CUYAHOGA COUNTY BOARD OF DEVELOPMENTAL DISABILITIES

Behavioral & Health Supports Department

Behavior Support Procedures Manual 2016

BEHAVIORAL & HEALTH SUPPORTS

Behavior Support Procedures Manual

Preface to the Manual

June, 2016

We are happy to present the 2016 revision of the Cuyahoga County Board of Developmental Disabilities (CCBDD) Behavior Support Procedures Manual. This manual is available on our internal Infonet as well on our website at www.cuyahogabdd.org.

This manual is intended for use by Cuyahoga County board staff, service providers, and other agencies and individuals with an interest in the provision of behavioral supports to those with a developmental disability.

The manual serves as a reference for the practices of the CCBDD as they relate to our mandated responsibilities for oversight and implementation of Ohio's Behavior Support Rule Ohio as codified in Ohio Administrative Code 5123:2-2-06. The manual is also meant to provide an overview of the philosophical framework and assumptions in our approach to behavior supports.

As with previous versions, the CCBDD Behavioral and Health Supports Department will offer periodic training opportunities which cover the key content areas of this manual to both our own agency employees as well as outside agencies and individuals. Time and resources permitting, specific requests for agency trainings can often be honored as well by contacting our central office at (216) 736-2719 and requesting the Chief Clinical Officer or Psychology Supervisor.

Highlighted Changes

The revision of the manual reflects the 2015 revision to the Behavior Support Rule. The following bullet points briefly highlight what are arguably the most notable (but not all) changes to previous practices.

- Both rights restrictions and time-out/restraints are now classified as "restrictive measures" and continue to require the approval of a Human Rights Committee (HRC) prior to implementation

- The HRC will approve the use of time out or restraint only in cases where there is an imminent and serious threat to health and safety whereas the criteria for approval of rights restrictions also includes a threat of serious legal sanction such as arrest or eviction.

- Restrictive measures are not employed for purposes of punishment nor are they viewed as interventions meant to teach or develop skills. Rather, they are viewed as measures which are taken when positive and preventive methods do not suffice to ensure safety and there is a critical need to either re-establish safety immediately or prevent serious harm from occurring.

- All restrictive measures must be reviewed by the interdisciplinary team at least every 90 days at which time data is reviewed and a determination is made as to whether or not there is still justification for the continuation of the restricted measure(s).

The Behavior Support Strategies Template (formerly the Behavior Support Plan) has been updated to:

  - Emphasize the unmet needs that individual's actions may be communicating
  - Increase sensitivity to trauma-related needs
  - Emphasize greater understanding of the individual by direct support staff as opposed to more rote memorization of highly specific instructions or interactional sequences
  - Simplify use and enhance understanding by direct care staff
  - Encourage more natural and genuine interactions between direct care staff and the individual
  - Underscore the importance of the relationship between staff and the individual
  - Facilitate direct integration of the "Daily Guide" section into the Individual Support Plan.

In addition to these highlighted and other changes, the manual reflects a continued emphasis on protecting the rights, choices and preferences of individuals; the requirement of a positive and preventive approach to supports; the minimization of restrictive measures, and an increased focus on understanding the role of trauma and its impact on the functioning of the individual.

Chapter 1

Key Concepts for Effective and Humane Supports

I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.

Maya Angelou

Behavioral Health Through Prevention and Positive Methods

The CCBDD is charged with ensuring that behavior support procedures are in compliance with Ohio Administrative Code 5123:2-2-06 pertaining to behavior support. At the most basic level we seek to improve quality of life through protecting the dignity, choices and rights of the individual balanced with the fundamental importance of preserving safety and well-being.

Our approach to supporting individuals is rooted in a positive and preventive philosophy that emphasizes the following:

1) Individuals who feel safe, understood, connected, have a sense of purpose and are engaged with their surroundings are less likely to experience behaviorally-based threats to safety or well-being.

    a. Humane and effective supports go beyond a singular focus on eliminating a given behavior and instead emphasize a process of attention to emotional, physical, environmental and related needs.

    b. Assessment of the individual's needs and the planning which follows is an ongoing process, not a one-time or yearly activity.

2) While health and safety is of primary importance, a central challenge is to find a balance between prevention vs. preserving the individual's right to choice and self-direction.

3) The fundamental importance of relationships and engagement in one's surroundings. Stated another way, valuing healthy interdependence rather than just independence.

4) The need for a sense of contributing, belonging and personal identity to healthy emotional functioning.

5) Understanding that attending to the basic needs of staff through training, supervision, respect, and support are of critical importance in creating an environment of warmth, safety and comfort for the individual.

The Importance of Traumatic Experiences

Stress and traumatic experiences can have a powerful and enduring impact on an individual's biological, emotional and cognitive functioning. While person-specific, some commonly identified issues include but are not limited to the following:

a. Changes in mood and/or ability to tolerate feelings or emotions
b. Dysregulation of physiological and emotional arousal
c. Intrusive thoughts, feelings or perceptions
d. Problems achieving satisfying relationships
e. Difficulty in distinguishing threats from non-threats
f. Impulsivity
g. Problems engaging fully in relationships or enjoyable activities
h. Impaired cognitive abilities
i. Medical issues
j. Increased likelihood of experiencing new traumas

In the absence of training and familiarity with trauma-related concepts, problems such as those highlighted here can easily be misinterpreted and contribute to misguided approaches to support. The CCBDD embraces the principals of a trauma-informed approach to supporting individuals. While an awareness of trauma principals is woven throughout this manual and the procedures described herein, we strongly encourage agencies and individuals who support of people with developmental disabilities to seek out training specifically in this area. As the time of this writing, there continues to be a community wide effort spanning multiple agencies and institutions (including the CCBDD) to offer training opportunities related to the principals of trauma and its impact. Additional information on existing training opportunities and resources can be provided by call our central office at (216) 736-2719 and requesting the Chief Clinical Officer or Psychology Supervisor.

A Framework for Addressing Behaviorally Based Threats to Safety

We encourage teams to operate under the assumption that all expressions of behavior are in fact adaptations which reflect the person's own unique history as it interacts with the circumstances, people, and events of daily life. As such, it is critical to develop an understanding of the individual's history and current needs and recognize that assessment is an ongoing process that should inform adjustment to support strategies as more is learned and as circumstances change. In practice, when behaviorally based threats to safety do occur, aside from establishing safety in the moment, the key questions to be asked are:

1) What is the unmet need that is leading to these actions and outcomes?
2) What can be done to help the person to meet that need in a manner that is safe, personally satisfying and promotes personal growth.

The answers to those questions are likely to be as varied as the individuals themselves. It is the responsibility of the individual's support team and the assigned behavioral health staff in particular to ensure that these questions are kept at the forefront of the effort to provide effective and humane support for the individual. When implemented consistently, such an approach will ensure that the supports provided are person-centered and sensitive to the uniqueness of the individual's history and current circumstances.

In practice, countless factors can be considered "needs". For some individuals, needs may be related to a severe mental disorder; a medical condition; core or associated features of a developmental disability; chronic and difficult problems in living such as poverty and loneliness; continued exposure to traumatic relationships; cultural insensitivities and overlearned but harmful behavioral adaptations. In those cases planning may require a coordinated effort across numerous individuals, natural supports, and clinical disciplines. When there is an ongoing risk of harm in spite of whole-person and needs-centered methods, it may be necessary and appropriate to add targeted behavioral methods that focus directly on the prevention or stopping of a specific behavior. Specific behavioral strategies, when indicated, should be weighted towards those which promote positive replacement adaptations. In some cases it may also be necessary to include techniques (e.g., planned ignoring, changes in physical environment) which seek to remove conditions which encourage or reward harmful actions. For some, experiencing the natural consequences that would apply to the general public may be appropriate. The use of punishment by staff, planned or otherwise, is not consistent with this approach and should neither be proposed nor will it be approved by our Human Rights Committees.

The Assessment and Daily Guide documents contained within this manual, while not required for use by private providers, are strongly encouraged. They are designed to guide implementation of the principals described in this manual. Together, those documents provide a framework for translating needs into a practical approach to

support which emphasizes understanding of needs and prevention first, followed by an incremental and hierarchical use of more targeted methods to the extent that they become necessary.

Note: On collecting data related to new learning

One important measure of success in behavior support is the extent to which a person is able to learn new and adaptive ways of having basic needs met. As such, good support strategies should be weighted towards helping staff to understand those needs and then provide guidelines for creating an environment which cultivates such learning. Towards that goal, the Daily Guide section of our Behavior Support Strategies document specifically asks the author to identify how successful new learning might appear to an observer when it is being displayed. We have made a deliberate decision, however, to not require that any such new learning be documented in a purely quantifiable way, such as, for example, attempting to count the number of times that an individual demonstrates the new skill of verbally expressing frustration with a roommate (as opposed to hitting). While we encourage collecting quantitative data when appropriate, experience has taught us that not all actions or outcomes can be realistically expected to be accurately counted by staff who are simultaneously being asked to remain engaged, emotionally present and working towards a comfortable and supportive relationship with the individual. As such, new learning can be reported either through quantitative measures if appropriate, or through more qualitative means – most likely descriptive statements by the staff involved. Such descriptive statements can be provided verbally or in writing at any time by the staff person, but will be sought out by the team and documented during the mandated 90 day reviews.

Restrictive Measures

Behavioral strategies are utilized to insure the welfare of individuals. They do this in part by ensuring the availability of appropriate choices and by consistently utilizing least restrictive means to limit risks to safety. Behavior supports must be provided with an utmost respect for the promotion of self-direction and community inclusion. Nonetheless, and as a last resort, restrictive measures may be needed in some cases to prevent an imminent risk of serious physical harm or legal sanction. Such measures are for the sole purpose of establishing safety and should not be considered as "interventions" used to teach or alter behavior. Their value lies solely in preventing harm.

Proactive/Preventative Restrictions: Procedures utilized non-contingently to minimize or prevent risk of harm or legal sanction due to a known history of behavioral or mental health problems which represent a threat to health and safety. Such interventions must be part of the individual's ISP. These restrictions require review by the Human Rights Committee. These have typically been referred to as "rights restrictions".

Reactive Restrictions: Specific implementation of restrictive measures which are implemented only when an immediate risk of physical harm is present. These types of restrictions are also part of the ISP and behavior support strategies and require documentation of implementation as well as review by the Human Rights Committee.

Note

When determining if an intervention represents a restriction of an individual's rights, the abilities and needs of the individual must be considered. Individuals with extensive or pervasive support needs may require levels of supervision and/or environmental supports that, when applied to a person with more limited needs, may appear restrictive. However, if implemented in response to the individual's lack of developed safety skills, such interventions may not constitute a restriction.

Example: Securing of an individual's medications would not be considered a restriction for an individual who has been assessed as unable to safely self-medicate or manage his or her prescribed medications

Example: An individual with pervasive support needs may not be safe if alone in the community as he may not be able to avoid or respond effectively to danger. For such a person close support or supervision would not be a restrictive measure. In contrast, should such strategies be applied to an individual due to more volitional behavioral choices, then such strategies should be recognized as restrictions and reviewed as appropriate. Similarly, if an individual lacks the awareness of the risks associated with chemicals (e.g., not able to differentiate chemicals from other consumables), locking of chemicals would not be a restrictive measure.

