*. These interventions include the following:

(i) intermediate and/or restrictive physical intervention techniques (see paragraph (j)(1) of this section);

(ii) the use of exclusionary time-out [(exclusionary and non exclusionary)] (see paragraph (j)(3) of this section);

(iii) the use of any mechanical restraining device with the intent to modify or control challenging behavior (see paragraph (j)(4) of this section);

(iv) the use of each medication for the purpose of preventing, modifying, or controlling challenging behavior that is not associated with a co-occurring diagnosed psychiatric disorder (see paragraph (j)(5) of this section); and

(v) other professionally accepted methods to modify or control behavior which are determined by agency/facility policy to be restrictive/intrusive interventions because they may present a risk to a person's protection or encroach unduly on a person's normal activities (*e.g.*, response cost, overcorrection, negative practice, non-exclusionary time out, and satiation).

Physical intervention techniques and/or mechanical restraining devices used to facilitate emergency evacuations/drills or medical/dental exams, procedures, and related healthcare activities (and to protect individuals, healthcare providers, and others during

such exams, procedures, and activities) are not considered to be restrictive/intrusive interventions that require inclusion in a behavior support plan. Such interventions may be incorporated in other individualized plans to address these situations.

(27) Limitation, Rights. The limitation of a person's rights as specified in section 633.4 of this Part including, but not limited to: access to mail, telephone, visitation, personal property, electronic communication devices (e.g., cell phones, stationary or portable electronic communication or entertainment devices, computers), program activities and/or equipment, items commonly used by members of a household, travel to/in the community, privacy, or personal allowance.

(28[5]) *Master trainer*. A party employed by OPWDD who has been approved to teach a curriculum approved by OPWDD on the use of positive behavioral approaches, strategies and/or supports and physical intervention techniques, and further certified by OPWDD to train and mentor new instructor-trainers and instructors in the teaching and implementation of the training curriculum. The master trainer serves in a leadership role overseeing the quality of Instructors, quality and consistency of trainings, and coordinating and monitoring implementation of the curriculum. The master trainer also reviews and approves new or modified physical intervention techniques as necessary.

(29[6]) *Mechanical restraining device*. See device, mechanical restraining.

(30[27]) *Medication*. For the purposes of this section, a pharmaceutical agent prescribed and used either to prevent, modify, or control challenging behavior, or to treat the symptoms of co-occurring diagnosed psychiatric disorders, by altering thoughts, feelings, mental activities, mood, or behavior. This definition includes medications which are not usually classified as psychotropic, when they are prescribed for their psychotropic effects such as mood stabilization or impulse control. (See subparagraph (j)(5)(vi) of this section for requirements specific to the use of medications used to treat a co-occurring diagnosed psychiatric disorder.)

(31) Pads, blocking. Any type of freestanding protective equipment or device (e.g. foam pads, mats, shields, bolsters, cushions, etc.), used to prevent or minimize harm from challenging behavior. This may include devices to block aggression towards others or block efforts related to self-injurious behavior. This definition does not include the use of a gel pad or dense foam pad used to prevent headbanging or other self-injury as part of a physical intervention procedure.

(32) Modified clothing. See clothing, modified.

(33[28]) *Plan, behavior support*. A written plan that outlines specific interventions designed to support, develop or increase replacement or alternative behaviors and/or modify or control a person's challenging behavior. The plan is a component of a person's overall plan of services. Agencies may

use other equivalent terms for such plans. (See subdivision (e) of this section.)

(34[29]) *Plan, monitoring*. A plan developed by a licensed psychologist, licensed psychiatric nurse practitioner, psychiatrist, licensed clinical social worker, or a behavioral intervention specialist that identifies the target symptoms of a co-occurring diagnosed psychiatric disorder that are to be prevented, reduced, or eliminated. The plan shall specify interventions that will be used to address associated challenging behaviors that may occur, and methods by which progress in symptom control and functional improvement will be measured, documented, and reviewed.

(35) **Psychiatrist**. For the purposes of this section, a physician licensed in the state of New York and who is board certified in psychiatry by the American Board of Psychiatry and Neurology.

(36[0]) *Restrictive/intrusive intervention*. See intervention, restrictive/intrusive.

(37[1]) *Senior member of the staff*. See staff, senior member of the.

(38[2]) *Specialist, behavioral intervention (BIS).*

(i) Level 1 BIS. In order for a party to be a Level 1 BIS, the party must:

(a) have the following educational background:

(1) at least a Master's degree from a program in a clinical or treatment field of psychology, social work, school psychology, or applied psychology as it relates to human development and clinical interventions, and documented training in assessment techniques and behavior support plan development; or

(2) a national board certification in behavior analysis (BCBA) or a NYS license as a Behavior Analyst (LBA); or[and a Master's degree in:

(i) behavior analysis; or

(ii) a field closely related to clinical or community psychology that is approved by OPWDD; or]

(3) a New York State license in mental health counseling; and

(b) have at least three[five] years of experience:

(1) working directly with individuals with developmental disabilities, including the development, implementation, and monitoring of behavior support plans; and/or

(2) providing supervision and training to others in the implementation of behavior support plans; or[.]

