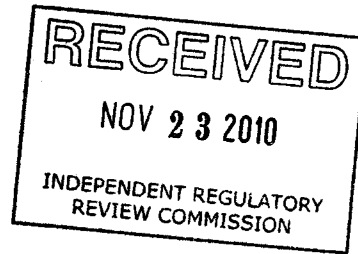

November 22, 2010

2878

TO: The Department of Public Welfare and the Pennsylvania Independent Regulatory Review Commission

FROM: Jessica Woods, Ph.D., BCBA-D and M. Christopher Tabakin, M.S. on behalf of Melmark's Children's Behavioral Health Program (Residential Treatment Facility)

RE: Considerations for proposed rulemaking 55 Pa. Code Chap 23. For Residential Treatment Facilities

On behalf of Melmark, a private nonprofit organization operating a Residential Treatment Facility in Pennsylvania, thank you for providing the opportunity to respond to the proposed regulations. Melmark's Children's Behavioral Health Program, which operates a residential treatment facility with a current capacity of 12 beds, provides residential and special education services to children and adolescents ages 5 to 21, with learning difficulties and/or challenging behaviors secondary to a dual diagnosis of a developmental disability and a co-morbid Axis-I diagnosis.. The population served is often severely and profoundly impacted by their disability, and require services in a very clinically rich environment with specialized services. The specific design of the service model at Melmark is best described as evidence-based and outcomes-driven. Applied behavior analysis is the primary treatment modality, which employs best practices in assessment, case conceptualization and treatment planning. Strategies employed include functional behavior assessment, empirically-supported clinical and educational interventions, daily data collection and frequent progress monitoring. These strategies are used to determine the environmental factors that influence an individual's problem behavior and skill deficits and to develop and monitor individualized interventions.

Our 24-hour learning model emphasizes high staff-to-student ratios, with individualized lessons, teaching methods, and goals that remain consistent across all settings. We ensure that students develop and practice essential self-care skills in the environments in which they are used. All services in this intensely staffed, skilled instruction program range from an approximate 1:1 (staff to child) ratio to a 1:2 ratio during waking hours. During sleeping hours, ratios are approximately 1:4. Other staffing ratios will be considered depending on the needs and abilities of the individual served.

The goal of Melmark's Children's Behavioral Health Program is to help each individual served have a meaningful life and attain the highest level of personal growth, achievement and independence. This is accomplished by stabilizing problem behaviors that have prevented the individual from living in less restrictive environments, increasing positive or desirable behaviors, and facilitating the reunification of the individual with their family to a less restrictive environment.

Operational, clinical, and fiscal staff at Melmark have evaluated the proposed regulations posted in the PA Bulletin. The proposed regulations include some positive suggested revisions including the addition of a ban on the use of prone (face down) restraints and identification that clinical best practice is key to a successful program. However, some language and proposed changes are of great concern in the proposed regulations. It is

with the children we serve, family members and our program's successful model in mind that we respectfully submit the following positions, and bring to attention the following for your review:

- **23.1 Purpose**– An identified purpose of this section is to establish minimum "treatment standards." Regulations are to set minimum licensing standards and expectations to protect the health, safety, and welfare of those who are provided service, not to dictate or direct clinical functions as this is best determined by professionals providing the services. The determination of treatment requirements are a clinical function and should be based on individual need, best practice, and research based standards, which are constantly developing. In a brief review of other similar regulations (2380, 2390, 3800, 6400, 6500, and 6600) it is noted that none of them direct or identify "treatment standards" within the purpose. It is recommended that this section be revised to state the following: "The purpose of this chapter is to protect the health, safety and well-being of those receiving care in a licensed facility through the formulation, application and enforcement of minimum licensing requirements, and to develop MA participation requirements and MA payment conditions for RTF's."

- **23.2 Applicability-** Within this applicability there is no identification of individuals with disabilities being served by RTF's. As noted above, the main population Melmark serves in this program are individuals with a primary diagnosis of a developmental disability and a co-morbid Axis I diagnosis. It appears that through this applicability section, and other aspects of these proposed regulations that the population of individuals with disabilities may not best served under this type of program. This is identified earlier under the "Purpose of Regulation" section where it notes that 3800 licensed RTF programs can be exempted from the accreditation requirements and applicability of these proposed regulations by licensing under the 5310 regulations if they are 8 bed RTF's not located on a larger campus. No basis is given for the requirement that this option is not available to those programs that operate on a larger campus, and this statement of "policy" not based on regulation, nor is it proposed to be codified anywhere in this proposed regulation. It is recommended that this "policy" be removed and that it be noted that any RTF serving individuals with disabilities has the option of licensing under the 5310 regulations regardless of size or location and that no accreditation would be required as a result. A policy is recommended to still identify these RTFs as eligible for receipt of MA payments by MCOs. Accreditation seems to be an unnecessary and costly addition to the regulations.

- **23.3 Definitions** – The following are definitions that are recommended for further evaluation and/or revision as follows:
    - Antipsychotic medication- The definition is recommended to be revised to state "a medication approved by the Food and Drug Administration for the treatment of psychosis or other associated disorders." The definition listed in the proposed regulations makes certain assertions which are best left out of definitions.
    - Drug Used as a Restraint - The definition is recommended to be revised to be consistent with other regulatory references (e.g. 6400) and should read as follows: "a drug used to control acute, episodic behavior that restricts the movement or function of an individual." The definition could also be revised to be listed as "chemical restraint."
    - Family Advocate- As noted in other parts of these recommendations, the requirement for a "family advocate" are recommended to be removed. This definition is recommended to be deleted.
    - Manual Restraint- The definition in the current 3800 regulations is recommended to be the basis for this definition as the proposed changes lack clarity. The definition is recommended to be revised to state the following consistent with current 3800 regulations: "A manual restraint is a physical hands-on technique that lasts more than 1 minute that restricts the movement or function of an individual or portion of an individual's body. A manual restraint does not include a manual assist of any duration for a child during which the child does not physically resist or a therapeutic

hold for a child who is 8 years of age or younger for less than 10 minutes during which the child does not physically resist. A Manual restraint also does not include the use of any devise."

