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Memorandum

To: James Smith
Independent Regulatory Review Commission
Commonwealth of Pennsylvania
Harrisburg, PA

From: Scott Spreat, Ed.D.
Vice President for Behavioral Health
Woods Services Inc.
Langhorne, PA, 19047

Date: 11/8/10

Regarding: Proposed Chapter 23 Residential Treatment Facility Regulations

Thank you for the opportunity to offer comments on IRRC document 2878 - **55 PA Code Chapter 23, Residential Treatment Facilities**. I will offer a broad argument that the imposition of a medical model on non-medically oriented programs is both clinically inappropriate and excessively expensive. In addition, I will offer specific feedback on individual regulations and how they will create undue burden on providers already quite capable of serving this vulnerable population of the Commonwealth's youth.

In order to provide you with a framework from which to view these comments, please allow me to briefly describe the residential program I represent. Crestwood is a component of Woods Services Incorporated in Langhorne, PA, Bucks County. It was designed to serve children and adolescents who have significant emotional and/or behavioral barriers to life in a less restrictive setting. These individuals present with diverse needs due to the challenging nature of their psychiatric disabilities, learning difficulties, and challenging behaviors; in layman's terms, they are individuals with significant emotional disturbances. The philosophy of the Crestwood program reflects an appreciation of each child's strengths, coupled with a systematic and highly individualized approach to therapeutic intervention, including a focus on individual, group and family therapy. The integration of clinical and educational services within a residential community, which fosters trust, personal responsibility and socialization, is central to the Crestwood Program. The staff to client ratio is 1:3. Note that all clients in this program attend school on a daily basis, year round. There are approximately 70 children or adolescents living in Crestwood. The average age is about 15, with a range from 9 to 20. The most frequently employed psychiatric diagnoses are ADHD and Intermittent Explosive Disorder. New York, New Jersey, and Pennsylvania are the primary referring states. It should be noted that Crestwood has been recognized as a

model for residential mental health services by the Office of Children, Youth, and Families.

Imposition of a Medical Model

The regulations are quite clear in the requirement that residential treatment facilities are to be operated under a medical model. There must be a medical director of each program (even if all medical services are procured from community physicians). A psychiatrist must be the leader of the treatment team. There is a mandated role for nursing, even for programs that don't currently employ nurses. The expectation is abundantly clear that Residential Treatment Facilities are to be operated as medical organizations; as opposed to educational, psychosocial or interdisciplinary treatment programs – models that are nationally recognized as more therapeutic and cost effective.

This dramatic change is objectionable for both pragmatic and economic reasons. Crestwood has operated outside of a medical model since its opening in 1993. We do have a part time psychiatrist, but he is a *member* of the team, not the leader of the team. Because our model is more of a psychosocial model than a biological model, it seems only appropriate that the leader be a clinician with a broader psychosocial background. The practice of psychiatry at Crestwood is largely a biological function. With our psychosocial model, we have witnessed considerable treatment success. We have returned children to their homes and to a continuum of community placements. By all objective measures, Crestwood must be considered a successful program. It is difficult to see that the imposition of a medical model on Crestwood would enhance the quality of services we provide; in fact, it likely would be a detriment to effective programming.

Given that the medical model was abandoned by most residential treatment programs 20-30 years ago, we are curious as to why it is being reintroduced at this time. The Child Welfare League of American (CWLA) notes that residential group care is based on a non-medical model, and that this selection of a model was purposeful. Residential group care is a means to provide children with safe, nurturing, protective, therapeutic environments where educational, social, behavioral, and emotional needs can be properly addressed. Residential facilities were meant to be step-down, less-intensive, and non-medical ways of keeping children in or near their home communities. CWLA notes that just as in private families, physicians are not part of the daily interaction and behavior management strategies. Direct care staff are typically the primary care givers and have the day to day involvement with the children. These direct care staff are trained in the psychosocial model we employ and have a great deal of success in implementing this model.

Significant Cost Increases

As noted in the documentation accompanying the proposed regulations, these regulations will result in a significant cost increase for most programs. I have attempted to estimate the costs that would be associated with transitioning our

Crestwood Program to operate under these proposed regulations. I estimate the additional annual costs to be in the area of \$1.3 million, with one-time transitional costs adding another \$470 thousand. [see attachment A for a detailed explanation of these costs.]

Please note that because Crestwood, like many other RTFs, is above the maximum size permitted under the proposed regulations, one dimension of cost will be associated with the termination of excess staff and loss of income from the census reductions. Beyond costs associated with reduction in census is the human impact resulting from these program discharges that will place consumers in the difficult position of transitioning to new services before clinically recommended. The overall reduction in capacity seems to be in contrast to the ever increasing demand and need for these types of services. One immediate effect of this will be an increase in waiting lists of un-served or under-served individuals in the Commonwealth.

Imposition of a clinical model

It is clear that the commonwealth has a vested interest in imposing a medical clinical model on service providers. This approach, however, is not prudent for the best interests of the individuals served. Organization clinical professionals spend years studying the most current best practices which evolve over time and are in no way static. Though aspects of trauma informed care, for example, are beneficial to some individuals, it is not the best modality for others. This imposition does not seem to take in to account individuality and the unique needs of each individual. Staff training in trauma informed care is mandated under the proposed regulations. Trauma history must be included in Health and Safety plans. Restraint reduction plans must include reference to trauma. In addition to these proposed regulatory impositions, the commonwealth has supported training on trauma informed care.

Trauma informed care is a model that many providers have adopted, but it is not a universally held clinical approach. I am not interested in arguing the relative merits of this approach, but I would suggest that the decisions regarding clinical models and clinical approaches are best left to professional clinicians. The purposes of regulations are to provide the basic protections and expectations for providers of service, and not to dictate clinical approaches which could both limit and inhibit the most appropriate services for children. It seems entirely reasonable for the commonwealth to mandate the use of approaches with adequate empirical evidence supporting their use (or experimental research with appropriate design and protections), but the commonwealth should not be in the business of attempting to mandate what constitutes best practice or required practice. The commonwealth should require professionals to comply with their professional ethics and implement only treatments with solid empirical support.

