PROPOSED AMENDMENT OF SECTION 19.5 OF THE RULES OF THE BOARD OF REGENTS AND SECTIONS 200.1, 200.4, 200.7 AND 201.2 OF THE REGULATIONS OF THE COMMISSIONER OF EDUCATION AND PROMULGATION OF A NEW SECTION 200.22 OF THE REGULATIONS OF THE COMMISSIONER OF EDUCATION PURSUANT TO SECTIONS 207, 210, 305, 4401, 4402, 4403 AND 4410 OF THE EDUCATION LAW, RELATING TO BEHAVIORAL INTERVENTIONS, INCLUDING THE USE OF AVERSIVE INTERVENTIONS

ASSESSMENT OF PUBLIC COMMENT

Since the publication of a Notice of Proposed Rule Making on July 12, 2006, the State Education Department received approximately 400 comments on the proposed regulations. This assessment is based upon written comments submitted to the Department and comments presented at public hearings held on the proposed rule by the Department.

In General

COMMENT:

Approximately 85 percent of the comments from individuals/organizations expressed opposition to use of aversive interventions with students. Most individuals commended New York State (NYS) for prohibiting the use of aversive interventions, but opposed any child-specific exceptions to this prohibition under any circumstances. Reasons for opposition to any exception to aversives included: ethical and moral reasons; psychological effects that the use of aversive interventions would have on the students receiving aversives as well as on students observing such interventions with other students; concern that such interventions exist more for the benefit/convenience

of staff rather than for students; allowing child-specific exceptions to the prohibition on aversives leads programs to be less than committed to applying other interventions; aversive interventions punish the child and cause pain and humiliation, stress and possibly long term trauma; children may stop behaviors temporarily out of fear of these interventions but when the opportunity presents itself students who are mistreated will lash out at others; allowing these interventions would be a violation of students' civil rights; the regulations should do more than minimize the risks for students with disabilities but should eliminate them all together by never allowing aversive interventions; and the State has an obligation to protect children from such abuse.

Others commented that the regulations and the procedures put in place will limit aversive interventions and help to assure that children are receiving other appropriate interventions based on well-established principles. One comment recommended a one-year pilot project that would be evaluated with the opportunity for public review and input prior to extending the use of aversives beyond one year.

Others opposed any restrictions on the use of aversive interventions stating that they are more effective than positive interventions for some students and less intrusive and harmful than psychotropic medications. Some expressed concern regarding the restrictions on the use of aversive interventions and reported that using positive behavioral interventions only has not been effective in treating some children's behaviors.

DEPARTMENT RESPONSE:

The Department has carefully considered the use of aversive interventions in relation to its treatment value for students with severe self-injurious behaviors, its basis

in scientific research and its potential effect on a student's health and safety, moral and ethical issues; and the Department's capacity to ensure the health and safety of students in school programs where aversive interventions are used. Prior to the promulgation of the emergency regulations adopted in June 2006, aversive interventions were being used with students in the absence of any State standards and for some students, without the knowledge of the school districts that placed the students in such programs. The proposed rule provides significant safeguards to ensure appropriate assessment of student behavior, behavioral intervention plans (BIPs), oversight and review by school districts, Human Rights Committees, agency quality assurance reviews, and parent consent. The child-specific exception in the proposed rule takes steps to ensure that positive interventions have been considered to address a student's behavior prior to the consideration of the use of aversive interventions.

The Department does not support the use of aversives. Even with these regulatory safeguards, aversive interventions pose significant health and safety risks for students with disabilities. However, some parents expressed that without this intervention, they believe their children's health and safety are at risk because of their severe self-injurious behaviors. Therefore, a number of revisions to the proposed rule have been made to provide additional limits on the types of aversive interventions that may be used and the schools that may use such interventions; to provide additional responsibilities for school districts to monitor a student's program and placement when aversive interventions are used; and to prohibit the use of such interventions with preschool students without exception. The revised proposed rule authorizes the child-specific exception for the use of aversive interventions by public and private schools

until June 30, 2009, provided that the child specific exception process would continue to be available in subsequent years only for students whose individualized education programs (IEPs) include the use of aversive interventions as of June 30, 2009. The Department will take steps during the next two years to ensure that effective research-based alternative behavioral interventions are available for all NYS students.

Section 19.5(a) - Prohibition of corporal punishment

COMMENT:

Prohibit corporal punishment without exception; repeal subparagraphs (iii) and (iv) in section 19.5(a)(2) that authorize the use of reasonable physical force to protect property and to address pupil refusals to comply with requests to refrain from further disruptive acts and apply the provisions concerning the emergency use of restraint or holding when a child is behaviorally out of control; clarify the difference between the use of physical force and corporal punishment; and prohibit the use of aversives because it is the same as corporal punishment.

DEPARTMENT RESPONSE:

No revision is necessary to address the first comment since the regulations in section 19.5(a) prohibit corporal punishment without exception. No revisions to the proposed regulation have been made to respond to the other comments since the recommended changes go beyond the scope of the proposed rulemaking, which was to establish standards for behavioral interventions, including a prohibition on the use of aversive interventions. The proposed rule distinguishes between corporal punishment and aversive interventions and provides for the use of aversive interventions only as part of a student's individual behavioral intervention program and only for those self-

injurious or aggressive behaviors that threaten the physical well being of the student or that of others and pose significant health and safety concerns.

Section 19.5(b)(2) and Section 200.1(lll) – Definition of Aversive Behavioral Intervention

COMMENT:

The definition should be revised to remove the word “behavioral” from the term “aversive behavioral intervention;” replace the term “aversive interventions” with “restrictive interventions” and categorize these interventions on different levels, each with its own procedures for approval and parent consent (e.g., most restrictive would require comprehensive review and approval process and continuous monitoring by the Department; another level would not require Department approval but would require parent permission and continuous internal monitoring; a third level would require continuous internal monitoring but not parent permission.)

DEPARTMENT RESPONSE:

The purpose of the proposed rule on aversive interventions is to set limitations and standards on interventions that would result in pain or discomfort to the student and have the potential to negatively affect the health and safety of the student. This rulemaking does not propose to limit other forms of behavioral interventions that may be used as part of a student's behavioral plan. We agree that the term “aversive behavioral intervention” should be replaced with "aversive intervention" and this change has been made throughout the proposed rulemaking.

COMMENT:

Revise the definition of aversive interventions to specify those aversives that would be allowed, including which ones that do not cause undue harm, and which are just a form of abuse or would be considered crimes.

DEPARTMENT RESPONSE:

We agree with the comments that the proposed rulemaking should clarify which aversive interventions should never be allowed through a child-specific exception and have revised the proposed regulation to define "aversive intervention" in section 19.5(b) as an intervention that is intended to induce pain or discomfort to a student for the purpose of eliminating or reducing maladaptive behaviors, including such interventions as contingent application of noxious, painful, intrusive stimuli or activities; contingent application of noxious, painful, or intrusive spray, inhalant or tastes; contingent food programs that include the denial or delay of the provision of meals or intentionally altering staple food or drink in order to make it distasteful; movement limitation used as a punishment, including but not limited to helmets and mechanical restraint devices; and other stimuli or actions similar to the interventions described above.

Because certain forms of aversive intervention are manifestly inappropriate by reason of their offensive nature or their potential negative physical consequences, or both, proposed section 200.22(e) has been revised to add that no child-specific exception to the Regents prohibition on the use of aversive interventions shall be granted for interventions used as a consequence for behavior intended to induce pain or discomfort that include any of the following: ice applications, hitting, slapping, pinching, deep muscle squeezes, use of an automated aversive conditioning device, the combined simultaneous use of physical or mechanical restraints and the application of

an aversive intervention; withholding of sleep, shelter, bedding, bathroom facilities; denial or unreasonable delays in providing regular meals to the student that would result in a student not receiving adequate nutrition; the placement of a child unsupervised or unobserved in a room from which the student cannot exit without assistance; or other stimuli or actions similar to the described interventions.

COMMENT:

The term “movement limitation used as a punishment, including but not limited to helmets and mechanical restraint devices" should be changed to “mechanical restraint used as punishment.”

DEPARTMENT RESPONSE:

Because there are other forms of movement limitation that could be used as a punishment beyond mechanical restraints, no change has been made to the examples of movement limitation.

COMMENT:

Definitions of “positive practice,” and “physical prompts” should be added to the regulations. “Overcorrection” and “physical restraints” should be added to the list of interventions not considered aversive interventions.

DEPARTMENT RESPONSE:

The purpose of the proposed rule is to establish standards and limitations for aversive interventions. There is no need to, and nor would it be practicable, to define the many forms of other behavioral interventions, including such interventions as 'positive practice' and 'physical prompts.'

