Positive Behavior Supports

Intensive Tier of Supports

Guidance for Providers Implementing Positive Behavior Supports

Massachusetts Department of Developmental Services

Revised February 2025

This guidance document was developed to assist the DDS community to implement Positive Behavior Supports and as guidance it is not a substitute for a thorough understanding of applicable law, regulation, and DDS policy. In the event of inconsistency between this guidance and law of DDS policy, the latter shall prevail. See 115 CMR 5.00

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DDS Positive Behavior Support Policy

It is the policy of the Department Developmental Services (DDS) to establish procedures and the highest practicable professional standards for the treatment of people with intellectual and developmental disability, and to assure the dignity, health, safety, of its clients. System-wide PBS is a widely accepted and utilized framework for both system change and individual treatment which supports individuals to grow and reach their maximum potential. Positive Behavior Supports (PBS) emerged from three major sources:

(a) Applied behavior analysis
(b) The normalization/inclusion movement; and
(c) Person-centered values

Journal of Positive Behavior Interventions, Positive Behavior Support: Evolution of an Applied Science, (Carr, Edward, Dunlap, Glen, Horner, Robert, et al.) Vol. 4, No. 1 (2002).

PBS provides a means for selecting, organizing, and implementing evidenced-based practices in the treatment of individuals. It focuses on clearly defined outcomes, data-based decision making and problem-solving processes that support fidelity and durability. PBS emphasizes the use of positive behavior approaches and recognizes that behavior is often an individual's response or reaction to the environment and the need to communicate his or preference and wants to others. Therefore, PBS focuses on environmental modifications, antecedent strategies, teaching desired and replacement strategies as well as reinforcement for teaching these desired and functional replacement behaviors. The strategies used to modify the behavior of individuals should involve PBS which promotes the dignity and respect of individuals and should not be unduly restrictive or intrusive. It is both law and policy to use only procedures which have been determined to be the least restrictive or least intrusive alternatives. 115 CMR 15.14(1)

INTENSIVE TIER OF SUPPORT

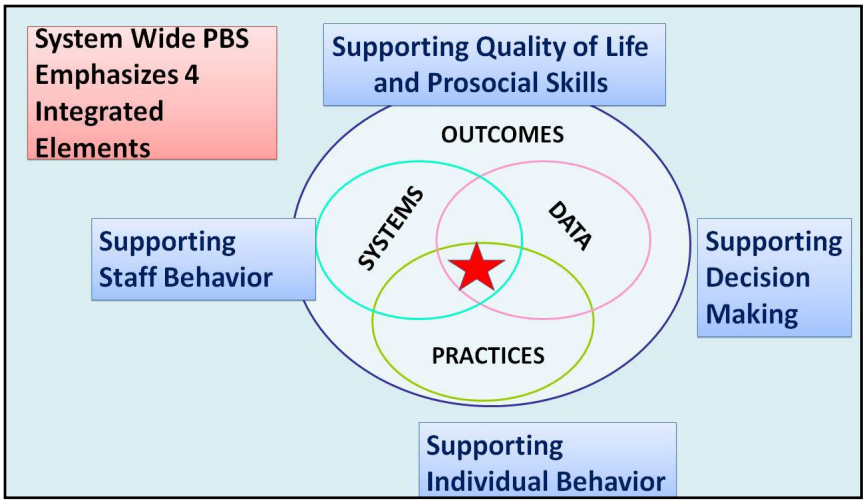
I. PURPOSE

Intensive Tier of Supports (Intensive Supports) may be implemented for dangerous or significantly interfering behavior such as those behaviors that put a person or others at risk of harm or result in significantly poorer quality of life. The need for an Intensive Positive Behavior Support Plan (I-PBSP) is typically related to significant challenging behaviors such as physical altercations, forensic or legal involvement, frequent episodes of challenging behavior directed at self or others, behavioral health hospitalizations, and many psychoactive medications. Intensive Supports usually are considered only after the person has had access to robust solid Universal Supports and Targeted Behavior Supports and even with those supports the behavior of concern presents risk of harm or a diminished quality of life.