One could argue that the empirical support for trauma informed care is emerging, despite the somewhat discouraging meta analysis across nine different studies (Cocozza, Jackson, Hennigan, Morrissey, Reed, Fallot, and Banks, 2005). I have no

interest in trying to discredit the trauma informed care model. The real point, however, is that there are many clinical approaches with strong empirical support that do not incorporate trauma informed care. Some of the more behavioral approaches would probably reject the very notion of trauma informed care because trauma is a hypothetical construct rather than something that can be objectively quantified. Room must be left for ethical, adequately trained professionals to choose models of treatment in coordination with the appropriate team members and families, at times other than those based on trauma informed care.

Mandated Reduction in Size of Business

Empirically, there is nothing magical or desirable about the maximum size of 48 clients. It must be recognized that Crestwood, like many other RTF's in Pennsylvania, has developed strengths and options because its size allows for the investment in various programs and supports. The Commonwealth has little, if any, rational reason for such limitations other than (perhaps) ideology. In today's economy, such thinking is counterproductive in regard to cost control.

Policy Approval by DPW

While DPW has the right to review provider policies, it is not clear that they should be given the right to approve or disapprove our policies. The provider is the one that will be held legally accountable for the policies and, of course, is the single entity liable for claims of harm. A major complaint of providers to the disability community is that various offices within DPW go beyond their statutory authority in dictating policy, standards and practices on a fairly routine basis. Attempts to bypass the regulatory review process are practically standard operating procedure. There are many examples of this that could be presented by the various provider professional associations.

Specific Comments

- **Purpose of Regulation (page 1)** – The proposed regulations require that Residential Treatment Facilities, in addition to state licensure, must become accredited by one of any number accrediting agencies (like JCAHO, etc.). This seems a bit redundant in an age of limited funds. Given that accreditation standards are generally more stringent than licensing standards, was consideration given to simply waiving state licensure inspections for those facilities with accreditation?
- **23.1 Purpose (page 9)** – one purpose of the proposed regulations is to establish minimum treatment standards. The establishment of treatment standards is typically a professional decision rather than a state function. One might raise the

concern that a regulatory establishment of treatment standards may have the side effect of stifling the development of new treatment procedures because these new procedures, by their very definition, are not yet a treatment standard. It would seem reasonable for the commonwealth to require providers and professionals to comply with professionally defined standards of care, but the imposition of commonwealth defined standards of care are both stifling of new treatment development and arguably, not based on the judgement of professional clinicians. If the commonwealth persists in the imposition of treatment care standards, it would seem that it incurs the responsibility to encourage, support, and even fund research on new treatments in a manner to prevent stagnation of treatment services. Because regulations don't tend to be flexible documents, it has been my experience that it is relatively rare for standards of care to be codified.

- **23.3 Definitions (page 10)** - A definition of antipsychotic medication is listed. The definition presumes both a level of power and a mechanism of biological action that may limit the inclusiveness of the definition. Wouldn't it be better to simply define an antipsychotic medication as any medication that the FDA has approved to be marketed for the treatment of psychosis?
- **23.3 Definitions (page 13)** - A definition of intimate sexual contact is provided, and is very vague and unclear.
- **23.3 Definitions (page 13)** - A minor is under 18 years of age, but a child is under the age of 21. This will cause difficulties and confusion throughout the regulations and program since the age of majority is 18, but throughout the regulations child is referenced and includes up to 21 years of age.
- **23.3 Definitions (Page 14)** - A definition of psychotropic medication is provided. It should be noted that some drugs that typically fall into other classifications are used by psychiatrists. The most frequently used such classification would be antiepileptic medications that are sometimes used for bipolar disorder.
- **23.3 Definitions (Page 14)** - A definition of restraint is provided, and it is confusing. It says that a restraint does NOT include holding. I'm suspicious of some sort of typographical error here.
- **23.3 Definitions (Page 14)** - There is a definition of Residential Treatment Facility. It would appear to be so broad as to include literally every program currently licensed under the 3800 regulations. Several colleagues and I tried to figure out whether these proposed regulations will pertain to our programs, and we could reach no conclusion. This is a key definition, and it is too vague.
- **23.12 Inspections and certificates of compliance (page 16)**. A copy of "this chapter" must be publicly and conspicuously posted. This chapter is 186 pages long and it is not practical to post these, nor does it contribute to a home-like

environment. In an effort to “go green” we are focused on reduction in paper and not an increase as we move to make documents available electronically.

- **23.14.a - Maximum Capacity (page 17)** –What is to happen to the programs that currently exceed this size limitation? Will they be grandfathered? Certainly, the commonwealth can elect to not do business with larger providers, but by what right can the commonwealth direct an independent business to downsize or lose their license? Who will become responsible for the unemployment costs associated with such actions? Will the commonwealth indemnify individual providers for actions taken at the commonwealth’s direction? Does the commonwealth really want to cause the lay off of so many workers?
- **23.14.b – Maximum Capacity (page 17)** – It is written that the commonwealth will determine the maximum capacity of a program, but no information is given regarding what rules or formulae they are to follow in making such decisions. It leaves the door open for capricious actions. Isn’t capacity usually a business decision typically left to the business owner? Certainly the commonwealth can elect to limit the amount of business they do with any business, but what gives the commonwealth the right to limit the size of a business? Who will serve the individuals who lose service as a result of the reduction in capacity and at what social and monetary cost?
- **23.14.c – Maximum Capacity (page 17)** – This regulation says that the department can reduce capacity if it decides that such action is required by the clinical programming. Again, one must ask by what standards such determination will be made and what is the empirical research base for making such decisions?
- **23.16.a – Child abuse (page 18)** – Suspected abuse of a child must be reported to Childline. Child is defined as a person up to the age of 21 years, but Childline only accepts reports on people up to the age of 18.
- **23.17.a.6 – Reportable Incidents (page 19)** – Attempted sexual contact between children is a reportable offense. Given that a child can be older than a minor, we may have a situation in which two adults (i.e., over 18) are kissing each other and may meet the expectation of a reportable incident. Based on the unclear definition of “intimate sexual contact” (noted above) is this reportable? Is this appropriate for reporting?
- **23.17.a.18 – Reportable Incidents (page 19)** – The provider is supposed to report any criminal convictions of staff. Is there an expectation of regular ongoing criminal checks on all staff? Once hired, we don’t typically do more than ask staff to report arrests and convictions.
- **23.17.e – Reportable Incidents (Page 20)** – This regulation requires an investigation of every reportable incident report. Is there an expectation of a full