COMMENT:

Withholding food or bathroom facilities may be appropriate interventions under certain circumstances. Revise the definition to clarify that withholding sleep, shelter, bedding, bathroom facilities or clothing applied “contingently to punish behavior” would be considered an aversive intervention.

DEPARTMENT RESPONSE:

The proposed regulation does not prohibit reasonable delays in use of bathroom facilities or in the provision of meals. The proposed regulation has been revised to clarify that child-specific exceptions shall not be granted for certain aversive interventions including withholding of sleep, shelter, bedding, bathroom facilities, or denying or unreasonably delaying regular meals to a student that would result in a student not receiving adequate nutrition. An aversive intervention is defined as an intervention that is intended to induce pain or discomfort to the student for the purpose of reducing or eliminating maladaptive behaviors.

COMMENT:

The Department should select “humane aversives” such as helmets and restraints that are necessary to avoid injury and eliminate the “harmful aversives” such as electric shock and noxious sprays.

DEPARTMENT RESPONSE:

The proposed regulation provides that interventions medically necessary for the treatment or protection of the student such as helmets to protect children from injuries to the head resulting from self-injurious behaviors are not considered aversive interventions. The proposed regulation has been revised to clarify the use of emergency interventions necessary to protect a student.

Section 19.5(b) - Exception to the prohibition on aversives

COMMENT:

Regulations should not allow for a child specific exception to the prohibition on the use of aversive interventions. These interventions have no place for any student in NYS and the Department must minimize the risk of harm to students by never allowing aversive interventions. Use language from the March 2006 Regents draft definition that prohibited the use of aversive interventions to eliminate maladaptive behaviors. Allowing exceptions provides the opportunity for misuse and misinterpretation. Prohibit and disallow exemptions for aversive interventions that could endanger the health and well being of students, could cause physical pain, and violate the dignity and/or privacy of students. Clarify how any forms of intervention intended to induce pain could be in the best interest of a child.

DEPARTMENT RESPONSE:

The regulations provide for very limited exceptions to the use of aversive interventions for students with the most serious forms of self-injurious and/or aggressive behaviors that threaten the safety or well-being of the student or that of others. The regulations further limit the application of aversive interventions to only those self-injurious/aggressive targeted behaviors; and establish high standards for the consideration, oversight, monitoring and review when such interventions are determined necessary. The decision to allow very limited exceptions for the use of aversive interventions is intended to protect the safety of such students who may have not had the opportunity to benefit from the most current research and practice on the effective use of other interventions, including positive behavioral supports and interventions. The

proposed regulations place the responsibility for the determination of the use of aversive interventions with the Committee on Special Education (CSE), in consideration of the determination of the State panel of experts, and require frequent and ongoing review by the CSE of such interventions. The requirements for the Human Rights Committee and the quality assurance reviews by the program administering the aversive interventions provide additional safeguards intended to protect the health, safety and dignity of the students.

COMMENT:

The use of mild aversives may be more appropriate than the use of time out or restraints.

DEPARTMENT RESPONSE:

It is unclear what is meant by ‘mild’ aversives, since any intervention intended to induce pain or discomfort to a student should not be considered ‘mild.’

COMMENT:

The regulations, as proposed, are too broad and nonspecific in many areas (e.g., well-defined criteria for the use of aversive intervention related to the severity of self-injurious or life threatening nature of a behavior, medical/psychiatric approval, oversight and intervention, staff qualifications and training, etc.).

DEPARTMENT RESPONSE:

The determination of whether an aversive intervention is necessary for an individual student can only be made based on a review of an individual student's evaluations, including medical information, and a student’s functional behavioral assessment, and history of the use of positive and other behavioral interventions used

with the student. However, to address the concerns regarding medical/psychiatric approval, oversight and staff qualifications and training, the proposed regulation has been revised to require the full CSE, to which the school physician member must be invited, to make the recommendation for the use of aversive interventions on a student's IEP; and to require that, when recommended, aversive interventions be administered by appropriately licensed professionals or certified special education teachers or staff under the direct supervision and direct observation of such staff.

COMMENT:

The Department should read research on what is and is not an effective behavioral intervention before implementing these regulations.

DEPARTMENT RESPONSE:

The proposed regulations were based on a review of the research.

COMMENT:

NYS should seek alternatives to aversive interventions and the interventions that are excluded from the definition of aversive interventions should be further explored to determine their efficacy, but still require appropriate training, monitoring, supervision and oversight of these interventions. The Department should provide training to schools on positive behavioral interventions for students and to parents, make efforts to strengthen structures to support teaching techniques and intensify monitoring of districts' obligation to properly evaluate students prior to developing behavior plans, and put money into manpower to support school personnel to use humane interventions. Training should be provided to all staff on the principles of behavior analysis.

DEPARTMENT RESPONSE:

The Department promotes the use of positive behavioral interventions and supports for students with disabilities in its regulations as well as through training and technical assistance.

COMMENT:

Regulations should clarify who will determine what defines an exception because the definition is subjective and open to controversy.

DEPARTMENT RESPONSE:

To address the comment, the proposed regulation has been revised to identify those aversive interventions that would be prohibited without exception. The determination of the Panel of the need for an exception to use aversives is to be made based on the professional judgment of the Panel members consistent with the regulations.

COMMENT:

Techniques prohibited in other State-run facilities or agencies should also be prohibited in schools. The Department should solicit input on whether there is evidence for the use of aversives for the treatment of children with behavioral disorders from entities that promulgate standards of care for mental and behavioral health before implementing the regulations and work with the Office of Mental Health (OMH) and Office of Mental Retardation and Developmental Disabilities (OMRDD) to develop consistent strategies for the use of aversive interventions across State agencies.

DEPARTMENT RESPONSE:

The proposed regulations were developed in review of the regulations governing other State agency programs and specifies that, for an education program operated by

another State agency, if a provision of the proposed regulations conflicts with the rules of the respective State agency operating such program, the rules of such State agency shall prevail and the conflicting provision of the regulations would not apply.

COMMENT:

Aversives should only be used as a medically necessary treatment. These interventions should be developed as part of a treatment plan and not as part of a BIP in school, and treatment should be administered by properly qualified treatment professionals and in a setting that meets their intensive treatment needs. Only licensed and qualified personnel with expertise in the treatment of disabilities should be making treatment decisions, consistent with the research, treatment guidelines in the professional literature, and the ethical dictates of their respective professions and relevant State and federal laws.

DEPARTMENT RESPONSE:

The definition of “aversive intervention” expressly excludes “interventions medically necessary for the treatment or protection of the student.” In addition, consistent with the concerns raised in these comments, the proposed rule has been revised to limit and phase out the use of aversive interventions by public and approved private schools.

COMMENT:

Allowing child specific exceptions will increase the use of aversive interventions rather than reducing these strategies. If aversive interventions are allowed, schools will have less incentive to use positive programming. The use of aversives may have unintended consequences that may increase a student's negative behaviors.

DEPARTMENT RESPONSE:

We disagree that the proposed regulations that allow a child-specific exception will increase the use of aversive interventions. Prior to the promulgation of regulations in this area, aversive interventions were being used at the discretion of individual program providers, often without the knowledge of the CSEs and sometimes without the informed consent of the parent. Further, such interventions were used with students who did not present with serious self-injurious and/or aggressive behaviors and were used to address a broad range of behaviors including noncompliant or disruptive behaviors. In addition, the Department was not always informed when a program was providing such interventions and there were no standards for the administration, oversight and monitoring when such interventions were used. We agree with the comment that the use of aversives may have unintended consequences that may lead to an increase in the student's behaviors. For this reason, the proposed regulations require the program to provide ongoing monitoring of student progress, including the assessment of and strategies used to address any indirect or collateral effects the use of aversive interventions may be having on students, including, but not limited to, effects on a student's health, increases in aggression, increases in escape behaviors and/or emotional reactions.

COMMENT:

Students with Tourette’s Syndrome are unable to control certain behaviors that could be considered behaviors appropriate for an exception to the use of aversive interventions; the use of punishment will only make these behaviors worse. Most

children that would be candidates for aversive therapies are not able to regulate appropriate responses due to neurological conditions.

DEPARTMENT RESPONSE:

We agree with the comment that often students with severe behaviors present with neurological or other conditions that affect the student's ability to control such behaviors. The proposed regulations address this concern by requiring the outside review by a panel of experts to advise the CSE as to whether a child-specific exception is warranted in consideration of the student's diagnosis(es), the student's functional behavioral assessment and current and prior BIPs, and relevant individual evaluations and medical information that allow for an assessment of the student's cognitive and adaptive abilities and general health status, including any information provided by the student's parents. To strengthen these requirements, the proposed regulation has been revised to require that the school physician be invited to the CSE when a recommendation for the use of aversive interventions is being considered.