PBS INTENSIVE SUPPORTS GOAL: TO ENHANCE PERSONAL FREEDOM AND QUALITY OF LIFE

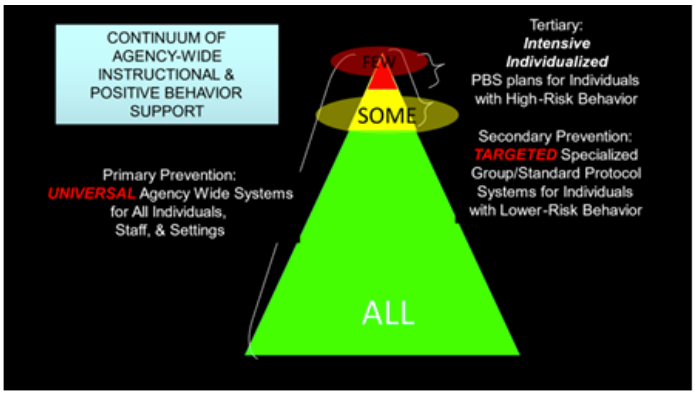
Four Integrated PBS Elements

PBS consists of four key integrated elements: outcomes, systems, data, and practices. These elements are integrated and interdependent so that no one element can singularly accomplish the goal of providing demonstrably effective ***outcomes*** for individuals. Each provider should determine their meaningful, measurable outcomes that support pro-social skills and enhance the quality of life for all individuals served. To support these outcomes, PBS employs three activities: systems to help support staff behavior in implementing evidenced- based practices with ongoing data-based decision-making measuring fidelity and individual outcomes. The most important component of system-wide Positive Behavior Support is the systems component. Systems are used to build capacity in each organization to implement PBS practices with fidelity, regular data-based decision-making by a team to problem-solve the effectiveness and efficiency of the evidenced-based practices to improve the quality of life of individuals served. Evidenced- based ***practices*** are those that can be found in the research literature or have been shown to be effective with data in the organization. These practices should be selected to match areas of need and suggested as the most efficient and effective interventions. They should be practical and implemented proactively so that problems are less likely to occur or significantly disrupt an individual's life. Staff should be trained with knowledge and understanding of an individual's values, motives, actions, and trained in effective responses to communication. PBS relies on the regular collection of ***data*** to communicate the effectiveness of practices and systems so that problems can be



identified and remedied in a timely way. Objective, measurable data guide decision making at every level of support. [1]

There are three Tiers of Positive Behavior Support: Universal Tier of Supports referred to as Tier I, Targeted Tier of Supports referred to as Tier 2, and Intensive Tier of Supports, referred to as Tier 3. At each Tier, the goal is for the individual to achieve meaningful outcomes and improved quality of life. The PBS triangle below represents the typical distribution of the Tiers and may not be representative of any particular provider. Information on the three Tiers and Interventions can be found at www.masspbs.com.



II. INTRODUCTION TO INTENSIVE TIER

Many individuals served by DDS will succeed with supports provided at the Universal and Targeted Supports tiers. However, some challenging behaviors may require additional supports to allow an individual to live and work in the least restrictive environment possible. When Intensive Supports are implemented, the Intensive Support Team is expected to use evidence-based practices, that is, those procedures that have been adequately researched and are the most efficient, positive, and proactive intervention(s) available to help improve the behavioral and social functioning of an individual needing support. When Intensive Supports are used there is an ongoing commitment to avoid interventions that force participation. Further, data-based decision making is especially important at the Intensive supports tier where individuals experience the greatest disruption to daily life and are at most risk for continued distress.

While clinical input is important at all levels of support, guidance and standards for clinically appropriate practice become even more important at the Intensive Supports tier. To thoroughly understand the basis for the challenging behavior and to provide for the individual's needs, Intensive Supports require greater participation by all members of the organization and must include a PBS Qualified Clinician to provide such supports. Intensive Supports also require greater levels of review by the provider and DDS and may require the inclusion of resources external to the team.

[1] Definition developed by sub-committee of the Commissioner's Advisory Board on PBS and adopted at 115 CMR 5.02.

III. WHO SHOULD RECEIVE INTENSIVE SUPPORTS

Individuals are referred for Intensive Supports when there are concerns that the health, safety, or emotional well-being of the individual, or others, is at risk, or the individual's quality of life is seriously impeded due to challenging behavior. Intensive Supports typically are not implemented until Universal and Targeted Supports have been implemented with integrity and data have shown them not to be sufficient for meaningful behavioral change. However, when there is danger of harm to self or others, Intensive Supports may be utilized immediately. In these situations, there is an expectation that Universal and Targeted Supports will be introduced concurrently, and that Intensive Supports include measures to assist the individual to access Universal and Targeted Supports wherever possible.

IV. INTENSIVE SUPPORT TEAM

Intensive Support Team Membership

The PBS Leadership Team is required to determine the number and composition of Intensive Support Team(s) and to document membership in the provider's PBS Action Plan. The number of teams will depend on the need within a provider for Intensive Supports. A provider with a number of individuals requiring Intensive Supports may need more than one Intensive Support Team. A provider serving a small number of individuals may not have the need or resources for an Intensive Support Team. Depending on the number of individuals needing support at each tier, the Leadership Team may decide to combine the Universal and Targeted Teams or the Targeted and Intensive Teams. In some small number of cases, it may be necessary to combine Universal, Targeted, and Intensive Support Teams. When teams are combined, it is recommended that separate meetings occur for each support tier, and separate meeting minutes are written to accomplish the tasks of each support tier.

An individual in an executive leadership position with decision-making authority and a PBS Qualified Clinician are required members of the Intensive Support Team. Other members may include other clinical, managerial, administrative, and support staff.

Due to the serious nature of behavior leading to referral for Intensive Supports, the Intensive Support Team must have one or more members with substantial clinical expertise. The Intensive Support Team will work with the guidance and clinical leadership of a PBS qualified clinician who is a Team member.

Duties of Administrative members of Intensive Support Teams

- Ensure there is a data system that provides objective and valid information to inform the Team's work
- Ensure data are used to guide decision-making;
- Ensure that resources are available so that Intensive Supports can be implemented;
- Create and maintaining a system that encourages staff behavior that is caring and supportive of all individuals including those for whom the Intensive Supports are provided; and
- Ensure that fidelity checks are conducted regularly and provided to the Intensive Support Team for review.

