CUYAHOGA COUNTY BOARD OF DEVELOPMENTAL DISABILITIES

Behavioral & Health Supports Department

Behavior Support Procedures Manual 2010

BEHAVIORAL & HEALTH SUPPORTS

Behavior Support Procedures Manual 2010

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Preface to the Manual

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Cuyahoga County Board of Developmental Disabilities Behavioral & Health Supports Department announces the release of the *CCBDD Behavior Support Manual 2010*. This important document is available on the Infonet as well as the board's own website, www.cuyahogabdd.org. This manual outlines critical functions and practices of CCBDD as it relates to our mandated responsibilities for oversight and implementation of the Ohio Department of Developmental Disabilities Behavior Support Rule. We encourage all stakeholders in the behavior support process to access and review this manual as its goal is to ensure that the individuals we serve receive appropriate supports including those services that promote the development of meaningful relationships and opportunities for personal growth on behalf of individuals receiving CCBDD services.

The revision of the manual reflects the continued emphasis on a positive intervention culture including the role of behavior support in assisting individuals to develop their skills and promote growth and a sense of security while recognizing the central importance of the needs and preferences of the individuals served by CCBDD. The manual underscores the importance of positive behavior development as a primary tool in reducing the health and safety risks associated with maladaptive or otherwise dangerous behaviors. The manual also reinforces the mandate that aversive interventions, including restraint and time-out procedures, are appropriately used ONLY when there is a clear risk to the health and safety of the individual or those around him/her. This is a continuation of the existing intent to eliminate the use of unnecessary restraint including previous advisories against the use of manual restraint in response to property destruction and aversive interventions in response to verbal aggression.

The following paragraphs briefly highlight important elements, including changes to existing practices, which will impact the implementation of behavior supports within Cuyahoga County in the coming years.

- A newly clarified hierarchy of restrictive and aversive interventions, including the more widely utilized general intervention strategies, is a primary element of the new manual. This hierarchy recognizes the importance of ensuring that individuals' preferences and needs are considered in the development of behavior guidelines or a more formal behavior support plan. The *2010 Manual* outlines the required review for each level of intervention and provides definitions and guidance for the development of appropriate strategies. A related change is the elimination of the level of risk assessment protocol, previously outlined in the 2004 Manual, for determining the review requirements for a behavior support plan. The updated hierarchy of restrictive/aversive procedures is based on criteria consistent with the current emphases of DODD oversight practices

- The use of level systems has been addressed in the *2010 Manual*. Please see pages 10-11; the use of level systems will typically require the highest level of review as the related use of response cost is identified as an aversive intervention. However, additional guidance is provided to assist in determining the appropriateness of such interventions and the necessary oversight.

- The *2010 Manual* more specifically defines procedures traditionally associated with time-out. Within Cuyahoga County, time-out will be specifically defined as consisting of two levels, both of which involve confining an individual in a designated location; the use of a time-out room as well as any other location wherein barriers prevent an individual from removing him/herself must be viewed as aversive interventions

and require the highest level of review. Additional procedures in which a change of environment is used as an intervention are also identified and defined. Please reference pages 12-14 of the manual for further information on this topic.

- A primary element of the *2010 Manual* is the development of the newly formatted CCBDD Behavior Support Plan and CCBDD Transportation Vest Behavior Support Plan. These documents can be found on pages 28 and 40 of the manual. These forms help to ensure that all necessary components of a behavior support plan, including the supporting assessment and training, are incorporated into the plan. Microsoft Word versions of these documents can also be accessed on the CCBPublic drive: CCBPublic/Behavior Support/2010 BSP Forms

- A component of this updated hierarchy of interventions is the inclusion of specific review procedures for restrictive interventions (rights restrictions) that may be incorporated into Individual Service Plans (ISPs) or Behavior Support Plans (BSPs). An annual Human Rights Committee review is now a standard requirement for all such interventions. See Chapter Three, pages 44-47, for more information on this topic.

- As previously communicated in various formats, the role of the Support Administrator in the behavior support process has been more clearly defined. The SA role in both rights review (assuring inclusion in the ISP) and regional behavior support committee reviews (attendance and participation in annual reviews of BSPs with aversive interventions) are identified.

- In recognition of the changes that can occur over time in all individuals, new guidelines have been developed for renewal of Human Rights Committee review/approval (every four years) and OT/PT evaluation for manual/mechanical restraints (also every four years). Please see pages 56-57 and 66-67 for more information on OT/PT evaluations.

- The *2010 Manual* also provides useful tools for Plan Coordinators as they assist in implementing and monitoring the effectiveness of an individual's Behavior Support Plan. Please see page 59 for the "Plan Coordinator Checklist" and page 61 for the "Document Filing Checklist."