COMMENT:

The same prohibition on the use of aversive interventions that applies to nondisabled students should also apply to students with disabilities. The regulations appear to discriminate on the basis of disability by allowing a child-specific exception to the prohibition on aversive interventions only for students with disabilities. Regulating aversive interventions to a specific class of individuals based on their disability is a violation of the Americans with Disabilities Act. The regulations should require that behavior intervention plans for developmentally disabled students not subject students to any greater risk of harm or injury than that to which students in the

general population are subjected. Aversive procedures that the regulations authorize for disabled students would constitute corporal punishment if employed as interventions for nondisabled students.

DEPARTMENT RESPONSE:

The regulations limit the use of aversive interventions only to students who display severe self-injurious and/or aggressive behaviors and only as part of a behavioral intervention plan. It is unlikely that a student displaying such behaviors would not have been identified as having a disability. The regulations were intended to provide safeguards and to limit inappropriate behavioral interventions used with students with disabilities. The regulation that prohibits the use of corporal punishment applies to all students.

COMMENT:

There have been no studies to determine the possible effects of negative behavior reinforcers. Studies on the use of aversive techniques are designed to show diminution or elimination of specific behaviors but do not indicate the psychological or behavioral effects on persons subjected to these treatments. There has been trauma, injury and deaths attributed to the use of aversives.

DEPARTMENT RESPONSE:

There have been studies on the possible effects of negative behavioral reinforcers and on the possible collateral effects of such interventions. The proposed regulations require the program to assess and address the collateral effects of the use of aversive interventions.

COMMENT:

Studies have shown that positive only programs are not always successful. Research studies support the effectiveness and safety of aversive interventions.

DEPARTMENT RESPONSE:

There has been extensive peer-reviewed research that provides evidence of the effectiveness of positive behavioral supports and interventions and other interventions that do not include the use of aversive interventions as defined in the proposed regulations.

Section 200.7 - Approval of private schools

COMMENT:

The onsite program review visit for conditional approval of private school programs should be done by program staff of the Education Department and not just by fiscal staff as regulations now allow.

DEPARTMENT RESPONSE:

No revisions to the proposed regulation have been made since the recommended changes go beyond the scope of the proposed rulemaking, which was to establish standards for behavioral interventions, including a prohibition on the use of aversive interventions. The Department may consider this recommendation in future rulemaking.

Section 200.22(a) – Functional Behavioral Assessment

COMMENT:

The Department should prohibit the use of aversives and support the development of functional behavior assessments (FBAs) and positive behavior intervention plans. Positive behavioral approaches were barely mentioned, defined, or

required in the regulations. The Department should mandate that all school staff be fully trained in positive behavioral supports and have appropriate access to resources. Allowing the use of aversive interventions is not consistent with the Individuals with Disabilities Education Act (IDEA), which requires the use of positive behavioral support for students with behavioral issues. The use of punishment undermines the FBA required by law.

DEPARTMENT RESPONSE:

IDEA requires the IEPs of students with disabilities to include positive behavioral supports and services and functional behavioral assessments and behavioral intervention programs for students with behaviors which impede learning. The proposed regulations must be read with other requirements in the Regulations of the Commissioner of Education that require the CSE to consider positive behavioral supports and services and other approaches to address a student's behavior. To further address this comment, the definition of behavioral intervention plan in sections 200.1 and 201.2 of the Regulations of the Commissioner of Education have been revised to require intervention strategies to include positive behavioral supports and interventions.

COMMENT:

Regulations should require a “functional behavioral analysis” not just a functional behavioral assessment (FBA) be completed as part of a broader assessment when shock is used as an intervention, as it provides more detailed information about a student’s behavior. An “analogue functional analysis” should be conducted as part of a

broader assessment in the case of contingent shock; doing this would require additional training and oversight by individuals with expertise in this procedure.

DEPARTMENT RESPONSE:

No revisions to the proposed regulations are necessary since proposed section 200.22(a) provides specific requirements for FBAs. These requirements provide for an in-depth assessment based on multiple sources of data that identify a student's problem behavioral with regard to frequency, duration, intensity and/or latency across activities, settings, people and times of the day and includes sufficient information to form the basis for a behavioral intervention plan for a student that addresses antecedent behaviors, reinforcing consequences of the behavior, recommendations for teaching alternative skills or behaviors and an assessment of student preferences for reinforcement.

Section 200.22(b) – Behavioral intervention plans

COMMENT:

Regulations should define who is considered a “qualified professional” that can design and supervise behavioral intervention plans. The definition of qualified personnel should be broadened to include Board Certified Behavior Analysts. Individuals supervising behavioral intervention plans that include aversive interventions should have a minimum of three years clinical experience in treating severe behavior disorders.

DEPARTMENT RESPONSE:

The regulations have been revised to delete the requirements in proposed section 200.22(f)(2)(x) that indicated behavioral intervention plans be designed and

supervised by qualified professionals in accordance with their respective areas of professional competence as this is self-evident and because behavioral intervention plans are often developed by teams of qualified individuals.

COMMENT:

Regulations should require that all interventions, including antecedent and other consequences, be supported by peer reviewed research practices.

DEPARTMENT RESPONSE:

The regulations in section 200.4 require the IEP to include, to the extent practicable, programs and services that are based on peer-reviewed research. Therefore, no further revisions to the proposed regulations are necessary.

Section 200.22(c) – Time Out Rooms

COMMENT:

The term “time out room” should be defined. One individual commented time out should be defined as a walk around a building with an aide or counselor for regrouping and gaining composure.

DEPARTMENT RESPONSE:

The proposed regulation in section 200.22(c) has been revised to define the term “time out room” as "an area for a student to safely deescalate, regain control and prepare to meet expectations to return to his or her education program.”

COMMENT:

The term “emergency intervention” is undefined and no restrictions are placed on the use of time out room under such circumstances.

DEPARTMENT RESPONSE:

The proposed regulation was revised to delete reference to “emergency intervention” in relation to the use of time out rooms and to clarify that the use of a time out room should only be used in conjunction with a behavioral intervention plan except for unanticipated situations that pose an immediate concern for the physical safety of the student or others.

COMMENT:

Regulations should clarify that the use of time out rooms as punishment or to decrease targeted behavior is an aversive intervention that is permissible only with a child-specific waiver.

DEPARTMENT:

The proposed regulation has been revised to define “time out room” as “an area for students to deescalate, regain control and prepare to meet the expectations to return to their education programs,” whereas, an “aversive intervention” is an intervention that is intended to induce pain or discomfort to decrease maladaptive behaviors.

COMMENT:

Regulations should require that when students are removed from classrooms that they be taken to a safe, well lit, clean, decent size room, with a trained staff member for a certain amount of time commensurate with their age. The temperature of time out rooms should be within the normal comfort range of 70-74 degrees. Require that time out rooms conform to health code regulations. IEPs should indicate the maximum amount of time a child may be kept in a time out room and the maximum instances per day be specified in the written plan. Regulations should specify that the maximum amount of time that a student age 9 or younger can spend in a time out room

for non-emergency situations be restricted to no more than one hour per day and for students ages 10-21 no more than two hours.

DEPARTMENT RESPONSE:

The proposed regulations in section 200.22(c) require that the physical space used as a time out room meet certain standards, including that the room must be of adequate width, length and height to allow the student to move about and recline comfortably; wall and floor coverings must be designed to prevent injury to the student and there must be adequate lighting and ventilation in the room. Further, the proposed regulations require the temperature of the time out room to be within the normal comfort range and consistent with the rest of the building and the room to be clean and free of objects and fixtures that could be potentially dangerous to a student and to meet all local fire and safety codes. The comment that the regulations be revised to require schools to set a standard for a maximum temperature in a school building is beyond the scope of this rule making. The proposed regulation requires that when a student's BIP includes the use of a time out room, that the IEP include the maximum amount of time a student will need to be in a time out room as a behavioral consequence as determined on an individual basis in consideration of the student's age and individual needs. The proposed regulation has been revised to add the requirement that the school's policy and procedures on the use of time out rooms include time limitations for the use of the time out room.

COMMENT:

The use of time out rooms should allow "emergency seclusion in the event of serious physical injury to the students or others."