Duties of All Intensive Support Team Members:

- Attend and participate in Intensive Support Team meetings
- Review target behavior and replacement behavior aggregated data as well as treatment integrity data for individuals receiving supports at the Intensive Supports tier at each Intensive Support Team meeting

- Assist in reviewing Functional Behavioral Assessments/Analysis of challenging behaviors identified as needing additional supports
- Allocate resources to Intensive Positive Behavior Support Plan (I-PBSP) creation/modification and assign responsibility for implementation and follow-up
- Assist in the referral of the individual to other clinicians both inside and outside the provider agency
- Seek consultation by other qualified clinician(s) when other (e.g., physical or mental health) reasons for the challenging behavior have been ruled out and despite the current clinician/Intensive Support Team's best efforts, the individual still is burdened by significantly challenging behavior; and
- Participate in clinical and life planning work as needed to support the individual to live a safer and/or more engaged life.

PBS Qualified Clinician

PBS Qualified Clinician requirements can be found at CMR 115.5.14(10)(a):

(a) A PBS qualified clinician shall:

1. be currently licensed in Massachusetts in accordance with applicable law as one of the following:
   (a) a psychologist;
   (b) an independent clinical social worker;
   (c) an applied behavior analyst;
   (d) a masters or doctorate level speech pathologist;
   (e) a physician;
   (f) a masters or doctorate level teach with certification in special education
   (g) a licensed mental health clinician (LMHC); or
   be a doctorate level special education teacher actively teaching the topics of positive behavior support or applied behavior analysis at the college or university level.
2. have at least three years of training, including post graduate class work or formal training, and/or experience in function based behavioral assessment and treatment; and
3. have at least three years of clinical experience in the treatment of individuals with developmental disabilities.

In addition to training and experience, PBS Qualified Clinicians must also have sound clinical judgment and possess the ability to work directly with individuals with intellectual and developmental disabilities, program staff, and families as needed. PBS embraces a broad-based understanding of the roots of human behavior and the Intensive Support Team, including the PBS Qualified Clinician, must have the clinical judgment to make referrals to other professionals for assessments, opinions, and other service needs.

The Department expects that all professionals work in an ethical manner and do not work outside their areas of competence. There is no domain in which it is acceptable for clinicians without adequate qualifications or without rigorous clinical supervision from a qualified clinician to work with individuals with intellectual disability or developmental disability.

Duties of the PBS Qualified Clinician

1) Describe and operationalize the nature of the behavior problem;

2) Develop, implement, and monitor the I-PBSP including:
    a) Assume responsibility for conducting the FBA
    b) Select effective interventions for developing the person's functionally equivalent replacement behaviors, general adaptive skills, and the least restrictive interventions that will be effective in diminishing the challenging behaviors;
    c) Participate in obtaining consent from guardian or individual;
    d) Develop a data collection system specific to the target behaviors and replacement behaviors defined in the Intensive Positive Behavior Support Plan (I-PBSP);
    e) Review and analyze data collected related to the I-PBSP;
    f) Address all aspects of implementation of the I-PBSP;
3) Engage a system of coaching;
    a) Ensure staff are trained to competence in all aspects of the Plan (e.g., data collection, implementation of interventions);
4) Designate a systematic process for monitoring and quality improvement
5) Develop or implement available fidelity tool to evaluate the quality of I-PBSP implementation;
6) Develop usable tools (e.g., data sheets that are understandable and from which meaningful data flow), to effective follow-up when staff performance improvement issues exist.
7) Make revisions in I-PBSP as needed and, with help from Team, inform guardian, DDS, and other interested parties of changes. [(c) 3]
8) Assist in the referral of the individual to other clinicians both inside and outside the agency
9) With others from Team, present I-PBSP for review at all required review committees.
10) Evaluate results over time and
11) Participate in clinical and life planning as needed to support the individual to live a safer and/or more engaged life.

Intensive Support Team Meetings

Intensive Support Team meetings are required to occur regularly (at least monthly is recommended) and as needed. The Intensive Support Team is expected to maintain adequate records (e.g., minutes) of these meetings as part of the ongoing monitoring and review of the individual's progress and as a reference for all Team members. The agency PBS Leadership Team reviews minutes from the Intensive Support Team meetings. When individuals are referred to in meeting minutes, names must be redacted for review as needed. Intensive Support Teams examine the progress toward goals or lack thereof and consider whether there are systemic reasons for the lack of progress.

The Intensive Support Team should not be confused with the Department's requirement that individuals have an Individual Service Plan (ISP) Team. An individual's ISP Team addresses all aspects of a person's vision and goals and all domains in which support is needed. An agency's Intensive Support Team may include some ISP Team members although extensive overlap is not expected. When an Intensive Support Team is part of the agency's PBS Action Plan, it is anticipated that it is a standing group focused on improving the quality of life for a person with significant challenging behavior.