investigation (with statements, interviews of all nearby staff, collection of evidence) of such relatively benign incidents as a child falling off a bicycle and cutting his/her leg or being seen at the hospital for illness? The term investigation has a specific meaning to many providers, and it typically is a laborious process. It would be more beneficial to clarify that investigations are to be conducted for such reportable incidents as allegations of abuse, neglect, or unknown origin injuries that require hospitalization. If the intent is being communicated clearly in the proposed regulation additional costs will be incurred including additional staff being certified to conduct investigations and perhaps hiring full time investigators to conduct these investigations.

- **23.17.e – Reportable Incidents (Page 20)** – The regulation requires a provider to initiate an investigation immediately following the identification of the incident. In cases of child (under 18) abuse, we are forbidden to take any sort of investigatory action that might corrupt the investigation of the Office of Children, Youth, and Families. We are not permitted to investigate until OCYF authorizes us to do so. Similarly, when police are involved, the initiation of an investigation by a provider could corrupt the more important police investigation.
- **23.17.j.1 – Reportable Incidents (page 21)** – Providers are required to notify the CMS regional office of the death of a child. If the child is not funded by Medicaid, wouldn't this constitute a HIPAA violation? Would reporting in HCSIS suffice, or would multiple separate contacts need to be made.
- **23.18.3 – Recordable Incidents (page 23)** – The use of the word “intentionally” should be deleted. Intent is unknowable, and philosophically a fuzzy construct. Most scientists deny the notion of free will, making the notion of intention an impossibility.
- **23.18.4 – Recordable Incidents (page 23)** – Property damage over \$500 is considered a recordable incident. Why? The property doesn't belong to the commonwealth. The destruction of property not belonging to the commonwealth is not the business of the commonwealth.
- **23.20.a – Consent to Treatment (page 24)** – Act 169 regarding substitute health care decision making should be added to this list of pertinent regulations.
- **23.20.b.2 – Consent to Treatment (page 25)** – Written consent is required for non-routine treatment, but non-routine treatment is not defined. Presumably, chemotherapy is a routine treatment for cancer. Would consent not be required to administer chemotherapy? Similarly, antipsychotic medication is the standard of care for treatment of schizophrenia. Is consent no longer needed because it is a form of routine treatment? At a broader level of questioning, is the process of obtaining and collecting medical consent even the responsibility of the provider (unless of course the provider actually provides the medical

treatment). Isn't the collection of consent properly the responsibility of the treating physician or the hospital that provides the treatment?

- **23.20.b.2 – Consent to Treatment (page 25)** – Is witnessed verbal consent unacceptable? It has been our experience that a significant number of families fail to return consent forms, leaving a child without necessary treatment. Over the phone, they are willing to consent to the treatment, but simply don't return forms. Some provision for witnessed verbal consent should be considered lest the provision of needed treatment be jeopardized.
- **23.21.b.1 – Confidentiality of Records (page 26)** – May information be released to police in the event of a client running away?
- **23.32.a – Specific Rights (page 29)** – replace “sex” with “gender”
- **23.32 g.2 – Specific Rights (page 29)** – Consideration needs to be given for children who cannot read or who cannot even communicate the need for assistance with mail. There should be some provision for providing assistance.
- **23.32.i – Specific Rights (page 30)** – The proposed regulation states that a child has a right to appropriate rehabilitation services. Many providers who deal with children with autism and/or intellectual disability are not dealing with rehabilitation, but rather with habilitation. Our clients have not lost skills that need to be redeveloped, but rather have never acquired the skills. Is there also a right to habilitation? Is it the intent of the commonwealth to create a right to treatment? In *Romeo v. Youngberg*, the Supreme Court only recognized a right to treatment sufficient to eliminate need for restraint. This regulation would seem to go far beyond that which the court has decided.
- **23.32.q – Specific Rights (Page 31)**. The prohibition against the use of restraint, while consistent with current social sensitivities regarding restraint use, does result in denying children access to an evidence based form of treatment for serious behaviors. You may want to consider the Association for Behavior Analysis International position statement on the use of restraint that permits the use of contingent restraint as a form of treatment. Kennedy Krieger, the pre-eminent acute care behavioral treatment program in the country, employs contingent restraint on a regular basis. I recognize that there is little choice regarding this regulation, but we need to be clear that it will deny some children treatment, and as such, it may come into conflict with 23.32.i.
- **23.33.c – Prohibition against Deprivation of Rights (page 31)** – Family visits may not be used as reward or sanction. I would assume that families may elect to make such visits contingent. Perhaps the regulation should be rewritten to note that providers may not use family visits as rewards or sanctions.