- Intimate Sexual Contact- The definition is recommended to be revised to the following: "An act of a sexual nature involving unclothed contact between two people."
- Minor-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. The definition is recommended to be revised to the following: "An individual under 18 years of age."
- Restraints- The definition is potentially misleading and confusing. It appears that this should be separated from another definition that should be added, which is "Restrictive Procedures" (see below). The current definition of "Restraint" is recommended to be deleted. A definition of manual restraint and chemical restraint are already present. A definition of mechanical restraint is recommended to be added which states: "A mechanical restraint is a device that restricts the movement or function of a child or portion of a child's body. Examples of mechanical restraints include handcuffs, anklets, wristlets, camisoles, helmets with fasteners, muffs and mitts with fasteners, poseys, waist straps, head straps, papoose boards, restraining sheets and similar devices. The use of a mechanical restraint is prohibited. Devices used to provide support for functional body position or proper balance and a device used for medical treatment, such as sand bags to limit movement after medical treatment, a wheelchair belt that is used for body positioning and support or a helmet used for prevention of injury during seizure activity, are not considered mechanical restraints."
- Restrictive Procedure- It is recommended that the current definition of these procedures in the 3800's be updated to: "A restrictive procedure includes chemical restraint, manual restraint, mechanical restraint, and time-out procedure."
- RTF- If these regulations are to apply to individuals served in these programs who are diagnosed primarily with a disability, it should be identified and reflected in this section as well as throughout the regulations. The definition is recommended to be revised to include in the definition: "individuals with disabilities and co-occurring behavioral or other disorders." The definition is also recommended to also be more specific to identity which programs these regulations would cover.
- Serious Injury- The definition is recommended to be revised to the following: "A significant impairment of the physical condition of a child as determined by qualified medical personal. This will require treatment above or beyond first aide to be completed by an external medical professional."
- Trauma Informed Care- As will be noted elsewhere in these recommendations, trauma informed care is only one treatment modality option, and should not be dictated as a requirement. If trauma informed care is left elsewhere in the regulations as a recommendation for a treatment modality, then this definition could remain in this section. Even based on the definition itself including the phrase "a philosophy," and not a scientifically based model, it is recommended that it be deleted from all sections of the regulations starting with this definition. Treatment modalities may be recommended by the department, but should not be included or reflected as preferred method in regulation.

- **23.12 (a) Inspections and certificates of compliance** adds a requirement of at least one unannounced inspection per year, so first sentence should state that "An RTF will be individually inspected at least twice per year" given this additional requirement. This is twice as frequent as the current annual inspection under 3800 regulations and will require numerous additional state inspectors to complete these additional inspections. This also reinforces that the proposed need for accreditation is unnecessary.

- **23.12 (c) Inspections and certificates of compliance** states that 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. This section is recommended to be revised to the following: "The RTF must post in a conspicuous and public place within the licensed building the current certificate of compliance. A copy of this chapter must also be available in each building."

- **23.14 Maximum capacity.** This regulation places a maximum capacity on program size based on what can only be perceived as an arbitrary maximum capacity of 48 children. This will limit program expansion at a time when hundreds of PA's children are currently being served out-of-state due to the lack of appropriate programs in state. Additionally, there is a clause for further space and capacity constraints being set fourth based on the perceived clinical needs of "the population of the children residing in the RTF, and/or the treatment intensity of the RTF" which gives tremendous latitude to the state to limit programs in a manner that is neither clinically nor fiscally effective. Allow the providers to make these clinical and informed decisions, based on their expertise, internal infrastructure and systems and supports. Given the alarming rate of needed services, it is recommended that regulations do not allow regulatory confines to limit service provisions.

- **23.16. a – Child abuse**– Suspected abuse of a child must be reported to Childline. Child is defined as a person up to the age of 21 years. Childline only accepts reports on people up to the age of 18. The section is recommended to be revised to the following: "An RTF shall immediately report suspected abuse of a child under the age of 18, in accordance with...."

- **23.17(a) 4, 13, 14, 15, and 18 – Reportable Incidents**– The definition of 23.17 (a) 4 is recommended to be revised to the following: "An injury, trauma, or illness of a child requiring emergency room treatment." The definition of 13 and 14 are recommended to include the phrase "for more than 24 hours" to provide clarity and direction on a timeframe. Otherwise if a building were "closed" for renovations or cleaning for several hours for example, this would be included in a reportable incident. The definition of 13 is recommended to also include the term "unplanned" before closure. Number 15 is recommended to be deleted because it is potentially difficult to diagnosis, and if it is diagnosed would be cover already under 23.17(a) 11 concerning reportable diseases as required by the Pennsylvania Department of Health's list of reportable diseases, when diagnosed by a physician. Under 18, the provider is to report any criminal convictions of staff after initial criminal history check. We are concerned about how this will be completed without regular and ongoing criminal history checks being completed. At this time our policy is for staff to inform us of any subsequent criminal convictions that are listed on the disqualifying list for staff employment. If such a conviction were to occur we are required to end the employment relationship if the conviction is included on the list. It is recommended that 18 be deleted.

- **23.17 (c and d) - Reportable Incidents-** It is recommended that this section be revised to the following: "An RTF shall complete an initial report for reportable incidents in a format prescribed by the department within 24 hours of the incident occurring or being discovered. This report shall be provided to appropriate departmental offices and/or licensing bodies as necessary. The reportable incident shall be communicated at minimum to the contracting agency for the affected individual(s). A copy of the report must be maintained by the agency." The current section does not take in to account the current reporting system, HCSIS (Home and Community Services Information System), and how this system automatically notifies various departments of an incident being reported. In order to reduce multiple reporting and redundancy, this should be taken in to account and options further explored to reduce the redundant and multiple reporting burden for providers. Section (d) creates further burden for reporting certain categories of incidents. If the HCSIS system is utilized to its intended capacity, the notification of an incident of serious nature can be viewed within the system immediately upon it being entered. As such, the 24 hour requirement for all incidents is recommended to also apply to this section and as a result, this section (d) is recommended to be deleted. As a general statement for reporting of incidents, in a number of places the specific reporting by provider agencies to advocacy organizations, such as

Disabilities Rights Network, is noted. This process is recommended to be removed as a responsibility of providers, and the department be responsible for reviewing and approving or disapproving provider incident reports should be responsible for communication to advocacy organizations in the event concerns are identified. To report all incidents to advocacy organizations seems to infer that all incidents are questionable and of concern beyond that which can be addressed by the provider or department. It is noted that many advocacy organizations already have access to incident reports in HCSIS.