We are excited to share this document with all CCBDD employees and other stakeholders in the behavior support process. This communication is the first in a planned course of training on the new manual and its related implementation. Please watch for future notifications of training opportunities as we work to incorporate the *2010 Manual* into CCBDD practices.

Revision 1.1

March 1, 2011

In order to more clearly define the goals of the manual and provide greater clarity for implementation of the manual's guidelines, the following additions have been made:

- As Voluntary Change of Environment does not involve a restriction on the person's choices and is a self-selected reaction intended to help the person remain in control of their own behavior, this intervention has been reclassified as a General Intervention Strategy. Pages 8, 9 and 14 have been amended to reflect this change

- The use of Level Systems has been added as a specific intervention under the Restricted Interventions heading. This is to underscore that level systems will generally involve a witholding or delay of access to possessions or events pending achievement of behavioral goals. As such they represent a rights restriction. Please see page 9.

- The 2010 manual provides checklists for Plan Coordinators and Documentation Filing to aid in increasing consistency of behavior supports across the county. Specific record keeping guidelines are provided on page 60. The BSP outline (page 29 of the manual) has been updated to include an additional data point that requires identification of the location where the plan and all related approvals will be filed. Please see #7 of Plan Coordinator responsibilities in the BSP outline.

- The rights review process has been clarified to specifically address the approval process for rights restrictions that become necessary for health and safety concerns during the course of an ISP span period. Procedures for submitting ISP addendums including restrictions for HRC review are outlined on page 71. In brief, if a rights restriction is recommended in order to immediately prevent further threats to an individual's health and safety, the SA or other designated person must notify the HRC coordinator of the new restriction immediately. Upon notification, the HRC coordinator will schedule the addendum/new restriction for HRC review and provide a thirty day temporary approval to the team for the implementation of the restriction. Continued approval will be obtained within 30 days following review by the full HRC. If a restriction is not intended to address an imminent risk to health and safety but, rather, is intended to manage ongoing behavioral difficulties, then the HRC must approve the change prior to its implementation.

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Chapter

1

The Purpose of this Manual

The mission of the Cuyahoga County Board of Developmental Disabilities is to support and empower people with developmental disabilities to live, learn, work, and play in the community.

The Behavior Support Procedures Manual supports the mission of the Cuyahoga County Board of Developmental Disabilities (CCBDD) by guiding the development, implementation, and monitoring of behavior supports that are necessary to *both* maintain the health, safety, and well-being of an individual and aid in their empowerment to live a full and satisfying life. The manual can also, however, serve as a valuable reference to parents, consumers, and individuals from other departments or agencies who need to understand the philosophy, procedures and requirements of behavior support in Cuyahoga County. The Manual documents guidelines and requirements that will ensure that the methods used in behavior support are consistently humane, respectful of individual differences, positive and non-punitive in emphasis, and centered on preserving the rights of the individual. In addition, the Manual also aims to provide a framework to support effective decision making and assist multidisciplinary teams in developing strong, effective plans. All behavior support policies and procedures, including administrative resolution of complaint procedures, are included in this manual and are hereby made available to all staff, individuals receiving county board services, parents of minor children, legal guardians, and providers.

Philosophy and the Positive Intervention Culture

The Cuyahoga County Board of Developmental Disabilities (CCBDD) is charged with ensuring that behavior support procedures are in compliance with Ohio Administrative Code 5123:2-1-02(J) pertaining to behavior support. CCBDD will employ behavior support methods with the safeguards and supervision necessary to ensure that the safety, welfare, due process, and civil and human rights of individuals receiving services are protected. Our philosophy is rooted in a positive intervention culture.

As such, much of this manual is aimed at providing a detailed account of how such standards are to be met by those who are engaged in providing behavioral support to

board eligible individuals. One potential pitfall of such a manual, however, is the ease at which one can lose sight of the overall purpose for which the rules and procedures have been developed in the first place. While most will agree that ensuring health, safety and well being is in fact the most basic goal, taken alone that goal is not sufficient.

In recent years, there has been a strong and growing emphasis by the Ohio Department of Developmental Disabilities in regards to the merits, both from a rights and values perspective, as well as from an effectiveness point of view, of a positive culture for supporting individuals with developmental disabilities. While there are many aspects to a positive culture, for our purposes we will describe it as a culture in which:

- warm and engaged relationships are valued and sought
- prevention-focused, positive and non-coercive methods to provide a foundation for the support of individuals
- the needs and preferences of the individual are of central importance
- there is a consistent effort aimed at helping the individual to feel safe, cared for, comfortable, and at home in his or her surroundings
- there is an awareness of and respect for the inherent uniqueness of individuals and their right to express that uniqueness in their choices, actions and preferences
- interactions and speech that reflect respect, dignity and a positive regard for the individual
- there is an absence of group punishment
- demeaning, belittling or degrading speech or punishment is explicitly prohibited
- staff employ speech that is even-toned, made in positive and personal terms and without threatening overtones or coercion
- conversations are with the individual rather than about the individual while in his or her presence
- there is respect for the individual's privacy by not discussing the person with someone who has no right to the information
- there is a consistent use of people-first language instead of referring to the individual by trait, behavior or disability