- **23.34.d – Notification of RTF Restraint Policy (page 32)** – I don't understand what is being said here. It almost appears as if a word or phrase has been left out of the proposed regulation.
- **23.41.4 – Family Participation in the Treatment Process – (page 32)** – Family therapy is mandated for the benefit of the child. This presents a number of concerns. First, don't all participants in family therapy have to consent to the participation? If it is mandated, consent is meaningless. Second, how does one mandate a form of treatment without an appropriate diagnosis and assessment? This regulation would even mandate the provision of family therapy for a child with autism who perhaps is completely unable to communicate. This is insensitive, ineffective, and not the best use of valuable programming time. This requirement could detract from other more effective clinical programming. The decision to provide therapy is a clinical decision, not an administrative one. Not every child will be able to participate in family therapy, and not every child will be able to benefit from it. In some instances, the provision of family therapy might even be counter therapeutic. A better form of this regulation would be to require that each child be evaluated for possible inclusion in family therapy as appropriate. Family therapy could then be required if there is professional judgement that the child would benefit from family therapy. Many times family training and other forms of support are more effective. For the commonwealth to mandate family therapy in an RTF is like the commonwealth requiring that everyone entering a hospital must receive respiratory therapy. Professional judgements should be left to the professionals.
- **23.41.6 – Family Participation in the Treatment Process (page 33)** – It seems like consent for medical treatment should appear somewhere in this section, but it is notably absent. Parents should get to do more than merely participate in the decision making around medication and medication decisions; they have the power of consent. This should be included .
- **23.41.9.iv – Family Participation in the Treatment Process (page 34)** – The phrase “when possible” must be removed. What possible justification is there for using anything other than evidence based treatments? The only possible exception would be for experimental treatments, which would need to be conducted in accordance with regular scientific evaluative procedures. We cannot allow this phrase to be a back door admission for non-empirically validated and “fad-like” treatments like facilitated communication, dolphin assisted therapy, secretin, or orgone therapy. Based on the way this is written providers may be responsible for any such therapy.
- **23.54 – Medical Director – (page 35)** – Shouldn't this be re-titled “Psychiatry Director?” It would seem that medical director is a title that should be reserved for someone with training in pediatrics or internal medicine. While psychiatrists are physicians, they are specialists. In many cases, psychiatrists are only

minimally involved in medical care, and many would suggest that it not their area of expertise.

- **23.54.a – Medical Director (page 53)** - It must be recognized that psychiatry has become a largely biological profession, with many exceptionally competent psychiatrists having little to no experience in the provision of therapy or the overall operation of programs. The clinical director should be the one in charge of overseeing the delivery of services and programs to children. Nothing would prevent the psychiatry (or medical) director from serving as clinical director, but this position should be open to other professionals of equal qualifications and license.
- **23.54.c.7 – Medical Director – (page 36)** – The Clinical Director should be responsible for the coordination and supervision of RTF staff, including the psychiatry director. Hasn't the field moved from the medical model of service for a reason? Let the Medical/psychiatry director report to the clinical director who actually runs the program. Better yet, let the program decide how to best establish a table of organization that will maximize service to children.
- **23.59.b.4.iii – Primary Contact – (Page 40)** – It should be noted that not every child in an RTF will be eligible for MA. Some children are referred and funded by their school districts, and as such, they may be on the parents' regular insurance policies, or they may have no insurance at all.
- **23.60 b.2 – Family Advocacy – (Page 41)** – The focus on restraint reduction makes the faulty assumption that all restraint use is inappropriate. Clearly, there are situations in which restraint is the appropriate and expected response for dangerous and unsafe individuals. Providers have the legal responsibility to protect the health, safety, and welfare of those they serve and at times that includes the appropriate use of physical modalities such as restraints to do so by trained and competent staff. The focus should be on reducing the frequency of behaviors that would legitimately warrant the use of restraints. In doing so, restraint use should decline. The attention towards restraint reduction is misguided, and advocates should spend increased energy lobbying for the use of evidence based behavior modification programs to reduce the frequency of socially devalued behaviors that in most real world situations would result in restraint use.
- **23.61.a – Supervision – (Page 41)** – The proposed regulation requires 15 minutes observation checks of the child. In most cases, this will be fine, however, consider the child whose team has concluded his behavior is such that greater levels of independence are essential to his continuing development? An example might be the child who secures a job at the local McDonalds. Should staff stop by the McDonalds every 15 minutes to check on the child? There needs to be a little team based latitude in this area.

- **23.62.c.5 – Staff Training – (page 44)** – Is the 20 hours referenced in this proposed regulation included in the annually required 40 hours of training, or is it in addition to the mandated 40 hours? This needs to be clarified.
- **23.62.c.5.vi – Staff Training – (page 44)** – While trauma informed care has become a topic of interest in Pennsylvania, does it really have the substantial empirical support needed to warrant inclusion as a regulation? Not all schools of psychological thought accept it as a primary principle. This modality talks about hypothetical constructs, rather than observable events. One must question why training in trauma informed care is to be mandated by regulation, while therapeutic strategies with significantly greater degrees of empirical evidence, such as applied behavior analysis, are not so included?
- **23.62 .5.d.3.v – Staff Training (page 46)** – Least restrictive is a term that professionals have failed to define in any meaningful way, and its inclusion in the proposed regulations will only continue the confusion that the term creates. Academic considerations of the topic recognize that least restrictive is best represented by a mathematical summary of treatment efficacy, treatment duration, distress caused by the treatment, and distress caused by the continuing emission of the behavior (cf. Axelrod, Sprent, Moyer, & Berry, 1993; Bailey, in press). Within this model, it is entirely possible that response contingent electric shock for the treatment of self injurious behavior may be less restrictive than repeated gentle reprimands. Even though 1 shock is clearly more intrusive than 1 gentle reprimand, if a small number of shocks can eliminate an extremely harmful behavior, shock must be considered less restrictive. I am suggesting that the term “least restrictive” be deleted. Few people providing the training and even fewer receiving the training are prepared for an adequate review of the exceptionally complex topic. Oversimplification of the topic will result in a gross misunderstanding of the issue.
- **23.121.b – Fire Safety (page 55)** – This standard appears in the 3800 regulations and the 6400 regulations. A number of providers have received waivers to install delayed openers to reduce runaway risk. My program interpreted this regulation as an absolute, and gave no thought to requesting delayed door openers which would have saved a child's life. Something should be added to this proposed regulation that would somehow indicate that the department was receptive to waiver requests based on clinical need.
- **23.133 – False Alarms – (page 59)** – It should be noted that many children learn to pull the fire alarms, and repeated instances of this behavior are really a matter for the clinical team to address, rather than the quality assurance group. The quality assurance group may consult as needed.
- **23.141.c.7 – Child Health and Safety (page 60)** – the mandate that trauma history be recorded imposes a certain clinical model on professionals that may reject that model. Trauma is a hypothetical construct, and hypothetical

constructs have no place within behavioral clinical orientations. The concept itself is unclear and ignores the phenomenology of trauma. How can one reliably ascertain whether an event was traumatic, particularly if the individual involved is unable to communicate? Should we merely assume that certain events were probably traumatic? The inclusion of trauma history in this set of regulations lends support to a clinical orientation rather than other such orientations and this may not be appropriate for all individuals.