(c) have been employed as a Level 2 BIS, at the master's degree level, for three years.

Note: New material is underlined and deleted material is in [brackets].

(ii) Level 2 BIS. In order for a party to be a Level 2 BIS, the party must meet the qualifications outlined in clauses (*a*), (*b*), or (*c*) of this subparagraph:

(a) The party must have a BCBA or an LBA[and a Master's degree in:
  (1) behavior analysis; or
  (2) a field closely related to clinical or community psychology that is approved by OPWDD]; or

(b) The party must:
  (1) have either:
    (i) a Master's degree in a clinical or treatment field of psychology, social work, school psychology, applied psychology as it relates to human development and clinical intervention, or a related human services field; or
    (ii) a New York State license in mental health counseling; and
  (2) have or obtain OPWDD-approved specialized training or experience in functional assessment techniques and behavior support plan development; or

(c) The party must:
  (1) have a Bachelor's degree in a human services field; and
  (2) have provided behavioral services for an agency in the OPWDD system as of, and continuously since, December 31, 2012; and
  (3) either:
    (i) is actively working toward a Master's degree in an applied area of psychology, social work, or special education; or
    (ii) completes at least one graduate-level course in an applied health service area of applied psychology, social work, or special education each year.
    (iii) The qualifying Master's degrees referenced in this paragraph, including any degree obtained through an online educational or distance learning program, must have been awarded by a regionally accredited college or university, or one recognized by the NYS Education Department as following acceptable educational practices. If the Master's degree

was awarded by an educational institution outside the United States and its territories, the party must provide independent verification of equivalency from one of the approved entities used by the NYS Department of Civil Service for educational equivalency reviews.

(iv) Notwithstanding any other provision of this section, parties who are employed by New York State and function in a title included in a New York State Civil Service title series shall provide behavioral services or supervision of such services described in this section as included in their job descriptions.

(v) Notwithstanding any other provision of this paragraph, a party may be considered a BIS in the event that OPWDD has approved a waiver of a specific required qualification upon application of a provider (see paragraph (c)(12) of this section).

(39[3]) *Staff, senior member of the*. As used in this section, that staff member, by whatever title he or she may be known who is designated by the chief executive officer (CEO) as a senior member of the administrative structure of an agency, and as such, may carry out designated responsibilities delegated by the CEO. This may be someone who is responsible for a group of facilities (*e.g.*, team leader, residence manager, head of shift, unit supervisor).

(40[34]) *Team, program planning*. For the purposes of this section, the program planning team includes at least a licensed psychologist, a licensed clinical social worker, or psychiatrist;[or] a[n] behavioral intervention specialist, the person, the service coordinator or party designated with the responsibility for coordinating a person's plan of services, the person's advocate or correspondent (including the Consumer Advisory Board for Willowbrook class members that it fully represents), and any other party deemed necessary for identifying a person's behavioral needs and developing an appropriate plan to address those needs (*e.g.*, direct support professional, health care professional). A registered nurse or other medical professional shall be a member of the team when the use of medication is part of the plan.

(41[35]) *Time-out*. Time-out is an [restrictive/intrusive] intervention in which a person is temporarily removed from positive reinforcement or denied the opportunity to obtain positive reinforcement and during which the person is

under constant visual and auditory contact and supervision. Time-out interventions include:

(i) placing a person alone in a specific time-out room, commonly referred to as exclusionary time-out (See paragraph (j)(3) of this section for requirements specific to the use of exclusionary time-out.);

(ii) removing the positively reinforcing environment from the individual, commonly referred to as non-exclusionary time-out. [(See paragraph (j)(3) of this section for requirements specific to the use of time-out.)]

- **Existing clause 633.16(c)(7)(ii)(c) is amended as follows:**

(c) restrictions of the amount of food or type of diet (including food/beverage consistency requirements)that a person consumes, or other health-related limitations may be made for clinical reasons related to the person's specific healthcare status, pursuant to documentation and order by a qualified healthcare professional, which shall specify the clinical justification for the restriction and the time period that such restriction shall be in effect, and which shall be included in the individual's written service plan, and in accordance with section 636-1.4 of this Title;

- **Existing subparagraphs 633.16(c)(8)(ii), (iv), and (v) are amended as follows:**

(ii) the use of exclusionary time-out [(exclusionary and non exclusionary)] (see paragraph (j)(3) of this section);

(iv) the use of medication [solely] to prevent, modify, or control challenging behavior (see paragraph (j)(5) of this section); and

(v) other professionally accepted methods to modify or control behavior which are determined by agency/facility policy to be restrictive/intrusive interventions because they impose a risk to a person's protection or encroach unduly on a person's normal activities (*e.g.*, response cost, overcorrection, negative practice, non-exclusionary time out, and satiation).

- **Existing paragraph 633.16(c)(10) is amended to read as follows:**

(10) Any objection to a person's current or proposed behavior support plan or to a proposed revision of a current plan must be made following the

Note: New material is underlined and deleted material is in [brackets].

process specified [as outlined] in section 633.12 of this Part, except for objections to the use of restrictive/intrusive interventions by the party providing informed consent and objections to medication use by an individual receiving services. (See subdivision (h) of this section.)