DEPARTMENT RESPONSE:

The revised proposed regulations clarify that except for unanticipated situations that pose an immediate concern for the physical safety of the student or others, the use of a time out room is to be used in conjunction with a behavioral intervention plan. Under no circumstances should a time out room in a school program governed by these regulations be used for seclusion of the student, where the term 'seclusion' is interpreted to mean placing the student in a locked room or space or in a room where the student is not continuously observed and supervised.

COMMENT:

Regulations should require annual reporting to the Department on the use of time out rooms; require a school district to document the number of IEPs and behavioral intervention plans allowing the use of time out rooms, the amount of time spent by students in time out rooms and the number of students who have time out rooms removed from their IEPs.

DEPARTMENT RESPONSE:

The proposed regulation has been revised to add that a school's policies and procedures on the use of time out rooms must include data collection to monitor the effectiveness of the use of time out rooms. Such data would be subject to review by the Department upon request.

COMMENT:

Regulations should require that parents provide prior informed consent for the use of time out room, be given an explanation of the potential benefits and risks for the

use of time out room as part of behavior plan, and be allowed to view the time out room upon request.

DEPARTMENT RESPONSE:

The proposed regulation has been revised to add that the school district must inform parents prior to the initiation of a behavioral intervention plan that includes the use of a time out room, provide the parent with the opportunity to see the physical space that will be used as a time out room, and give the parent a copy of the school's policy on the use of time out rooms. The parent is a member of the CSE and the use of a time out room must be included on the student's IEP . The parent receives prior notice as to the recommendations on a student's IEP and may request due process in the event the parent does not agree with the CSE recommendations.

COMMENT:

Specific behaviors resulting in time out should be required to be listed in the behavioral intervention plan.

DEPARMENT RESPONSE:

We agree that specific behaviors that may require the use of a time out room should be specified in the behavioral intervention plan. The definition of behavioral intervention plan requires that it include a description of the problem behavior and the intervention strategies to address the behavior.

COMMENT:

The regulations regarding restraints and time out/seclusion lack protections for the physical and mental health of students. Regulations should require that a student be examined by a physician to insure that a child has no medical complications that

would preclude the use of time out rooms; that the student be assessed by a licensed psychologist or certified school psychologist with expertise in the student's disabilities to insure that the child has no psychiatric or social history that would preclude the use of time out rooms. Require staff that monitor a student in seclusionary time out have the necessary medical and clinical skills to determine if a child's physical or emotional health is in danger.

DEPARTMENT RESPONSE:

The use of a time out room as part of a student's behavioral intervention plan must be based on the results of the student's FBA and documented on a student's IEP. As such, the CSE must consider the student's needs, including the potential impact on the student's physical and/or emotional well-being. No student may be placed in 'seclusionary' time out where such term means the student is placed in a room unobserved or unsupervised.

COMMENT:

The language in the proposal relating to time out rooms brings the regulations into greater alignment with the prohibitions and standards in federal laws such as 42 USC 15009 and 43 USC 290jj, and the NYS Penal Code and federal regulations that protect the health and safety of mentally ill youth under age 21 in psychiatric and certain non-medical facilities.

DEPARTMENT RESPONSE:

The comment was supportive and therefore no changes to the proposed regulation are necessary.

COMMENT:

Prohibit locks on the door of any room used for time out/seclusion. Require any student that might be placed in a time out room be informed that the room is unlocked and the door can be opened from the inside.

DEPARTMENT RESPONSE:

The proposed regulation specifies that “the time out room shall be unlocked and the door must be able to be opened from the inside. The use of locked spaces for purposes of time out is prohibited. The proposed regulation has been revised to further add that a school’s policies and procedures on the use of time out room must prohibit placing the student in a locked room or space.

The decision as to whether to inform the student that the room is unlocked is best left to the staff supervising the student in consideration of the individual needs and concerns for the physical and psychological well-being of the student.

COMMENT:

Regulations should require that students be able to exit a time out room without assistance, except for emergency safety situations involving imminent risk of serious physical injury to the child, and that when time out is used for an emergency safety situation, the student be allowed to leave the room as soon as the emergency is over.

DEPARTMENT RESPONSE:

The proposed regulations require the use of a time out room only be used in conjunction with a behavioral intervention plan, except for unanticipated situations that pose an immediate concern for the physical safety of a student or others.

COMMENT:

Require documentation on the use of time out rooms include the date, time of day, antecedent conditions, specific behavior that led to the use of time out room, and the length of time in the room. Require all instances of seclusion in time out rooms and injuries during seclusion be reported to the child's parent in writing and to the State.

DEPARTMENT RESPONSE:

The proposed regulation has been revised to require the school policy and procedures on the use of time out rooms to include data collection to monitor the effectiveness of the use of the time out rooms. Such data collection should appropriately include the information provided in the above comment. A time out room in a school program governed by these regulations may not be used for "seclusion" of the student, where such term means placing the student in a room unobserved or unsupervised.

COMMENT:

Any student in a time out room for more than one hour should be assessed by a qualified and licensed or certified clinician to assess the student for possible adverse emotional responses and, for students with sufficient cognitive and verbal abilities, all instances of time out should be followed by a debriefing by clinical personnel or appropriately trained staff to insure the student understands the reasons for the use of time out.

DEPARTMENT RESPONSE:

The proposed regulation requires the IEP to specify the maximum amount of time a student will need to be in a time out room as determined on an individual basis. The proposed regulation has been revised to add that the school's policy and procedures to

include time limitations for the use of the time out room. It would be appropriate to notify school administration or other personnel in the event a student is placed in a time out room for excessive amounts of time and to consider such information to determine the effectiveness of the student's behavioral intervention plan and the use of the time out room for the student. Whether the student requires a debriefing following the use of a time out room is best left to the staff knowledgeable about the individual student.

COMMENT:

The regulations do not specify what staff member is assigned to monitor time out rooms; does not specify the level of clinical training, if any, that staff must possess to continuously monitor the student consistent with federal mandates (i.e., 42 C.F.R. 482.13).

DEPARTMENT RESPONSE:

The proposed regulation has been revised to require the school's policy and procedures to include inservice training for staff on the policies and procedures related to the use of the time out room.

Section 200.22(d) - Emergency use of physical restraints

COMMENT:

Centers for Medicaid and Medicare Services prohibit non-emergency restraint use in facilities receiving federal funding, as does the Children’s Health Act of 2000.

DEPARTMENT RESPONSE:

The proposed regulations in section 200.22(f)(13) states that "nothing in this section shall authorize a school or agency to provide aversive interventions that are otherwise prohibited by the State agency licensing such program." Therefore, no

revisions to the proposed regulations are necessary to address this comment. Part H of the Children's Health Act of 2000 prohibits the use of any restraints or involuntary seclusions imposed for purposes of discipline or convenience and provides an exception for restraints imposed to ensure the physical safety of the resident, a staff member or others. The proposed regulations are not inconsistent with the provisions of this Act.

COMMENT:

NYS should adopt federal law (42 USC §15009), which prohibits the use of seclusion and physical restraint except when absolutely necessary to ensure the immediate physical safety of the student or others and prohibits the use of restraint and seclusion as a punishment or as a substitute for a habilitation program. Future drafts of the regulations should include all federal protections that apply to restraint and seclusion outlined in 42 CFR Ch. IV, Subpart G. NYS should follow the US Department of Health and Human Services Substance Abuse and Mental Health Services and take the position that restraints and seclusion to treat individuals with mental illness be eliminated.

DEPARTMENT RESPONSE:

The proposed regulation is consistent with the federal laws cited. To clarify the restrictions on the use of emergency interventions and seclusion, the proposed regulation has been revised in section 200.22(c) to clarify that time out is not seclusion when such term means that a student is placed in isolation in a locked room. Section 200.22(d) "Emergency use of physical restraints" has been revised to be titled "emergency interventions" and a definition of the term "emergency" has been added to

mean a situation in which immediate intervention involving the use of reasonable physical force pursuant to section 19.5(a)(3) of this Title is necessary; to add that emergency interventions shall not be used as a punishment; to require emergency interventions to be used only in situations in which alternative procedures and methods not involving the use of physical force cannot reasonably be employed; and to require the school to maintain documentation on the use of emergency interventions for each student. Section 100.2(l) of the Regulations of the Commissioner of Education requires that a school submit a written semiannual report to the Commissioner, by January 15th and July 15th of each year commencing July 1, 1985, setting forth the substance of each complaint about the use of corporal punishment received by the local school authorities during the reporting period, the results of each investigation, and the action, if any, taken by the school authorities in each case.

COMMENT:

NYS should establish a consistent, comprehensive approach to the use of physical restraints.

DEPARTMENT RESPONSE:

Pursuant to "Billy's Law", NYS agencies are working to develop uniform standards for the use of restraints in NYS treatment programs serving children and youth.