Interventions that are routinely utilized to support individuals without developmental disabilities are not typically viewed as restrictive. Modifications or supports to aid with physical needs or limitations that may be found effective for the general population do not require identification as a restrictive measure nor do they require HRC review.

Example: An individual with dysphagia or other physical disability that interferes with his/her ability to swallow food may have a physician's order for a modified consistency diet. As modified diets are routinely implemented for any individual with a risk of choking, such diet modifications do not require HRC review. An exception would occur in the case of an individual who wants to reject the diet and for which the level of risk is assessed to be at a level which precludes supporting such a choice. In such cases the modified diet would be considered to be a restricted intervention and thus subject to all conditions in the rule.

Example: An individual who does not have trunk control or motor skills necessary to independently ambulate or transfer in/out of a chair or bed may require a bed rail or wheelchair belt to prevent non-intentional falls or injury. Such interventions are routinely implemented for individuals with physical limitations and would not require HRC review unless the individual was refusing or resisting use of the intervention.

Preventative Restrictions

The following list (while not all inclusive) identifies those procedures that may constitute a restrictive measure. These restrictions are likely to be restrictive measures when utilized due to an assessed need to restrict a willful choice or preference or when they are perceived as aversive to the individual.

- Alone time restrictions
- Cameras in the home
- Locked doors/windows
- Access to money restrictions
    - Use of self-funded monetary reinforcement is prohibited
- Motion sensors
- Phone access restrictions
- Restricting access to community
- Restricted access to parts of home/items in home (sharp knives or objects, etc)
- Restricting access to types/listening time/volume of music
- Restricting family visits
- Searches of personal property, space, or person
- TV watching limitations/restrictions
- Non-contingent wearing of protective clothing that restricts access (but not fine/gross/functional motor abilities)
    - In most cases, such cases of restrictive clothing will involve relatively low functioning individuals in situations where there are habitual, high frequency behavioral concerns that are predominantly motivated by sensory factors rather than those that are clearly willful in nature.

Interventions which require extra scrutiny:

The following describes interventions which had historically been used for some individuals but which require special consideration.

Chimes or alarms on windows: If a chime or alarm is used to alert staff that an individual is opening a door or window, the procedure may or may not be determined to be a restrictive measure. To be considered a non-restrictive measure both of the following conditions must be met:

1) The individual does not find the chimes or alarm to be aversive

2) Staff do not use any form of restraint, coercion or consequence (implied or real) to stop the individual from making the choice that they are engaging in – typically leaving the room. Encouraging the individual in a non-threatening and respectful way to consider a different choice would be allowed.

Level Systems: Level systems which either remove a privilege as a consequence of a behavior with the intent of punishing the individual for a behavior or require the earning of basic privileges when there is no clear indication of a risk to health and safety are not permitted. In contrast a level system which incrementally adds additional independence and choice in situations with inherent risk and is tied directly to the individual gaining the skills needed to exercise the decisions while maintaining safety would be permitted if all requirements for a restrictive measure are met. In such cases reverting back to a lower level cannot be used as a punishment or consequence for an action but would instead have to be justified in terms of a clear threat to the individual's safety.

Dietary and Food Restrictions: The ability to choose what, when, where, with whom, and how much to consume is considered a basic right and is to be subject to the highest level of protection. This is true even if a person is overweight and/or may be at some risk for an eventual threat to health based on over-consumption. Exceptions can occur but in all cases would be considered a restrictive measure that is subject to all associated conditions and should receive the highest level of scrutiny. For a dietary or food restriction to be approved there needs to be an assessment which indicates a clear, serious, and relatively immediate risk of harm should the recommended diet not be followed.

Example: A physician "orders" that consumption of soda pop be limited to one can per day as a means of controlling weight and possible future medical problems. In this example the risk cannot reasonably be stated to be in the near term or a certainly.

Example: A physician orders a controlled diet in an individual with a more immediate and serious risk of harm (life-threatening diabetic complications). This could be supported with the appropriate assessment and documentation and should be presented to the Human Rights Committee for review.

Example: A support team documents data indicating that consumption of more than two energy drinks within a three hour period has resulted in violent actions on multiple occasions and these have posed a clear and serious risk of harm. In this case a restriction on consumption may be presented to the Human Rights Committee for review.

1:1 Support or Supervision levels. Support ratios are determined based on the need of the individual and are determined by the SSA or by an SSA in conjunction with other team members. In cases where a 1:1 support levels is in place due to an assessed need to prevent an individual from a willful, deliberate action then that support should be considered to be a rights restriction. Conversely, if the need for 1:1 support is intended not to thwart a given choice or action but instead to help the individual to better cope with the demands of the environment, mitigate the impact of a mental illness or otherwise meet basic emotional, cognitive or HPC-related needs then the 1:1 support staff will not be viewed as a rights restriction.

Example: John has a history of deliberately seeking out opportunities to engage in sexually intrusive behavior. A 1:1 staff person is assigned monitor and prevent such actions. This would constitute a rights restriction as we are attempting to prevent deliberate actions.

Example: Beth has an assessed need for frequent reassurance that she is not alone and that she recognized by important others. When such reassurance is not available Beth has a history of becoming emotionally distraught which then gets expressed in various ways such as crying, hitting others, screaming, and/or running out of the building into the street. It has been determined that the proximity and ongoing attention received from a 1:1 staff person is required to help Beth to regulate her emotions and avoid acute periods of distress. As such this would not comprise a rights restriction. It should be noted that such a situation should also be accompanied by ongoing attempts to help Beth learn or experience alternative ways of coping in hopes of mitigating her distress and maximizing independence.

Note

- A specific court-ordered restriction of an individual is not considered a restrictive measure for purposes of behavior support planning and is thus not subjected to review. In practice, however, care must be taken to ensure that actions used to support or implement the court order are not restrictive in nature. For example, if a an individual is prohibited by the court from consuming alcohol and a support team proposes to search the individual's room for hidden alcohol, then this would constitute a violation of rights and would be subject to all conditions of the rule. In this example the court simply ordered the prohibition of alcohol use, not to search his/her room.

Therefore, the actions of the team exceed the specifics of the order and this would be a restricted measure.

Reactive Restrictions

The following list (while not all inclusive) identifies those procedures that require HRC review as a reactive restrictive measure:

- Chemical Restraint
- Manual Restraint (physical crisis intervention)
- Mechanical Restraint
- Time-out
- Time-out Room

Note

Restrictive measures are never to be used for punishment, retaliation, instruction or teaching, convenience of providers, or as a substitute for specialized services.

The use of restraint or time-out cannot be used as an intervention for property destruction where there is no clear risk to the health and safety of the individual or others

The following sections provide critical information, definitions, and implementation criteria for the use of specific restrictive measures as required in the State of Ohio Behavior Support Rule.

Time-Out

We consider the use of time out in an adolescent or adult to be a particularly intrusive measure and one which is employed only when assessment documents in a clear and convincing manner that for the individual in question, it is the most appropriate and humane method for re-establishing safety in the face of an immediate risk.

Time-out is defined in behavior theory as removing an individual from all sources of positive reinforcement, contingent upon the occurrence of a negative behavior.

The State of Ohio Behavior Support Rule currently defines time-out as:

> "confining an individual in a room or area and preventing the individual from leaving the room or area by applying physical force or by closing a door or constructing another barrier, including placement

in such a room or area when a staff person remains in the room or area." OAC 5123:2-2-06

Time-Out

For the purposes of behavioral support in Cuyahoga County, time-out consists of two levels:

1) **Time-out in an approved time-out room. This is viewed as the most restrictive level and consists of the confinement of an individual to a room that has been specifically identified as a time-out room and contains the safeguards identified in OAC 5123:2-2-06C(11)(c).**

2) **Time-out in a designated space that is not a dedicated time-out room, but rather a space in which the individual will be confined and in which staff are present in the room. For example, confining an individual to a designated hallway area with staff serving as the barrier preventing egress. In this case, special care must be taken to ensure that the environment is safe for this purpose.**

In both cases, time-out is considered to be a restrictive and intrusive behavioral intervention because it involves the removal of access to reinforcement and/or removes an individual from his or her typical activities or environment. In some cases it will also be stigmatizing. It must always be used in conjunction with an array of positive reinforcement/intervention, and only in situations where there is a clear risk or threat of serious harm to self or others and when it has been determined that it is the safest and most humane way to re-establish safety for the individual. Time out is to cease as soon as the threat to safety (as determined by constant observation) has been determined to be at an acceptable level. Pre-determined durations in time out are not appropriate and will not be approved - the time out is to end as soon as the threat to safety is over.

Example 1: John ignores staff prompts to leave his area and begins to punch a peer with closed fists. Using a CPI Transport Position, John's staff escort John to the time-out room. Once John enters the time-out room, staff utilize the pressure lock to prevent his egress and document the time he enters the room. When John has shown that he is calm (is able to answer simple questions, is sitting calmly and breathing slowly), staff will open the door and verbally prompt John to return to his classroom. Staff will document the time at which John exited the time-out room.

Example 2: Despite verbal prompts to calm and continued hitting of her peer, staff utilize a CPI Transport Position to escort Susan to the hallway at the end of the production area. Once there, staff remain with Susan and using their physical presence, do not allow her to leave the hallway area or return to her typical work environment until she has demonstrated calm breathing and speech. Once calm, Susan is allowed to return to her primary environment. Staff document the time Susan arrived in this time-out location and the time she left the time-out location.

The use of Time-out and a Time-out room require review by HRC. A record must be kept of the amount of time an individual remains in time-out or a time-out room. This record must be immediately shared with all providers in the event that further use of time-out is required during the day.

- Time-out may not exceed thirty minutes for any one incident, and may not exceed more than 1 hour in a 24-hour period

Time-Out Room Requirements

While the CCBDD has eliminated all use of time-out in our internal programs, the following requirements are provided for purposes of guiding other providers and/or in recognition that all future needs cannot be anticipated.

There are clear specifications as to how the use of a time-out room is to be implemented in the State of Ohio Behavior Support Rule. Use of a time-out room involves the confinement of an individual in a designated and approved time-out room which prevents egress from that room by the application of physical force or other physical barrier (pressure lock) for a specified amount of time. The criteria identified below must also be met.

- A time-out room shall not be key-locked, but the door may be held shut by a staff or by a mechanism that requires constant physical pressure from staff to keep the mechanism engaged.
- A time-out room must be adequately lighted and ventilated, and provide a safe environment for the individual.
- An individual in a time-out room must be protected from hazardous conditions, including, but not limited to, presence of sharp corners & objects, uncovered light fixtures, or unprotected electrical outlets.
- An individual in time-out must be kept under constant visual supervision by staff at all times.
- A record of time-out activities must be kept.
- **Time-out shall cease immediately once risk of harm has passed or if the individual engages in self-abuse, becomes incontinent, or shows other signs of illness.**

Voluntary/Involuntary Change of Environment

Change of Environment

"Timeout" does not include periods when an individual, for a limited and specified time, is separated from others in an unlocked room or area for the purpose of self-regulating and controlling his or her own behavior and is not physically restrained or prevented from leaving the room or area by physical barriers.