- **Existing paragraph 633.16(c)(12) is amended to read as follows:**

(12) Notwithstanding any other provision of this section, a party lacking the specified credentials may perform the functions of a Level I BIS, Level II BIS, [licensed psychologist, or licensed clinical social worker]or supervising clinician, as specified in this section if OPWDD has granted a waiver of a specific required qualification for that particular party. The waiver may limit the functions that may be performed by such party.

(i) OPWDD may approve a waiver upon application of the provider if all of the following conditions are met:

(a) the provider documents that it is unable to employ, or access contractual services from, a party who meets the requirements for a Level 1 BIS, Level 2 BIS, licensed psychologist, [or] licensed clinical social worker, or psychiatrist; and

[(b) the provider is in a rural area; and]

(b[c]) the provider has demonstrated a sustained hardship condition concerning its ability to obtain the necessary clinical services.

(ii) In the event that New York State law requires licensure for parties to legally provide any of the services specified in this section, a party performing such services pursuant to a waiver which are inconsistent with the law may no longer perform those services.

- **Existing subdivision 633.16(d) is amended to read as follows:**

(d) Functional behavior[al] assessment.

(1) Prior to the development of a behavior support plan to address challenging behavior that is not solely the result of a co-occurring diagnosed psychiatric disorder, a functional behavior[al] assessment must be completed by a clinician with training in functional behavior assessment techniques to obtain relevant information for effective intervention planning. A functional behavior[al] assessment must:

(i) identify/describe the challenging behavior in observable and measureable terms;

Note: New material is underlined and deleted material is in [brackets].

(ii) include identification and consideration of the antecedents for the behavior(s);

(iii) identify the contextual factors or setting events, including cognitive, environmental, social, physical, medical and/or psychiatric conditions, that create or may contribute to the behavior;

(iv) identify the likely reason(s) or purpose(s) for the challenging behavior;

(v) identify the [general conditions or] probable consequences that may maintain the behavior;

(vi) determine whether[include an evaluation of whether environmental or social alterations, or] further assessments are needed to rule out a contextual factor that could be contributing to challenging behavior(s)[, would serve to reduce or eliminate the behavior(s)];

(vii) include an evaluation of preferred reinforcers or preference assessment;

(viii) consider multiple sources of data including, but not limited to:

(a) information gathered through direct observations of the individual;

(b) information gathered from interview and/or discussion with the individual, parent/caregiver, and other relevant service providers; and

(c) a review of available clinical, medical, behavioral, or other data from the individual's record and other sources;

(ix) not be based solely on an individual's documented history of challenging behaviors; and

(x) provide a measurable and quantifiable baseline of the challenging behaviors that may include[ing] frequency, duration, intensity and/or latency across settings, activities, people, and times of day.

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(2) In exceptional circumstances (*e.g.*, unexpected admission to a residential program) a behavior support plan may need to be developed or modified primarily on the basis of historical information to assure staff or the family care provider have sufficient tools and safeguards to manage potentially dangerous behaviors of the person who is beginning to receive services. In these cases, a functional behavior[al] assessment shall be completed within 60 days of admission or the commencement of services.

(3) The functional behavior assessment should be reviewed and revised, as appropriate, when the behavior support plan is reviewed or revised.

- **Existing subdivision 633.16(e) is amended to read as follows:**

(e) Behavior support plan.

(1) Level 1 Behavioral Intervention Specialists (BIS) may develop and/or provide supervision for behavioral support plans or services that do not include restrictive/intrusive interventions. Level 2 BIS may develop behavioral support plans or services that do not include restrictive/intrusive interventions under the supervision of Level 1 BIS. Behavior support plans or services which include restrictive/intrusive interventions may be developed by a Level 1 or a Level 2 BIS under the supervision of a licensed psychologist, [or] licensed clinical social worker (LCSW), or a psychiatrist (see paragraph (3) of this subdivision).

(2) All behavior support plans must:

(i) be developed by a BIS, [or a] licensed psychologist, [or a] licensed clinical social worker, or psychiatrist with training in behavioral intervention techniques;

(ii) be developed or updated in consultation, as clinically appropriate, with the person receiving services and/or other parties who are or will be involved with implementation of the plan;

(iii) be developed on the basis of a functional behavioral assessment of the target behavior(s);

(iv) include a concrete, specific description of the challenging behavior(s) targeted for intervention;

(v) include a hierarchy of evidence-informed[based] behavioral approaches, strategies and supports to address the target

Note: New material is underlined and deleted material is in [brackets].

behavior(s) requiring intervention, with the preferred methods being positive approaches, strategies and supports;

(vi) include a personalized plan for actively reinforcing and teaching the person alternative skills and adaptive (replacement) behaviors that will help or reduce challenging behaviors and enhance or increase the individual's personal satisfaction, degree of independence, or sense of success;

(vii) include the least restrictive or least intrusive methods possible in the behavioral approaches, strategies and supports designed to address any behaviors that may pose an immediate risk to the health or safety of the person or others;

(viii) provide a method for collection of adaptive (replacement)[positive] and challenging[negative] behavioral data with which treatment progress may be evaluated; and

(ix) include a schedule to review the effectiveness of the interventions included in the behavior support plan no less frequently than on a semi-annual basis, including examination of the frequency, duration, and intensity of the challenging behavior(s) as well as the replacement behaviors.