V. FUNCTIONAL BEHAVIOR ASSESSMENT PROCESS

Consistent with current recommendations in person-centered-planning and clinical-behavioral psychology, the individual's preferences, history, ensuring that both big traumas (Big Ts) as well as small traumas (Small t's) are described and considered, and current supports are all an important part of understanding how to best provide support. The information in a Functional Behavior Assessment (FBA) orients the reader to the individual and avoids an unreasonably narrow focus on "behavior" without considering personal history, trauma, health, means of communication, individual differences and preferences, environment, context, and the nature and value of relationships in the individual's life. Understanding the history of trauma informs the FBA to consider what interventions will assist the individual to feel safe including significant people in the individual's life, how control over decision-making and the interpersonal connections play a role in understanding current functioning and help direct how those areas can help the individual move forward.

It is important to note that PBS interventions flow from the findings of the FBA and address specifically identified hypotheses. Functionally equivalent replacement behaviors (FERBS) will be identified through the FBA and teaching or strengthening those behaviors will be a critical part of the I-PBSP to reduce the occurrence of challenging behaviors. In a separate document entitled PBS FUNCTIONAL BEHAVIOR ASSESSMENT, the format for completing an FBA has been shared and major elements of the process are addressed and can be found at www.masspbs.com

Role of Competing Pathway

The competing pathway model provides the link between the Functional Behavior Assessment and the development of the Intensive Positive Behavior Support Plan. The I-PBSP should focus on both the function of the behavior derived from the FBA as well as the teaching of an alternative replacement behavior or skill. The competing pathway helps the PBS Qualified Clinician develop a comprehensive I-PBSP that determines strategies that make the target challenging behavior ineffective, inefficient, or irrelevant because the replacement behavior or skill serves the same function. Since challenging behaviors continue to occur (maintained) because they are positively rewarded (reinforced) it is critical during the FBA to analyze and develop a hypothesis about what the individual gets in/or out of by engaging in the challenging behavior. A trauma-informed FBA will also note where there is a likelihood that the individual is not consciously choosing the challenging behavior to get in/or out of something, but rather as a trauma response that for some reason makes sense to the person as a protective measure. The replacement behavior represents the response the clinician wants to occur rather than the challenging behavior.

VI. INTENSIVE POSITIVE BEHAVIOR SUPPORT INTERVENTIONS

PBS makes a commitment to use the most efficient, positive, and proactive intervention(s) available to support individuals in their daily lives. The emphasis of Positive Behavior Supports includes an overlay of values that does not allow implementation of a procedure over an individual's resistance unless doing so is necessary to maintain the safety or dignity of the person or others. Thus, no I-PBSP will include such a procedure. When there is danger to the person or others due to serious and not yet decelerated challenging behavior, the expectation is that the agency's Crisis Prevention and Restraint Curriculum (CPRR) would be used to guide the work needed to support the person and others safely while the Intensive PBS work continues. It is important for the provider to consider

and implement the Behavior Safety Plan while the work on reducing the challenging behavior occurs. The Behavior Safety Plan can also be found at www.maspbs.com

Overview of Intensive Support Plans Elements

- Antecedents, triggers, events and actions prior to the challenging behavior
- Teaching Functionally Equivalent Replacement Behavior (FERB)
- Consequences

There are three essential components to an I-PBSP including 1) addressing the events, actions or circumstances, i.e. antecedent conditions, that occur prior to the challenging behavior, 2) teaching, and/or strengthening functionally equivalent replacement behaviors (FERBS), and 3) developing consequences to decrease the occurrence of challenging behavior and increase (reinforce) the likelihood of more appropriate behavior over time. These three components are equally important when developing procedures to reduce challenging behavior and to enhance an individual's quality of life. Inadequate attention to one or more of these three components is likely to result in only partial or temporary behavior change. It should be noted that developing consequences in the context of challenging behavior resulting from an internal trauma response need to be developed in conjunction with a clinician trained in trauma-informed approaches so as to avoid inadvertently creating further trauma. Only by addressing all aspects of the physical, social, cognitive, and behavioral environments can challenging behavior successfully be replaced with behavior that produces equivalent results and achieves lasting, positive change.

Each element will be discussed below:

Procedures that may be used to decrease/diminish (decelerate) challenging behavior

All procedures that are not prohibited may be proposed for use in increasing desired functionally equivalent replacement behavior as well as decreasing, i.e. decelerating challenging behavior. An Intensive Positive Behavior Support Plan does not presume the need to use restrictive procedures, but they may be necessary as well as the possibility of restriction of rights. A I-PBSP equates with greater effort and focus on fully understanding the individual's life, health, history, and challenging behavior. The Intensive Team should consider clinically sound alternative procedures and carefully monitor their usage. Restrictive Procedures and Restriction of Rights included as part of an Intensive Positive Behavior Support Plan must be reviewed by Peer Review and Human Rights per 115 CMR 5.14 (13) (14) and 5.04 (1-6).

Intensive Supports will include the following:

- Additional resources that will be devoted to the individual.
- Increased emphasis on teaching or strengthening effective replacement behaviors that are functionally equivalent to the challenging behavior and that offer a broader range of reinforcement strategies may be used
- Increased monitoring of all aspects to ensure fidelity and treatment integrity. For example, checks to make sure all behavioral and medical interventions are administered as designed (these could include checks on interventions as varied as (1) frequency, timing, and quality of praise given and (2) blood levels of seizure and/or psychiatric medication).