Change of Environment: The individual loses access to reinforcement by virtue of leaving, or being removed from, the area/activity. Change of Environment can be considered either a voluntary/non-aversive (self-initiated or posed clearly as a voluntary

option by staff) or involuntary/aversive (through a staff directive or actual use of physical redirection) intervention.

- **Voluntary Change of Environment**: The use of Voluntary Change of Environment indicates that the individual themselves initiated the act of removing themselves from the area or were given a clearly voluntary option by the staff to leave the area. There should be no aversive implications, however subtle, as it relates to the individual's perception and experience of the change of environment intervention. Voluntary Change of Environment is not considered an aversive or restrictive intervention.

  Example: After a housemate steals her cookie from the dinner table, Susan becomes agitated and attempts to hit the housemate. Verbal redirection is not successful and despite separating the individuals, Susan remains upset and physically aggressive towards staff. As Susan has learned relaxation skills in previous counseling sessions, staff remind her that she can use these skills to calm and that she can choose to go to her bedroom until she feels better and desires to return to the living room. Susan agrees and spends the next 15 minutes alone in her bedroom.

- **Involuntary Change of Environment**: Involuntary Change of Environment indicates that the individual is directed by staff to leave the area either by verbal request and/or physical intervention (which would also constitute a manual restraint requiring its own approval) Involuntary Change of Environment is presumed to be aversive to the individual and thus requires appropriate oversight and review by the HRC

  Example: John continues to engage in physically aggressive behavior towards a defenseless peer. John's staff verbally prompt John to leave the classroom area and walk to the recreation area of the building where he can calm down. John ignores staff's verbal suggestion and continues to attempt to hit his peer. Staff tell John that he must leave the area and go to the recreation area to calm down; and follow him as he walks to the recreation area. Once he has arrived in the recreation area, John sits or walks until he has calmed and indicates his desire to return to his routine. John is not confined or prevented from leaving the area.

Restraints

Restraint refers to restricting the free movement of, normal functioning of, or normal access to a portion or portions of an individual's limbs, head, or body through manual or mechanical means as a part of a systematic, planned behavioral intervention. Behavioral restraints are used to re-establish safety in the face of an immediate or imminent danger. They are never to be used for the convenience of staff, as a punishment or consequence, or as a substitute for positive programming. They are to be used in a way that will not cause physical injury to the individual and result in the

least possible discomfort. Such use must be approved by an interdisciplinary team that includes medical staff and, as appropriate, a physical and/or occupational therapist.

Guidelines for Use of Restraint

- Restraint should be used only as a last resort in a systematic, planned, and positively focused plan.
- Restraint shall be used only when clearly necessary to protect health and safety.
- Restraint may be used as an emergency procedure, but MUI guidelines must be followed. If a restraint occurs on a regular basis, implementing behavior support strategies incorporating those techniques should be considered.
- Restraint should only be used with behaviors that are destructive to self or others, and only when all other conditions listed above are met.
- An individual in restraint shall be under constant visual supervision by staff.
- Restraint shall cease immediately once risk of harm has passed.
- An OT/PT assessment is required as part of the development and approval process for plans incorporating manual and mechanical restraints.
- **Use of restraint shall be discontinued if it results in serious harm or injury to the individual or does not achieve the desired results as defined in the behavior support strategies.**

Types of Restraint

Manual Restraint

Manual behavioral restraint means use of a hands-on method, but never in a prone restraint, to control an identified action by restricting the movement or function of an individual's head, neck, torso, one or more limbs, or entire body, using sufficient force to cause the possibility of injury and includes holding or disabling an individual's wheelchair or other mobility device. Manual restraint may only be used as a last resort after all verbal means of managing the situation have been exhausted, and there is no other way to protect the individual and others from injury

Mechanical Restraint

Mechanical restraint means use of a device, but never in a prone restraint, to control an identified action by restricting an individual's movement or function. Mechanical restraint does not include a seatbelt of a type found in an ordinary passenger vehicle or age-appropriate child safety seat, a medically-necessary device use for supporting or positioning an individual's body, or a device that is routinely used during a medical procedure for patients without developmental disabilities. Mechanical restraints are most typically restraints that the individual cannot remove easily. Mechanical restraints may include easily removable restraints that the individual is not permitted to remove, or which are put back on upon their removal. Restraints are designed and applied with concern for good body alignment and comfort of the individual. All use of mechanical restraints should be utilized keeping the individual's comfort and cooperation in mind,

and should the individual react negatively, all steps should be taken to minimize or eliminate this reaction. The interdisciplinary team should be notified of these situations and meet as needed.

Mechanical behavior restraints may include:

- easily removable wrist bands applied to prevent self-biting and reapplied when the individual takes them off
- harnesses/vests used on buses
- helmets that are tied or affixed in such a manner that removal cannot be easily accomplished by the individual
- a jump suit used reactively for situational control of a low-frequency behavior
- padded leather belts and leather cuffs fastened around the wrist with a small tie
- soft ties
- tie jackets
- use of a splint to prevent self-injurious behavior or self-stimulation while facilitating movement in some way
- use of a Velcro strap to prevent an ambulatory individual from getting out of his seat or to prevent an individual who is non-ambulatory from willfully trying to get out of his wheelchair

Note

If there is a physician's order for the use of a mechanical device, its purpose must be clarified. Use of a device for medical/therapeutic purposes does not require the development of a behavior support plan. Devices intended to prevent an individual from engaging in a known harmful behavior must be incorporated into the ISP Behavior Support Strategies and reviewed by HRC.

Medical/ Therapeutic Restraint

Medical or therapeutic restraint is a type of restraint the involves using items or measures to inhibit, control or limit the movement or normal function of any portion of an individual's body to permit medical treatment, promote healing, or prevent an infection in order to protect the individual from injuring himself/herself. Medical restraints are not considered mechanical restraints (and therefore not subject to the rule) unless they are intended to prevent the individual from making deliberate choices, are being resisted by the individual, or require the use of force or coercion to implement. In general, medical restraints are those restraints used to promote healing or prevent injury in individuals who do not have an ongoing behavior problem as the

source of the medical problem (for example, individual who must wear a helmet while walking or seated due to seizures). **Use of medical restraints must be determined and monitored by the interdisciplinary team with nurse or physician consultation.**

Chemical Restraints

Chemical restraints are subject to oversight per the Ohio Department of Developmental Disabilities (DODD) and as indicated in the Ohio Administrative Code 5123:2-2-06. As with mechanical and manual restraints, they require review and approval by the human rights committees prior to implementation, and notification to the DODD.

Chemical Restraint

The Ohio Administrative Code 5123:2-2-06 defines a chemical restraint as:

A medication prescribed for the purpose of modifying, diminishing, controlling, or altering a specific behavior. "Chemical restraint" does <u>not</u> include the following:

- **Medications prescribed for the treatment of a diagnosed disorder as found in the current version of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM);**
- **Medications prescribed for the treatment of a seizure disorder.**
- **Medication that is routinely prescribed in conjunction with a medical procedure for patients without developmental disabilities.**

In our experience, it is necessary to have additional guidelines beyond this definition to determine if a given prescription for psychotropic medication constitutes a chemical restraint. The rationale applied here focuses on the extent to which the medication aids in reduction of symptoms that are being attributed to the diagnosis vs. a more generalized reduction in all behavior and/or alertness. This determination does require that some degree of judgment be applied. In addition, we look for evidence that psychosocial supports are in place for the individual such that prior to the administration of the prn there is an effort to both prevent symptoms (where that is possible) and to mitigate symptoms once they have been displayed. In short, we look for evidence that the medication is not being used as a substitute for individualized behavioral supports. For purposes of making this determination for county board funded situations, the following criteria apply:

<u>Conditions for which a prescription will NOT be classified as a Chemical Restraint (all must be present)</u>

- The individual is diagnosed with an illness or condition per a current version of the DSM or ICD.
- There are clear instructions from the physician regarding use of the medication.

- There is no evidence of a generalized loss of ability as evidenced by an interference with the person's ability to participate in services or a significant and observable reduction in alertness or level of consciousness, nor is there an over reliance on the medication as evidenced by high frequency use (as determined by the physician).

- Psychosocial and environmental supports are in place. These include an emphasis on both prevention of the symptoms as well as non-pharmacological support during symptom expression.

- There is no evidence that the medication is being used for staff convenience, to compensate for poor staff training, or as an alternative to sound psychosocial planning and supports.

Pertaining to PRN Medication

Because of the potential for misuse, questions pertaining to the classification of PRN medications as chemical restraint receive additional scrutiny.

In general, the following guidelines should be noted in regards to psychotropic PRN use:

1. Referral for a Psychotropic Medication Assessment should be made by the SSA to the CCBDD Behavioral and Health Supports Department when a new psychotropic PRN order is written or when there is any indication of a downward change in functioning level following an adjustment made to an existing order.

2. Orders for PRN psychotropic medication prescribed for addressing anxiety or related symptoms prior to or during medical appointments will not be classified as chemical restraints

Chemical Restraint Plan Requirements

Regarding the content of a plan containing chemical restraint, the following elements should be present in the SAISP/BSS. Many of these same standards may apply even when a psychotropic medication is used that does not employ chemical restraints.

1. There must be documentation of ongoing communication between the prescribing physician and a member of the person's team. The names of the physician and the person responsible for communicating with the physician should be included in the "Staff Involved" section of the SAISP/BSS.

2. Data collection shall be focused on the individual's actions which led to the administration of the medication.

Prohibited Actions

Prohibited Actions

Interventions or actions that are potentially harmful to an individual's health or safety, mental and emotional well-being, or personal dignity and self-esteem are expressly prohibited by CCBDD. Such actions include, *but are not limited to*, the following:

1. Prone restraint. "Prone restraint" means a method of intervention where an individual's face and/or frontal part of his or her body is placed in a downward position touching any surface for any amount of time.

2. Use of a manual restraint or mechanical restraint that has the potential to inhibit or restrict an individual's ability to breathe or that is medically contraindicated.

3. Use of a manual restraint or mechanical restraint that causes pain or harm to an individual.

4. Disabling an individual's communication device.

5. Denial of breakfast, lunch, dinner, snacks, or beverages.

6. Placing an individual in a room with no light.

7. Subjecting an individual to damaging or painful sound.

8. Application of electric shock to an individual's body.

9. Subjecting an individual to any humiliating or derogatory treatment.

10. Squirting an individual with any substance as an inducement or consequence for behavior.

11. Using any restrictive measure for punishment, retaliation, instruction or teaching, convenience of providers, or as a substitute for specialized services.

Chapter 2

Behavior Support Process

The development of behavior supports is guided by a desire to promote positive relationships, feelings of safety and security, increased independence, and to encourage self-determination and self-management.

The following information outlines the approach to behavior supports and the process for ensuring that the behavior support procedures are developed and implemented in a manner which reflects respect for the individual and a recognition of best practice in behavior support. Behavioral assessment is key to effective and ethical intervention. Behavior support strategies should always be developed with a primary emphasis on proactive and positive interventions. The use of restrictive practices should only be considered when positive teaching and support strategies have been demonstrated to be ineffective for the individual.