(3) A behavior support plan which incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights (see paragraph (c)(9) of this section) shall be designed in accordance with the following:

(i) Level 1 and/or Level 2 BIS who develop and/or provide behavior support services to implement behavior support plans which include restrictive/intrusive interventions shall function under the supervision of a licensed psychologist, [or] licensed clinical social worker, or psychiatrist.

(ii) A plan that incorporates a restrictive/intrusive intervention and/or a limitation on a person's rights must include the following additional components:

(a) a description of the person's behavior that justifies the incorporation of the restrictive/intrusive intervention(s) and/or limitation on a person's rights to maintain or assure health and safety and/or to minimize challenging behavior;

Note: New material is underlined and deleted material is in [brackets].

(b) a description of all positive, less intrusive, and/or other restrictive/intrusive approaches that have been tried and have not been sufficiently successful prior to the inclusion of the current restrictive/intrusive intervention(s) and/or limitation on a person's rights, or [and] a clear justification of why the use of less restrictive alternatives would be inappropriate or insufficient to maintain or assure the health or safety or personal rights of the individual or others;

(c) designation of the interventions in a hierarchy of implementation, ranging from the most positive or least restrictive/intrusive to the least positive or most restrictive/intrusive, for each challenging behavior being addressed;

(d) the criteria to be followed regarding postponement of other activities or services, if necessary and/or applicable (*e.g.*, to prevent the occurrence or recurrence of dangerous or unsafe behavior during such activities);

(e) a specific plan to minimize and/or fade the use of each restrictive/intrusive intervention and/or limitation of a person's rights, to eliminate the use of a restrictive/intrusive intervention and/or limitation of a person's rights, and/or transition to the use of a less intrusive, more positive intervention; or, in the case of continuing medication to address challenging behavior, the prescriber's rationale for maintaining medication use;

(f) a description of how each use of a restrictive/intrusive intervention and/or limitation on a person's rights is to be documented, including mandated reporting; and

(g) a schedule to review and analyze the frequency, duration and/or intensity of use of the restrictive/intrusive intervention(s) and/or limitation on a person's rights included in the behavior support plan. This review shall occur no less frequently than on a semi-annual basis. The results of this review must be documented, and the information used to determine if and when revisions to the behavior support plan are needed.

Note: New material is underlined and deleted material is in [brackets].

(iii) A behavior support plan incorporating the use of restrictive physical interventions and/or exclusionary time-out rooms is prohibited in family care homes and [hourly] community habilitation. However, a behavior support plan incorporating restrictive physical interventions in hourly community habilitation may be permitted if specifically authorized by OPWDD.

(4) Prior to implementation of a behavior support plan which incorporates a limitation on a person's rights and/or a restrictive/intrusive intervention[:

(i)] the plan shall be approved by the behavior plan/human rights committee established pursuant to subdivision (f) of this section.[; and]

(5) Prior to the implementation of a behavior support plan which incorporates a restrictive/intrusive intervention or a limitation of a person's rights as specified in section 636-1.4 of this Title

[(ii)] written informed consent shall be obtained from the individual or appropriate consent-giver for restrictive/intrusive interventions.

(6[5]) If a behavior support plan is necessary in more than one service setting, the agency developing such a plan shall consult and coordinate with other service settings, in order to prevent conflicting or inappropriate strategies.

(7[6]) If an agency will be using a behavior support plan developed by a different service setting/agency, the agency that developed the plan shall provide documentation to the other service setting/agency regarding current informed consent for the plan and its approval by a behavior plan/human rights committee.

(8[7]) Nothing in this subdivision shall be construed to prevent the use of physical intervention techniques in an emergency when used in conformance with paragraph (j)(1) of this section.

(9[8]) Nothing in this subdivision shall be construed to prevent the use of limitations on a person's rights in an emergency when used in conformance with paragraph (j)(2) of this section.

(10[9]) Nothing in this subdivision shall be construed to prevent the use of medication to prevent, modify, or control challenging behavior in an emergency when used in conformance with subparagraph (j)(5)(iv) of this section.

- **Existing subdivision 633.16(f) is amended to read as follows:**

Note: New material is underlined and deleted material is in [brackets].

(f) Behavior plan/human rights committee.

(1) Every agency with oversight responsibilities for one or more programs that serve people in need of behavior support plans that include restrictive/intrusive interventions and/or rights limitations shall establish a behavior plan/human rights committee to protect the rights of persons whose behavior support plans incorporate the use of restrictive/intrusive interventions and/or a limitation on a person's rights. It may be a separate committee created solely for the purpose of meeting the requirements of this section, or it may be part of another committee. [An agency is not required to have a behavior plan/human rights committee if:

(i) no individual served is in need of a behavior support plan that includes a restrictive/intrusive intervention; and

(ii) no individual served is in need of a behavior support plan that includes a limitation on the person's rights.]