As many of those who have worked in support roles can attest to, however, at least some of these values, while relatively easy to speak of, can in fact be quite challenging to consistently embody in the face of real world challenges such as staff turnover,

entrenched beliefs, limited training opportunities, large caseloads, extreme behaviors, and the like. Yet, when practiced consistently and combined with well informed, assessment-driven planning and interventions, such methods hold the promise of greatly enhanced effectiveness over more purely reactive or restrictive methods. Moreover, working towards a culture of support that is consistently positive in it's methods and mindful of the fundamental value of feeling safe, comfortable, and connected to others is, simply put, the right thing to do. The reader of the manual is, therefore, encouraged to seek out continued training and support from those within and outside of their respective organizations who adopt the philosophy of a positive culture and are committed to finding tangible and viable methods for achieving it.

Hierarchy of Interventions

The development of behavioral support strategies following a thorough assessment of an individual's needs may involve a number of interventions. The primary focus of behavior support should be on the development of positive skills and proactive strategies chosen to promote growth and development while minimizing the health and safety risks of maladaptive behaviors. The following areas outline the range of behavioral support strategies as the increase from low risk/low restrictiveness to high risk/aversiveness.

Development of Positive Behaviors

A key aim of the Behavior Support Plan (BSP) is to help the individual develop positive behaviors to use in replacement of the undesirable behaviors that the plan is trying to decrease. If it is difficult to figure out what positive behaviors you wish to increase then consider revisiting your functional assessment and/or conducting a motivational assessment. These assessments should help identify the potential driving forces for the undesirable behaviors. Once we know the motivating forces that information can be useful in finding behaviors that help the individual expand their behavioral repertoire and develop more adaptive behaviors.

Although the BSP will have much information about the reactive strategies to utilize when faced with undesirable behaviors the most important part of the plan will be creating positive opportunities for the individual to develop and learn more effective ways of dealing with their environment and learning new behaviors that can achieve the same motivational ends.

Development of Positive Behaviors

Many of the positive skill/behavior strategies target one of the following three goals:

1. Reinforce and teach alternative behaviors that serve the same function or meet the same need as the target behavior. An example would be using reinforcement strategies to increase the individual's choice of using verbal requests instead of stealing items or acting aggressively to acquire a desired item.

2. Assisting the individual in altering the problem situation by learning new interpersonal or social skills. An example would be to use training trials to assist the

individual in learning how to utilize a communication device to request attention rather than engaging in self-injurious behavior.

3. Using teaching opportunities to model and teach the individual how to cope with difficult and possibly avoidable situations. An example would be to use modeling and instructional techniques to teach the person self-calming or relaxation techniques.

General Intervention Strategies

General intervention strategies are an essential component of a positive culture in that they are a primary means of supporting positive growth and development. General intervention strategies have a positive influence on the experiences of an individual by addressing lifestyle and ecological factors as well as social relationships which relate to otherwise detrimental behaviors. These strategies may, as needed, be implemented in a proactive or reactive manner.

General intervention strategies are instructional or preventative procedures, which may be used to prevent, increase, decrease, generalize and/or maintain behavior and that involve minimal risk. When these strategies are employed, formal oversight by the behavior support and human rights committees are usually not required. However, if there are indications that a person is adversely affected by an intervention or there is a concern about it, then further assessment may be indicated followed by the appropriate level of committee review.

Proactive General Intervention Strategies

Proactive strategies are used non-contingently to address target behaviors.

Environmental Interventions: Modifying the physical environment to foster learning and avoid provoking maladaptive behavior. Examples:

- Assigning a seat where the individual faces a view with relatively few distractions but has freedom to turn around to gain attention or observe
- Errorless Learning - setting up the situation so that no or few error responses occur
- Giving all the necessary cues, prompts, instructions, etc. that are necessary to get the target or desired behavior to occur
- Intercepting inappropriate behavior. For instance, if an individual starts to throw something, you might remove the item, hold the item down, or move the individual away from the item to another item or activity.
- Minimizing disruptions, distractions and noise, including offering commercially available sound mufflers for individuals whom are or may be agitated by noise.
- Minimizing distractions. This could include the use of the following provided that implementation is non-contingent, the individual does not resist its use, and implementation is never used as punishment for undesirable behavior :
    - study carrels