- **23.17(e) – Reportable Incidents**– As written, this section requires an investigation of every reportable incident report. This appears to be an error as not all incidents require further investigation. The term "investigation" has a very specific meaning based on the DPW approved certified investigator 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. It is recommended that this section be revised to the following: "An RTF shall initiate an investigation as necessary for certain reportable incidents including, but not limited to, incidents of alleged abuse, neglect, rights violations, misuse of funds, and serious injuries of unknown origin." It is recommended that a statement of policy, bulletin, or licensing instrument separate from the regulations be utilized to further clarify expectations in this area aside from regulation.

- **23.17 (f) - Reportable Incidents-** This section is recommended to be revised to be consistent with section 23.17 (c) as follows: "An RTF shall complete a final report for reportable incidents in a format prescribed by the department within 30 days of the incident occurring or being discovered, unless an extension is filed as prescribed by the department as a result of extenuating circumstances."

- **23.17. (j).1 and 2 – Reportable Incidents**– Providers are required to notify the CMS regional office of the death of a child. If the child is not funded by Medicaid, this could constitute a HIPAA violation. It is recommended that the department be responsible for reporting deaths to CMS as necessary, and that this be based on the provider reports completed in HCSIS and indication within that system of funding agencies. It is recommended that 23.17 (j) 1 and 2 be deleted. In general as noted above, the multiple reporting requirements and redundancy will result in greater staff time and resources being allocated to reporting to the various separate agencies. In addition, many times the separate agencies have different reporting formats which further require time and effort to fulfill. It is recommended that a streamlined process be explored as recommended above to promote efficiency and cost/time savings while maintaining regulatory protections and reporting.

- **23.17 (k)- Reportable Incidents-** It is recommended that the phrase "as soon as possible" be deleted and replaced with "within 24 hours." This is consistent with other regulations.

- **23.17 (l) 1, 2, 3, and 5- Reportable Incidents-** For the same reasons noted above concerning multiple reporting requirements, redundancy, and potential HIPAA and other confidentiality violations, section 23.17 (l) 1-3 is recommended to be deleted.

- **23.18 – Recordable Incidents**– This requires the documentation of these incidents to be maintained in a specific location. It is unclear what a "business office" would constitute since there is no definition, and assumes that each location will have a separate office of this type. It is recommended that this state the following: "An RTF shall maintain for 6 years a record of the following:"

- **23.18.2 – Recordable Incidents-**It is recommended that "statements" be added to read "Suicidal gestures and/or statements."

- **23.18.4 – Recordable Incidents (page 23)** – Property damage over $500 is considered a recordable incident. It is unclear what the rationale is behind this as this does not indicate personal property of individuals, and suggests that property even belonging to the provider, if damaged, would need to be recorded. It is recommended that 23.18.4 be deleted.

- **23.33. Prohibition against deprivation of rights.** "A child's visits with family may not be used as a reward or sanction." It is unclear as to whether the term "visits" refers to onsite visits, offsite visits (e.g., day passes and/or overnight home passes) or both. A child has been placed in an RTF due to behaviors that pose a risk to the child's safety if they were to occur in less restrictive settings, even with additional supports. It is conceivable that there may be times when an offsite family visit poses a risk to the child's safety and an onsite visit may interfere with behavioral progress. Decisions regarding the clinical appropriateness of family visits should be reserved for the ISP treatment team, which includes the family. Clarification as to the definition of "visit" should be provided and add the phrase, "except when agreed upon by the ISP team."

- **23.33(c) Prohibition against deprivation of rights-** Recommend adding language that programs may also impose basic parameters around visitation hours in the program, in order to ensure basic structure/therapeutic milieu in the program, ensure normal routines for the children and ensure space for all families have a private area in which to meet, a regulation proposed later in this chapter.

- **23.41. (3).** It is unclear how the RTF would demonstrate opportunities for "frequent and regular family contact". In addition, frequent contact such as daily phone calls, weekly visits at the family home, as well as community activities may be contraindicated. Decisions regarding the frequency and form of family interactions should be determined by the family and the other members of the ISP treatment team. This section is recommended to be deleted.

- **23.41. (4).** The decision to provide family therapy is a clinical one and should be made by the ISP treatment team. There may be times when family therapy is counter therapeutic or is not an evidence based treatment. This is recommended to be revised to indicate that these treatments will be provided "when deemed clinically appropriate by the ISP treatment team".

- **23.41 (9).** Some families may not be able to participate in an onsite meeting within the first 7 days of admission, especially when they reside some distance away. It is recommended to revise to indicate the meeting will be onsite "whenever possible."
  - Reviewing family participation in treatment requires monthly ISP team meetings. Holding monthly meetings for all residents of an RTF places an undue burden on the provider and takes away time from active treatment. It is recommended to remove the requirement to review family participation on a monthly basis.

- **23.43. Space onsite for family visits.** Requiring RTFs to have a designated area onsite for private family visits may require providers to decrease capacity in order to convert bedroom space into a visitation room. This places an undue burden on the provider and decreases opportunities for children to receive RTF services. It is recommended to add the phrase "when possible" or delete this section altogether.

- **23.44. Assistance with coordination of transportation for family contacts.** Although providers may assist with planning transportation, mandating coordination places an undue burden on the provider. This section is recommended to be deleted.