Elements of Effective Behavioral Treatment

As identified throughout this manual, behavior supports are to be implemented with a strong emphasis on positive, supportive, and proactive interventions specifically designed to meet the needs of the individual. Effective interventions are based on a thorough and appropriate behavioral assessment; furthermore, behavior support strategies are a component of the individual service plan (ISP) which provides the framework for all the supports the individual receives. The behavior support strategies should reflect the overall goals of the ISP in as much as these related elements share the goal of supporting the individual to feel safe and comfortable within their environment while having the opportunity for engaged relationships with others.

The behavior support strategies (BSS) template provided in this manual is a tool to promote the attainment of these goals. The following section is a brief guide to the BSS to aid in efficiently developing behavior support strategies and preparing them for review and implementation.

Qualifications of Personnel Involved in Behavior Support Procedures

Persons who conduct assessments and develop behavior support strategies that include restrictive measures shall:

- Hold professional license or certification issued by the Ohio board of psychology; the state medical board of Ohio; or the Ohio counselor, social worker, and marriage and family therapist board; or

- Hold a certificate to practice as a certified Ohio behavior analyst pursuant to section 4783.04 of the Revised Code; or

- Hold a bachelor's or graduate-level degree from an accredited college or university and have at least three years of paid, full-time (or equivalent part-time) experience in developing and/or implementing behavioral support and/or risk reduction strategies or plans.

Behavioral Assessment

Behavioral assessment forms the basis for developing an understanding of the individual and thus provides a rationale for identifying appropriate and effective interventions. As such the assessment is a critical and required element of all behavior support strategies. While the specific form of an assessment will vary to some extent based on the training and experiences of the individual completing the assessment, the following elements are viewed as critical to a good assessment:

- A functional analysis including a clear identification of the behavior that poses risk of harm or legal sanction, the level of harm or type of legal sanction that could reasonably be expected to occur with the behavior, the frequency in which it is displayed (baseline data), the settings in which it occurs, behavioral antecedents, factors which are maintaining the behavior, and a hypothesis as to the function that the behavior is serving for the individual.

- A comparison of the frequency and form of the behavior as it varies between environmental settings (such as at home vs. at work) and an analysis of why such differences may be present.

- An examination of the mental health and medical histories and consideration of how such issues may be impacting the expression of the behaviors of concern.

- A psychosocial history aimed at accounting for key developmental events (psychological, medical, and familial) as well as important past and present relationships.

- An inquiry into a possible history of trauma and a clear analysis of how any such trauma may be related to the current behaviors as well as implications for a trauma-informed approach to care.

Inclusion of Restrictive Measures in Behavior Support Strategies

When necessary to minimize risk of harm or legal sanction, the use of restrictive measures such as those identified in Chapter One may be included in the behavior support strategies of an individual's Individual Service Plan. When included, these strategies shall:

- Be designed in a manner that promotes healing, recovery, and emotional wellbeing based on understanding and consideration of the individual's history of traumatic experiences as a means to gain insight into origins and patterns of the individual's actions;

- Be data-driven with the goal of improving outcomes for the individual over time and describe behaviors to be increased or decreased in terms of baseline data about behaviors to be increased or decreased;

- Recognize the role environment plays in behavior;

- Capitalize on the individual's strengths to meet challenges and needs;

- Delineate measures to be implemented and identify those who are responsible for implementation;

- Specify steps to be taken to ensure the safety of the individual and others;

- As applicable, identify needed services and supports to assist the individual in meeting court-ordered community controls such as mandated sex offender registration, drug-testing, or participation in mental health treatment; and

- As applicable, outline necessary coordination with other entities (e.g., courts, prisons, hospitals, and law enforcement) charged with the individual's care, confinement, or reentry to the community.

Behavior Support Strategies Documents

Behavior Support Strategies

The Behavior Support Strategies document includes two separate but related components: the strategies for implementation as well as the supplemental documentation required for behavior support strategies with restrictive measures as identified by the State of Ohio Behavior Support Rule.

Transportation Vest/Restraint Strategies

A separate outline has been developed for use with transportation vest or other transportation restraints.

Rights Restriction Request for Human Rights Committee Review

The Human Rights Committee Referral Form has been developed to provide an outline for documenting the information most relevant to the review and approval of proposed preventative restrictive measures. The form also documents informed consent for the proposed restrictive measures.

These forms are found on the following pages.

SA ISP

My Name: John Doe **DOB:** 1/1/60 **Plan Period:** 12/31/16 **To:** 12/30/17

Section: Behavior Support Strategies: A Daily Guide

For CCBDD Assistance: Author/Assist Name **Phone:** 216-931-xxxx

Plan to be implemented in: [ ] Home [ ] Day Setting [ ] Transportation

Brief Summary of Behavior Support Needs: Click here to enter text.

Key supportive personal relationship(s): Click here to enter text.

What are the most serious potential threats to safety or well-being? Click here to enter text.

What is he/she telling us with these actions? Click here to enter text.

Targets for New Learning	
What are we teaching?	**What will success look like?**

How to Teach and Support XXXX
Do
Don't

If restrictive measures are needed to prevent or reduce risk of harm/legal sanction, list them here and identify the related safety threat

If Threats to Health and Safety Do Occur	
If:	**Then:**

All supporting documentation relating to Behavior Support Strategies are filed in CCBDD records and a copy forwarded to individual's provider(s) at time of implementation.

My Name: John Doe **DOB: 1/1/60** **Plan Period: 12/1/16 To: 12/30/17**

Behavior Support Strategies – Supporting Documentation

For CCBDD Assistance: Author/Assist Name Phone: 216-931-xxxx

Name:	DOB:	Guardian:	
Use: [ ] Home [ ] Day Setting [ ] Transportation			
Plan Coordinator:		Phone#:	Agency:
Day Program Staff Contact:		Phone#:	Agency:
Home Program Staff Contact:		Phone#:	Agency:
Transportation Contact:		Phone#:	Agency:
Plan Author Signature:		Name:	Date:
Approval Signature (REQUIRED TO IMPLEMENT):			Date:
[ ] Initial BSS Review	[ ] Periodic/Annual Review	[ ] Preventative Restrictions	[ ] Reactive Restrictions

Targeted Behavioral Safety Threats	
Safety Threat	**Specific Action Involved (Description)**

Preventative Restrictive Measures Contained in this Plan	
Specific RM	**Related Safety Threat**

Reactive Restrictive Measures Contained in this Plan	
Specific RM	**Related Safety Threat**

Functional Analysis Summary (complete for each specifically targeted safety threat)

Safety Threat:	
Severity and likelihood of risk/legal sanction present:	
What is the function of the behavior and	

what is the action telling us about unmet needs?	
Which places, times and with whom is it most likely to happen?	
When is it least likely to happen?	
What other factors may be contributing (mental health, medical, environmental, interpersonal, trauma-related reaction)?	
What skill, new learning or situational change is needed to better meet this need?	

Safety Threat:	
Severity and likelihood of risk/legal sanction present:	
What is the function of the behavior and what is the action telling us about unmet needs?	
Which places, times and with whom is it most likely to happen?	
When is it least likely to happen?	
What other factors may be contributing (mental health, medical, environmental, interpersonal, trauma-related reaction)?	
What skill, new learning or situational change is needed to better meet this need?	

Previously Attempted Non-Restrictive Measures and Results: Click here to enter text.

Additional Comments: Click here to enter text.

Supplemental Behavioral History Assessment

Abilities and Needs

Cognitive level, Communication Abilities, Sensory Issues: Click here to enter text.

Notable Strengths: Click here to enter text.

Personal preferences during a crisis or distress:

Preferred person to have contact with: Click here to enter text.
Things he/she does not want in a crisis: Click here to enter text.
Other helpful tools, techniques or activities during a crisis or period of distress: Click here to enter text.

Psychosocial History

Relevant Psychosocial History (Familial, Interpersonal): Click here to enter text.

Describe any history or suspected history of traumatic experiences: Click here to enter text.

Mental Health History and Psychotropic Medications

Brief Summary of Mental Health and Medical Issues: Click here to enter text.

Current Psychiatric Diagnoses: Click here to enter text.

Current Mental Health Provider(s): Click here to enter text.

Staff should be familiar with individual's currently prescribed psychotropic medications and common side effects of those medications. Refer to individual's current Medication Administration Record (MAR) for these medications.

Staff Responsibilities:

Responsibilities of the BSS Coordinator: Obtain required approvals from the individual, guardian, team Monitor consistency and accuracy of daily behavioral data collection Provide data to BHS staff/team on a monthly basis Participate in quarterly BSS reviews Identify needs for additional training as appropriate	Click here to enter text.
Responsibilities of the BHS Staff (if applicable): Facilitate revision of strategies as appropriate based on team review Review/Evaluate monthly data submitted by provider(s) Participate in quarterly team reviews Compile and submit strategies to HRC for review as needed Submit plan for approval following HRC review	Click here to enter text.
Person(s) responsible for initial training of BSS:	Click here to enter text.
Person responsible for training of NVCI techniques included in the BSS:	Click here to enter text.
Person responsible for all Substitute/New Hire Training (documentation of both behavior support strategies and NVCI (if applicable) training required for all substitute/newly hired staff prior to their implementing the BSS)	Click here to enter text.

Data

Summary of behavioral occurrences prior to implementation of behavior support strategies (baseline information): Click here to enter text.

Most Current Data:

Year:	First											Last
Targeted Safety Threats												
Reactive Restrictive Measures												
Other Tracked Information												

For renewing Behavior Support Strategies, provide a narrative analysis or summary of the past year including discussion of any changes in the safety threat, changes in the mental health, emotional, or interpersonal needs of the individual that have become evident, and effectiveness of restrictive measures. Provide summary of team's quarterly reviews. (To what extent is he/she showing success with new skills we are attempting to teach? Has there been anything particularly helpful in the achievement this learning?)

Click here to enter text.

Name/Date: Click here to enter text.

Informed Consent Information

NAME: _____

Why is positive programming not enough? Click here to enter text.

What are the risks and benefits of the strategies? Click here to enter text.

What alternatives exist and the risks/benefits of each? Click here to enter text.

What are the likely consequences of not having these strategies? Click here to enter text.

I have received a copy of _____'s behavior support strategies for implementation between _____ and _____. It has been explained to me by _____

_____(phone)_____whom I may contact with any questions or concerns.

He or she explained what might go wrong or could hurt me, how the plan might help me, and other things that we could have done instead. I was able to ask questions and have them answered. I know that the plan may not work exactly the way that is hoped for. I also know that I can ask more questions later if I want to and that I can change my mind at any time and decide that I no longer want to accept this plan. If I change my mind and no longer want this plan, I will need to tell an appropriate staff person. I know that I will not be punished in any way if I decide that I no longer want this plan.

I approve the plan for the implementation dates shown above _____

Signature Date

I DO NOT approve_____

Signature Date

Witness _____

Signature/Relationship Date

For individuals who are their own guardians the date of most recent informed consent evaluation _____

COMMENTS: (Include any reservations/dissent regarding the approval decision. Use additional paper if necessary.)