        - room dividers for individuals with required assigned seating
    - Providing adequate play or leisure materials and activities
    - Providing adequate adaptive equipment
    - Providing furniture which fits the individual
    - Seating two individuals apart who distract each other
    - Setting up the environment or occasion for the specific response for which you are looking.
    - "Toddler-proofing"

- <u>Schedule/Routine/Activities</u>: Modifying routines and schedules to prevent or minimize undesirable behaviors and to increase desirable behaviors or the situations that provoke them. Examples:
    - Arranging for adequate gross motor outlets
    - Alternating simple and complex activities
    - Meeting individual's basic needs (including the need for varied and interesting activities, opportunities for exercise, "breaks" etc.)
    - "Orchestrating" interesting experiences
    - Positive Behavioral Contract - A program in which an agreement or contract is made between the person who wishes change and the person whose behavior is to be changed. The contract specifies the relationship between behavior and the consequences and includes specified goals and rewards for appropriate behavior.
    - Providing choices
    - Providing developmentally appropriate activities and expectations
    - Varying body position by scheduling a standing activity, then a seated activity, then a gross motor activity

- <u>Social/Interpersonal</u>: Modifying the style and the way that one interacts with the individual to prevent or minimize undesirable behaviors and to increase desirable or adaptive alternative behaviors. Examples:
    - Consistent and calm intervention with a caring attitude
    - Developing a positive courteous and supportive atmosphere
    - Developing good rapport (for example, developing a good first impression, greeting the individual with a smile, and being sensitive to what is being communicated)

- Distraction/redirection – the individual is directed to a more appropriate task or area using prompts.
- Graduated guidance, including physical prompts which do not involve the use of force and which may help the individual understand what you want. Also known as hand-over-hand or physical guidance.
- Holding an individual's hand during transportation.
- Modeling appropriate behavior, role playing, rehearsal techniques – a procedure where the individual observes a demonstration of the desired behavior and then matches the behavior.
- Proximity control - A process in which a staff member moves closer to an individual whose behavior is problematic or becoming so. Proximity can also be achieved by having the individual bring something to the staff member.
- Relaxation or calming techniques. For instance, taking an individual who is agitated for a walk (verbal or gestural indication that a particular behavior which has just occurred is undesirable).
- Self-management techniques - Self-management includes any of a variety of activities designed to encourage the individual to participate in reflecting upon, monitoring, regulating, and providing feedback on their own behavior.

- <u>Positive reinforcement and other principles of learning</u>: Applying the principles of learning to reduce undesirable behaviors and to increase desirable behaviors. Examples:
  - Schedules of reinforcement – using a positive consequence to increase a behavior (edible, activity/privilege, sensory, social, tangible).
  - DRO (differential reinforcement of other behavior) - Delivering reinforcement when the target behavior is not emitted for a specified period of time. Reinforcement is contingent upon the nonoccurrence of a behavior. Behaviors other than the target behaviors are specifically reinforced.
  - DRI (differential reinforcement of incompatible behavior) - A procedure in which reinforcement is carefully arranged so it only follows one or more behaviors chosen because they are fully or partially incompatible with engaging in a behavior judged to be inappropriate and, therefore, targeted for reduction.
  - Behavior Chaining (Forward/Backward) - A procedure in which reinforcement is initially given following the first step in the chain and is subsequently shifted to follow the first step plus successively longer portions of the chain (forward), or a procedure in which reinforcement is initially given following the final step in the chain and is subsequently shifted to follow the last two steps, the last three steps, and so on until the entire chain is required for reinforcement (backward).

- Extinction procedures - A procedure in which the reinforcer that has been sustaining or increasing an undesirable behavior is withheld. RBSC *approval is recommended for extinction procedures when applied to behaviors injurious to self or others.*
- Fading - The gradual removal of prompts, reinforcement. The goal is to have the individual do the task independently.
- Satiation - The condition that exists when an overabundance of a reinforcer has been provided with a corresponding decrease in the future occurrence of the behavior.
- Sensory extinction (excludes anything an individual would wear).
- Shaping - In this procedure a new behavior is developed by immediately reinforcing successive approximations to the desired behavior in a systematic way. Successive approximations are responses that increasingly resemble the desired behavior.
- Token Economy - A system in which token reinforcers (symbolic objects exchangeable for a reinforcer of value to the individual) are earned.

Note

The use of a consumer's own funds for reinforcement of desirable behavior is prohibited. It is not appropriate for an individual to re-earn something that is already theirs.

Reactive General Intervention Strategies

Reactive interventions are contingent responses to maladaptive behaviors that involve minimal risk to the individual.