(2) Agencies shall create their own behavior plan/human rights committee, if needed, or may coordinate with other agencies in the creation of a shared behavior plan/human rights committee.

(3) Prior to the implementation of the proposed behavior support plans, the committee shall approve or refuse to approve, in writing, proposed plans which contain a limitation on a person's rights (see paragraph (c)(9) of this section) and/or utilize one or more restrictive/intrusive interventions specified in paragraph (c)(8) of this section, except for monitoring plans in which medication is used solely for the treatment of a co-occurring diagnosed psychiatric disorder. The term *psychiatric disorder* means those psychiatric disorders which are recognized as such by the American Psychiatric Association or World Health Organization. For the purposes of this section, the term *co-occurring psychiatric disorder* does not refer to the following: intellectual disability [mental retardation], specific learning disorder[s], motor [skills] disorders, communication disorders, autism spectrum disorder[pervasive developmental disorders], social (pragmatic communication disorder), attention-deficit/hyperactivity disorders and disruptive, impulse-control, and conduct disorders. [behavior disorders, and impulse control disorders.]

(4) The committee must review the behavior support plans identified in paragraph (3) of this subdivision to verify that all required components are included (see subdivision (e) of this section).

(5) The committee chairperson must verify that:

(i) the proposed behavior support plans presented to the committee are approved for a time period up to [not to exceed] one year and are based on the needs of the person; and

(ii) written informed consent is obtained prior to the implementation of the approved behavior support plan that contains

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restrictive/intrusive interventions or specific rights limitations as identified by section 636-1.4 of this Title. If written informed consent cannot be obtained [within a reasonable period of time] prior to the initiation or continuance of a plan, verbal consent may be accepted only for the period of time before written informed consent can be [reasonably] obtained. Verbal consent must be witnessed by two members of the staff, and documented in the person's record. This verbal consent is valid for a period of up to 45 days and may not be renewed.

(6) The committee must specifically approve (or refuse to approve):
  (i) the use of a mechanical restraining device that is not commercially available or is not designed for human use (*e.g.*, modification of a commercially available device) pursuant to subclause (j)(4)(ii)(*a*)(*2*) of this section; and
  (ii) modification of intermediate and restrictive physical intervention techniques, and new intermediate and restrictive physical intervention techniques, consistent with the provisions of subparagraph (j)(1)(iii) of this section.

(7) The committee shall review and make suggestions to the agency's management and/or governing body about its policies, practices, and programs as they relate to topics addressed by this section.

(8) Behavior plan/human rights committee membership.
  (i) A behavior plan/human rights committee must have a minimum of four members including:
    (a) a licensed psychologist or a behavioral intervention specialist, with training in assessment techniques and behavioral support plan development;
    (b) a clinician, currently licensed, certified, or registered in New York State as one of the following: social worker, physician, physician assistant, nurse practitioner, registered nurse, speech pathologist, occupational therapist, physical therapist, or pharmacist; and
    (c) an additional party, preferably with no ownership, employment relationship, or other interest in the agency. This party may be, but is not limited to:
      (1) someone charged with the responsibility for advocating for a person's rights (*e.g.*, an ombudsperson, a volunteer, or an advocacy organization representative); or
      (2) an individual[someone] with a developmental disability, or a guardian or family member of someone with a developmental disability.

Note: New material is underlined and deleted material is in [brackets].

(ii) A committee member must recuse himself/herself from reviewing a plan for a person for whom he/she is actively involved in the delivery of services.

(iii) The committee must have a minimum of three members present to proceed with its deliberations.

(9) Temporary approval by the behavior plan/human rights committee chairperson/designee may be provided for urgent situations in which a behavior plan has been created or updated to include a restrictive/intrusive intervention or rights limitation and appropriate informed consent, where required, has been obtained. In such cases, temporary approval may continue only until the committee is able to review and may not exceed 45 days.

- **Existing subparagraphs 633.16(g)(1)(i), (ii), and (iii) are amended to read as follows:**

(i) Written informed consent is required prior to implementation any time that a restrictive/intrusive intervention or a rights modification as specified in section 636-1.4 of this Title is included in a behavior support plan to modify or control challenging behavior. However, if written informed consent cannot be obtained [within a reasonable period of time] prior to the initiation or continuance of a plan, verbal consent may be accepted only for the period of time before written informed consent can be [reasonably] obtained. Verbal consent must be witnessed by two members of the staff, and documented in the person's record. This verbal consent is valid for a period of up to 45 days and may not be renewed.

(ii) Written informed consent is required prior to implementation of a physician's order for planned use of medication to treat a co-occurring diagnosed psychiatric disorder (see subparagraph (j)(5)(ii) of this section). However, if written informed consent cannot be obtained [within a reasonable period of time] prior to the initiation or continuance of a medication, verbal consent may be accepted only for the period of time before written informed consent can be [reasonably] obtained. Verbal consent must be witnessed by two members of the staff, and documented in the person's record. This verbal consent is valid for a period of up to 45 days and may not be renewed.