COMMENT:

The proposed regulation on emergency use of physical restraints should also apply to mechanical restraints. The terms physical restraint, chemical restraint and mechanical restraint should be clearly defined.

DEPARTMENT RESPONSE:

The proposed regulation has been revised to use the term emergency intervention and defines emergency to mean a situation in which immediate intervention involving the use of reasonable physical force is necessary. Therefore, it is not necessary to define the terms physical and mechanical restraint in this section. Aversive interventions as such term is defined in the proposed regulation may not be used as an emergency intervention. The use of medications/chemical restraints as an emergency intervention is a medical decision beyond the scope of this rule making.

COMMENT:

Regulations regarding emergency physical restraints should specify the appropriate durations for the use of restraint.

DEPARTMENT RESPONSE:

It is not possible to specify the appropriate duration of an emergency intervention. The proposed regulation has been revised to require documentation by the school of the duration of the emergency intervention used with the student.

COMMENT:

Regulations should require that every instance of emergency physical restraints be reported to the State. Recommend this be reported to families and the Department. Require that school administrators keep an on-going record of all reported instances of physical restraint and CSEs meet to review a student's IEP and BIP if two or more physical restraints are used in thirty school days. Uniform forms should be used for reporting. Restraints that result in physical injury to student or staff should be reported to the Department within five school days, including a copy of all physical restraints

used by the program for a thirty day period prior to the date of the reported restraint; and that the Department review the report and notify the program within thirty calendar days of receipt of the report if it is required to take any action, such as personnel training or policy/procedure changes.

DEPARTMENT RESPONSE:

While section 100.2(l) of the Regulations of the Commissioner of Education requires that a school submit a written semiannual report to the Commissioner, by January 15th and July 15th of each year commencing July 1, 1985, setting forth the substance of each complaint about the use of corporal punishment received by the local school authorities during the reporting period, the results of each investigation, and the action, if any, taken by the school authorities in each case, it does not require that each use of physical force used on a student be reported to the Department, nor is it appropriate to make such a requirement. The proposed regulation has been revised, however, to add that the school must maintain documentation on the use of emergency interventions for each student, which shall include: the name and age of the student; the setting and location of the incident; the name of the staff or other persons involved; a description of the incident and the emergency interventions used, including the duration of such intervention; a statement as to whether the student has a current behavioral intervention plan; and details of any injuries sustained by the student or others, including staff, as a result of the incident.

COMMENT:

Regulations should require reporting physical restraints to school administration and parents, including information about the incident and the condition under which the

restraint occurred; and that a verbal report be provided to parents and the administrator as soon as possible and a written report be provided to the administrator by the next school day and to the parents within three school days. A written report should be put in the student's file within three days and a copy given to the administrator and parent. A meeting of the parents, the person using the restraint, behavior specialist, and the student should be held within 24 hours of using restraint to determine why it occurred and how to prevent it in the future. Any restraint over ten minutes should be considered an extended restraint and include additional consideration and reporting requirements including the informed authorization of school psychologist or nurse or similarly qualified personnel and consideration of student's health and medical condition.

DEPARTMENT RESPONSE:

The proposed regulation has been revised to require specific documentation on the use of emergency interventions, including the duration of the intervention, which must be reported to the appropriate school administrator and medical personnel. Follow-up resulting from the review of the emergency intervention documentation is best left to the discretion of the administrator and/or medical personnel, as appropriate.

COMMENT:

Regulations on restraints should require specific research validated methods for restraints to defuse a crisis. Staff using restraint should be trained and certified in safe restraint procedures (e.g., Strategies for Crisis Intervention and Prevention (SCIP) or a similar model). Staff should be provided with appropriate training in crisis de-escalation. The Department should set minimum levels of training and certification in

crisis management and restraint and this decision should not be left to districts. Only qualified and licensed personnel should be allowed to administer restraint and time out/seclusion interventions, consistent with federal regulations relating to the treatment and rights of mentally ill and developmentally disabled youth.

DEPARTMENT RESPONSE:

The proposed regulations require staff who may be called upon to implement emergency interventions to be provided with appropriate training in safe and effective restraint procedures. The proposed regulation has been revised to add that such training be in accordance with section 100.2(l)1)(i)(g) of this Title relating to the school's conduct and discipline policy and section 200.15(f)(1) relating to the training of personnel in residential schools regarding physical restraints.

COMMENT:

The regulatory policies on physical restraint are too restrictive and nearly impossible to enforce.

DEPARTMENT RESPONSE:

We do not agree the proposed regulations that establish a standard to limit emergency interventions, to require staff be appropriately trained, and that incidents of emergency interventions be documented and reviewed are overly restrictive and nearly impossible to enforce.

COMMENT:

Students who might need emergency restraint should be examined by a physician to determine if restraint is permissible at all and if so what kind. Students who might need emergency restraint should be examined by a licensed psychologist or

certified school psychologist with expertise in the student's disabilities who can determine if the child has a psychiatric or social history that might preclude restraint or necessitate only using a particular type of restraint by a particular type of staff. Appropriately qualified clinical personnel should assess the child's emotional status following emergency restraint. Medically trained personnel should be required to monitor students in emergency restraint. Students should be debriefed following any instance of emergency restraint.

DEPARTMENT RESPONSE:

While we agree that it would be most appropriate to know if there are any medical or psychological contraindications for use of physical force with a student, it is not practicable to require a physical or psychological examination of the student prior to intervening during an emergency situation for the first time. The proposed regulation has been revised to require documentation of the emergency intervention be submitted to school administration and medical personnel. The need for an assessment of the student's emotional status following an emergency intervention is best left to school and family.

COMMENT:

Informed consent should be obtained prior to use of physical restraint.

DEPARTMENT RESPONSE:

Since an emergency is an unanticipated situation, it would not be practicable to require informed parent consent prior to intervening to keep a student or others safe.

COMMENT:

The Department should allow physical restraint to be used as a contingent, not emergency, procedure used only after other less restrictive interventions have been attempted and failed, and that contingent application of restraint be removed from the list of aversive interventions but still be required to meet all other requirements including parent consent, human rights committee review and approval and continuous monitoring. It was further recommended that the regulations include a section that outlines the parameters under which physical, not mechanical restraint may be used.

DEPARTMENT RESPONSE:

The proposed regulation does not permit physical restraint to be applied contingent upon a student's behavior for other than emergency interventions. Proposed section 200.22(d) has been revised to define and address emergency interventions. All other use of physical restraint would be considered either corporal punishment or an aversive intervention.

COMMENT:

Information on risks associated with using restraints, seclusion, and physical force with disabled students should be disseminated to teachers and other school personnel.

DEPARTMENT RESPONSE:

The proposed regulations prohibit seclusion. Information on risks associated with the use of physical force should be provided pursuant to section 100.2(l)(1)(i)(g) of the Regulations of the Commissioner of Education for staff training relating to the school's conduct and discipline policy and section 200.15(f)(1) requires the policy to address the training of personnel in residential schools regarding physical restraints. Section

200.22(d)(5) of the proposed regulation has been revised to require that staff who may be called upon to implement emergency interventions be provided with appropriate training in safe and effective restraint procedures in accordance with section 100.2(l)(1)(g) and, as appropriate, 200.15(f)(1).

Section 200.22(e) - Child-specific exception to use aversive interventions

COMMENT:

The panel does not include individuals that have experience with aversive therapy and would therefore be biased against its use.

DEPARTMENT RESPONSE:

The proposed regulation requires the panel to be comprised of professionals with appropriate clinical and behavioral expertise to make a determination as to whether a student is displaying self-injurious or aggressive behaviors that threaten the physical well being of the student or that of others and the extent to which positive behavioral interventions have been employed. Therefore, it is not necessary for such individuals to have experience using aversive interventions.

COMMENT:

The regulations do not specify that the panel include experts in positive behavior supports, family members, self-advocates, special educators or others with vital knowledge to make recommendations regarding the use of aversive interventions. Some parent and parent organizations representatives should be included on the panel. A medical professional should be a required member of the child-specific panel.

DEPARTMENT RESPONSE:

It is not necessary to describe the qualifications of the individuals to serve on the child-specific panel in regulations. The proposed regulation requires the panel members to have appropriate clinical and behavioral expertise to make a determination of whether a student may require an aversive intervention. Parents and parent organization representatives, unless otherwise qualified, would not meet the requirement. While the panel does not include a medical doctor, the proposed regulation has been revised to require the CSE to invite the school physician to the CSE meeting whenever a recommendation for the use of aversive interventions is being considered.