- Brief Contingent Removal of Materials (for up to 5 minutes)
- Voluntary Change of Environment (see page 14)
- Contingent Observation - A procedure wherein the individual is allowed to remain in the instructional/reinforcing environment, but is not allowed to engage in activities that would earn him/her reinforcers for up to five minutes. Exit is not physically prevented and the individual is seated comfortably in the same room, facing the "action" (not a corner).
- Reduced Attendance Schedule – for 90 days or less due to a serious psychiatric condition and/or other observed problem coping with the existing environment
  - If a reduced schedule exceeds 90 days, the IDT should request HRC review of the individual support plan.
- Response interruption, including Blocking, Brief Hands Down (no risk of physical harm; brief duration of 10 seconds or less; lack of clear physical force; no evidence

of struggle) - The strategy refers to physically stopping an individual from performing an incorrect or undesired behavior for a brief period of time. This does not include NVCI restraints or any procedure that uses sufficient force to cause the possibility of injury.

- Restitution/Simple Self-Correction - In this procedure, an individual is required to repair any damage that they did to their environment. This should not require the repair or cleaning of anything that the individual did not disrupt (i.e., no overcorrection is involved with simple self-correction). Also physical prompts should only be to assist with the task if necessary, not to overcome resistance. This does not include financial restitution.

Restrictive Interventions

While maintaining an utmost respect for the promotion of self-determination and community inclusion, behavioral strategies are often utilized to insure the welfare of individuals by ensuring the availability of appropriate choices and utilizing necessary means to limit the potential risks of known behavioral difficulties.

Restrictive interventions involve limiting an individual's access to typical activities, possessions, experiences, or freedoms for the purposes of either preventing harm or minimizing the risks associated with a known or current behavior.

Proactive/Preventative Restrictions: Procedures utilized non-contingently to minimize or prevent risks to health and safety due to a known history of behavioral or mental health problems which represent a threat to health and safety. Such interventions may either be part of the individual's ISP or BSP. These restrictions require review by the Human Rights Committee.

Contingent Restrictions: Specific implementation of restrictive procedures (i.e. loss of privilege) which are implemented only following display of target behavior or specified criteria. These types of restrictions are part of a formal behavior support plan and require documentation of implementation as well as review by Regional Behavior Support Committee and 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 appropriate to receive unsupervised alone time in the community as he may not be able to anticipate and respond to unanticipated safety risks. However, 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.

Restrictive Interventions

The following list (while not inclusive) identifies those procedures that constitute a restriction:

- Alone time restrictions
- Cameras in the home
- Cigarette schedules/restrictions
- Dietary restrictions
- Level Systems which delay or withhold the individual's access to preferred or routine items and activities contingent upon behavior
- Locked doors/windows; door/window chimes
- Access to money restrictions
    - Use of self-funded monetary reinforcement is prohibited
- Motion sensors
- One on One Supervision
- 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
- 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.

Aversive Interventions

It is recognized that there is, at times, a need for interventions which have the potential to be experienced as undesirable or aversive by an individual. Such needs arise when the health and safety of individuals are at risk. The emphasis on creating a positive culture for individuals requires that such interventions are developed only in response to serious risks to well-being and after a lack of success with a variety of positive and less restrictive interventions.

> **Note**
>
> Aversive interventions are never to be used for retaliation, staff convenience, or as a substitute for active treatment.

Aversive Interventions

The following list (while not inclusive) identifies those procedures that constitute an aversive intervention:

- Chemical Restraint
- Involuntary Change of Environment (see page 14)
- Manual Restraint (physical crisis intervention)
- Mechanical Restraint
- Monetary Restitution
- Overcorrection - having the individual engage in repetitive behavior as a penalty for having displayed an inappropriate behavior
  - CCBDD discourages the use of overcorrection; as such any use of overcorrection can be expected to receive heightened scrutiny due to the potential for a perceived or actual punitive element.
- Response Cost – involves the loss of previously earned reinforcers following a target behavior
  - Level systems involving response cost are assumed to be an aversive intervention and require RBSC/HRC review unless certain criteria are met. If these criteria are met the level system can instead be classified as a rights restriction (requiring only

documentation on the ISP and Human Rights Committee review). The criteria are as follows:

1. Any consequence such as a drop in an individual's level and resulting privileges/reinforcers is meant not as a punishment for a specific behavior but rather to allow for the reestablishment or return of the individual to a designated level of competence that is necessary for the higher level, AND
2. The return to a higher or previous level is dependent upon the individual's ability to demonstrate competence as defined by the program and not the passage of specified time period (e.g., two weeks

- Suspension (from work or money making activities due to behavior)
- Time-out
- Time-out Room
- Emerging Methods

Note

"Emerging methods" refers to new methods of restraint or seclusion that create possible health and safety risks for the individual, including methods or technology that were not developed prior to the development of the Behavior Support Rule (OAC 5123:2-1-02(J).

Such interventions require prior approval from the director of DODD; any other extraordinary measure designated by the director such as brief application of electrical shock to a part of an individual's body following an identified behavior also requires prior approval from DODD.