(iii) Written informed consent is also required for short-term use of medication when there is no behavior support plan. If it is necessary for the medication to be administered before written informed consent can be [reasonably] obtained, verbal consent

may be accepted for only the period of time before written informed consent can be [reasonably] obtained, but no longer than 45 days. Verbal consent must be witnessed by two members of the staff and documented in the person's record.

- **Existing paragraphs 633.16(g)(2) and (3) are amended to read as follows:**

(2) Written informed consent shall be documented and kept in a person's clinical record.
(3) Written informed consent obtained in accordance with this subdivision shall be valid for up to [have a maximum duration of] one year.

- **Existing clause 633.16(g)(6)(i)(g) is amended to read as follows:**

(g) an informed consent committee (see paragraph (8) of this subdivision) or a court of competent jurisdiction. [(see paragraph (8) of this subdivision).]

- **Existing subparagraph 633.16(g)(7)(i) is amended as follows:**

(i) In the first instance, it shall be the program planning team's responsibility to determine the person's capacity to give informed consent for each proposed restrictive/intrusive intervention. The team's determination and documentation shall be included and available in the person's record.

- **Existing paragraph 633.16(h)(1) is amended as follows:**

(1) Any objection to a person's proposed behavior support plan or a proposed revision of a current plan (except those relating to restrictive/intrusive interventions or rights modifications specified in section 636-1.4 of this Title), must be made in accordance with the process that is outlined in section 633.12 of this Part.

- **Existing subparagraph 633.16(h)(2)(ii) is amended as follows:**

(ii) The following applies to the use of restrictive/intrusive interventions (except for the refusal of the person receiving services to take medication as described in paragraph (3) of this subdivision) and rights modifications specified in section 636-1.4 of this Title. If there is lack of informed consent, and the agency considers use of the intervention/treatment/specified rights modification to be necessary

Note: New material is underlined and deleted material is in [brackets].

to provide services safely and appropriately to the individual, the agency must apply for court approval for the use of such intervention/treatment/specified rights modification. Notice of such application shall be sent to MHLS at the time of filing. While such a court application is pending, the agency may only use the restrictive/intrusive intervention in accordance with the emergency use provisions set forth in paragraphs (j)(1) and (5) of this section. Agencies may also impose limitations on the person's rights in an emergency (see paragraph (j)(2) of this section). However, if a surrogate consent giver has withdrawn consent for the administration of medication, and the immediate cessation of the administration of the refused medication would be harmful or dangerous to the person, then the medication shall be suspended in accordance with accepted medical practice. The surrogate shall be advised regarding the accepted medical practice for the suspension of the medication that is being followed by the agency.

- **Existing subparagraph 633.16(h)(3)(iv) is amended as follows:**

(iv) If repeated attempts to resolve the issue of refusal of medication intended to modify or control challenging behavior or to treat a diagnosed psychiatric disorder are unsuccessful, and the agency considers the administration of the medication to be necessary for effective treatment of the individual's disorder, such agency must apply to a court of competent jurisdiction for a hearing to determine whether the individual has the capacity to make a reasoned decision with respect to the proposed medication use and whether the medication should be administrated over objection. Notice of any such application shall be given to the authorized surrogate decision maker, if any, and [the Mental Hygiene Legal Service]____ MHLS.

- **Existing subparagraphs 633.16(j)(1)(vi), (x), (xi), (xii), (xiii) are amended as follows:**

(vi) After the use of any physical intervention technique (protective, intermediate, or restrictive), the person shall be inspected for possible injury as soon as reasonably possible after the intervention is used. The findings of the inspection shall be documented in the form and format specified by OPWDD or a substantially equivalent form. If an injury is suspected, medical care shall be provided or arranged. Any injury that meets the definition of a reportable

incident (Per section 624.3 of this Title)or notable occurrence (per section 624.4 of this Title) [serious reportable incident] must also be reported in accordance with Part 624 of this Title.

(x) The use of any intermediate or restrictive physical intervention technique in an emergency more than two times in a 30-day period or four times in a six month period shall require a comprehensive documented review by the person's program planning team, in consultation with a licensed psychologist, a licensed clinical social worker, psychiatrist, or behavioral intervention specialist. The team shall determine if there is a need for a behavior support plan to address the exhibited behavior(s), a need to change an existing plan, or to establish the criteria for determining if a plan will need to be developed in the future.

(xi) The use of restrictive physical intervention techniques is not permitted in family care homes. The use of restrictive physical intervention techniques is not permitted in [hourly] community habilitation unless specifically authorized by OPWDD.

(xii) The use of an intermediate or restrictive physical intervention technique that is not in conformance with the requirements of this section is considered to be a reportable incident [physical abuse] and must be reported pursuant to Part 624 of this Title (except as noted in subparagraph (xiii) of this paragraph).