_____

_____

Approvals

NAME: _____

INTERDISCIPLINARY TEAM – Meeting Date _____

[ ] IDT approves

[ ] IDT does not approve

[ ] IDT has reviewed (for individual's that are their own guardian) the individual's ability to give informed consent in situations where one of the following has occurred:

1. There has been a change in the individual's cognitive status since the last review or
2. There has been an addition of a new aversive/restrictive procedure to the plan since the last review

COMMENTS: (Include any reservations/dissent regarding the approval decision. Use additional paper if necessary.)

SIGNATURE	POSITION	SIGNATURE	POSITION	SIGNATURE	POSITION
/		/		/	
/		/		/	

NAME: _____

Human Rights Committee – Meeting Date _____

[ ] These strategies have been reviewed and are cleared for training. Once training is complete, they must be approved and signed as ready for implementation.

[ ] These strategies are NOT cleared for training. They are being returned to the author for changes and resubmission. The main problems identified are as follows:

1)_____

_____

2)_____

_____

3)_____

_____

Signatures

Printed Name	Signature	Date

COMMENTS: Include any dissenting opinion or reservation regarding decision. Use separate sheet of paper if necessary.

_____

_____

_____

_____

_____

_____

MONTHLY DATA SHEET – USE ONE FOR EACH SHIFT AS APPLICABLE

Name: _____ **Month/Year:** _____

Enter appropriate counts for each category/entry below; time and duration are recorded on back of form

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Targeted Safety Threats to Decrease																																
Reactive Restrictions (see reverse)																																
Additional Tracking Needs																																
	Initials																															

STAFF SIGNATURE _____ INITIALS _____ STAFF SIGNATURE _____ INITIALS _____

STAFF SIGNATURE _____ INITIALS _____ STAFF SIGNATURE _____ INITIALS _____

STAFF SIGNATURE _____ INITIALS _____ STAFF SIGNATURE _____ INITIALS _____

For any use of restraint/time out: Document here the date, time, duration, and specific intervention (i.e., Team Control Position, Transport Position, Time Out)									
Date	Safety Threat	Time	Duration	Intervention	Date	Safety Threat	Time	Duration	Intervention

Training Documentation

Confirmation of Behavior Support Strategies (BSS) Training
CUYAHOGA COUNTY BOARD OF DEVELOPMENTAL DISABILITIES

Behavior Support Strategies were trained on this date_____ from the HRC-approved strategies

to be implemented from _____ to _____as developed for _____.

Signatures and titles of those persons attending the training described above:

Printed Name	Signature	Title	Printed Name	Signature	Title

_____

TRAINER SIGNATURE, TITLE, and DATE

Confirmation of Nonviolent Crisis Intervention Training Specific to BSS
NVCI
CUYAHOGA COUNTY BOARD OF DEVELOPMENTAL DISABILITIES

Nonviolent Crisis Intervention (NVCI) was trained on this date_____ for the approved manual restraints to be utilized in the Behavior Support Strategies to be implemented from _____ to _____as developed for _____.

Signatures and titles of those persons attending the training described above. Signatures indicate that the individual successfully demonstrated the ability to perform the required NVCI techniques.

Printed Name	Signature	Title	Printed Name	Signature	Title

_____
TRAINER SIGNATURE, TITLE, and DATE

SA ISP

My Name: John Doe DOB: 1/1/60 Plan Period: 12/31/16 To: 12/30/17

Section: Behavior Support Strategies: Transportation Safety

For CCBDD Assistance: Author/Assist Name Phone: 216-931-xxxx

Brief Summary of Behavior Support Needs: Click here to enter text.

Key supportive personal relationship(s): Click here to enter text.

What are the most serious potential threats to safety or well-being? Click here to enter text.

What is he/she telling us with these actions? Click here to enter text.

Targets for New Learning	
What are we teaching?	**What will success look like?**
Safe Ridership	*Define outcome for individual*

How to Teach and Support XXXX
Do
Utilize identified mechanical restraint (Transportation Vest, Buckle Boss, etc) during transportation • The restraint will be applied prior to boarding the vehicle • Duration of use: Click here to enter text. minutes door to door • Restraint will be removed upon arrival at day site/residence • On all community based outings, the individual will only use the restraint on the transportation vehicle for the length of time spent on said vehicle. The restraint will be released/removed prior to disembarking the vehicle Watch for changes in mood, energy, socialization, and other signs of comfort, pain, or satisfaction Encourage independent and appropriate behavior as the person gets on and off the vehicle Model appropriate and safe ridership Fade Procedure: *Outline fade process, frequency, and documentation*
Don't
Ignore attempts to communicate Leave restraint in place upon arrival at destination.

All supporting documentation relating to Behavior Support Strategies are filed in CCBDD records and a copy forwarded to individual's provider(s) at time of implementation.

My Name: John Doe **DOB: 1/1/60** **Plan Period: 12/31/16 To: 12/30/17**

Behavior Support Strategies – Supporting Documentation

For CCBDD Assistance: Author/Assist Staff Phone: 216-931-xxxx

Name:	DOB:	Guardian:	
Use: [ ] Home [ ] Day Setting [ ] Transportation			
Plan Coordinator:		Phone#:	Agency:
Day Program Staff Contact:		Phone#:	Agency:
Home Program Staff Contact:		Phone#:	Agency:
Transportation Contact:		Phone#:	Agency:
Plan Author Signature:		Name:	Date:
Approval Signature (REQUIRED TO IMPLEMENT):			Date:
[ ] Initial BSS Review	[ ] Periodic/Annual Review	[ ] Preventative Restrictions	[ ] Reactive Restrictions

Targeted Behavioral Safety Threats	
Safety Threat	**Specific Action Involved**
Unsafe Ridership	Getting out of seat while on CCBDD vehicle *individualize to person*

Preventative Restrictive Measures Contained in this Plan	
Specific RM	**Related Safety Threat**
Mechanical Restraint:	Describe risk of harm:

Functional Analysis Summary (complete for each specifically targeted safety threat)

Safety Threat:	
Severity and likelihood of risk present:	
What is the function of the behavior and what is the action telling us about unmet needs?	
Which places, times and with whom is it most likely to happen?	
When is it least likely to happen?	
What other factors may be contributing (mental health, medical, environmental, interpersonal, trauma-related reaction)?	
What skill, new learning, or situational	

change is needed to better meet this need?	

Previously Attempted Non-Restrictive Measures and Results: Click here to enter text.

Additional Comments: Click here to enter text.

Supplemental Behavioral History Assessment

Abilities and Needs

Cognitive level, Communication Abilities, Sensory Issues: Click here to enter text.

Notable Strengths: Click here to enter text.

Personal preferences during a crisis or distress:

Preferred person to have contact with: Click here to enter text.
Things he/she does not want in a crisis: Click here to enter text.
Other helpful tools, techniques or activities during a crisis or period of distress: Click here to enter text.

Psychosocial History

Relevant Psychosocial History (Familial, Interpersonal): Click here to enter text.

Describe any history or suspected history of traumatic experiences: Click here to enter text.

Mental Health History and Psychotropic Medications

Brief Summary of Mental Health and Medical Issues: Click here to enter text.

Current Psychiatric Diagnoses: Click here to enter text.

Current Mental Health Provider(s): Click here to enter text.

Staff should be familiar with individual's currently prescribed psychotropic medications and common side effects of those medications. Refer to individual's current Medication Administration Record (MAR) for these medications.

Staff Responsibilities:

Responsibilities of the BSS Coordinator: Obtain required approvals from the individual, guardian, team Monitor consistency and accuracy of daily behavioral data collection Provide data to BHS staff/team on a monthly basis Participate in quarterly BSS reviews Identify needs for additional training as appropriate	Click here to enter text.
Responsibilities of the BHS Staff:	Click here to enter text.

Facilitate revision of strategies as appropriate based on team review Review/Evaluate monthly data submitted by provider(s) Participate in quarterly team reviews Compile and submit strategies to HRC for review as needed Submit plan for approval following HRC review	
Person(s) responsible for initial training of BSS:	Click here to enter text.
Person responsible for all Substitute/New Hire Training training required for all substitute/newly hired staff prior to their implementing the BSS	Click here to enter text.

Data

Summary of behavioral occurrences prior to implementation of behavior support strategies (baseline information): Click here to enter text.

Most Current Data:

Year:	First											Last
Targeted Safety Threats												
Fade Implementation												
Identify Measure Reported												
Restrictive Measures												
Mechanical Restraint												

For renewing Behavior Support Strategies, provide a narrative analysis or summary of the past year including discussion of any changes in the safety threat, changes in the mental health, emotional, or interpersonal needs of the individual that have become evident, and effectiveness of restrictive measures. Provide summary of team's quarterly reviews. (To what extent is he/she showing success with new skills we are attempting to teach? Has there been anything particularly helpful in the achievement this learning?)

Click here to enter text.

Name/Date: Click here to enter text.

Informed Consent Information

NAME: _____

Why is positive programming not enough? Click here to enter text.

What are the risks and benefits of the strategies? Click here to enter text.

What alternatives exist and the risks/benefits of each? Click here to enter text.

What are the likely consequences of not having these strategies? Click here to enter text.

I have received a copy of _____'s support strategies for implementation between _____ and _____. It has been explained to me by _____

_____(phone)_____whom I may contact with any questions or concerns.

He or she explained what might go wrong or could hurt me, how the plan might help me, and other things that we could have done instead. I was able to ask questions and have them answered. I know that the plan may not work exactly the way that is hoped for. I also know that I can ask more questions later if I want to and that I can change my mind at any time and decide that I no longer want to accept this plan. If I change my mind and no longer want this plan, I will need to tell an appropriate staff person. I know that I will not be punished in any way if I decide that I no longer want this plan.

I approve the plan for the implementation dates shown above _____

Signature Date

I DO NOT approve_____

Signature Date

Witness _____

Signature/Relationship Date

For individuals who are their own guardians the date of most recent informed consent evaluation _____

COMMENTS: (Include any reservations/dissent regarding the approval decision. Use additional paper if necessary.)

_____

_____

Approvals

NAME: _____

INTERDISCIPLINARY TEAM – Meeting Date _____

[ ] IDT approves

[ ] IDT does not approve

[ ] IDT has reviewed (for individual's that are their own guardian) the individual's ability to give informed consent in situations where one of the following has occurred:

3. There has been a change in the individual's cognitive status since the last review or
4. There has been an addition of a new aversive/restrictive procedure to the plan since the last review

COMMENTS: (Include any reservations/dissent regarding the approval decision. Use additional paper if necessary.)

_____

_____

SIGNATURE	POSITION	SIGNATURE	POSITION	SIGNATURE	POSITION
_____/	_____	_____/	_____	_____/	_____
_____/	_____	_____/	_____	_____/	_____

NAME: _____

Human Rights Committee – Meeting Date _____

[ ] These strategies have been reviewed and are cleared for training. Once training is complete, they must be approved and signed as ready for implementation.

[ ] These strategies are NOT cleared for training. They are being returned to the author for changes and resubmission. The main problems identified are as follows:

1)_____

_____

2)_____

_____

3)_____

_____

Signatures

Printed Name	Signature	Date

COMMENTS: Include any dissenting opinion or reservation regarding decision. Use separate sheet of paper if necessary.