- **23.54. Medical director.** Requiring a medical director places an undue financial burden on the provider. Many of the responsibilities described in this section could be completed by the RTF director or are better provided by other members of the interdisciplinary ISP treatment team with support from a consulting psychiatrist and general practitioner. This section is recommended to be deleted.

- **23.55. Clinical director** – The qualifications for a person supervising the treatment delivery in an RTF should be defined by the treatment model used in an RTF. For instance, if the model is therapy based, then a licensed psychologist, social worker, or counselor, is necessary. If the model is behavior analytic, then a more appropriate qualification is certification by the Behavior Analyst Certification Board. If the argument is that the person must be licensed for billing purposes then the additional requirement that the person be a licensed behavior specialist per Act 62 should be sufficient. Comments below regarding recognition of applied behavior analysis as best practices for individuals with autism and mental retardation are appropriate here.
- **23.56. Mental health professional.** Many scientific, government, and professional agencies including the Surgeon General of the United States (1998) support applied behavior analysis based procedures as best practices for interventions for individuals with autism and mental retardation (e.g., Association for Science in Autism Treatment, Autism Speaks, Surgeon General of the United States, New York State Department of Health). The requirements to be a mental health professional is recommended to be revised to include a graduate degree in applied behavior analysis or deleted altogether to allow providers and the treatment model to dictate the appropriate professionals to implement that model.
    - "A graduate degree in a generally recognized clinical, mental health discipline" is not necessary to be a competent and skilled staff supervisor. Supervision of mental health workers and aids should not be restricted to mental health professionals. Furthermore, providers should be able to determine their own organizational structure. It is recommended that the description of a mental health professional be deleted.

- **23.57. Mental health worker and mental health aide.** Requiring mental health workers to have "12 credit hours of education in psychology, sociology, social work, counseling, nursing, education or theology", unduly restricts opportunities for those individuals who hold an undergraduate degree in other areas of study. Furthermore, it narrowly defines the qualifications for an entry level position to such an extent that it may be difficult for providers to fill positions. Also, the requirement of 12 credit hours of education seems arbitrary. Unless there is evidence indicating that staff with that background perform the required duties of a mental health worker better than those without that background, the requirements for pre-service and ongoing staff training should be sufficient. It is recommended to remove the requirement for "12 credit hours of education in psychology, sociology, social work, counseling, nursing, education or theology".

- **23.58. Staff Ratios. (b) (4).** Requiring one mental health professional to be onsite at the RTF for every 6 children present during all waking hours places an undue burden on the provider. If an RTF has a capacity of 48 children, this would require the RTF to have approximately 24 mental health professionals in order to have 8 mental health professionals onsite 16 hours per day, 365 days per year.

Filling and maintaining this many positions with individuals trained at the graduate level may be difficult when it requires working evenings, weekends and holidays, a schedule that is not desirable to many staff members, let alone licensed professionals. In addition, it is unclear as to why availability by phone is sufficient for RTFs with less than 6 children present but not for other RTFs. It is recommended that this additional requirement for RTFs with more than 6 children present be deleted.

- **23.59. (c).** Some families, especially those who reside some distance from the RTF, may not be able to participate in an onsite meeting within the first 7 days of admission. It is recommended to revise to indicate the meeting will be onsite "whenever possible."

- **23.60 – Family Advocacy –** It is unclear what the function of this position would serve. The qualifications for such a position appear to be very specific and would likely be very difficult to fill and retrain. Providers already have the legal responsibility to protect the health, safety, and welfare of those they serve, as do the professionals in these programs who must adhere to the clinical and ethical guidelines surrounding their license to practice, a responsibility regulated by state licensing bodies, not by the Department of Public Welfare. The functions and responsibilities listed for this position seem to be better served by a Quality Management staff member. Quality Management should be independent from the direct reporting chain of command and direct care responsibilities to provide more objective and collaborative oversight. It is recommended that 23.60 be deleted, and best practice for oversight of quality be left up to providers instead of mandating a particular management structure or additional staff.

- **23.61.** An appropriate level of supervision is a clinical decision and should be left to the ISP treatment team. The ability to safely function independently for intervals of time greater than 15 minutes while awake may be a requirement for a child to transition to a less restrictive setting such as the home. It is recommended to remove the word "awake" from this section.

- **23.62. Staff Training.**
  - **(c) Ongoing training.** Given that the age, characteristics, diagnosis, and developmental needs of the children served vary across providers, staff would be better prepared if providers were allowed more latitude to determine the most appropriate training topics for their staff.
    - **(c) (2).** Requiring staff to demonstrate their competency at first aid, Heimlich (recommended to change to abdominal thrusts), and cardiopulmonary resuscitation techniques on an annual basis even if the certification is for longer than 1 year places an undue financial burden on the provider. It is recommended to remove this requirement.
    - **(c) (5) (vi).** Not all providers follow a trauma informed care model. The Department should not dictate the philosophy and approach used by providers. It is recommended that this section be removed.
    - **(c) (5) (ix).** As direct care staff do not prescribe nor administer medication, time could be better spent training on topics more relevant to their specific duties than types and appropriate uses of psychotropic medications. It is recommended that this requirement be removed.
    - **(c) (5) (x).** As direct care staff do not prescribe nor administer medication, time could be better spent training on topics more relevant to their specific duties than types and appropriate uses of psychotropic medications. This section is recommended to be removed.

        - **(c) (5) (xvi).** Recovery and resiliency are not appropriate topics for all providers. For instance, one cannot recover from being autistic or having mental retardation. This section is recommended to be removed.
        - **(c) (5) (xviii).** Training on principles of child development would not be appropriate for staff working in settings that serve children with developmental disabilities. Rather characteristics of specific disabilities are more relevant. This section is recommended to be removed.
    - **(d) (3) (ix).** It is unclear what is meant by "vital signs". Many vital signs are monitored using specialized equipment (e.g., thermometer, blood pressure cuff, etc) and it is unclear how this equipment could be used safely during a restraint. Furthermore, application of medical equipment during a restraint may be frightening or upsetting further escalating the child and prolonging the need for restraint. It is recommended to revise this requirement to clearly indicate what vital signs need to be monitored.
    - **(d) (3) (x).** This is redundant from **23.62 (c) (2).** It is recommended that this be deleted.