COMMENT:

The regulation regarding child-specific exceptions is too loosely written and will be interpreted differently by everyone. The panel's ability to determine whether or not a child needs aversive interventions is limited to a review of written documentation.

DEPARTMENT RESPONSE:

The panel determination of whether a student may require an aversive intervention will be made based on the professional judgments of three professionals with appropriate clinical and behavioral expertise after review and consideration of the documentation provided by the school district. The list of required documentation should be sufficient for the panel to make a determination

COMMENT:

Clarify how a school district would get an independent panel together in some of the smaller communities in the State as it will be difficult to get an independent panel together the way the law is written based on the lack of available qualified professionals.

DEPARTMENT RESPONSE:

The proposed regulations do not require an individual school district to form a panel. The panel is formed by the State.

COMMENT:

Clarify the purpose of the panel if the CSE can accept or reject their proposal.

DEPARTMENT RESPONSE:

The purpose of the panel is to provide the CSE with expert opinions that the CSE may not have available to them and to ensure that the determination for all students is based on a uniform standard. A CSE that provides a child-specific exception inconsistent with panel's determination can only make such a recommendation by applying the standard for whether an aversive intervention is appropriate in accordance with section 200.22(e)(6).

COMMENT:

Clarify what type of tracking of information by districts will be required.

DEPARTMENT RESPONSE:

It is unclear what the commenter was asking. The proposed regulations require the school district to monitor and review the student's program at least every six months and specify the minimum requirements for the information that must be reviewed to monitor the student's progress.

COMMENT:

Districts should be required to notify the Department if a previously approved aversive plan is discontinued so that data on the use of aversives can be collected.

DEPARTMENT RESPONSE:

We agree with the comment and have revised the proposed regulation to require the CSE to notify and provide a copy of the student's IEP to the commissioner when a child-specific exception has been included in the student's IEP and when the student's IEP is amended to no longer include a child-specific exception.

COMMENT:

Regulations should include an enforcement mechanism so that school districts would be held accountable for noncompliance.

DEPARTMENT RESPONSE:

The Department will closely monitor school district requirements with these regulations.

COMMENT:

The regulations take steps to provide necessary protections and guidelines for use of aversive interventions with a limited number of students with disabilities.

DEPARTMENT RESPONSE:

Because of the nature of the comment, no response is necessary.

COMMENT:

The CSE should be allowed to apply to the Commissioner’s panel for permission to increase the intensity, frequency, or duration of the aversive intervention or to attempt a different aversive intervention if alternative procedures that are considered when an aversive intervention fails to result in suppression or reduction of the behavior or fails to achieve the medically or therapeutically necessary result and student is still in danger due to serious self-injurious behavior.

DEPARTMENT RESPONSE:

The proposed regulation does not prohibit a CSE from submitting another application to the panel to request a child-specific exception.

COMMENT:

Parent’s rights are being taken away; they should be allowed to decide on appropriate treatments for their children. NYS should follow Massachusetts’s law, which allows the court ordered use of aversive interventions with parental consent.

DEPARTMENT RESPONSE:

The proposed regulations provide greater protections for students and parents when a program serving that student proposes to use an aversive intervention by requiring parent consent prior to the use of an aversive intervention and setting standards for oversight of such programs by the Department. The determination of whether a child's behavioral intervention plan should include aversives is more appropriately determined by professionals with knowledge and expertise regarding behavioral interventions and by a multidisciplinary team knowledgeable of the student's unique needs than by the court.

COMMENT:

Regulations should require that there be a formal hypothesis as to where the breakdown in service/intervention occurred when deciding whether or not aversive therapy should be part of a child’s IEP.

DEPARTMENT RESPONSE:

No revision is necessary since the proposed regulation requires the panel to consider the student's prior behavioral intervention plans in its determination of the student's need for an aversive intervention.

COMMENT:

The final decision regarding the use of aversive interventions should not be left to a CSE. The Department should not allow local school districts the power to decide if aversive interventions will be used with students. The CSE should be required to consult with or involve a certified behavior analyst or psychologist with extensive experience in behavior analysis and program design in making its recommendation. CSEs should be required to consult with a licensed physician and licensed psychologist or certified school psychologist with expertise in the student's disabilities to examine or assess students and advise the CSE as to whether there are any medical or psychiatric/psychological complications or contraindications to the use of an aversive behavioral intervention. The Department should provide training and guidelines to CSEs for making decisions regarding the use of aversive interventions. A CSE should be prohibited from authorizing a child-specific exception when the panel of experts did not recommend the use of an aversive intervention for a particular student. The independent panel should have the authority to deny a waiver child-specific exception and their decision should be based on the majority vote.

DEPARTMENT RESPONSE:

IDEA provides authority only to the IEP team (CSE) to develop recommendations for a student's IEP consistent with the standards of the State Educational Agency. The proposed regulation identifies the information and standards that the CSE must consider in making its recommendation and requires the CSE to consider the determination of the panel in making its recommendation. The CSE is encouraged, but not required, to consult with other professionals including psychologists and/or

physicians, as appropriate, in making their recommendation. The proposed regulation requires the panel to make a determination in consideration of the consensus of the members.

COMMENT:

The independent panel should be given the option of specifying the training of personnel that would be required before further consideration could be given for a child specific exemption.

DEPARTMENT RESPONSE:

The function of the independent panel is to provide a determination as to whether a student is displaying self-injurious or aggressive behaviors that threaten the physical well being of the student or that of others and the extent to which positive behavioral interventions have been employed. Accordingly, matters of training are beyond the intended function of the panel. However, training of individuals who would provide aversive interventions is addressed in section 200.22(f) of the proposed amendment.

COMMENT:

The regulations should require that the application for a child specific waiver include: a statement that the child was examined by a licensed physician or other appropriate health care professionals with expertise in the student's disabilities who have considered the potential physical and psychological risks and benefits and who have determined that the proposed intervention is necessary; a statement as to the training and certification or licensure of the school personnel involved in implementing, monitoring, and assessing the student's response to the intervention; a statement as to how often the CSE will reconvene to review the student's progress and to determine if

the aversive intervention should be continued, faded or terminated; and a description of the specific behaviors or symptoms that will result in the aversive consequences or noxious stimuli, the anticipated frequency, location and duration of the consequences, the proposed schedule of reinforcement.

DEPARTMENT RESPONSE:

The proposed regulation has been revised to require the CSE to invite the school physician to the CSE meeting where a recommendation for the use of aversive interventions is being considered. No changes to the proposed regulation are necessary to address the comment regarding training and certification and oversight and monitoring of the student's program by the school district as these requirements are included in the proposed regulations in section 200.22(f).

COMMENT:

The regulations should define what would be considered an “appropriate period of time” for determining if behavioral interventions are working before recommending an aversive intervention.

DEPARTMENT RESPONSE:

The proposed regulation provides discretion to the independent panel of experts to determine the appropriate period of time for the individual student.

COMMENT:

It is wrong to assume that if positive behavioral strategies are unsuccessful that aversive interventions should be used.

DEPARTMENT RESPONSE:

Consistent with IDEA, it is inappropriate to use aversive interventions with a student when a full range of positive interventions have not been consistently tried. No changes to the proposed regulations are necessary to address this comment, however, as the use and effectiveness of positive behavioral supports is only one factor in the determination.

COMMENT:

Require that all aversive interventions must be reapplied for and renewed each year.

DEPARTMENT RESPONSE:

The proposed regulation has been revised to clarify in section 200.22(e)(11) that "any such child-specific exception shall be in effect only during the time period such IEP providing such exception is in effect. If the continued use of an aversive intervention for a student is being considered for subsequent IEP(s), the CSE shall submit an annual application to the commissioner for each such IEP(s)."

COMMENT:

Clarify if the application for a child-specific exception requires prior parent approval.

DEPARTMENT RESPONSE:

No revision to the proposed rule is necessary since proposed section 200.22(f)(10) provides that "Nothing in this section shall authorize the use of aversive interventions without the informed written consent of the student's parent."

<u>Section 200.22(f) Program standards for the use of aversive interventions</u>

COMMENT:

The Department should prohibit the use of aversive interventions in public programs and identify and approve one or two agencies in each region of the State to deliver “restrictive interventions” and prohibit the use in other programs. The use of aversive procedures should only be used by facilities that have staff specifically trained in this model of treatment and are carefully monitored to achieve compliance with the highest standards of medical and educational activities.

DEPARTMENT RESPONSE:

Because of the extensive State oversight required of a program that provides aversive interventions, the proposed regulation has been revised to limit the programs that may use aversive interventions with NYS students to those programs whose policies and procedures for such use are approved by June 30, 2007 and to prohibit without exception the use of aversive interventions by approved preschool programs.