- **23.143 – Child Health Exams – (Pages 61-63)** – It appears that the ordering is not correct here.
- **23.147 – Use of tobacco – (Page 68)** – Child is defined as a person under 21 years of age, and Pennsylvania law permits persons 18 or older to smoke. The proposed regulation would prevent an 18 year old child from using or possessing tobacco products would seem to conflict with proposed regulation 23.33 that indicates that civil rights may not be limited.
- **23.183.c – Use of Prescription Medications – (Page 73)** - This is a major area of ethical concern. If a psychiatrist or team is in some way prevented from providing what he/she believes to be appropriate care, he/she has a duty to refer the patient elsewhere. They cannot allow themselves to be placed in a position where they are giving something other than what they believe to be appropriate care. With this regulation, DPW has taken away the option of discharging the patient whose family does not permit appropriate treatment, and it has created a legal Catch-22 for the psychiatrist and team. Note also that the regulation may conflict with the child protective services law. The psychiatrist is a mandated reporter of abuse, and if he/she believes that the parent's refusal to consent treatment constitutes medical neglect, he/she is obligated to call Childline. This is obviously a negative consequence for parents. Providers offer specific services and admit individuals based on the understanding they will be able to provide services consistent with their own professional judgement and permission of the family. If a family is unwilling to work with the team and denies the provider their ability to provide services consistent with the best professional judgement of that provider, providers should be able to end the relationship through discharge. At times disagreement in treatment modalities may occur, but the provider should be under no obligation to provide treatment they may ethically and philosophically disagree with for the individual.
- **23.183.g.i – Use of Prescription Medications – (page 74)** - This proposed regulation creates a potentially serious ethical dilemma for a treating physician. Let us suppose that a physician employed by the provider diagnoses a child with schizophrenia. The standard of care for treatment of schizophrenia includes the use of antipsychotic medications; in fact, the physician could be found negligent for failing to prescribe such medications. In the community, when a parent refuses such a recommendation, the physician is obligated to refer the parent to another provider. A provider employee, however, retains a case on his caseload

and he/she is prevented from treating that child in the appropriate manner. The only ethical options for that physician are to seek a court order (or threaten to seek a court order) or seek discharge of that client. This proposed regulation serves to create a situation in which the physician is unable to exercise his/her professional judgement, and hence, exposes him/her to considerable liability.

- **23.187.a.5 – Administration – (Page 76)** – DPW already has an extensive training program to prepare direct care staff to administer medications. The Office of Developmental Programs has been using this model in the community for years. The 3800 regulations permit direct care staff to administer medications. With the current ongoing shortage of nurses, the only way some facilities can get medications administered to clients is with the use of trained medication technicians. It is absolutely unrealistic to take this option away at this time, particularly with the difficulty in attracting nurses. Further, our data on medication errors suggests that the trained medication technicians actually commit fewer medication errors than our nurses. Does DPW have empirical evidence that would suggest that our findings are somehow unique to our program? The rationale for imposing this change on programs (not to mention the employees who work as medication technicians) without evidence to suggest that the use of medication technicians is somehow dangerous to children is not readily apparent. It should also be noted that a number of medication technicians have been motivated to attend nursing school, thereby helping to ease the hiring crisis.
- **23.190 – Medication Performance monitoring – (page 78)** – This proposed regulation will require providers to present the commonwealth with partial information regarding psychotropic medication. We will be required to report numbers/percents of people on various medications, but not the reasons for such medication. Data on drug use are largely meaningless without accompanying information on diagnosis or reason for which the medication was prescribed. A provider supporting a high percentage of children with significant Axis I disorders would certainly be expected to have a high percentage of psychotropic medication use. Without diagnostic information, the counts of medications are without utility for quality assurance purposes. This should be dropped entirely, and replaced by the requirement the provider developed and maintain a review system for the use of psychotropic medication.
- **23.201 – General Information – (page 78)** – Restrictive procedures are discussed, but never defined. Subsection b designates three procedures as restrictive, but leaves out numerous evidence based procedures that are generally recognized as restrictive (overcorrection, aversive consequences, token economies for people with 6400 licensed programs). Are restraints the only restrictive techniques? Restraints are restrictive techniques but do not encompass the entire range of restrictive techniques. A definition is needed.

- **23.201.c – General Information – (page 78)** –It appears that time out is a restrictive procedure, but is not permitted in an RTF? Even Oprah recommends the use of time out! I'm not clear here. Can an RTF use time out as a treatment procedure? This needs to be clarified. If time out is determined to not be an acceptable treatment, this must be reconsidered and though restrictive, should be available as a treatment option.

23.201.f – General Information – (Page 79) – It is naïve to think that an emergency restraint can be expected to have no possibility of harming a child. Risks are even included in restraint consent forms. The literature makes the possibility of injury quite clear. Would it not make more sense to say something like “the restrictive procedure is believed to be less likely to result in harm than the failure to implement the procedure?”

- **23.203.a – Written plan to create a restraint free Environment – (page 79)** – Once again, a proposed regulation attempts to impose a clinical model on the providers. Trauma informed care is not a universally accepted approach. It would be reasonable for the commonwealth to mandate providers to develop and submit plans or overall procedures to reduce inappropriate and unnecessary restraint use and overall restraint use as is clinically and ethically appropriate, but it is inappropriate to mandate that such plans must be based on the trauma informed care model. This imposition is no different than attempting to mandate that all RTFs adopt a psychoanalytic model of service. There are a variety of models, many with evidence supporting their use. The commonwealth should not be pushing a particular model.
- **23.204 – Time Out – (Page 80)** –This is confusing. In 23.201.c, time out was excluded from the list of permitted interventions, but here is an entire section on the use of time out. Perhaps 23.201 needs revision to clarify it is an acceptable restrictive option.
- **23.204.a – time out – (page 80)** – This proposed regulation is revisionist in terms of the definition and intent of time out. The correct name of time out is time out from positive reinforcement, and it entails sending a child to an area of reduced reinforcement. It is essentially an unpleasant consequence to a behavior that is administered with the hope of reducing the future probability of the behavior that preceded it. Arguably, that is the definition of punishment. Nothing in the original research on time out suggested that it offered a child an opportunity to learn to gain self control. It was a means with which to reduce reinforcement, and thereby reduce the future probability of undesired behaviors. What you describe in this definition might be better called ‘taking a break’ or ‘therapeutic regrouping.’ It is clearly not time out. I think we need to exercise considerable caution to avoid adopting psychological jargon and applying it to slightly different constructs than initially intended.