- **23.102(c) Child bedrooms.** Reduces current maximum capacity in each bedroom from four children to no more than two children per bedroom. Although this is a desirable arrangement when possible, many existing programs and structures were built around the allowance for up to four children per bedroom. Determination of the optimal care and learning environment should be based upon the clinical profile of the children served as and best left at current regulatory level, given then increasing needs for RTF services and few skilled providers. Minimally the regulations should allow grandfathering clause for existing programs at 4 per bedroom with some scheduling and capital support for programs with existing physical structures.

- **23.121 (b) Unobstructed Egress (b***)* states that "Doors used for egress routes from rooms and from buildings may not be equipped with key-locking devices, electronic card operated systems or other devices which prevent immediate egress of a child from the building." Given the nature of the population served by Melmark, and the severity of needs that require an RTF level of care, an electronic/magnetic operated system would minimize darting and/or elopement risks. This, coupled with the lack of safety awareness by many of our individuals, would be an added safeguard. There are commercially available systems that automatically disengage upon a fire alarm sounding and are currently used in many RTF and other inpatient settings across the country. It is likely a waiver would be sought for this provision if passed as written.

- **23.133. False Alarms-** Some of the children served at Melmark will attempt to pull the fire alarm in an effort to gain access to attention. Melmark has put safeguards in place to minimize the social and monetary costs of such events, by placing covers over alarms, on-going staff training and increasing the individual's level of supervision to minimize the opportunities for false alarms. It is recommended again that provides are permitted to make these adjustments based on their clinical expertise and knowledge of population served. The Quality Assurance group may consult on an as needed basis.

- **23.141. c.7 – Child Health and Safety** – The mandate that trauma history be recorded imposes a certain clinical model on professionals that may find the model clinically inappropriate for populations served. 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, instead relying on projection. 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. It is recommended to replace "trauma history" with history of reported abuse.

- **23.143 – Child Health Exams** – Expectation to complete child health exams within 3 days is unrealistic as the medical director may be absent from the program for 3 consecutive days during periods of illness, vacation, etc.... It is recommended to change timeline from 3 days back to existing 15 day window.

- **23.147 – Use of tobacco** – Child is defined as a person less than 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 indicate that civil rights may not be limited. It is recommended this be clarified.

- **23.164 – Withholding or forcing of food prohibited** – Many children served in RTF levels of care may have significant food refusal, food selectivity and/or failure to thrive medical concerns which can be life-threatening. It is recommended to add "unless otherwise recommended in writing by a licensed physician, certified registered nurse practitioner or licensed PA for a specific child" or clarify the definition of "forced" relating to eat/drink (may include physical prompting, forced compliance, differential reinforcement, escape extinction).

- **23.183. c – Use of Prescription Medications** - 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 failing to protect the health, safety and welfare of the patient/child, such is the solemn vow and ethical responsibility of every physician when taking the Hippocratic oath. 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 and not preferable. Providers offer specific services and admit individuals based on the understanding they will be able to provide said services. If a family is unwilling to work with the team and denies the provider their ability to provide the services agreed upon, providers should be able to end the relationship through discharge as all parties (individual, family, and provider) will not benefit from the ongoing relationship. At times disagreement in treatment modalities may occur, and the provider is under no obligation to be forced in to treatment they may ethically and philosophically disagree with for the individual. It is recommended to add the statement "unless clearly indicated by licensed physician that it may be harmful to the child or disruptive to treatment to refuse the clinical recommendation".

- **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 judgment, and hence, exposes him/her to considerable liability. It is recommended to add the statement "unless clearly indicated by licensed physician that it may be harmful to the child or disruptive to treatment to refuse the clinical recommendation".

- **23.201- 23.206. RESTRICTIVE PROCEDURES-** The concerns with this entire section are numerous. Many concerns will be addressed individually below, but as a general statement, this entire section is recommended to be revised in order to assure that appropriate protections are in place, clear guidance is given on expectations for uses of restrictive procedures including restraints, and that unintended harm and outcomes do not result for specific populations of individuals potentially served under these requirements, specifically individuals with co-occurring disability and behavioral disorders. Please see specific comments identified below.

- **23.201 – General Information –** Restrictive procedures should be based on the previously recommended definition as part of the definition section. A clear differentiation should be made between restraints, which are restrictive, and other restrictive procedures which do not always include restraint. At this time both definitions are comingled and are confusing. Expectations are recommended to be set up for all restrictive procedures. Specific requirements for any restraint should also be developed but clearly separate for other restrictive procedures (such as time out) as necessary. For example, **23.201 (b)** includes time-out in the definition of restrictive procedures and **23.201 (c)** indicates that only drugs used as a restraint and manual restraint are permitted in an RTF, however, **23.204** describes time out and guidelines for use in an RTF. It is recommended that these clarify the definition of a restrictive procedure and what restrictive procedures are permitted in an RTF. It is recommended to delete reference to refusal requiring evaluation for inpatient hospitalization as protest by an individual in crisis is very common, especially if that intervention involves a medication that may be injected (injections are commonly feared stimuli among individuals not in crisis and not in RTF levels of care.

- **23.201. c – General Information** —It appears that time out is a restrictive procedure as noted on 23.201 (b), but is not permitted in an RTF based on 23.201 (c).It is unclear why this is listed in both (b) and (c), but left off of restrictive procedure options available. 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. A better option for the section is to identify which procedures are unacceptable, such as aversive conditioning/positive punishment, or restraints used for staff convenience, retribution, or prior to less restrictive procedures being attempted.

- **23.201 (d) - General Information-** To be consistent with other recommended changes, the term "A restrictive procedure" should be replaced with "A restraint." Restraints should not be used in the manner identified in this section.