- Data collected on both target challenging behaviors for decrease and replacement behaviors to increase which is reviewed at regular and frequent intervals by the PBS Qualified Clinician and the Intensive Support Team.
- Additional preparatory work to include a detailed functional behavior assessment that identifies the establishing operations, setting events, predictors, and functions of the challenging behavior
- Development of an I-PBSP based on the FBA and with input from multiple sources; resources are dedicated to staff training and monitoring to allow full implementation of the I-PBSP with fidelity.
- Peer review of the I-PBSP when restrictive procedures are included
- Human rights review when any restriction of rights is part of the I-PBSP
- More frequent reviews of results by Intensive Support Team/key clinician and others.

Antecedents

Behavior always occurs for a reason. Often in the early stages of assessment, a behavior may seem capricious as if it "came out of the blue." However, further assessment will result in identification of the conditions of when and where the behavior is most likely to occur. The process for conducting this assessment is available through the FBA. An FBA provides a systematic, thorough approach to looking at conditions affecting behavior so that a coherent picture emerges of what maintains the behavior for the individual.

An FBA may generate hypotheses suggesting that the antecedent conditions (events preceding behavior) are external to the individual such as when a non-preferred food item is presented, or a housemate's radio is played at high volume. Antecedents that are generally more difficult to identify are those that are internal to the individual (often referred to as setting events). These events "set the state" for the behavior to be more likely to occur. For example, pain, hunger, constipation, or fear, may result in challenging behavior especially for an individual who has not been taught alternative ways of communicating internal states of distress. Antecedent conditions may be further complicated by a combination of conditions. For example, an individual may be aggressive when his housemate's radio is played loudly but only when enduring the pain of a headache.

Determining the antecedents to a challenging behavior that has a low frequency, but high intensity occurrence can be difficult. When dangerous behavior occurs at a low frequency, it may be difficult to acquire sufficient information to determine reliable antecedents to the behavior. In this case, it is important to continue the FBA and to carefully document so that conditions or patterns emerge over time.

Antecedent conditions connected to the challenging behavior may be complicated relationships, such as aggression occurring when a non-preferred task is prompted. In this case, escape would be identified as the reinforcer. However, when identifying antecedents, it is important to ask qualifying questions such as does it matter who makes the request or when the request is made (e.g., is request made by a non-preferred staff before lunch)? The function of the challenging behavior may be nuanced by specific antecedents that are important for adequately addressing conditions to promote lasting behavior change. Similarly, attention or lack of attention may be identified as a reinforcer of a challenging behavior. Qualifying questions such as why the attention is sought are needed. For example, attention may be sought for protection due to the antecedent of fear or for the desire for stimulation.

Teaching

A hallmark of PBS is the teaching or strengthening of functionally equivalent replacement behaviors (FERB). FERB is an acceptable behavior that serves the same function for the individual as the challenging behavior. As with identifying antecedents, this intervention strategy flows from the findings of the FBA. Once hypotheses regarding the function and antecedents of the challenging behavior are identified, then the task of teaching behaviors to replace the challenging behavior can begin. Emphasis is placed on selecting behaviors that are positive, pro-social, and functionally equivalent to the challenging behavior. For example, if a behavior functions to gain attention, then the replacement behavior must be equally effective in gaining attention as well as considered to be socially acceptable. If replacement behaviors are more difficult to engage in or less effective, then the individual will find it more expedient to engage in the challenging behavior, change will be less likely to occur, and most importantly, the person's needs will not be met.

Sometimes the task is to take an existing behavior, e.g., person says "No" and via stimulus control (when an individual behaves one way in the presence of a stimulus and another way in its absence), teach the person when to say "No" so that the challenging behavior is unnecessary. When teaching a new skill is needed, the replacement behavior must be defined in observable and measurable terms and as noted, serve the same function as the challenging behavior. The I-PBSP clearly defines how the new behavior will be prompted, what positive response will occur following the behavior to be taught, and who will provide the response. There are many schedules for applying positive reinforcement; however, the schedule of reinforcement and the schedule for thinning and fading reinforcement should be specified as part of Intensive I-PBSP.

Consequences

Each person experiences the world differently and as such, no particular event will necessarily be effective in promoting pro-social behavior. Similarly, no particular consequence (event following a behavior that increases or decreases the likelihood the behavior will occur again) will be effective for all. What serves to reinforce behavior varies across individuals and can vary for an individual over time and place. Thus, no intervention can be guaranteed to produce an outcome, and it may be misleading to label interventions as "reinforcing" (event following behavior and increases the likelihood that behavior will occur again) or "punishing" (event following behavior that decreases the likelihood that behavior will occur again) since the components of that intervention will be experienced differently by everyone. For example, one individual may be encouraged to engage in a behavior if money is offered. However, another individual will find this offer offensive and not engage in the behavior. In one case, money served as a reinforcer and not in the other. Intensive PBS work will be preceded by a reinforcer assessment (as part of FBA) so that reinforcement of non-interfering behavior can occur.