- **23.204.b – time out – (Page 80)** – A child cannot really request time out. That makes no sense; if a child requests time out, it isn't really a time out. A child can request a break or request the opportunity to go somewhere to calm down, but this is not time out.
- **23.204.c – time out – (page 80)** – Once again, the regulation fails to understand the traditional definition of time out. "Time out" is always used in a "punitive" manner as it is in response to a behavior.
- **23.204.d.4 – Time out – (page 81)** – One cannot judge whether time out was successful at the conclusion of the time out period. The success of time out can only be judged in a longitudinal manner, by looking at target behavior data over time. If each aggressive act is followed by brief time out, and if the rate of aggression is declining, time out is successful. That is the only way to ascertain success of time out.
- **23.205.a.2.- Emergency Safety Interventions – (Page 81)** – It is unclear whether mechanical restraints are permitted to permit healing? For example, some physicians will order helmets or mitts to permit an open wound to heal. Once healed, the devices are no longer permitted. Such actions were consistent with the 3800 regulations. Is such use permitted under these proposed regulations?
- **23.205 e.4 – Emergency Safety Interventions – (Page 83)** – "Adversive" is an incorrect term. The correct term is "aversive." For purposes of clarification, I note that the exclusion of aversive (sic) events is contained within the emergency safety intervention section of the proposed regulations. Most literature on the use of aversive stimulation incorporates it as part of a planned clinical intervention. Is such non-emergency use of aversive stimulation also precluded? I assume that it is, but the regulation should be made clear, lest someone try to argue the point with the commonwealth at a later date.
- **23.205.f.2 – Emergency Safety Interventions – (Page 83)** – According to the regulation, each application of restraint must be ordered. This is unrealistic and does not lend itself to the idea that restraints are used in response to crisis situation for safety. These "emergency" situations are unplanned and to require an order for a restraint would preclude the provider from protecting the safety of the individual as needed, placing both parties at increased risk. For example, if an individual is engaged in self injurious behaviors that place themselves at risk for serious injury, and other less restrictive procedures have been attempted unsuccessfully, would it not be the responsibility of the provider to implement a restraint for safety absent a "direction" or "order" to do so? Even if a person with the authority to authorize a restraint were on grounds when a restraint was required, how long would it take to get them to the situation so that they might assess and issue an order? The essence of this type of situation is that it is an emergency – It means that one cannot wait for 5-10 minutes for the physician to

show up and confirm that it was indeed an emergency. This also is in contrast to the goal of restraint reduction as restraints are used typically in imminent danger situations, and if one were to be able to wait until a physician were able to come and assess, it is assumed that the situation is not truly constituting an emergency which would require a restraint and could altogether be avoided in the first place.

- **23.205.f.10 – Emergency Safety Interventions – (page 86)** –I am concerned that this regulation may have the impact of prolonging restraint. We routinely teach staff to attempt to release so that we don't restrain individuals longer than necessary. Sometimes, they attempt release too early, and the client must be restrained a second time. To require a second order may create a contingency in which staff are punished by attempting to release a client. They are punished in that they have to seek and get a 2nd order. They could perceive it to be much easier simply to continue the restraint.
- **23.205 .g.7 – Emergency Safety Interventions – (Page 87)** – How are staff supposed to monitor vital signs on a client during a restraint who is likely moving? It can be assumed that if the individual requires a restraint that they are in a situation of risk and are likely engaging, or attempting to engage in some physical activity. I'm not sure that this type of monitoring is possible. You can visibly monitor color and respiration, but it is pretty difficult to get temperature, blood pressure, and other traditionally defined vital signs on a person being restrained. If these types of assessments are able to be completed it would seem that there is not a need for ongoing restraint at that time.
- **23.205.i.1 – Emergency Safety Interventions – (Page 88)** –Notifying the parents within five hours may be unreasonable and insensitive to some parents who request other communication. Some parents are unreachable and other parents are at work and cannot take phone calls. Some parents don't want to be notified of each restraint. We have a number of parents who have requested in writing summaries on a weekly or monthly basis only. One must also consider that sometimes restraints occur in the middle of the night. If a restraint occurs at 12:30AM, should the family be called in the middle of the night to advise them of a restraint, or would it be more reasonable to wait for the next day? We recommend that flexibility be provided in this section and a 24 hour timeframe be recommended.
- **23.205.k.1 – Emergency Safety Interventions – (Page 90)** – Is debriefing to be a witch hunt or an honest search for how the restraint could have been avoided through improvements? It seems that there is a lack of recognition of the risk to direct care staff in participating in a debriefing session. If a staff acknowledges that perhaps he/she should not have implemented a restraint, is that any different than an admission of client abuse, and would this admission not need to be reported and handled as any other type of abuse? The administrator present will have no choice but to file a child abuse report, and the staff could ultimately lose his/her job. Under these contingencies, how likely is it that staff will participate in

an open, honest, and constructive manner if the focus is solely on the negative? Some identification that judgment is necessary in situations and is acceptable to an extent should be made. It should also be identified that unless truly unnecessary or inappropriate, that staff have the ability to debrief in an open and honest way to improve the system of program delivery for the individual without fear of retribution. They need some sort of protection, whether it be a grant of immunity or the guideline that the meeting be conducted absent management staff. It seems unrealistic to hope that direct care staff will be honest in a situation that places their employment in jeopardy.

With rotating schedules of staff, getting all staff together with the client within 24 hours may be impossible. Because of the imperative to supervise all of the children in the program, there is little way this sort of meeting could be held without incurring substantial overtime costs or adjustments in supervision requirements for individuals.