- **23.201 (e)- General Information-** This section requires that communication with the child with whom a restrictive procedure is being utilized to be informed of clear criteria for ending the procedure. As noted above, the term restrictive procedure in this section should be changed to "restraint procedure" as some restrictive procedures, such as token economies, may be "ongoing" as a procedure and would not have specific criteria for termination as a time limited procedure. Secondly, communication during a restraint may not always be clinically appropriate or beneficial. For example, when behavior is attention-seeking and/or maintained by staff attention, this type of communication or attention might be reinforcing to the behavior and result in escalation of, or continued behavior. Providing attention of any kind, including a description of criteria for discontinuation, during a restrictive procedure may be counter therapeutic and delay a child regaining self-control. In situations where the child has little to no receptive language skills (e.g., a child with ASD and profound MR) providing verbal instructions is likely to have little to no effect. Determination of if, how, and when a child will be informed of the criteria for discontinuation of a restrictive procedure is a clinical decision and best determined in coordination with the family and other members of the ISP treatment team. It is recommended to revise to indicate that the ISP treatment team will determine whether a child will be informed of the discontinuation criteria for restrictive procedures as well as when and how the child will be informed. It is recommended that this section be revised to the following: "A restraint procedure shall be discontinued when a child demonstrates safe

behavior. Staff involved implementing a restraint procedure shall inform the child in an easily understandable language during the procedure if appropriate, of the criteria for discontinuation of the procedure."

- **23.201 (f) – General Information** – It is recommended that the term "restrictive procedure" be changed to "restraint procedure." It is also recommended that this section be changed to the following: "If during a restraint, it appears that the child may be experiencing difficulty breathing, and/or signs or symptoms of medical distress, the procedure will be terminated immediately and medical attention provided." It is possible that injury may result from a restraint procedure and the consent documentation identifies this possibility. All measures are taken to minimize this possibility including training and oversight, but this possibility cannot be completely eliminated, and regulations should not reflect this expectation since it is unrealistic. Restraint procedures are only implemented when a child poses a real and imminent danger to him/herself and others, therefore the child id already engaging in unsafe behavior and will likely continue to do so prior to regaining self-control or in an attempt to get out of a restrictive procedure. Therefore, some measure of risk is possible and outlined in the informed consent process and in consideration of the injury caused to the child for failure to implement a restraint procedure.

- **23.203. (a-c) – Written plan to create a restraint free environment** —As identified earlier, regulations are not appropriate forums to include requirements and mandates for clinical models. The ultimate goal for providers should be to be restraint free if possible. However, it is concerning to identify in regulations this as a mandate. Each provider serves a different population, some exhibiting more intense and severe behaviors which can place themselves and others at serious risk for injury or harm. A provider wide mandate to be "restraint free" also does not take in to account the ongoing progress and attrition of children served. For example, a child may come in to the program with high rates of behavior placing him or herself at risk, which would require use of restraint when necessary. Over time with effective programming, these rates would hopefully reduce, perhaps to the point of the child no longer requiring the services of the provider in the program. This child may be discharged and a new child admitted again with high rates of behaviors. Section 23.203 a, b, and c are recommended to be deleted and replaced with the following: "Providers should develop mechanisms for data collection, oversight, and regular review of restraint use and develop individualized plans to work towards reduction of restraint when possible." It should be cautioned that if regulations push some providers towards a restraint free environment, their solution may be for increased psychiatric medication use and/or may result in increased use of law enforcement and inpatient hospitalizations. Data should be evaluated for the potential correlation between "restraint free environments" for populations of individuals with severe behavioral disorders, and the uses of other methods such as law enforcement and medication, before this type of mandate is included in policy, let alone regulation. It is recommended that this requirement should be revised to have providers create plans to "**minimize** the use of restraint".

    - **23.203 (a).** Not all providers follow the trauma informed care philosophy. The Department should not dictate the philosophical approach used by providers. It is recommended to remove this and all references to a trauma informed care approach.
    - **23.203 (b) (1).** Not all providers follow the trauma informed care philosophy. The Department should not dictate the philosophical approach used by providers. It is recommended to remove references to a trauma informed care approach.
    - **23.203 (b) (2).** It is unclear what data and manner of data collection the Department will require. This should be clarified.
    - **23.203 (c).** A better focus would be on how to minimize the use of restraint. This requirement should be revised to have providers create plans to "**minimize** the use of restraint". "Department approval" is referenced toward the end of this requirement. There is no mention of the criteria the department will use to determine approval of a plan as well as consequences for a plan not

being approved, appeals process, etc. It is recommended this be removed and if necessary a separate unregulated policy be set forth for review.

- **23.204. Time out.** Based upon earlier requirements it is unclear as to whether time out is a restrictive procedure or is allowed in an RTF. This should be clarified. In addition, even when implemented as an intervention for a child in a private home, time out is intended to be an unpleasant consequence or a removal of attention, toys, etc… such that the child will be less likely to engage in that behavior again in the future. As described within these regulations, a more fitting term might be "required relaxation". The label for this procedure should be revised throughout this document.
    - **23.304 (b).** If the purpose of "time out" is to "provide the child an opportunity to learn how to gain self-control", it seems that a child who request "time out" has met this goal, thus the child is not requesting time out, rather he/she is requesting the opportunity to take time to regain self-control. A child requesting a break seems to be a pro-social behavior and not a restrictive procedure. This should be revised so that child requested time away should not be considered time out or tracked as a restrictive procedure.
    - **23.204 (d) (2).** A child requested opportunity to regain self-control should not be considered time out. It is recommended to remove "including whether it was requested by the child."
    - **23.204 (d) (4).** It is unclear how a staff will measure the effectiveness of a timeout or the reason a time out was not successful without data tracking. It is recommended to remove this requirement.
    - **23.204 (c) This requirement and the following one are labeled incorrectly.** If the purpose of a time out is to allow a child an opportunity to" regain self-control and function in a more positive manner" then it is likely that a child who has not yet regained self-control may try to leave the designated area. Allowing a child to do so may place the safety of the child and or others at risk thus necessitating the use of other restrictive procedures such as restraint. Staff should be able to prevent a child from leaving an unlocked room. It is recommended to delete this requirement.
    - **23.204 (d).** Seclusion is defined as "placing a child in a locked room". Not permitting a child to leave the time out area by means other than locking the door (e.g., telling them the child that "he/she needs to stay in the room until he/she is calm" or redirecting them back into the area) should not be considered seclusion. It is recommended to delete this statement.