(xiii) Notwithstanding any other provision of this section, any physical contact that is necessary to address an immediate health or safety risk to the person or to others, and which does not involve the use of more force than necessary, shall not be considered a reportable abuse or restraint incident [to be physical abuse] pursuant to Part 624 of this Title or a violation of the requirements of this section. However, in the event that the level of physical contact would be considered to be comparable to an intermediate or restrictive physical intervention, the agency must comply with the provisions of subparagraphs (vii)-(ix) of this paragraph concerning visual inspection for possible injury and notifications. In addition, the person's program planning team must be notified. The person's program planning team shall consider whether changes might be needed in an existing behavior support plan or whether a plan needs to be developed.

- **Existing subparagraph 633.16(j)(2)(iii) is amended as follows:**

(iii) The emergency or unplanned limitation of a person's rights more than four times in a 30 day period, or an ongoing limitation in place

Note: New material is underlined and deleted material is in [brackets].

for more than 30 days, shall require a comprehensive documented review by the program planning team in consultation with the licensed psychologist, licensed clinical social worker, psychiatrist, or behavioral intervention specialist. The team shall determine if there is a need for a behavior support plan to address the exhibited behavior(s), a need to change an existing plan, or to establish the criteria for determining if a plan will need to be developed in the future.

- **Existing subparagraphs 633.16(j)(3)(i)-(iv) is amended as follows:**

(i) Time-out is an [restrictive/intrusive] intervention in which a person is temporarily removed from positive reinforcement or denied the opportunity to obtain reinforcement and during which the person is under constant visual and auditory contact and supervision. Time-out interventions include:
  (a) placing a person alone in a specific time-out room, commonly referred to as exclusionary time-out;
  (b) removing the positively reinforcing environment from the individual, commonly referred to as non-exclusionary time-out.

(ii) Time away, when a person is redirected to a quieter or less stimulating area of the program and where staff do not actively prevent egress from that area, is not considered a form of exclusionary time-out.

(iii) Exclusionary t[T]ime-out shall not be used in an emergency.

(iv) Requirements for the use of exclusionary time-out rooms.
  (a) The placement of a person alone in a room from which his or her normal egress (ability to leave) is prevented by a staff member's direct and continuous physical action shall be considered exclusionary[a form of] time-out (see glossary). The use of a time-out room shall be in conformance with the following:
    (1) such action shall be taken only in accordance with a person's behavior support plan;
    (2) constant auditory and visual contact shall be maintained. If at any time the person is engaging in behavior that poses a risk to his or her health or safety staff must intervene.
  (b) The use of a time-out room where normal egress is prevented, or placement of a person in a secured room or area from which he or she cannot leave at will, and which is

not in conformance with the requirements of this section is considered a reportable incident, pursuant to Part 624 of this Title.

(c) The maximum duration of time a person can be placed in a time-out room shall not exceed one continuous hour. Use of a time-out room on five or more occasions within a 24-hour period shall require the review of the behavior support plan by the program planning team in consultation with the licensed psychologist, licensed clinical social worker, psychiatrist, or behavioral intervention specialist within three business days.

(d) Each use of a time-out room in accordance with an individual's behavior support plan shall be reported electronically to OPWDD in the form and format specified by OPWDD.

(e) Any time a room is to be used for exclusionary time-out, that room must meet the following stipulations:

- **New paragraph 633.16(j)(4) is added as follows and existing 633.16(j)(4) is renumbered 633.16(j)(5)**

(4) Blocking pads.

(i) General provisions.

(a) Blocking pads shall be employed:

(1) Only as a means to protect individuals or staff from harm.

(2) Only in a defensive or protective manner.

(b) Blocking pads may not be used:

(1) In an offensive manner to move, physically redirect, push back, or physically contain a person.

(2) To strike or hit an individual.

(3) To remove an individual from an area.

(4) To trap or contain a person against a wall, corner, room, or ground.

(5) For the purpose of blocking or preventing a person from leaving a room or otherwise creating a situation that is effectively exclusionary "time out" as defined by this regulation.

(ii) The use of blocking pads to prevent or minimize harmful consequences related to challenging behavior shall be in conformance with the following:

(a) Planned use of blocking pads shall be specified in the individual's behavior plan.

Note: New material is underlined and deleted material is in [brackets].

(b) Blocking pads are not to be viewed as therapeutic or used in lieu of an ongoing comprehensive treatment plan designed to reduce or eliminate challenging behavior.
(c) The use of blocking pads shall be documented.
(d) The use of blocking pads in an emergency situation without a behavior plan is permitted. If blocking pads have been used in an emergency more than six times in a six-month period, the team shall meet to determine whether the implementation of a behavior plan is necessary.
(e) Blocking pads shall be maintained in a clean and sanitary condition and in good repair.
(f) Agency policies/procedures governing the use of blocking pads shall address the sanitizing of the devices.
(g) The behavior support plan shall specify the following conditions for the use of blocking pads:
(1) the facts justifying the use of the pads;
(2) staff or family care provider action required when the pads are used;
(3) a description of how the use of the pads is expected to be reduced and eventually eliminated.

(5[4]) Mechanical restraining devices.