_____

_____

_____

_____

_____

_____

Daily Program Data Sheet for Mechanical Transportation Restraint

Name: _____ **Client #:** _____ **Month/Year:** _____

Department #: TSC
Route# AM: _____
Route # PM: _____

Program Area: BEHAVIOR SUPPORT
Frequent of Review: Monthly/Quarterly
Frequency of Implementation: 2x/day
Duration: Bus ride to/from day program

Service Providers:
Initials/Signatures/Titles

_____

_____

Initials/Signatures/Titles

_____

_____

AM Route	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Mechanical Restraint (Y/N)																															
Agitation present (Y/N)																															
Physical Aggression *if appropriate* (Y/N)																															
Fade Procedure Utilized (Y/N)																															
Response to Fade (+ = success; - = unsafe response)																															
Initials																															

PM Route	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Mechanical Restraint (Y/N)																															
Agitation present (Y/N)																															
Physical Aggression *if appropriate* (Y/N)																															
Fade Procedure Utilized (Y/N)																															
Response to Fade (+ = success; - = unsafe response)																															
Initials																															

Training Documentation

Confirmation of Behavior Support Strategies (BSS) Training
CUYAHOGA COUNTY BOARD OF DEVELOPMENTAL DISABILITIES

Behavior Support Strategies were trained on this date_____ from the HRC-approved strategies

to be implemented from _____ to _____as developed for _____.

Signatures and titles of those persons attending the training described above:

Printed Name	Signature	Title	Printed Name	Signature	Title

_____

TRAINER SIGNATURE, TITLE, and DATE

CUYAHOGA COUNTY
Board of Developmental Disabilities

Human Rights Committee Referral Form
Request for Rights Restriction Review

Individual: _____ DOB: _____

Address: _____

Guardian: _____ Date of Submission: _____

1. Dates of Implementation (Start date – End Date):

2. Implementation Setting: ☐ Home ☐ Day Program ☐ Both ☐ Other

3. Requested Restrictions:

4. What teaching or treatment will be in place to address the safety threat?

5. What information or data will the Team review to determine if the restriction is continued or discontinued and who will provide that information?

6. Describe the specific threats to safety:

7. What events or situations are most likely to lead to the threats to safety?

8. What does this tell us about the needs of the individual?

9. What less restrictive approaches have been tried?

10. What alternative will be used if the restrictions are not approved?

11. What concerns regarding the individual's interpersonal, environmental, medical, mental health, and emotional needs or other motivational factors that may influence the individual's behavior have been identified and are these being addressed?

12. Other relevant factors:

Referred by (SA):

Assessment Completed by (Person completing rights referral):

Informed Consent

You are being asked to approve specific instructions that will restrict your rights by limiting some of your choices. This is being done to keep you safe. By signing below you are saying that you discussed and agree to each of the following points and that you are giving your permission for people to use these strategies to support you. They will use the plan for the dates shown above or until you tell your SA or provider that you no longer want it to be used.

What are the risks and benefits of the restrictive measure(s)?

What alternatives exist and the risks/benefits of each?

What are the likely consequences of not having these strategies?

1) You understand that you have the right to say no to part or all of these strategies and it will not be held against you in any way. You do not have to agree to these strategies if you do not want to.
2) Even if you agree to this plan, you can change your mind at any time. If you change your mind you will need to tell your SA or a staff person and then they will stop using it.

I have had the chance to discuss each of the above points and by signing here I am giving my permission to use these strategies in my plan.

_____ _____
Signature Date

I do NOT approve _____ _____
Signature Date

_____ _____
Witness Date

Human Rights Committee Decision

☐ Approved ☐ Denied ☐ Other

Comments

Next Team Review Dates: _____

Signatures with date

Chapter 3

Levels of Review

The purpose and content of the Individual Support Plan will determine what review procedures are necessary.

Review Requirements

The majority of behavior support interventions do not contain restrictive interventions; when necessary, such restrictive measures may be included as part of these strategies. The review process for restrictive measures involves completion of informed consent with the individual and his/her guardian, approval by the Interdisciplinary Team, and review by the Human Rights Committee.

Informed Consent

The State of Ohio Behavior Support Rule requires that the person or the guardian must provide informed consent prior to the implementation of behavior support strategies with restrictive measures. These rules also require that informed consent must be updated on an annual basis, if the same behavioral support strategies are still being implemented.

At the time behavior support strategies with restrictive measures are initially developed, an individual with a developmental disability who is their own guardian is assessed for his/her ability to provide informed consent.

Interdisciplinary Team

Purpose of the Interdisciplinary Team (IDT)

The IDT is composed of the individual and/or his/her guardian, the service provider, support administrator, and any other people the individual wishes to have involved in developing plans for him or her. The role of the IDT is to develop a plan to assist the individual in achieving his/her goals based on a person centered approach. Sometimes these goals involve behavioral issues and there is a need to develop specific behavioral strategies to address these issues. Behavioral health staff may be consulted and part of

the called in as part of the Interdisciplinary Team to assist in the development of these plans.

IDT Composition

"Team" means the group of persons chosen by the individual with the core responsibility to support the individual in directing development of his or her individual service plan. The team includes the individual's guardian or adult whom the individual has identified, as applicable, the service and support administrator, direct support staff, providers, licensed or certified professionals, and any other persons chosen by the individual to help the individual consider possibilities and make decisions.

IDT Responsibilities

When support strategies involve restrictive measures, it is the team's responsibility to ensure timely development and approval of the strategies as well as conduct 90 day reviews of the restrictive measure in accordance with the rule.

Human Rights Committee

Purpose of the HRC

The role of the Human Rights Committee (HRC) is to review, approve or reject, monitor, and reauthorize strategies that include restrictive measures.

The Human Rights Committee shall:

- Ensure that the planning process outlined in this rule has been followed and that the individual or the individual's guardian, as applicable, has provided informed consent and been afforded due process;
- Ensure that the proposed restrictive measures are necessary to reduce risk of harm or likelihood of legal sanction;
- Ensure that the overall outcome of the behavioral support strategy promotes the physical, emotional, and psychological wellbeing of the individual while reducing risk of harm or likelihood of legal sanction;
- Ensure that a restrictive measure is temporary in nature and occurs only in specifically defined situations based on risk of harm or likelihood of legal sanction;
- Verify that any behavioral support strategy that includes restrictive measures also incorporates actions designed to enable the individual to feel safe, respected, and valued while emphasizing choice, self-determination, and an improved quality of life; and
- Communicate the committee's determination in writing to the qualified intellectual disability professional or service and support administrator submitting the request for approval.

HRC Committee Composition

The committee will be composed of four members:

Required Members:

- Individual receiving or eligible to receive services from CCBDD
- Qualified persons who have either experience or training in contemporary practices for behavioral support

Additional Members:

- Parent/family member or guardian of an individual eligible to receive services from a county board.
- County Board or Provider Agency Representative

Committee membership will represent a 50/50 balance between persons who receive services and those who are providers of service or professionals in the DD system.

A quorum of 3 voting members is required to review and approve plans.

When a member is unable to attend a meeting, they will be able to provide written or verbal input prior to the HRC meeting.

CCBDD will maintain a roster of trained alternates in the event of an anticipated absence by a standing committee member. Substitutions will maintain the 50/50 balance.

HRC Documentation

1. Minutes of each meeting and a log of cases reviewed.
2. Signed copies of the HRC approval sheets with comments documented, as appropriate, from members.

Schedule of the HRC

There are five HRCs such that an HRC meeting is held most weeks of the year. New behavior strategies will be scheduled at the next available meeting date to facilitate quick response to the needs of individual.

HRC Review Process

Plans with restrictive measures may be submitted for Human Rights Committee review by the SA or Behavioral Health Staff, as determined by the individual team.

Once received by the HRC coordinator, all plans will be reviewed at the next available committee meeting or as previously scheduled. The HRC Coordinator will notify the SA and/or Behavioral Health Staff of the outcome within two business days of the meeting.

Training Guidelines

Training Requirements

Prior to the implementation of behavior support strategies with restrictive measures (whether initial or revised), the staff assigned to work with the individual must be trained on the specific behavior support strategies. Training should include a review of the behavior assessment as well as detailed training on the interventions outlined in the behavior support strategies. Typically, the plan author or plan coordinator will have the responsibility of completing and documenting this staff training.

If behavior support strategies include the use of manual restraint interventions such as Nonviolent Crisis Intervention, additional training on the plan-specific techniques is also required. This training must be completed by a certified CPI Instructor, or equivalent, as specified by CPI or other guidelines. The BHS Assist staff/plan coordinator is responsible for ensuring that this training is completed and documented. The Instructor must provide his/her signature that training has been provided to the staff involved in implementing the behavior support strategies.

SUBSTITUTE TRAINING: Training on the individual's BSS is mandatory for substitute care providers who are assigned the responsibility for implementing and/or documenting the BSS. Each IDT must specify the individual responsible for completing and documenting this training

Restrictive Measures Notification

The Ohio Department of Developmental Disabilities requires that they be notified of behavior support strategies that include any type of restrictive measure as defined in this manual and in the behavior support rule. According to the State of Ohio Behavior Support Rule, the county board or the ICF must notify DODD prior to implementation of the strategy that includes restrictive measures

Following receipt of all necessary documentation (individual/guardian consent, HRC approval, verification of all necessary training), CCBDD Behavioral Health will complete the RMN and submit via identified method

Responsibilities for Approving Behavior Support Plans for Persons Residing in ICF Facilities –

For individuals residing in an ICF facility, plans with restrictive measures will be reviewed by the Human Rights Committee of the ICF. CCBDD reserves the right to request a re-review of strategies implemented within CCBDD environments if there are concerns that said strategies may be overly restrictive or do not represent the least restrictive approach to supporting the individual.

Chapter 4

Appendices

Board Policy

1. CCBDD Policy Manual 2016

9.6 Behavior Supports

The CCBDD shall formulate and follow procedures for the use of restrictive measures that conform to procedural requirements of the Ohio Department of Developmental Disabilities rule 5123:2-2-06 of the Ohio Administrative Code. Procedures are specified in the *CCBDD Behavior Support Procedures Manual* that also specifies an overall philosophy of behavior supports and provides concrete guidance and expectations for the use of clinically-sound and least-restrictive approaches to providing behavior support.

Human Rights Committees are organized by the CCBDD according to Ohio Administrative Code, section 5123:2-2-06 and are run in conjunction with community partners, individuals being served and/or the relatives of individuals being served. The Human Rights Committees are charged with reviewing and rendering final approval or disapproval of any plan that contains a restrictive measure as defined in the rule. The primary aim of a Human Rights Committee is to ensure that the rights of individuals are preserved and that any use of restrictive measures are used only as a last resort and in compliance with 5123:2-2-06 of the Ohio Administrative Code.

In the case of a person living in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) residential facility, the behavior support committee and the Human Rights Committee that reviews the plan may be either those formed by the CCBDD or those formed by the provider of ICF/IID residential supports.

9.6.1 Crisis

The CCBDD recognizes that, on occasion, an emergency arises to necessitate crisis management to protect an individual or others from injury and to prevent property damage.

9.6.2 Suspension

All due process procedures governing the suspension of services to school-age children with developmental disabilities shall be followed in accordance with the rules of the Ohio Department of Education, the policy and procedures of the Federal Office of Special Education Programs, and any applicable court decisions.