- **23.205. A.1 and 2. - Emergency Safety Interventions** – 23.205 (a) 1 is recommended to be revised to state the following: "Mechanical restraints are prohibited for behavior control. Devices prescribed by physicians used for safety to provide support for functional body position or proper balance and a device used for medical treatment, such as sand bags to limit movement after medical treatment, a wheelchair belt that is used for body positioning and support or a helmet used for prevention of injury during seizure activity, are not considered mechanical restraints."

- **23.205 (e) (4).** It is recommended to replace "adversive" with "aversive"

- **23.205 (f).** Restraints are implemented in emergency situations where the health and safety of the child or others is at imminent risk. Delaying implementation of restraint during an emergency in order to obtain an order to use a restraint will result in increased likelihood of injury to the child and or others. This requirement, by definition, is counter to the responsibility of the provider to maintain a child's safety. This section and all references to restraint orders are recommended to be removed.

- 23.205 (f) (8). Guidelines for ordering and administering drugs used as a restraint should remain.

- **23.205 (g) (2) (iii).** Any hands-on-technique has an inherent risk which is noted in the consent to implement restraint documentation. Indicating that providers will "ensure safe use of restraint" provides an unrealistic impression that restraints are risk free. It is recommended this section be removed.

- **23.205 (g) (3).** It is recommended to revise to indicate that staff will monitor and document signs of distress at least every 10 minutes during a restraint. It is recommended to delete the section indicating where this should be documented.

- **23.205 (g) (8) (iii).** It is unclear how someone conducting an assessment 1 hour after the implementation of a restraint would be able to "determine the appropriateness of the intervention measures." In addition, this individual may not be qualified to measure the appropriateness of an intervention (e.g., drug used as a restraint). It is recommended that this section be deleted.

- **23.205 (h) (2).** Having staff meet with supervisory staff following each restraint that results in minor injury such as redness or scratches would be time consuming and likely provide little useful information. It is recommended to revise this section to indicate staff will meet with supervisors following each restraint that results in serious injuries.
- **23.205 (8) (i) (1).** This does not take into consideration personal preferences of families. For instance a family may wish to be informed of restraint use on a weekly basis. In addition, if a restraint were to occur overnight, many families would prefer to be notified in the morning as opposed to during the overnight hours. It is recommended to revise this section to indicate that "parents will be notified within 24 hours of a restraint, or on a schedule agreed upon by the family and other members of the ISP treatment team."

- **23.205 (j).** It is recommended to revise this section to reflect changes suggested in 23.205 (f) removing references to restraint orders.

- **23.205 (K).** This section requires three debriefing sessions for every restraint. The amount of time and resources required to complete these sessions places an undue burden on the provider. This section does not take into consideration that staff may not be scheduled to work, having them participate in a meeting on a day off would require payment of overtime, and if they are scheduled to work, coverage would need to be secured for the time that they were in the debriefing meetings. Also, this section requires two meetings with the child, which are in addition to the 1 hour evaluation. This is a large amount of attention provided to the individual and may actually reinforce engaging in unsafe behaviors increasing the likelihood of future restraints. It is recommended that this section be revised to indicate that the ISP treatment team will review emergency safety situations that result in restraint and make recommendations for changes to the treatment plan as necessary.

- **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 situations for safety. The unintended result of this requirement may be increased risk of safety to the child or others, and perhaps increased law enforcement activity. 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?

- It is recommended that 23.205(f) 1 through 7 and 9 through 10 be deleted. 23.205 (f) 8 can remain as necessary.

- **23.205 (g) 2 (iv and v) - Emergency Safety Interventions-** As noted above, this requirement might be counter productive. It is recommended that 23.205 (g) 2 (iv) be deleted. It is recommended that 23.205 (g) 2 (v) be revised to be consistent with definition recommended above, specifically: "A restraint procedure shall be discontinued when a child demonstrates safe behavior."

- **23.205 (g) 3- Emergency Safety Interventions-** It is recommended that the last sentence be revised to: "Staff must document the condition of the child for at least each 10 minute intereval." Specifying where this is to be documented is unnecessary.

- **23.205 (g) 4 and 5- Emergency Safety Interventions-** For the reasons noted above, these sections are recommended to be deleted.

- **23.205(i) 1 and 2 – Emergency Safety Interventions**– Notifying parents/ guardians within five hours may be unreasonable and creates an undue burden. In addition, it may be insensitive to some parents who request other communication methods or times. Some parents are unreachable and other parents are at work and cannot take phone calls. Some parents do not want to be notified of each restraint. Melmark has a number of parents who have requested in writing that they receive summaries on a weekly or monthly basis only. It is recommended that this be revised to the following: "An RTF shall notify a parent....within 24 hours of the restraint procedure." 23.205 (i) 2 is recommended to be revised to: "An RTF shall document that the parent and..." The specification of location where this document must occur should be removed.

- **23.205 (j) 1- Emergency Safety Interventions-** It is recommended that this be revised to the following: "Documentation of a restraint must be completed and include the following:"

- **23.205 (j) 1 (ii, iii, iv, and viii) - Emergency Safety Interventions-** It is recommended that 23.205 (j) 1 ii, iii, iv, and viii each be deleted consistent with other recommendations.

- **23.205. K.1 through 4 – Emergency Safety Interventions** –It is recommended that this section be deleted and replaced with the following: "Providers shall develop a debriefing process to be utilized following restraints." Regulations should set minimum expectations and not be overly prescriptive on process. The clinical team and management of the provider should be permitted to structure processes to best suit the children they serve and the organization.