- **Renumbered subclause 633.16(j)(5)(ii)(a)(2) is amended as follows:**

(2) the device shall be commercially available (including situations in which a device has been specifically designed or adapted for the individual by a health care professional)and designed for human use. Alternatively, if the device is not commercially available or is not designed for human use (*e.g.*, modification of a commercially available device), it must be approved by the behavior plan/human rights committee and approved by OPWDD; and

- **Renumbered subclause 633.16(j)(5)(ii)(b)(1) is amended as follows:**

(1) mittens, helmets, face masks, goggles, and sleeve boards (by whatever name known), modified clothing [(*e.g.*, jumpsuit, leotard, or custom-designed clothing such as shirts or pants made of non-shredable cloth), bolsters, and mats used to safely contain a person];

Note: New material is underlined and deleted material is in [brackets].

- **Renumbered subclause 633.16(j)(5)(ii)(i)(1) is amended as follows:**

(1) Except when asleep a person in a mechanical restraining device shall be released from the device at least once every hour and fifty minutes for a period not less than 10 minutes, and provided the opportunity for movement, exercise, necessary eating, drinking and toileting. In the case of modified clothing only; removal from the clothing shall occur as specified in the physician's order and consistent with the behavior plan, and at other appropriate times (e.g., changing, toileting, comfort needs).

- **Renumbered clause 633.16(j)(5)(ii)(j) is amended as follows:**

(j) At least once every 30 minutes (60 minutes for modified clothing), including when a person is asleep, or more frequently if directed by a physician or previously designated in a risk management or behavior support plan, the person's physical needs, comfort, and safety shall be monitored. Monitoring shall incorporate any specific components that are included in the physician's order (*e.g.*, checking vital signs, skin integrity, and circulation). If the person is asleep, this monitoring shall be completed through observation only while not awakening the person. The person shall also be monitored after removal of the mechanical restraining device. Documentation of the monitoring and action taken must be entered in the person's clinical record.

- **Existing paragraph 633.16(j)(5) is renumbered 633.16(j)(6) as follows:**

(6[5]) Medication.

- **Renumbered clause 633.16(j)(6)(ii)(d) is amended as follows:**

(d) The effectiveness of the medication shall be re-evaluated at least semi-annually at the program plan reviews by the program planning team in consultation with a licensed psychologist, licensed clinical social worker, psychiatrist, or behavior intervention specialist, and a health care professional. The goal(s) of this aspect of the plan review

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include: ensuring that medication is at the minimum and most effective dose; identifying a potential need for a medication with fewer or less intrusive side effects; evaluating the evidence presented to support continuation of the medication at a maintenance level, or recommending reduction or discontinuation of medication use if clinically indicated and authorized by the prescriber.

- **Renumbered clauses 633.16(j)(6)(iii)(d) and (h) are amended as follows:**

(d) The staff person or family care provider who is responsible for support and supervision of a person who has a behavior support plan or monitoring plan must document in the person's clinical record a summary of the results of each[the] medication use in behavioral terms.

(h) If the as-needed medication is not administered during a six-month period, the program planning team, in consultation with the licensed psychologist, licensed clinical social worker, psychiatrist, or behavioral intervention specialist, must review the behavior support plan and develop a recommendation to the prescriber regarding the appropriateness of continuing the as-needed medication as part of the plan. If the order is continued, a clear justification is to be documented in the record.

- **Renumbered clause 633.16(j)(6)(iv)(d) is amended as follows:**

(d) The emergency use of medication to control challenging behavior or acute symptoms of a co-occurring diagnosed psychiatric disorder in more than four instances in a 14-day period shall require a comprehensive review by the program planning team in consultation with the licensed psychologist, a licensed clinical social worker, psychiatrist, or behavioral intervention specialist within three business days of the fifth medication administration.

- **Renumbered clause 633.16(j)(6)(v)(d) is amended as follows:**

(d) Within five working days of the first administration of the medication or of the admission to such programs of a person with such a pre-existing medication regimen, a person's

program planning team, in consultation with a licensed psychologist, licensed clinical social worker, psychiatrist, or behavioral intervention specialist, shall conduct a review of the circumstances which necessitated the use of such medication. The program planning team shall determine if it is necessary to develop a behavior support plan to prevent, modify, or control the behavior or to modify an existing plan of services, or shall establish the criteria for a future decision that a plan will be needed. All determinations shall be documented.

- **Renumbered clause 633.16(j)(6)(vi)(b) is amended as follows:**

(b) The term *psychiatric disorder* means those psychiatric disorders which are recognized as such by the American Psychiatric Association or World Health Organization. For the purposes of this section, the term *co-occurring psychiatric disorder* does not refer to the following: intellectual disability, specific learning disorder, motor disorders, communication disorders, autism spectrum disorder, social (pragmatic) communication disorder, attention-deficit/hyperactivity disorder and disruptive, impulse-control, and conduct disorders[mental retardation, learning disorders, motor skills disorders, communication disorders, pervasive developmental disorders, attention-deficit and disruptive behavior disorders, and impulse control disorders].

Note: New material is underlined and deleted material is in [brackets].