Due process procedures for suspensions of services to individuals other than of school-age children shall be followed in accordance with Ohio Revised Code 5101.35 if the service the individual is suspended from is funded through a Medicaid waiver or Ohio Administrative Code 5123:2-1-12 and Section 3.4.1 of this policy manual if the service is funded through local dollars.

Any suspension of a service for an adult individual receiving supports is based on the assessed presence of a significant threat to the safety or well-being of the individual or others in the given setting. Suspension is not used for purposes of punishment and must end once the threat of harm has been determined to be within acceptable limits. The CCBDD does not, however, have the authority to prevent an employer from suspending or terminating an individual receiving services from employment.

State of Ohio Behavior Support Rule

5123:2-2-06 **Behavioral support strategies that include restrictive measures.**

(A) Purpose

This rule limits the use of and sets forth requirements for development and implementation of behavioral support strategies that include restrictive measures for the purpose of ensuring that:

(1) Restrictive measures are used only when necessary to keep people safe;

(2) Individuals with developmental disabilities are supported in a caring and responsive manner that promotes dignity, respect, and trust and with recognition that they are equal citizens with the same rights and personal freedoms granted to Ohioans without developmental disabilities;

(3) Services and supports are based on an understanding of the individual and the reasons for his or her actions; and

(4) Effort is directed at creating opportunities for individuals to exercise choice in matters affecting their everyday lives and supporting individuals to make choices that yield positive outcomes.

(B) Scope

(1) This rule applies to persons and entities that provide specialized services regardless of source of payment, including but not limited to:

(a) County boards of developmental disabilities and entities under contract with county boards;

(b) Residential facilities licensed pursuant to section 5123.19 of the Revised Code, including intermediate care facilities;

(c) Providers of supported living certified pursuant to section 5123.161 of the Revised Code; and

(d) Providers of services funded by medicaid home and community-based services waivers administered by the department.

(2) Individuals receiving services in a setting governed by the Ohio department of education shall be supported in accordance with administrative rules and policies of the Ohio department of education.

(C) Definitions

(1) "County board" means a county board of developmental disabilities.

(2) "Department" means the Ohio department of developmental disabilities.

(3) "Director" means the director of the Ohio department of developmental disabilities or his or her designee.

(4) "Individual" means a person with a developmental disability.

(5) "Individual plan" or "individual service plan" means the written description of services, supports, and activities to be provided to an individual.

(6) "Informed consent" means a documented written agreement to allow a proposed action, treatment, or service after full disclosure provided in a manner the individual or his or her guardian understands, of the relevant facts necessary to make the decision. Relevant facts include the risks and benefits of the action, treatment, or service; the risks and benefits of the alternatives to the action, treatment, or service; and the right to refuse the action, treatment, or service. The individual or his or her guardian, as applicable, may revoke informed consent at any time.

(7) "Intermediate care facility" means an intermediate care facility for individuals with intellectual disabilities as defined in rule 5123:2-7-01 of the Administrative Code.

(8) "Prohibited measure" means a method that shall not be used by persons or entities providing specialized services. "Prohibited measures" include:

(a) Prone restraint. "Prone restraint" means a method of intervention where an individual's face and/or frontal part of his or her body is placed in a downward position touching any surface for any amount of time.

(b) Use of a manual restraint or mechanical restraint that has the potential to inhibit or restrict an individual's ability to breathe or that is medically contraindicated.

(c) Use of a manual restraint or mechanical restraint that causes pain or harm to an individual.

(d) Disabling an individual's communication device.

(e) Denial of breakfast, lunch, dinner, snacks, or beverages.

(f) Placing an individual in a room with no light.

(g) Subjecting an individual to damaging or painful sound.

(h) Application of electric shock to an individual's body.

(i) Subjecting an individual to any humiliating or derogatory treatment.

(j) Squirting an individual with any substance as an inducement or consequence for behavior.

(k) Using any restrictive measure for punishment, retaliation, instruction or teaching, convenience of providers, or as a substitute for specialized services.

(9) "Provider" means any person or entity that provides specialized services.

(10) "Qualified intellectual disability professional" has the same meaning as in 42 C.F.R. 483.430 as in effect on the effective date of this rule.

(11) "Restrictive measure" means a method of last resort that may be used by persons or entities providing specialized services only when necessary to keep people safe and with prior approval by the human rights committee in accordance with paragraph (F) of this rule. "Restrictive measures" include:

(a) Manual restraint. "Manual restraint" means use of a hands-on method, but never in a prone restraint, to control an identified action by restricting the movement or function of an individual's head, neck, torso, one or more limbs, or entire body, using sufficient force to cause the possibility of injury and includes holding or disabling an individual's wheelchair or other mobility device. An individual in a manual restraint shall be under constant visual supervision by staff. Manual restraint shall cease immediately once risk of harm has passed. "Manual restraint" does not include a method that is routinely used during a medical procedure for patients without developmental disabilities.

(b) Mechanical restraint. "Mechanical restraint" means use of a device, but never in a prone restraint, to control an identified action by restricting an individual's movement or function. Mechanical restraint shall cease immediately once risk of harm has passed. "Mechanical restraint" does not include:

(i) A seatbelt of a type found in an ordinary passenger vehicle or an age-appropriate child safety seat;

(ii) A medically-necessary device (such as a wheelchair seatbelt or a gait belt) used for supporting or positioning an individual's body; or

(iii) A device that is routinely used during a medical procedure for patients without developmental disabilities.

(c) Time-out. "Time-out" means confining an individual in a room or area and preventing the individual from leaving the room or area by applying physical force or by closing a door or constructing another barrier, including placement in such a room or area when a staff person remains in the room or area.

(i) Time-out shall not exceed thirty minutes for any one incident nor one hour in any twenty-four hour period.

(ii) A time-out room or area shall not be key-locked, but the door may be held shut by a staff person or by a mechanism that requires constant physical pressure from a staff person to keep the mechanism engaged.

(iii) A time-out room or area shall be adequately lighted and ventilated and provide a safe environment for the individual.

(iv) An individual in a time-out room or area shall be protected from hazardous conditions including but not limited to, sharp corners and objects, uncovered light fixtures, or unprotected electrical outlets.

(v) An individual in a time-out room or area shall be under constant visual supervision by staff.

(vi) Time-out shall cease immediately once risk of harm has passed or if the individual engages in self-abuse, becomes incontinent, or shows other signs of illness.

(vii) "Time-out" does not include periods when an individual, for a limited and specified time, is separated from others in an unlocked room or area for the purpose of self-regulating and controlling his or her own behavior and is not physically restrained or prevented from leaving the room or area by physical barriers.

(d) Chemical restraint. "Chemical restraint" means a medication prescribed for the purpose of modifying, diminishing, controlling, or altering a specific behavior. "Chemical restraint" does not include medications prescribed for the treatment of a diagnosed disorder identified in the "Diagnostic and Statistical Manual of

Mental Disorders" (fifth edition) or medications prescribed for treatment of a seizure disorder. "Chemical restraint" does not include a medication that is routinely prescribed in conjunction with a medical procedure for patients without developmental disabilities.

(e) Restriction of an individual's rights as enumerated in section 5123.62 of the Revised Code.

(12) "Risk of harm" means there exists a direct and serious risk of physical harm to the individual or another person. For risk of harm, the individual must be capable of causing physical harm to self or others and the individual must be causing physical harm or very likely to begin causing physical harm.

(13) "Service and support administrator" means a person, regardless of title, employed by or under contract with a county board to perform the functions of service and support administration and who holds the appropriate certification in accordance with rule 5123:2-5-02 of the Administrative Code.

(14) "Specialized services" means any program or service designed and operated to serve primarily individuals with developmental disabilities, including a program or service provided by an entity licensed or certified by the department. If there is a question as to whether a provider or entity under contract with a provider is providing specialized services, the provider or contract entity may request that the director of the department make a determination. The director's determination is final.

(15) "Team," as applicable, has the same meaning as in rule 5123:2-1-11 of the Administrative Code or means an interdisciplinary team as that term is used in 42 C.F.R. 483.440 as in effect on the effective date of this rule.

(D) Development of a behavioral support strategy that includes restrictive measures

(1) A behavioral support strategy shall never include prohibited measures.

(2) A behavioral support strategy may include manual restraint, mechanical restraint, time-out, or chemical restraint only when an individual's actions pose risk of harm.

(3) A behavioral support strategy may include restriction of an individual's rights only when an individual's actions pose risk of harm or are very likely to result in the individual being the subject of a legal sanction such as eviction, arrest, or incarceration. Absent risk of harm or likelihood of legal sanction, an individual's rights shall not be restricted (e.g., by imposition of arbitrary schedules or limitation on consumption of food, beverages, or tobacco products).

(4) The focus of a behavioral support strategy shall be creation of supportive environments that enhance the individual's quality of life. Effort is directed at:

(a) Mitigating risk of harm or likelihood of legal sanction;

(b) Reducing and ultimately eliminating the need for restrictive measures; and 5123:2-2-06 5

(c) Ensuring individuals are in environments where they have access to preferred activities and are less likely to engage in unsafe actions due to boredom, frustration, lack of effective communication, or unrecognized health problems.

(5) A behavioral support strategy that includes restrictive measures requires:

(a) Documentation that demonstrates that positive and non-restrictive measures have been employed and have been determined ineffective; and

(b) An assessment conducted within the past twelve months that clearly describes:

(i) The behavior that poses risk of harm or likelihood of legal sanction;

(ii) The level of harm or type of legal sanction that could reasonably be expected to occur with the behavior;

(iii) When the behavior is likely to occur; and

(iv) The individual's interpersonal, environmental, medical, mental health, and emotional needs and other motivational factors that may be contributing to the behavior.

(6) Persons who conduct assessments and develop behavioral support strategies that include restrictive measures **shall**:

(a) Hold professional license or certification issued by the Ohio board of psychology; the state medical board of Ohio; or the Ohio counselor, social worker, and marriage and family therapist board; or

(b) Hold a certificate to practice as a certified Ohio behavior analyst pursuant to section 4783.04 of the Revised Code; or

(c) Hold a bachelor's or graduate-level degree from an accredited college or university and have at least three years of paid, full-time (or equivalent part-time) experience in developing and/or implementing behavioral support and/or risk reduction strategies or plans.

(7) A behavioral support strategy that includes restrictive measures **shall**:

(a) Be designed in a manner that promotes healing, recovery, and emotional wellbeing based on understanding and consideration of the individual's history of traumatic experiences as a means to gain insight into origins and patterns of the individual's actions;

(b) Be data-driven with the goal of improving outcomes for the individual over time and describe behaviors to be increased or decreased in terms of baseline data about behaviors to be increased or decreased;

(c) Recognize the role environment plays in behavior;

(d) Capitalize on the individual's strengths to meet challenges and needs;

(e) Delineate measures to be implemented and identify those who are responsible for implementation;

(f) Specify steps to be taken to ensure the safety of the individual and others;

(g) As applicable, identify needed services and supports to assist the individual in meeting court-ordered community controls such as mandated sex offender registration, drug-testing, or participation in mental health treatment; and

(h) As applicable, outline necessary coordination with other entities (e.g., courts, prisons, hospitals, and law enforcement) charged with the individual's care, confinement, or reentry to the community.