Just as consequences vary in their value between individuals, there is variability within an individual regarding the effectiveness of consequences. This variability is the result of events that momentarily change the value of reinforcers and punishers in an individual's life. For example, if an individual has not listened to music for many hours, the offer of music contingent on behavior may serve to increase the likelihood of that behavior occurring. When the value of a consequence is increased, this is called an establishing operation. However, if the same individual has just listened to music for two hours, music would not be expected to be effective in promoting behavior. In this case, the recent experience of listening to music is an abolishing operation.

An I-PBSP often will include the consequences for the occurrence of the challenging behavior. It is important that these are specified so that, in the future, the challenging behavior is much less likely to produce reinforcement of the challenging behavior. It is important to note that consequences, particularly the use of restrictions, may not be imposed for the sole purpose of extinguishing a person's particular behavior, separate from a path to skill acquisition and/or mitigating harmful outcomes.

Department of Developmental Services Restrictive Procedures

DDS defines Restrictive Procedures as a procedure that restricts an individual's freedom of movement or requires an individual through coercion to perform a task which is non-scheduled, not essential for acquiring a skill or learned task, or not essential for his or her health and well-being or removes something an individual owns or has earned. Restrictive procedures do not include hand-over hand assistance with activities of daily living or skill acquisition. 115CMR 5.02

Based on the general principles in designing an Intensive Positive Behavior Support Plan, there are specific Restrictive Procedures described in the regulations found at 115 CMR 5.02, 5.14 (14). The procedures permitted include the following, BUT ARE NOT LIMITED to:

- Time-out from Positive Reinforcement: The contingent withdrawal of the opportunity to earn positive reinforcement or the loss of access to a form of positive reinforcement for a specified period of time, is limited to a period not to exceed 15 minutes. Physical removal over -active resistance to a time out is a restraint.

- Overcorrection: A behavior reduction procedure in which contingent on the occurrence of the problem behavior the individual is required to engage/perform behavior that is directly related to the problem. There are many types of overcorrection procedures.

- Response Blocking: A procedure in which staff intervene as soon as the individual begins to emit a challenging behavior in order to prevent the completion of the targeted behavior. Response blocking is used mostly as a treatment to manage self-injurious behavior; however, it also is used as a defensive procedure when an individual is aggressing toward a staff person. Response blocking as described in CPRR-approved curricula (used defensively to block self-injury) is not a restrictive procedure.

- Protective devices as described at 115 CMR 5.12(1)(b)2. (See Glossary)

When considering the use of time-out from positive reinforcement pay close attention to how the individual moves to the time-out space. Any physical escort that involves the individual's active resistance is considered a restraint and must be reported as such following the DDS guidance. Once the individual is physically in the time-out space, providers must pay attention to the features of the time-out so as not to confuse time-out with the prohibited practice of seclusion.

Regulated Restrictions of Rights

DDS regulations define Rights in 115 CMR 5.03 and 5.04

Individuals served by DDS are subject to all applicable state or federal laws or judicial decrees pertaining to rights of all citizens as well as rights specific to individual being served by providers. These include the right to communicate, the right to be protected from private and commercial exploitation, the right to be visited and to visit others that are conducive to friendships and relationships, the right to basic goods and services, a reasonable right to privacy and the right to decline any service or support. (115CMR 5.04 (1-6).

- Restrictions of rights identified in 115 CMR 2.0, 3.0, and 5.0 require a human rights review.
- Restrictions of rights identified in 115 CMR 2.0, 3.0, and 5.0 must be accompanied by a training plan which is designed to work on the elimination of the need for the restriction which is documented in the ISP or included in a Positive Behavior Support Plan, if CLINICALLY required.
- All Intensive Support plans that include restrictive procedures require both Peer Review and Human Rights Review.
- All Intensive Plans that have significant Restrictions of Rights are subject to both Peer Review and Human Rights Review. (see below for additional information)

Prior to implementing a restriction of rights, a FBA needs to be completed to assess the nature of the challenging behavior. When a restriction of rights impacts the quality of life with a significant degree of frequency, intensity or severity the result is equivalent to a restrictive procedure and it belongs as part of an Intensive Positive Behavior Support Plan, including the requirement for Peer Review.

If the restriction of rights is at a low level, meaning it does not broadly impact quality of life due to its frequency, intensity or severity, it should be placed in a Targeted Behavior Support Plan. Note that the use of a Targeted Behavior Support Plan means that the behavior is low level and does not include behaviors that are challenging or dangerous to self or others.

> NOTE: Any Restriction of Rights under the sole guise of ***safety*** does not mitigate the need to consider whether such a restriction of rights should be formally incorporated into either a Targeted Behavior Support Plan or an Intensive Behavior Support Plan. All restrictions of rights must be accompanied by a written training plan (designed to progress toward the elimination of the restriction of rights) documented in the ISP or included in a Targeted or Intensive PBSP if clinically required.

In summary Intensive Positive Behavior Support Plans may include both Restrictive Procedures and Restrictions of Rights. Restrictions of rights identified in 115 CMR 2.0, 3.0, and 5.0 must be reviewed by Human Rights. All Intensive Positive Behavior Support Plans are subject to Peer Review and Human Rights review if they contain restrictive procedures.