Once more, the focus on restraint reduction as a target per se is misguided. The focus should be on promoting client behavior change, and thereby eliminating the need for restraint use. Instead of a debriefing on restraint use, perhaps there should be a required clinical review of the treatment program.

- **23.206.a.2 – Restrictive Procedure Records – (page 92)** – I'm not sure that anyone could say the reason that less restrictive approaches failed to work, unless the commonwealth were to accept as reason that the child continued to assault others.
- **23.221.b.10 – Description of Services – (page 94)** – While it is generally counterproductive to file charges against children in residential treatment, it must be recognized that staff have the absolute right to press charges. We do actively discourage them from taking this action because it tends to have absolutely no positive impact, but it remains the right of staff to take the meaningless action. Providers should not be writing a policy that in some way limits employee rights in this sensitive area. This could also have the opposite effect of encouraging staff to file such charges. Assaults on staff are frequent, and having a policy that in any way would formally discourage the exercise of rights would seem to appear like we are trying to hide a dirty secret – that clients do assault staff on a routine basis. These behaviors are many times in large part why they require services. The concern is that this sort of policy would only serve as possible promotion of any unionization effort. Further, having a policy and teaching this policy to staff might actually result in an increased number of police reports because we will have inadvertently empowered staff to report client behavior to the police. Ultimately we desire to employ staff who understand the types of individuals we serve and the risks and rewards associated with serving them; not those who view our individuals as “assaulting” them.

- **23.223.c – Development of the ISP – (page 97)** – It seems like the required team is loaded with people who won't actually be working with the child. What about the psychologist, teacher, nurse, occupational therapist, speech therapist, program specialist, and residential counselor?
- **23.228.b.1 – Behavioral Health Treatment – (page 103)** – delete the phrase "when possible" where used in reference to evidence based treatments. As noted earlier, the only acceptable forms of treatment are evidence based and experimental (with appropriate experimental design and data collection). There should be no option to permit the use of 'treatments' that lack evidence supporting their efficacy.
- **23.230.h – Discharge and Aftercare Planning – (page 106)** – this regulation makes the inaccurate assumption that the client is always a Pennsylvania resident and scheduled to receive services through the Pennsylvania system. The various offices listed in the proposed regulation will not pertain if the child lives in New Jersey for example.

REFERENCES

- S. Axelrod, S. Spreat, L. Moyer, and B. Berry. (1993). A decision making model for selecting the most appropriate treatment. Chapter in R. Van Houten and S. Axelrod (Eds.) Behavior analysis and treatment. New York: Plenum Press.
- J. Cocozza, E. Jackson, K. Hennigan, J. Morrissey, B. Reed, R. Fallot, & S. Banks. (2005). Outcomes for women with co-occurring disorders and trauma: Program level effects. *Journal of Substance Abuse Treatment*, 28(2), 109-119).

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The more readily recognized increases in costs will result from the increased service expectations. We anticipate increased costs in the areas listed below:

- 1. Medical Director** – Crestwood has operated successfully for 17 years without a medical director, but it appears that the proposed regulations would require us to add one. Our current .6FTE psychiatrist would be increased to full time (if possible), with a resultant increase in costs from about \$96,000 without benefits per year to about \$160,000 per year plus about 20% benefits. Total increase in cost would be about \$96,000 per year.
- 2. Mandated Frequency of Contact between psychiatrist and children** - As noted above, we currently use the services of a .6FTE psychiatrist. He is at Crestwood three days per week, and his primary function is that of a biological psychiatrist. He assesses, diagnoses, prescribes psychotropic medication, and monitors its efficacy. This is sufficient under our current model. Under the proposed regulation, the psychiatrist is both leader of the team, and he/she must spend at least 24 minutes each week with every child under his/her care, even if the child doesn't take psychotropic medication. With a maximum of 48 children, this would represent about 19.2 hours of direct client contact per week. With the regulatory expectation that the psychiatrist function as the leader of the treatment teams and the responsibility of the psychiatrist to monitor the medication of all clients, it is obvious that the expectations for the psychiatrist far exceed what can be accomplished in .6FTE (or 24 hours per week). Further complicating matters is the fact that children cannot be routinely pulled out of school to meet with their psychiatrist. This could be considered a violation of their IEP. Thus, the psychiatrist is typically limited to meeting with the child in the after school hours. To accomplish the necessary visitations, medication reviews, and team leadership, we anticipate that we will need about 2.0 FTE psychiatrist. One of these would have to function as the medical director. Thus, to our current .6 FTE psychiatrist, we would need to add 1.4 FTE psychiatrists (one of these could function as medical director, although we would then still need a primary care physician to provide medical care). With benefits, we anticipate the addition of a second full time psychiatrist to be around \$192,000 per year in additional cost.
- 3. Waking Hour Coverage by Professional Staff** - At this time, we employ 7 mental health clinicians to provide therapy and some case management services to our 70 clients. With 48 clients maximum, the proposed regulations would require us to have 8 mental health clinicians, and that 8 mental health clinicians would be available during all awake hours. To achieve 8 mental health clinicians during the 7-3 shift and 8 mental health clinicians on the 3-11 shift across all seven days will require a minimum of 17 FTE mental health clinicians, and this assumes creative flexible weekend

scheduling. For our seven current Mental Health Clinicians who serve a total of 70 children, our annual costs are approximately \$268,800 (\$32,000 plus 20% benefits). To fund 17 Mental Clinicians who will only serve 48 clients, the annual costs will be in the neighborhood of \$652,800 (\$32,000 plus 20% benefits). The net increase associated with serving fewer children would be approximately \$384,000.