COMMENT:

Clarify how a program that uses aversive interventions could ever provide for the “humane and dignified treatment of students” and “promote respect for personal dignity and a right to privacy.” Define the terms “humane” and “effective” as used in the regulations. Consider that aversives may be most humane and effective treatment for a student. The regulations provide no guidance on providing for the human and dignified treatment of students or promoting respect for personal dignity and privacy.

DEPARTMENT RESPONSE:

The proposed regulation places the responsibility on the program to ensure that the manner in which a behavioral intervention is applied does not diminish the dignity of the student. It is not necessary to define the terms "humane" and "dignity." The

proposed regulation specifies that the program shall promote respect for the student's personal dignity and right to privacy and shall not employ the use of threats of harm, ridicule or humiliation, nor implement behavioral interventions in a manner that shows a lack of respect for basic human needs and rights.

COMMENT:

Require the use of aversive interventions be limited to self-injurious and "seriously" aggressive behaviors. Clarify that aversive interventions are not to be used for disruptive or noncompliant oppositional behavior and that only behaviors or symptoms that pose a serious threat to student's or others' health and safety and have not responded to adequate trials of positive-based supports and interventions may be considered for aversive interventions.

DEPARTMENT RESPONSE:

The proposed regulation in section 200.22(f) specifies that the use of aversive interventions shall be limited to those self-injurious or aggressive behaviors identified for such interventions on the student's IEP. To further clarify this requirement, the proposed regulation in section 200.22(e)(1) has been revised to add that aversive interventions shall be considered only for students who are displaying self-injurious and/or aggressive behaviors that threaten the physical well being of the student or that of others and only to address such behaviors and that the IEP specify the self-injurious or aggressive behaviors to be addressed.

COMMENT:

The use of aversive interventions should not be limited to self-injurious and aggressive behaviors and should be allowed as a consequence for other behaviors such as noncompliance as there is no support for limiting aversive interventions to these two behaviors; “aggressive behavior” should be defined and regulations should clarify whether or not this includes antecedent behaviors.

DEPARTMENT RESPONSE:

The proposed regulation limits the use of aversive interventions to targeted self-injurious and/or aggressive behaviors. No revision has been made to the proposed regulations to allow such interventions for less serious behaviors since less serious behaviors can be effectively addressed with other nonaversive interventions.

COMMENT:

Regulations do not address behaviors such as property destruction, noncompliance and major disruptive behavior that interfere with education and social development. Increases in students’ inappropriate behaviors and academic regression since the changes in regulations went into effect were reported.

DEPARTMENT RESPONSE:

The use of an intervention intended to cause pain or discomfort to the student to change a behavior is the most extreme intervention that could be considered for a student and has the real potential to cause physical and/or psychological harm to a student. Therefore, it would be inappropriate to allow such an extreme and potentially dangerous intervention for any behavior other than those that directly impact on the physical well-being of the student. Allowing aversive interventions to be used for other behaviors would represent a method to control the student rather than to therapeutically

treat significant and serious behavioral problems for which a student may not have the cognitive ability to control. A student's BIP should be revised, based on the results of an FBA, to more appropriately provide other interventions for behaviors that are less serious.

COMMENT:

Regulations should ban electric skin shock and prohibit devices that administer electric shock.

DEPARTMENT RESPONSE:

A CSE recommendation to allow the use of skin shock must be limited to treat only the most serious self-injurious behaviors of a student. The proposed regulations impose standards on its use by providing that the use of any aversive conditioning device used to administer an electrical shock or other noxious stimuli to a student to modify undesirable behavioral characteristics shall be limited to devices tested for safety and efficacy and approved for such use by the United States Food and Drug Administration (FDA) where such approval is required by federal regulation. The magnitude, frequency and duration of any administration of aversive stimulus from such a device must have been shown to be safe and effective in clinical peer-reviewed studies. The use of automated aversive conditioning devices is prohibited.

COMMENT:

The prohibition on the use of automated aversive conditioning devices and the combining of physical/mechanical restraints and another aversive intervention limits a

program's ability to effectively treat some students. Regulations should clarify that the "unintended" use of automated aversive conditioning devices is prohibited.

DEPARTMENT RESPONSE:

An automated aversive conditioning device that continues to apply an aversive intervention such as skin shock to the student until the student ceases a behavior is dangerous. Any application of such an intervention should be directly under the control of an appropriate professional. The combination of an aversive intervention, such as shock, with a restraint of a student is unnecessary. There is no reason to provide, for example, mechanical restraint to an individual for the purpose of applying another aversive such as skin shock except for the purpose of corporal punishment, which is prohibited in NYS. The regulations prohibit without exception the use of an automated aversive conditioning device. If such a device cannot be used, there is no risk of "unintended" applications from such a device.

COMMENT:

Regulations should require that physicians examine children and approve the use of aversive interventions as medically safe; there are no requirements that psychiatrists/licensed psychologists evaluate children to ensure that the use of these interventions will not cause severe psychological trauma; and there are no requirements for a nurse/physician be on site when these interventions are used to ensure children are not harmed. These are required when children are placed in federally funded facilities of any kind for persons with mental illness or developmental disabilities and children should have the same protections in school. The presence of a physician or

Ph.D. level psychologist should be required when aversives, restraints or time out rooms are used.

DEPARTMENT RESPONSE:

The proposed regulation requires the school district to submit medical information on the student that would provide sufficient information to the panel of the student's general health status. In addition, the proposed regulation has been revised in section 200.22(e)(8) to require the CSE to request the participation of the school physician to any meeting where the recommendation for the use of aversive interventions is being considered and to require the aversive interventions to be administered only by appropriately licensed professionals or certified special education teachers or by staff under the direct supervision and direct observation of such staff. If medical oversight is necessary based on the needs of an individual student, such recommendation should be made by the CSE recommending such intervention for the student.

COMMENT:

Require the use of video cameras any place that aversive interventions are applied.

DEPARTMENT RESPONSE:

The proposed regulation was revised to require that aversive interventions be administered by appropriately licensed professionals or certified special education teachers or under the direct supervision and direct observation of such staff. While the regulation does not require the use of video monitoring systems, this is one means by which to ensure direct observation of the administration of such interventions.

COMMENT:

All programs implementing any type of behavior modification should be closely scrutinized with adherence to strict guidelines and the elimination of aversive interventions.

DEPARTMENT RESPONSE:

We agree with this comment. No revisions to the proposed regulation are necessary since section 200.22(f) requires individualized procedures for generalization and maintenance of behaviors and for the fading of the use of such aversive interventions and specifies progress monitoring and reporting requirements.

COMMENT:

Regulations should require regular monitoring of the integrity of aversive interventions by individuals with expertise in evidence-based punishment and severe behavior disorders as appointed by the State.

DEPARTMENT RESPONSE:

The proposed regulations establish standards for programs using aversive interventions with a child-specific exception. The State's review of a program using aversive interventions would include monitoring in accordance with these standards. The State could request the assistance of consultants in such reviews.

COMMENT:

Require programs to establish outcome measures of aversive treatment so that the degree of success and non-success of this therapy could be quantified.

DEPARTMENT RESPONSE:

No revision to the proposed regulation is necessary since proposed section 200.22(f)(7) requires progress monitoring and data collection and review to determine the effectiveness of the intervention with an individual student.

COMMENT:

Related services used in conjunction with aversive interventions also include "research-validated cognitive-behavior therapy" and "sensory integrative experiences."

DEPARTMENT RESPONSE:

The CSE must determine the appropriate related services that must be provided to an individual student when the student's behavioral intervention plan includes the use of aversive interventions.

COMMENT:

The regulations only require FDA approval for aversive conditioning devices "where such approval is required by federal regulations." Even though devices used must meet FDA approval, such devices are not permissible for other populations.

DEPARTMENT RESPONSE:

It is not possible for State regulations to require FDA approval of a device if the FDA does not also require such approval. The proposed regulations add additional safeguards on the use of aversive conditioning devices to ensure that the magnitude, frequency and duration of any administration of aversive stimulus from such a device must have been shown to be safe and effective in clinical peer-reviewed studies. A school program should never experiment in the application of aversives without clear evidence of the safety and effectiveness of the device for the population to be served.

COMMENT:

Regulations should require any equipment used to deliver aversive consequences to be tested and maintained per the manufacturers recommended maintenance schedule and that records be kept on the date and type of servicing.

DEPARTMENT RESPONSE:

Such requirements are self-evident.