In a separate document entitled “PBS Intensive Positive Behavior Support Plan, A Guide for Providers, Implementing Positive Behavior Supports”, a narrative description of the Intensive Positive Behavior Support Plan requirements as well as a sample plan format is provided and can be found at www.massbps.com

VII. CLINICAL REVIEW

Positive Behavior Support Plans with restrictive procedures must be reviewed by Peer Review subject to 115 CMR 5.14 (12) (b.) The I-PBSP also will be reviewed by a Human Rights Committee according to the regulations and guidelines provided by the Department 115 CMR 514 (13); restrictive procedures are de facto restrictions of rights. Also, when an Intensive PBS Plan includes restrictions of rights in addition to a restrictive procedure, a review by Human Rights Committee is a critical step in the approval process. It is important to note that any Intensive PBPS that uses either Seclusion, a prohibited practice, or Blocking pads must be reviewed by the DDS Statewide Consultation Team, and in the case of a prohibited practice such as Seclusion, the plan must continue to be reviewed at specified intervals for the purpose of discontinuing the prohibited practice in the most expeditious manner possible. Upon removal of the prohibited practice, a full Peer Review will be conducted and documented in the Peer Review checklist. A provider may also seek statewide Peer Consultation to discuss the types of interventions being used or considered as part of an IPBSP. All decisions to change the Tier of Support need to be guided by the data that supports decision-making. (See diagram 1 in the Introduction).

VIII. TRAINING REQUIREMENTS PRIOR TO IMPLEMENTATION

Prior to implementing an I-PBSP, it is essential to train staff to competence in all aspects of the I-PBSP. The PBS Qualified Clinician, the plan author, is responsible for this training. Training on definitions of target challenging behaviors and hypotheses generated by the FBA should be included in the training. Training on all interventions as well as data collection is required. It is recommended that some measure of staff competence in all aspects of the procedure be included as a standard part of this training. The PBS Qualified Clinician also must retrain staff at regular intervals and as needed. A video containing strategies for writing PBSPs and training for Direct Support Providers can be found on www.masspbs.com.

IX. PROHIBITED PRACTICES

Procedures that MAY NOT BE USED TO DECELERATE CHALLENGING BEHAVIOR

DDS regulations 115CMR 5.14(15) (a)(b) describe a number of procedures that are prohibited:

- Corporal punishment,
- Any noxious, unpleasant, uncomfortable or distasteful stimuli
- Chemical restraint
- Forced exercise
- Seclusion
- The locking of exits from buildings, except in accordance with 115 CMR 5.04 and 42 CFR 441.301(c)(4)
- Prone restraint and any physical restraint which causes pressure or weight on the lungs diaphragm or sternum causing chest compression or restricting airway, or basked hold in a seated position on the floor
- Removing, withholding, or taking money
- Denial of nutritionally sound diet including withholding of a meal
- Denial of adequate bedding or clothing
- Mechanical restraint.

To reiterate, PBS Qualified Clinicians must pay particular attention to ensuring that the prohibited practice of seclusion (5) as well as the locking of exits from buildings except in accordance with 115 CMR5.04 and 42CFR441.301(c)(4) does not occur. The definition of Seclusion versus the use of a time-out procedure is contained in the PBS Implementation Bulletin: Understanding Operational Principles with respect to Seclusion, Time-out from Positive Reinforcement, and Self-Management and can be found at www.masspbs.com. Below are important definitions and considerations in differentiating between Seclusion and Time-out.

Seclusion and Time-out Defined

Seclusion is a prohibited practice pursuant to DDS regulation 115 CMR 5.14(15(a)5. Seclusion is defined as "any act which involuntary places an individual alone in a locked room or other area from which there is no egress." [115 CMR 5.02].

Further, the CMS 1915(c) Home and Community-Based Waiver Application, Instructions, Technical Guide and Review Criteria [Version 3.6, January 2019] defines Seclusion as "the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving." This document also states that "for the purposes of this item, seclusion means involuntarily isolating an individual as a means of controlling the person's behavior."

Time-out from positive reinforcement, pursuant to 115 CMR 5.02, is defined as "the contingent withdrawal of the opportunity to earn positive reinforcement or the loss of access to a form of positive reinforcement for a specified period of time. Time out from positive reinforcement is limited to a period not to exceed 15 minutes."

Example definition: Individual is placed in a room involuntarily with no egress and is alone = Seclusion

Example: Individual is placed in a room involuntarily, his/her wheelchair is locked, the door is wedged so it cannot be opened by the individual = Seclusion

Note: if the individual is escorted to the room, or moved in an involuntary manner that constitutes a restraint and the placement in the room with no egress and no staff presence = Seclusion

Restitution

Except where noted Restitution is a prohibited practice. This means removing, withholding or taking the individual's money by unilaterally using the individual's personal care account, other monies, or requiring payment for a broken item. For information about one specific set of circumstances and conditions in which restitution may be permitted see PBS Guidance on Restitution which can also be found at www.masspbs.com.

Have the INTENSIVE SUPPORTS Led to Improved Quality of Life?

As with the other PBS interventions, concerted effort is dedicated to ensuring that staff implement the I-PBSP accurately and that data on implementation are generated and reviewed at each Intensive Support Team meeting.