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

Time-Out

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 and preventing the individual from leaving the room by applying physical force or by closing a door or other barrier, including placement in such a room when a staff person remains in the room with the individual." OAC 5123:2-1-02

Time-Out

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

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 5123:2-1-02 (J)(2)(q)(ix). In practice, this will most likely be limited to CCBDD-operated time-out rooms in CCBDD facilities.**

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 relatively aversive 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. 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 harm to self or others and when there is an approved behavior support plan containing the procedure.

> **Example 1**: John ignores staff prompts to leave his area and begins to punch the 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 RBSC and 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 one hour for any one incident, and may not exceed more than 2 hours in a 24-hour period

Time-Out Room Requirements

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.
- **Emergency placement (i.e. without a written plan) of an individual in a time-out room is not allowable.**
- **Time-out should only be used with behaviors that are destructive to self or others, and only when all other conditions listed above are met.**

- **Time-out 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 plan.**

Voluntary/Involuntary Change of Environment

Change of Environment

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/nonaversive (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 demands and/or physical intervention. Involuntary Change of Environment is presumed to be aversive to the individual and thus requires appropriate oversight and review by the RBSC and 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; staff use physical guidance to lead him to the door 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 means 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 primarily for the reduction or elimination of a dangerous behavior and are never to be used for the convenience of staff 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 a behavior support plan 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 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 plan.**

Prohibition of Prone Floor Restraint

The use of Prone Restraint is banned by the Ohio Department of Developmental Disabilities as of November 5, 2008. Prone restraint is defined by DODD as a method of aversive behavior intervention where an individual's face and or frontal part of his body is placed in a downward position touching any surface. Prone restraints are not to be written into Behavior Support Plans that may or may not be components of any person's Individual Services Plan. Prone restraints are not to be utilized at any point in time, including as a behavioral intervention in any crisis situation.

Types of Restraint

Manual Restraint

Manual behavioral restraint means physically holding an individual to inhibit control or limit the movement or normal function of any portion of a person's body. One type of application of manual behavioral restraint is **Nonviolent Crisis Intervention (NVCI)**. NVCI is a prescribed set of techniques that are utilized in administering manual behavioral restraints when needed for an occasional emergency measure. NVCI 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 and/or to prevent major property destruction. Examples of situations which may necessitate NVCI include the following:

- Refusing to leave a building during a fire drill.
- Lying down in the street.
- Blocking a fire exit during a fire drill.
- Sitting or lying on the floor or sidewalk in a place of high traffic or during a period of high traffic (for example, several groups of individuals are passing that spot on the way to lunch).
- Attempting to strike someone in a manner that could cause an injury.
- Severe self-injurious behavior presenting significant risk of harm to the individual.
- Moving an individual away from a dangerous violent individual.
- Moving an individual away from an immediately dangerous situation (for example, individual attempting to put something in an electric socket or biting an electrical cord that is plugged in).

A Word of Caution

There is some evidence that one of the situations where excessive use of force is most likely to occur is when force is used to move an individual from one location to another. Thus, DODD discourages the use of physical intervention due to an individual's difficulties with transitions.

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

Mechanical Restraint

Mechanical restraint means those devices used to inhibit, control, or limit the movement or normal function of any portion of a person's body applied for the purposes of behavior support, excluding the following: mechanical supports, medical restraints, and seatbelts on buses, cars, and cabs. 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
- locking of a wheelchair, or disabling a power wheelchair, to prevent willful behavior that endangers an individual

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 a BSP and reviewed by RBSC and HRC.

Exception: Use of car seats, booster seats, vests, or seat belts that are necessary for the safety of preschool children because of their size. The use of such restraints with preschool children is not classified as a behavioral restraint and is supported by law. Staff should be alert to those preschool children for whom mechanical restraint may be emotionally stressful, taking whatever steps are necessary to alleviate this stress.

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. 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

The purpose of this section is to provide a means for identifying chemical restraints, as well as describing the manner in which chemical restraints are to be reviewed and approved in all settings subject to the State of Ohio Behavior Support Rule. This document applies to persons served at county board sites, supported living and respite care settings, and all persons on Medicaid waivers. It does *not* apply to persons living in ICF-MR settings, *except* in instances where a chemical restraint is to be administered at a county board site.

Chemical Restraint

DODD defines a chemical restraint as:

A prescribed medication 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.**

Chemical restraints have been identified in the State of Ohio Behavior Support Rule as interventions requiring the highest level of oversight. This means that all chemical restraints must be reviewed and approved by the appropriate behavior support and human rights committees. In addition, when a behavior support plan involving the use of chemical restraint has been approved by local committees, the county board or the provider must notify DODD *within five working days*.