(8) When a behavioral support strategy that includes restrictive measures is deemed necessary by the individual and his or her team, the qualified intellectual disability professional or the service and support administrator, as applicable, **shall**:

(a) Ensure the strategy is developed in accordance with the principles of person-centered planning and incorporated as an integral part of the individual plan or individual service plan.

(b) Submit to the human rights committee documentation based upon the assessment that clearly indicates risk of harm or likelihood of legal sanction described in observable and measurable terms and ensure the strategy is reviewed and approved by the human rights committee in accordance with paragraph (F) of this rule prior to implementation and whenever the behavioral support strategy is revised to add restrictive measures, but no less than once per year.

(c) Secure informed consent of the individual or the individual's guardian, as applicable.

(d) Provide an individual or the individual's guardian, as applicable, with written notification and explanation of the individual's or guardian's right to seek administrative resolution if he or she is dissatisfied with the strategy or the process used for its development.

(e) Ensure the strategy is reviewed by the individual and the team at least every ninety days to determine and document the effectiveness of the strategy and whether the strategy should be continued, discontinued, or revised. A decision to continue the strategy shall be based upon review of up-to-date information which indicates risk of harm or likelihood of legal sanction is still present.

(E) Implementation of behavioral support strategies with restrictive measures

(1) Restrictive measures shall be implemented with sufficient safeguards and supervision to ensure the health, welfare, and rights of individuals receiving specialized services.

(2) Each person providing specialized services to an individual with a behavioral support strategy that includes restrictive measures shall successfully complete training in the strategy prior to serving the individual.

(F) Human rights committees

(1) Each county board, or county board jointly with one or more other county boards, or county board jointly with one or more providers, and each intermediate care facility shall establish a human rights committee to safeguard individuals' rights and protect individuals from physical, emotional, and psychological harm. The human rights committee shall:

(a) Be comprised of at least four persons;

(b) Include at least one individual who receives or is eligible to receive specialized services;

(c) Include qualified persons who have either experience or training in contemporary practices for behavioral support; and

(d) Reflect a balance of representatives from each of the following two groups:

(i) Individuals who receive or are eligible to receive specialized services or family members or guardians of individuals who receive or are eligible to receive specialized services; and

(ii) County boards or providers.

(2) All information and documents provided to the human rights committee and all discussions of the committee shall be confidential and shall not be shared or discussed with anyone other than the individual and his or her guardian and the individual's team.

(3) The human rights committee shall review, approve or reject, monitor, and reauthorize strategies that include restrictive measures. In this role, the human rights committee **shall**:

(a) Ensure that the planning process outlined in this rule has been followed and that the individual or the individual's guardian, as applicable, has provided informed consent and been afforded due process;

(b) Ensure that the proposed restrictive measures are necessary to reduce risk of harm or likelihood of legal sanction;

(c) Ensure that the overall outcome of the behavioral support strategy promotes the physical, emotional, and psychological wellbeing of the individual while reducing risk of harm or likelihood of legal sanction;

(d) Ensure that a restrictive measure is temporary in nature and occurs only in specifically defined situations based on risk of harm or likelihood of legal sanction;

(e) Verify that any behavioral support strategy that includes restrictive measures also incorporates actions designed to enable the individual to feel safe, respected, and valued while emphasizing choice, self-determination, and an improved quality of life; and

(f) Communicate the committee's determination in writing to the qualified intellectual disability professional or service and support administrator submitting the request for approval.

(4) Members of the human rights committee shall receive department-approved training within three months of appointment to the committee in: rights of individuals as enumerated in section 5123.62 of the Revised Code, person-centered planning, informed consent, confidentiality, and the requirements of this rule.

(5) Members of the human rights committee shall annually receive department-approved training in relative topics which may include but are not limited to: self-advocacy and self-determination; role of guardians and section 5126.043 of the Revised Code; effect of traumatic experiences on behavior; and court-ordered community controls and the role of the court, the county board, and the human rights committee.

(G) Use of a restrictive measure without prior approval by the human rights committee

(1) Use of a restrictive measure, including use of a restrictive measure in a crisis situation (e.g., to prevent an individual from running into traffic), without prior approval by the human rights committee shall be reported as "unapproved behavior support" in accordance with rule 5123:2-17-02 of the Administrative Code.

(2) Nothing in this rule shall be construed to prohibit or prevent any person from intervening in a crisis situation as necessary to ensure a person's immediate health and safety.

(H) Reporting of behavioral support strategies that include restrictive measures

After securing approval by the human rights committee and prior to implementation of a behavioral support strategy that includes restrictive measures, the county board or intermediate care facility shall notify the department in a format prescribed by the department.

(I) Recording use of restrictive measures

Each provider shall maintain a record of the date, time, duration, and antecedent factors regarding each use of a restrictive measure other than a restrictive measure that is not based on antecedent factors (e.g., bed alarm or locked cabinet). The provider shall share the record with the individual and the individual's team whenever the individual's behavioral support strategy is being reviewed or reconsidered.

(J) Analysis of behavioral support strategies that include restrictive measures

(1) Each county board and each intermediate care facility shall compile and analyze data regarding behavioral support strategies that include restrictive measures and furnish the data and analyses to the human rights committee. Data compiled and analyzed shall include, but are not limited to:

(a) Nature and frequency of risk of harm or likelihood of legal sanction that triggered development of strategies that include restrictive measures;

(b) Nature and number of strategies reviewed, approved, rejected, and reauthorized by the human rights committee;

(c) Nature and number of restrictive measures implemented;

(d) Duration of strategies that include restrictive measures implemented; and

(e) Effectiveness of strategies that include restrictive measures in terms of increasing or decreasing behaviors as intended.

(2) County boards and intermediate care facilities shall make the data and analyses available to the department upon request.

(K) Department oversight

(1) The department shall take immediate action as necessary to protect the health and welfare of individuals which may include, but is not limited to:

(a) Suspension of a behavioral support strategy not developed, implemented, documented, or monitored in accordance with this rule or where trends and patterns of data suggest the need for further review;

(b) Provision of technical assistance in development or redevelopment of a behavioral support strategy; and

(c) Referral to other state agencies or licensing bodies, as indicated.

(2) The department shall compile and analyze data regarding behavioral support strategies for purposes of determining methods for enhancing risk reduction efforts and outcomes, reducing the frequency of restrictive measures, and identifying technical assistance and training needs. The department shall make the data and analyses available.

(3) The department may periodically select a sample of behavioral support strategies for review to ensure that strategies are developed, implemented, and monitored in accordance with this rule.

(4) The department shall conduct reviews of county boards and providers as necessary to ensure the health and welfare of individuals and compliance with this rule. Failure to comply with this rule may be considered by the department in any regulatory capacity, including certification, licensure, and accreditation.

(L) Waiver of provisions of this rule

For adequate reasons and when requested in writing by a county board or provider, the director may waive a condition or specific requirement of this rule except that the director shall not permit use of a prohibited measure as defined in paragraph (C)(8) of this rule. The director shall grant or deny a request for a waiver within ten working days of receipt of the request or within such longer period of time as the director deems necessary and put whatever conditions on the waiver as are determined to be necessary. Approval to waive a condition or specific requirement of this rule shall not be contrary to the rights, health, or safety of individuals receiving services. The director's decision to grant or deny a waiver is final and may not be appealed.

Replaces: 5123:2-3-25, part of 5123:2-1-02
Effective: 01/01/2015
Five Year Review (FYR) Dates: 01/01/2020
CERTIFIED ELECTRONICALLY
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Rights of People with Developmental Disabilities

Legal Text Version	Simplified Sentence Version
(A) The right to be treated at all times with courtesy and respect and with full recognition of their dignity and individuality;	1. You should be treated nicely at all times and as a person.
(B) The right to an appropriate, safe, and sanitary living environment that complies with local, state, and federal standards and recognized the persons' need for privacy and independence;	2. You should have a clean safe place to live in and a place to be alone.
(C) The right to food adequate to meet accepted standards of nutrition;	3. You should have food that is good for you.
(D) The right to practice the religion of their choice or to abstain from the practice of religion;	4. You should be able to go, if you want, to any church, temple, and mosque.
(E) The right of timely access to appropriate medical or dental treatment;	5. You should be able to go to a doctor or dentist when you are sick.
(F) The right of access to necessary ancillary services, including, but not limited to, occupational therapy, speech therapy, speech therapy, and behavior modification and other psychological services;	6. You should be able to have people help you with the way you walk, talk, do things with your hands, act or feel, if you need it.
(G) The right to receive appropriate care and treatment in the least intrusive manner;	7. You should be able to have people help and teach you, if you want.
(H) The right to privacy, including both periods of privacy and places of privacy;	8. You should be able to have time and a place to go to be by yourself.
(I) The right to communicate freely with persons of their choice in any reasonable manner they choose;	9. You should be able to call, write letters or talk to anyone you want about anything you want.
(J) The right to ownership and use of personal possessions so as to maintain individuality and personal dignity;	10. You should be able to have your own things and be able to use them.
(K) The right to social interaction with members of either sex;	11. You should be able to have men and women as friends.
(L) The right of access to opportunities that enable individuals to develop their full human potential;	12. You should be able to join in activities and do things that will help you grow to be the best person you can be.
(M) The right to pursue vocational opportunities that will promote and enhance economic independence;	13. You should be able to work and make money.
(N) The right to be treated equally as citizens under the law;	14. You should be treated like everyone else.
(O) The right to be free from emotional, psychological, and physical abuse;	15. You should not be hit, yelled at, cursed at, or called names that hurt you.
(P) The right to participate in appropriate programs of education, training, and social development, and habilitation and in programs of reasonable recreation;	16. You should be able to learn new things, make friends, have activities to do, and go out in your community.
(Q) The right to participate in decisions that affect their lives;	17. You should be able to tell people what you want and be part of making plans or decisions about your life.
(R) The right to select a parent or advocate to act on their behalf;	18. You should be able to ask someone you want to help you, let others know how you feel or what you want.
(S) The right to manage their personal financial affairs, based on individual ability to do so;	20. You should be able to use your money to pay for things you need and want with help, if you need it.
(T) The right to confidential treatment of all information in their personal and medical record, except to the extent that disclosure or release of records is permitted under sections 5123.89 and 5126.044 of the Revised Code;	21. You should be able to say "yes" or "no" before people talk about what you do at work or home or look at your file.
(U) The right to voice grievances and recommend changes in policies and services without restraint, interference, coercion, discrimination, or reprisal;	22. You should be able to complain or ask for changes if you don't like something without being afraid of getting in trouble.
(V) The right to be free from unnecessary chemical or physical restraints;	23. You should not be given medicine that you don't need or held down if you are not hurting yourself or others.
(W) The right to participate in the political process;	24. You should be able to vote and learn about laws and your community.
(X) The right to refuse to participate in medical, psychological, or other research experiments.	25. You should be able to say "yes" or "no" to being part of a study or experiment.

Ohio Revised Code Section. 5123.62, as passed by the Ohio Legislature and signed into law by Governor Richard F. Celeste, 1986