COMMENT:

The Department should adopt policies and procedures, similar to those used by OMH and OMRDD, specific to the use of helmets, restraints and other mechanical devices to ensure the health and safety of a child, not to punish or inflict discomfort,.

DEPARTMENT RESPONSE:

No revision to the proposed regulation is necessary since section 19.5(b)(2) clarifies that "interventions medically necessary for the treatment or protection of the student" is not considered an aversive intervention.

COMMENT:

Program standards should also prohibit the use of aversive consequences in combination with negative practice (overcorrection) procedure.

DEPARTMENT RESPONSE:

The use of nonaversive negative consequences was not addressed in the proposed regulations and therefore no revision has been made to prohibit the combined use of negative practice with an aversive consequence.

Section 200.22(f)(3) – Human Rights Committee (HRC)

COMMENT:

The required membership of the HRC should include a special educator and an expert in positive behavior supports. One commenter recommended that the committee include school psychologists from neighboring districts or BOCES.

DEPARTMENT RESPONSE:

The proposed regulation was revised to include, in addition to the individuals who can review the human rights issues from legal, medical, psychological and parental perspectives, up to two additional individuals selected by the school or agency.

COMMENT:

The requirements for the HRC are not reasonable and should be modified to allow qualified staff employed by the agency and include at least three members not employed by the program from the current requirements.

DEPARTMENT RESPONSE:

The requirements for the HRC are consistent with HRC requirements of other States and accrediting agencies. It is important that the individuals serving on the HRC provide an objective human rights review and are not otherwise persuaded by employee or another affiliation with the program. The use of aversive interventions requires the highest level of oversight and review.

COMMENT:

The HRC should not allow a physician’s assistant or nurse practitioner to be used in place of a doctor and a law student or paralegal in place of a lawyer.

DEPARTMENT RESPONSE:

No revisions are necessary to address this comment since the proposed regulation provides flexibility to appoint a licensed physician, physician's assistant or nurse practitioner and an attorney, law student or paralegal.

COMMENT:

The establishment of a HRC is an absurd proposal that would monitor the human rights violations "accepted" by the regulations. The HRC role as oversight bodies to ensure fidelity to the research and methodologies of positive behavior supports would preclude their use as permission bodies for aversive interventions.

DEPARTMENT RESPONSE:

The purpose of the HRC is to provide an objective review of the program providing the aversive intervention in relation to the human rights of the individual students. The HRC might review, as examples, how the program uses functional analysis of the target behavior, documentation that indicates risks of the behavior and risks of the intervention, efforts to replace the target behavior, intervention to assess and address the collateral effects of the aversive interventions, documentation that the behavioral support plan is regularly monitored and, as appropriate, revised, and students' access to appropriate educational programs. An appropriately functioning HRC provides an important additional safeguard that would provide a regular review of the students' programs at the agency serving the students. The intent of the HRC is not to provide permission for the use of aversive interventions, but to identify human rights concerns that might otherwise preclude or modify its use.

<u>Section 200.22(f)(4) – Supervision and training requirements</u>

COMMENT:

The regulations should be revised to require the individual providing direct observation of staff using aversive interventions to be qualified as well as licensed or certified professional and that annual training also be provided on medication, medical and psychiatric factors that may increase the risk associated with use of aversive interventions, and the use of research-validated positive behavior supports and methods. Even with appropriate supervision, appropriate training and quality assurance review, it would be difficult to identify abuse or neglect when it occurs and that even the formation of and monitoring by a human rights committee may be unable to meet its goal of ensuring the protection of legal and human rights of individuals. Clarify the level of "appropriate supervision" of school personnel when aversive interventions are utilized. Clarify the expertise that is required to provide the training and supervision of staff providing aversive interventions. Clarify if a behavioral intervention plan that includes aversives is a remedial service, as the term is used in section 200.6, which would require that this service be provided by an appropriately certified or licensed individual. There is no requirement that staff and supervisors implementing aversive interventions have appropriate clinical background or training. Personnel involved in the development, application, monitoring, data collection or review of a behavioral intervention plan should be certified or "licensed."

DEPARTMENT RESPONSE:

The proposed regulation has been revised to require that, when recommended, aversive interventions shall be administered by appropriately licensed professionals or certified special education teachers or under the direct supervision and direct observation of such staff.

Section 200.22(f)(5) – Parental Consent

COMMENT:

Many parents do not understand their rights. Unless parents are provided with effective alternatives offered by competent experts, consent cannot be a reality. Regulations should require higher standards for ensuring that parents have provided informed consent prior to the use of an aversive intervention including counseling on the aversive interventions to be used and the school's policy on the use of behavioral techniques. Information should be provided in parents' native language. Another recommended that this be in an accessible format. Parents should be provided with a copy of the school's policy on the use of aversive interventions. Informed consent forms should indicate that the parent may withdraw consent, in writing, at any time.

DEPARTMENT RESPONSE:

No revision to the proposed regulation is necessary since section 200.1(l) of the Regulations of the Commissioner of Education defines consent to mean the parent has been fully informed, in his or her native language or other mode of communication, of all information relevant to the activity for which consent is sought, and has been notified of the records of the student which will be released and to whom they will be released; the parent understands and agrees in writing to the activity for which consent is sought; and the parent is made aware that the consent is voluntary on the part of the parent and may be revoked at any time except that, if a parent revokes consent, that revocation is not retroactive (i.e., it does not negate an action that has occurred after the consent was given and before the consent was revoked).

COMMENT:

The statement that “no parent be required by the program to remove the student from the program if he or she refuses consent for an aversive intervention” should be removed from the regulations as it has potential to create problems between schools, parents and programs.

DEPARTMENT RESPONSE:

No revision to the proposed regulation has been made since the proposed regulations ensures that a program does not intentionally or unintentionally coerce a parent to provide consent by suggesting that the child would be discharged from the program if the parent fails to provide such consent.

COMMENT:

The use of aversives should be a choice by an individual when he or she reaches adult age.

DEPARTMENT RESPONSE:

No revision to the proposed regulation can be made to address this comment as this would require a statutory change. At present, NYS law does not provide for the transfer of IDEA rights to the student at the age of majority.

Section 200.22(f)(7) – Progress monitoring

COMMENT:

A school district placing a student in a program that uses aversive interventions through a child-specific waiver should be required to observe the student at least once every three months and assess the student in terms of adverse psychological reactions at least once every three months.

DEPARTMENT RESPONSE:

The revised proposed regulations require the CSE to observe the student and, if appropriate, interview the student at least every six months.

Other:

COMMENT:

Many students currently receiving aversive interventions were previously on medication, which had negative side effects on students. Some of medications are not approved for children by the FDA. The Department should develop regulations on the use of medications.

DEPARTMENT RESPONSE:

The use of medication is a medical decision and beyond the scope of authority of the Commissioner of Education.

COMMENT:

The Department should establish positive behavioral supports schools with trained staff to implement positive support plans for student with challenging behaviors and appoint regional human rights committees that include a parent/parent advocate, a psychiatrist, positive behavioral support expert and a Department representative with additional members based on students' needs to review the cases of students who are challenging the school's behavior support team. The Department should: follow the treatment or intervention models as outlined and used by OMRDD known as SCIP-R and HUGS program, which were developed specifically for students with behavioral challenges; explore an approach similar to OPTS, a health care delivery model used by OMRDD to respond to individualized program needs; and/or require the use of the

psych-educational model (PEM), which is used at facilities run by OMH and changes the focus from punishing behaviors to education of why behaviors are inappropriate; adopt a program similar to the Neuro-Behavioral Project used by the Department of Health, which develops positive interventions for people with traumatic brain injury, to assist school districts in developing effective and appropriate interventions; provide a training program to educate school districts on the new regulations; put in place a policy that utilizes effective and safe strategies for youth and children in NYS.; increase classroom staff and supervision of staff to address behavioral concerns; bring students currently being sent out of State back to New York and instead, use funds paid to out of State programs to cover the costs of appropriate behavioral supports for these students, including training professionals and other staff involved in applying intervention plans. The Department should develop a database of behavioral specialists for different disabilities and regions of the State that school districts could use to assist them in addressing challenging behaviors; and disseminate information on research-validated methods to address behavior problems to schools and require that teachers and personnel be provided with training on the causes of behavior and research validated methods for managing behaviors.

DEPARTMENT RESPONSE:

Because of the nature of the comments, no revisions to the proposed regulations are necessary. The Department will consider these recommendations in its plans for policy communications, training and program development.

COMMENT:

The regulations are consistent with subdivision 7 of Billy's Law (483-d, Social Services Law.)

DEPARTMENT RESPONSE:

The comment was supportive and therefore no changes to the proposed amendments are recommended.