In general, interventions which meet the following conditions would not be considered a Chemical Restraint:

- Individual is diagnosed with a recognized psychiatric condition per current version of the DSM

  and

- Medication is prescribed specifically for that diagnosis

and

- The medication is in fact taken at the dosages specified by the physician

  and

- The medication (or combination of medications) is NOT prescribed at dosage levels that are deemed to be excessive, that interfere with the person's ability to participate in services, or result in an observable generalized reduction in alertness or level of consciousness and provided that these determinations have been made by appropriately qualified professionals.

Pertaining to PRN Medication

Because of the high potential for misuse, questions pertaining to the classification of PRN medications as chemical restraint are treated separately for purposes of this manual.

In general, the use of PRN psychotropic medications are viewed as "chemical restraints," when they do not meet the more general conditions regarding chemical restraint listed above. In addition, PRN medications will be viewed as chemical restraints **unless** the following additional criteria are also met:

1. The medication prescribed must be an approved ("on-label") use for the diagnosed psychiatric condition that is being treated.

2. There must be clear instructions from the treating psychiatrist or physician as to the criteria to be met before providing the medication.

3. There is clear and documented evidence that all staff charged with providing the PRN have been trained on and understand the criteria (including new hires and substitutes).

4. Each administration of the PRN is documented and there is a procedure in place for documented supervisory review of the PRN use (at least once per month) to ensure that usage patterns are in full compliance with physician orders and that the frequency of use is shared with the treating physician at the next scheduled visit.

5. There is no evidence that the PRN is resulting in a reduction in overall level of consciousness or a reduction in the individual's ability to participate in their usual and customary daily activities.

Finally, PRN medications prescribed in order to reduce anxiety and used only in anticipation of the individual undergoing planned medical and/or dental procedures will not be considered as "chemical restraints."

In some cases, it is anticipated that there will be a lack of clarity regarding whether a medication is or is not a chemical restraint. In these instances, the provider should contact CCBDD Chief Clinical Officer, (216-736-2693) for further clarification.

Chemical Restraint Review Requirements

When chemical restraint is used, the following requirements must be satisfied:

1. The individual or the guardian must provide informed consent for the use of the chemical restraint.

2. There must be a behavior support plan that addresses the target behaviors that the medication aims to decrease. It is important to note that medication should not be the *sole* treatment for the behavior problem and in fact a full complement of proactive and preventative procedures should still be viewed as essential to the overall plan.

3. As is the case with other types of behavior support plans, behavior support plans that include chemical restraint should be based on a thorough behavioral assessment and these plans should incorporate adaptive skills or replacement behaviors. Proactive or preventive strategies should also be part of the plan.

4. The behavior support plan must be reviewed and approved by the appropriate behavior support and human rights committees.

5. DODD must be notified within five working days after approval by the human rights committee, as noted previously.

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

1. There must be evidence that a Registered Nurse or other appropriately qualified health care professional has reviewed the BSP regarding the use of the chemical restraint, including possible adverse side effects.

2. 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 Behavior Support Plan (BSP).

3. There should be a description of the type of data that will be used to evaluate the need for chemical restraint. In practice, this will often involve some measure of the frequency and/or intensity of the target behaviors for the medication. The target behaviors should be identified via collaboration with the prescribing physician.

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. Any physical abuse of an individual such as striking, spitting on, scratching, shoving, paddling, spanking, shaking, squeezing, pinching, and corporal punishment. Any abusive action to inflict pain.

2. Any psychological, verbal, or gestural abuse such as threatening, ridiculing, or using abusive or demeaning language that causes the individual to feel devalued.

    - Includes swearing or yelling, although in an emergency yelling may be used to obtain an individual's attention to immediately stop the individual from injuring himself or another, or from being injured.
    - Examples of threatening behavior include threatening to wash out the individual's mouth with soap, gesturally threatening to hit with your hand or with anything in your hand (such as a ruler), and calling sharply to an individual several feet away while striking with force on any solid object.
    - Implying threat via non-verbal communications such as physical proximity, glaring, or verbal tone is prohibited.

3. Any sexual interaction with an individual.

4. Dealing with an individual in a disrespectful manner.

5. Allowing an individual to discipline another individual.

6. Total elimination of room illumination.

7. Subjecting the individual to damaging or painful sound, including excessive music volume

8. Squirting an individual with substances, including room temperature water mist, as a consequence for a behavior.

9. Aversive tickling (tickling may be used to distract an individual who is injuring someone when other NVCI options are not applicable or successful in interrupting the behavior).

10. Loss of meal or routinely scheduled snack.

11. Placing an individual in a time-out (TO) room:

    - that is key locked

- o without direct, constant supervision or without keeping a record of TO activities
- o without a written plan
- o for a time-out exceeding one hour for any one incident and exceeding more than two hours in a twenty-four hour period
- o without protecting the individual from hazards such as sharp edges, electrical outlets, etc.

