**Draft Behavior Regulations**

**Highlights to Consider/Understand:**

1. These regulations apply to all individuals 18+ with ASD/ID who receive services funded in part or full by DHHS. The exceptions are schools and correctional settings. These do apply to individuals under private and public guardianship. There is no distinction made in a person’s living environment (i.e. living with family, on own or in group home setting).
2. **Plans:**
* **Level 1 and 2**: Includes Positive Support Plans, Functional Behavior Assessment and Psychiatric Medication Plan which are developed, approved and monitored by the Planning Team (Person Centered Planning Team)
* **Level 3:** Includes Positive Support Plan, Functional Behavior Assessment, Psychiatric Medication Plan (as indicated) and Behavior Management Plan. This level plan includes elements that restrict rights in some way.
* **Level 4**: Includes Positive Support Plans, Functional Behavior Assessment, Psychiatric Medication Plan (as indicated), Behavior Management Plan with approval of the Planning Team and Review Team (formerly 3 Person Committee). This level plan may include restraints or coercive measures but not prohibited practices.
* **Level 5**: These are “exceptional and rare.” These include a Positive Support Plan, Functional Assessment, Behavior Management Plan, Psychiatric Medication Plan (as indicated), Psychological Assessment (within 6 months), Physician Assessment, Second Clinical Opinion, and Statewide Review Panel. All go to the Commissioner or Health and Human Services for consideration.
1. Definition of Challenging Behavior includes “imminent risk to health and safety/damage to others” but also to behavior that “seriously interferes with a person’s ability to have positive life experiences and maintain relationships”—this will include many of the behaviors that our loved ones may exhibit.
2. Positive Support Plans must be the first approach for all plans. These plans must include a Functional Assessment (see description p. 9) and a written Positive Support Plan (see description p. 10) that is approved by the Planning Team (Person Centered Planning Team) and must be reviewed every 3 years. The regulations say teams must “strive to avoid” token economies and if you have an “artificial reinforcer” you must have a written plan to move toward “natural reinforcer and personal control.” The plan must also include medical and mental health assessments by “licensed professionals”.
3. Use of Psychiatric Medication for any behaviors (which is what most behavioral health diagnoses are based on) must include a Psychiatric Medication Support Plan and Positive Support Plan (p. 12 see #1-8 required). This is to be approved by the Planning Team (Person Centered Planning Team) with specific monitoring required. This is outside of the doctor/patient/guardian relationship and discussion. This must be updated when medications change, which for some can be frequent.
4. Behavior Management Plans are required when a behavior threatens injury to self/others/property/loss of placement. Such plans can be developed and monitored by qualified professionals—psychiatrist, psychologist, psychological examiner, LCSW, LCPC or Board Certified Behavior Analyst (see p 14-15, #1-13). Training and monitoring requirements (see A-H on p 16). The Review Team must approve these quarterly (this is formerly the 3 Person Committee and does not include a clinically trained professional). No Behavior Management Plan can be implemented without the external Review Team’s approval, including any modifications/changes.
5. In- Home Stabilization (for safety only) has explicit restrictions and expectations (see p. 17 and 18). If community access is limited by more than an hour, it is a “level 3 restriction” which requires a Behavior Management Plan.
6. Behavior Management Plans are reviewed monthly by the qualified professional (p20). Plans are expected to cross settings and agencies.
7. See the list of required documentation for Level 1, Level 2, Level 3, Level 4, and Level 5 (helpful visual p 22 and 23) and requirements for oversight.
8. Prohibited practices (p.24 and 25) include any ”seclusion”, even where there is constant monitoring and where it can be a safer alternative for individuals to de-escalate in a low stimulation setting. Prohibited practices also include withholding money for behavior management, and “manipulation of personal property” unless with ”imminent risk”. “Aversive” practices are disallowed and described as “intervention/action to modify behavior that could arouse fear and distress in that person” ---this broad definition would include several evidence-based therapeutic techniques for example, systematic desensitization for phobic responses to stimuli).
9. Emergency Interventions: if restraint occurs 3 times in a two week period or 6 times in a year, the Planning Team must do a Functional Assessment and Positive Support Plan reviewed in a meeting (IST). If you have 3 IST meetings in a year, the Planning Team must develop a plan to address the challenging behavior.
10. Safety Devices (see p. 33-39): Definitions include gloves, locked cabinets. These need approval of the Review Team. Some safety practices do not need approval (i.e. seat belts in vehicle). The use of helmets for safety require a Level 3 Behavior Management Plan.

**Consider:**

1. How would these regulations impact your loved ones and their day to day activities/routines?
2. Do the regulations improve and protect? Are there items that that might interfere with other important areas (such as confidentiality, privacy)?
3. Are the right people making the recommendations and overseeing the plans for our family members (i.e. credentials, qualifications, experience)?
4. Should there be any difference for people living in family homes, on their own, or in group homes?
5. What is the role of probate court which oversees private guardianship? Do these regulations supersede the responsibilities of private guardianship?
6. What are the issues when you have a plan with multiple settings/providers? What if one agency is not in agreement with the plan? Who is ultimately responsible for the plan?
7. Does the Planning Team (Person Centered Planning Team) have the necessary skills and qualifications to develop, implement, and review Positive Support Plans, Medication Administration Plans, and Functional Behavior Assessments (Level 1 and 2 Plans)? Do team members have the ability to attend the number of meetings that would be required?
8. Are there conflicting rules in these draft regulations? What are they, and how can they be clarified?
9. Given the numbers of plans outlined in these regulations, there will be a significant increase in the number of approvals being requested. How will the Teams deal with the backlog to ensure that people with unsafe behaviors do not have to wait for adequate support plans?
10. Do the procedures outlined in the safety device section meet our loved ones’ needs? It covers a range from video monitoring to seat belts. Do the requirements provide the access to protections needed?