At each Intensive Support Team meeting, it is the responsibility of the Intensive Support Team to review the data for both target challenging behaviors for decrease and replacement behaviors for increase. The Intensive Support

Team should develop criteria for evaluating the data presented at the Team meeting. It is recommended that criteria are standardized so that all data are evaluated with a reliably objective measure. For example, criteria may be that data indicate an upward or downward trend for 3 consecutive months, behaviors are decreased and/or decreased by 25% of baseline for 3 or more months. Further, the Intensive Support Team must offer recommendations regarding the future direction of programming efforts when trends in data are not seen as adequate. For example, the Intensive Support Team might recommend that additional consultation is sought from a specialist, revising the I-PBSP, or revising data collection or presentation.

Intensive Support Team should assign the responsibility for conducting treatment fidelity checks to identified provider personnel and determining the frequency of checks. The frequency will be determined by the PBS Qualified Clinician and the Intensive Support Team. The Intensive Support Team must review aggregate treatment fidelity data that includes information from all I-PBSPs; it is recommended that this review be done at each Intensive Support Team meeting. The Team must determine necessary follow-up, person responsible for follow up, and timeline for follow-up when treatment fidelity data are not judged to be sufficient.

X. REFERRAL FOR ADDITIONAL SUPPORTS

The Intensive Support Team is required to assess the response to supports provided at regular intervals. The Intensive Support Team will determine how frequently and by what method individuals will be assessed for their need for additional support, in keeping with the overall referral processes as determined by the PBS Leadership Team. DDS recommends that the Intensive Support Team review aggregate data at least every 60 days to determine if individuals' target challenging behavior is improving, worsening, or in stasis. Following reviews of data collected on the impact of the interventions on presence of challenging behavior as well as treatment fidelity data for an implemented I-PBSP, the Intensive Support Team may recommend additional supports for the individual or may recommend a revised/new FBA, or a new set of interventions. The Intensive Support Team may request additional outside consultation, may ask for DDS statewide Peer Consultation, and may involve the individual's ISP team. Successful resolution of the identified challenging behavior is based on both the acquisition of functional replacement behavior and a decrease in the challenging behavior. The Intensive Support Team should establish clear measurable objectives to alert the ISP Team that additional supports are needed.

XI. APPENDICES

Appendix A - Glossary of Key Terms

A. Evidence-based Practice: found in 115 CMR5.02
    a. Strategies based on procedures, assessments and interventions validated through peer-reviewed research.
B. Informed Consent: found in 115CMR 5.02
    a. The knowing consent voluntarily given by an individual (or by the individual's guardian, if applicable) who can understand and weigh the risks and benefits involved in the particular decision or matter.
C. Protective Devices: found in 115 CMR 5.12 (1)(b)2
    a. Health related protective equipment used to prevent risk of harm during challenging self-injurious behavior, for example, a helmet or arm splints, may only be used when authorized by a PBS Qualified Clinician. Protective equipment used to prevent risk of harm during self-injurious behavior may only be used as part of an Intensive PBSP and is subject to human rights committee review.
D. Restrictive Procedures: found in 115 CMR 5.02
    a. A procedure that restricts an individual's freedom of movement or requires an individual, through coercion, to perform a task which is non-scheduled, not essential for acquiring a skill or learned task, or not essential for his or her health and well-being, or removes something an individual owns or has earned. Restrictive procedures do not include hand-over-hand assistance with activities of daily living or skill acquisition.
E. Response Blocking: found in 115 CMR 5.02
    a. A procedure in which staff physically intervene as soon as the individual begins to emit a challenging behavior in order to prevent the completion of the targeted behavior. Response blocking is used mostly as a treatment to manage self-injurious behavior; however, it also is used as a defensive procedure when an individual is aggressing toward a staff person. Response blocking as described in CPRR-approved curricula (used defensively or to block self-injury) is not a restrictive procedure.
F. Time-out from Positive Reinforcement: found in 115 CM5 5.02
    a. The contingent withdrawal of the opportunity to earn positive reinforcement or the loss of access to a form of positive reinforcement for a specified time. Time out from positive reinforcement is limited to a period not to exceed 15 minutes. Physical removal over active resistance to a time out is a restraint.
G. Overcorrection
    a. A behavior reduction procedure in which contingent on the occurrence of the problem behavior the individual is required to engage/perform behavior that is directly related to the problem. There are many types of overcorrection procedures.
H. Response Cost
    a. Response cost: the contingent loss of reinforcers, is a negative punishment designed to reduce the frequency of negative behavior. It excludes a monetary fine because that is a prohibited practice.
I. Crisis Prevention, Response and Restraint (CPRR) Curriculum: found in 115CMR 5.02
    a. A standard, Department approved curriculum which includes training on de-escalation using Positive Behavior Supports, debriefing requirements and the monitoring of persons subject to a restraint.

Each Department vendor may select from the list of Department qualified CPRR Curriculum providers and shall only use the procedures contained in the specific selected curriculum.

J. Seclusion: found in 115 CMR 5.02
    a. Seclusion is a prohibited practice pursuant to DDS regulation 115 CMR 5.14(15(a)5. Seclusion is defined as: Any act which involuntarily places an individual alone in a locked room or other area from which there is no egress.

Appendix B - Karyn Harvey Healing Triangle