- 4. Supervision of Direct Care Staff by Mental Health Professionals –** We currently employ four Residential Managers to supervise the activities of direct care staff. They are assisted in this process by a number of residential supervisors. It is our understanding of the regulations that these individuals would have to be replaced by mental health professionals; none of the current group would currently qualify despite the high quality of services that they ensure. The employment of these individuals would have to be terminated, with the resultant unemployment costs to be shouldered by Woods Services. These costs would be approximately \$40,000. They would be replaced by persons who meet the standard of mental health professional. Locating such individuals may be a significant task. It has been our experience that most clinicians do not find the role of residential supervision to be particularly rewarding, nor are many particularly good at it. We anticipate that we will need to pay a premium to attract mental health professionals to work, essentially outside their area of competence. We anticipate that hiring four mental health professionals to fill this role will cost as much as \$240,000 plus about 20% benefits. This would represent an increase of approximately \$96,000 per year.
- 5. Mandated census reduction and impact of number of workers –** At this point in time, Crestwood has approximately 125 FTE direct care positions. They are currently called Resident Counselors, but under the proposed regulations, they would be called Mental Health Workers. A reduction in census from 70 to 48 is a 31% reduction in staffing need. We would need to terminate the employment of some 39 direct care staff, or 31% of the direct care staff. This would result in unemployment costs in the neighborhood of \$390,000.
- 6. Medication delivery only by nursing staff –** Crestwood currently has one nurse, relying on medication administration trained staff to administer medication to clients. The training they received is approved and recognized by the Department of Public Welfare and implemented in other regulated programs. There are currently four medication trained staff whose role is solely to administer medication. Their employment would have to be terminated, resulting in unemployment costs in the neighborhood of \$40,000. To shift to only nurses administering medications would require hiring an

additional 3.0 FTE nurses at an estimated cost in the neighborhood of \$180,000 per year (\$50,000 plus 20% benefits).

7. **Consent must be obtained by physician** – Crestwood does rely on the psychiatrist to contact the family to obtain initial consent for any new medication. Because at our attorney's advice, these consents are considered valid for only about one year, we repeat the process on an annual basis. We typically rely on the mental health clinician to obtain this second consent, with the provision clearly expressed to the family that the psychiatrist is available for any questions. If we place this responsibility on the psychiatrist, we would anticipate in the neighborhood of 100 additional consent calls per year. Allowing for time to establish contact and discuss the medication with the family, it is prudent to estimate 30 minutes for this process. Thus, we will incur about 50 additional hours of psychiatrist time per year, or about \$4615 in annual costs.

8. **Restraint meetings** – The regulations require a series of post restraint meeting within 24 hours of all who were involved in a restraint. The regulations specify three such meetings. To estimate the costs associated with these additional meetings, we have to make a number of assumptions. First, because all clients must be supervised, we cannot pull direct care staff from their supervisory responsibilities to attend this meeting. The meetings must be done on overtime. Second, someone in management will probably lead the meeting. Third, each meeting will last at least 30 minutes. Fourth, because Crestwood specializes in serving persons whose dangerous behaviors result in a high probability of restraint, there will be a fairly high number of these meetings. We have been rather successful of late in reducing the number of behaviors that require the use of restraint. With Crestwood averaging in the neighborhood of 100 restraints per month, we must estimate that there may be as many as 300 additional meetings each month

The above assumptions suggest that over the course of a year, Crestwood will have to hold about 3600 post restraint meetings. This will consume about 1800 hours. Four staff and one management staff will be involved in each of the meetings, and hourly overtime rates for direct care are about \$16.50, and a non-overtime supervisory hourly rate is about \$18.82. This suggests that each half hour meeting will cost about \$42.41. Across the year, these meetings will cost Crestwood in the neighborhood of \$152,676. The number of meetings and costs associated with these meetings would be prohibitive, and create undue burden on the program with minimum beneficial outcome it appears. It is unclear what research or data supports this expectation for debriefing?

9. **Monthly ISP Review** – Per the regulations, ISP review frequency is increased from semi-annually to monthly. Thus, each child will have 12 meetings per year, rather than the 2 that are required by the 3800 regulations. Assuming 48 residents and an additional 10 meetings per year per resident, this will be an additional 480 meetings per year for Crestwood. While we have included the costs of these meetings in our projections for the psychiatrists, we need to estimate the costs associated with other mandated attendees. These would include psychologist (\$30/hour), Nurse (\$30/hour), Direct Care staff on overtime (\$16.50 per hour), Occupational therapist (\$20/hour), Teacher (\$20/hour), and social worker (\$20/hour). Excluding physicians, the projected hourly cost for an ISP meeting would be about \$136.50. If each meeting lasts about one hour, and if Crestwood incurs an additional 480 such meetings per year, the projected costs of this regulation to Crestwood will be in the neighborhood of \$65,520

10. **Required participation in the ISP** – The regulations require the participation of both a psychiatric social worker and an occupational therapist in these ISP meetings. We have neither on staff. To give reasonable caseloads to each person of about 24, we would have to hire two of each. Assuming that both positions can be hired for about \$35,000 plus 20% benefits, the total additional cost of these positions would be about \$168,000 per year.

The projected additional annual costs described above are listed below:

- \$ 288,000 – additional 1.4 FTE psychiatrists
- \$ 384,000 – waking hour coverage by professional staff
- \$ 96,000 - additional costs of Mental Health Professional Supervisors
- \$ 180,000 - medication delivery by nurses only
- \$ 4,615 - consent obtained by physicians only
- \$ 152,676 - additional post restraint meetings
- \$ 65,520 – Monthly ISP meetings
- \$ 168,000 – additional required ISP membership
- \$1,338,811 – additional annual costs (adds \$76.42 to per diem)

The projected one-time costs of \$470,000 are listed below:

- \$ 40,000 – unemployment costs for terminating managers
- \$ 40,000 – unemployment costs for terminating medication technicians

- \$390,000 – unemployment costs associated with terminating employees not needed to serve reduced population

When one sets about the task of summing these annual (only) costs, a rather large figure of **\$1,808,811** derives. This represents at least an increase of more than \$75 per day increase in our costs per client. It must be recognized also, that Crestwood competes with other providers throughout the Middle Atlantic Region. The bulk of our business is from outside of Pennsylvania. To impose these additional costs on us is to limit our ability to compete with agencies not saddled with the outdated medical model and its associated higher costs.

I note that the commonwealth proposes to offset these increased costs by reducing the length of stay for persons in the programs. One would hope that considerable evidence is provided to the IRRC to support this claim. This assumption is a dangerous one to make and may ultimately result in even more dramatic increases in costs as the most appropriate services are provided for individuals based on their needs and not a pre-determined or identified timeline. These services are entitled and not optional in most cases.