- **23.206. Restrictive procedure records.** As per the above recommendations, it is recommended to revise this section to remove references to restraint orders.

- **23.221. b.10 – Description of Services** — While it is generally counterproductive to file charges against children in residential treatment, it is recognized that staff have the right to press charges. Writing a policy on this topic however could have the opposite effect of encouraging staff to file such charges. The behaviors children exhibit, which may include aggression, are many times in large part why they require services. Ultimately we desire to employ staff who understand the populations we serve and the

risks and rewards associated with serving them; not those who view our individuals as "assaulting" them. It is recommended that 23.221 (10) be deleted.

- **23.222 b.6 – Admission Process** – Requiring a trauma screen may be an inefficient use of resources for an agency and unnecessary or even harmful for the child if no trauma history was reported. It is recommended to add "if possible history of trauma is reported".

- **23.222 b7 Admission Process**– What is "cultural discovery" defined as in this context? It I recommended to either delete or provide clarification as this may reference specific aspects of a clinical or philosophical model which are not clearly defined or adopted universally by all providers of RTF services.

- **23.223 b – ISP Development** – 14 days is an unrealistic time line to develop an ISP that includes all items listed in 23.224 and sufficient and accurate baseline assessment data. The timeframe is recommended to be extended.

- **23.223. c – Development of the ISP** – It seems like the required team is loaded with people who will not actually be working with the child. What about the psychologist, teacher, nurse, occupational therapist, speech therapist, program specialist, and residential counselor? The identified team members required may not be sufficient and may be unnecessary resources depending on the specific child.

- **23.224.6 Content of the ISP**– It is recommended to delete the phrase "including the following" related to child health and safety skills required to teach, and to add "may include the following".

- **23.228. b.1 – Behavioral Health Treatment** – It is recommended to delete the phrase "when possible" where used in reference to evidence based treatments. As noted earlier, the only acceptable forms of treatment are those which are evidence-based and have conclusive empirical support in the treatment literature for the population being served (with appropriate experimental design and data collection). There should be no option to permit the use of 'treatments' that lack evidence supporting their efficacy.

- **23.243 -Contend of child records-** There appears to be a spelling error in this title which should be "Content" and not "contend."

- **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.

- **23.243 -Contend of child records-** There appears to be a spelling error in this title which should be "Content" and not "contend."

- **23.243 Content of child records-** We applaud the department's insistence on data related to specific treatment goals and evidence of progress. Since documentation of family's participation in planning and treatment and documentation of goals of therapeutic leave and outcome/reviews of therapeutic leaves are required, all planned days of therapeutic leave, for the purposes of facilitating a successful reintegration into a less restrictive environment and/or reunification with the family, should be allowable billing days. Additionally, providers must be able to require participation by all families for continued placement in the RTF.

- **23.291 General participation requirements**- Most are reasonable parameters, with the following exceptions:
  - Have a transfer agreement with an acute care hospital and inpatient psychiatric hospital- It is difficult to identify in many areas of the Commonwealth high quality inpatient programs that will accept children with comorbid Axis I and Axis II disorders, along with significant behavioral challenges, and providers often must search out of state for this level of care
  - Receive and maintain certification by CARF, COA or JCAHO- will result in significant increase in cost of care if providers must meet this additional requirement beyond licensing with the Commonwealth. If these accreditations are required, the proposed regulations should be significantly streamlined as many proposed regulations in this chapter are redundant and/or may pose slight variations to the specificity required under these accreditation bodies.
  - Provide services under direction of board-certified psychiatrist- as stated previously, this is an assumption of a medical model which has long since been rejected by the field and imposes a specific clinical model on providers. Further, this model has no greater evidence of efficacy with the population served by Melmark and in many other RTF's, and less so than models based upon Applied Behavior Analysis.

- **23.294 Ongoing responsibilities of an RTF**. In addition, RTF must submit a new attestation of compliance with the use of restraint and seclusion in psychiatric residential treatment facilities whenever RTF management changes- unclear whether this means any change in the management structure (e.g., resignation of one mental health professional). It is recommended to delete this reference.

- **23.307 General payment policy.** Payment for RTF admission is subject to retrospective review and prior authorization review. Unclear whether reference to therapeutic leave being disallowed means that for an approved home pass, as prescribed by the treatment team and as part of the reunification plan for the child, will be disallowed under this regulation. It is recommended to delete this term.

- **23.331-332 Inspection of Care Reviews**- If alternate care for a child is recommended or the child fails to meet medical necessity criteria, only the child or their representative (parent or guardian, not the RTF) has 30 days to grieve decision or request fair hearing. If fair hearing requested within 10 days, payment for RTF care will continue pending outcome of hearing. If fair hearing not requested within 10 days, payment for RTF care will discontinue effective day the alternate care was recommended (inspection). This places the financial responsibility for payment of services in the hands of parents and guardians who may not adhere to established timelines or understand the appeals process. This could result in significant non-payment to providers for continued provision of services due to a parent or guardian's failure to meet an established timeline.

On behalf of Melmark, it's students, and it's staff, we thank you for your time and thorough attention to the recommendations. Melmark is pleased to continue to offer additional assistance in the form of information or specific language recommendations as necessary. Please feel free to contact us at any time.

Sincerely,

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References

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BUREAU OF CHILDREN'S SERVICES

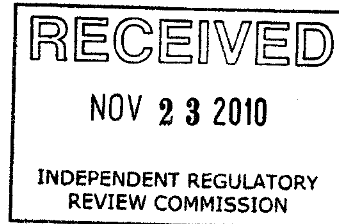
From: christabakin@melmark.org
Sent: Monday, November 22, 2010 3:39 PM
To: PW, RTFComments
Subject: No. 14-522
Attachments: DPW-IRRC Response to Proposed Chap 23 RTF regs.doc

Good Afternoon,

Please find comments attached for the proposed changes to the Residential Treatment Facility regulations. Reference # 14-522.

Please contact me with questions.

Thank you,



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