12. Medically or psychologically contraindicated procedures.

13. Medication for behavior control, unless it is prescribed by and under the supervision of a licensed physician who is involved in the interdisciplinary planning process.

14. The use of behavioral restraints (manual, mechanical, or chemical) when not in compliance with CCBDD's *Behavior Support Procedures Manual* (includes fastening an individual in a wheelchair with a seatbelt because they won't stay in the wheelchair or guiding an individual by placing your hand around or at the neck area in the absence of written monitored programs).

15. **The** use **of Prone Restraint is banned by the Department of Ohio Developmental Disabilities as of November 5, 2008. Prone restraint is defined by DODD as a method of aversive behavior intervention where an individual's face and or frontal part of his body is placed in a downward position touching any surface. Prone restraints are not to be written into Behavior Support Plans that may or may not be components of any person's Individual Services Plan. Prone restraints are not to be utilized at any point in time, including as a behavioral intervention in any crisis situation.**

16. Any other aversive procedure that qualifies according to the introduction of this section.

Note

Standing or as needed programs for the control of behavior are prohibited. A "standing or as needed program" refers to the use of a negative consequence or an emergency intervention as the standard response to an individual's behavior without developing a behavior support plan for the individual.

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 interventions should always be developed with a primary emphasis on proactive and positive interventions. The use of more restrictive or aversive practices should only be considered when positive and/or less aversive 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, a behavior support plan is an extension of the individual service plan (ISP) which provides the framework for all the supports the individual receives. The behavior support plan 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 plan (BSP) document provided in this manual is a tool to promote the attainment of these goals. The following section is a brief guide to the BSP to aid in efficiently developing a BSP and preparing it for review and implementation.

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 plans. 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 target behavior, the specific form that it takes, 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.

Qualifications of Personnel Involved in Behavior Support Procedures

Staff involved in behavioral treatment shall be identified and properly trained for the level of functioning appropriate to their designated position and duties. The superintendent or designee shall ensure that staff members are properly designated and appropriately trained. Persons that analyze data and/or write behavior support plans should have formal training or a combination of training and experience in behavioral methods.

Licensed staff participating in various tasks comprising behavioral treatment shall be governed by the ethics and scope of practice associated with their profession.

10 Steps to Completion of the BSP

1. Goals

   - As stated previously, the BSP is an extension of the individual's ISP and shares the same goals. The BSP should explicitly state the ways in which the outlined intervention support the broadest goals for the growth, support, and development of the individual.

2. Behavioral Descriptions, Operational Definitions

   - Frequently referred to as 'target behaviors," the BSP must include operational definitions of behavior that are specific to the individual and clear enough that anyone working with the individual will know exactly what the target behavior is.
   - The importance of developing positive, replacement behaviors is highlighted in the following section. Each BSP, whether including only positive/proactive or restrictive/aversive interventions must incorporate interventions designed to aid the individual in developing behaviors/skills that will help to alleviate the reliance on the maladaptive /target behaviors.
   - Just as behaviors must be specifically defined, any restrictive or aversive interventions must also be clearly identified.

3. Interventions

   - The following section of Chapter One outlines a variety of interventions which may be incorporated into the BSP. A good BSP has a heavy emphasis on proactive and positive interventions in addition to skill development strategies; the use of restrictive and/or aversive interventions are included as needed.
   - When included in a plan, aversive or contingent restrictive interventions should have release criterion, duration limits, and the individual's response to the intervention clearly identified.

4. Plan Responsibilities

   - To ensure that a plan is in compliance with the State of Ohio Behavior Support Rule, a plan coordinator should be identified for each plan. For joint plans, a coordinator must be identified in each setting. The plan coordinator will be responsible for obtaining the necessary approvals, arranging for necessary training, obtaining OT/PT evaluations when necessary, completing 30 day reviews, notifications, and documentation as well as the ongoing adjustment and monitoring of the BSP. Other responsibilities, including administrative oversight of the BSP, should also be clearly identified in the BSP.
   - See Interdisciplinary Team responsibilities outlined in Chapter Three of this manual for more details.

5. Data

   - Data is a critical element of behavioral treatment. Data allows for an evaluation of plan effectiveness and assists in determining if the need for a BSP continues. Baseline data is a required element and is part of a thorough behavior assessment. For renewing plans, a summary of annual data (including frequency of target behaviors and restrictive/aversive interventions) is required.

6. History

   - Prior to the implementation of a BSP, it is very likely that a variety of other options have been attempted. In addition, there are numerous other factors that can influence the individual's behaviors and, by extension, the development of BSP interventions. Necessary historical information includes information on the person's abilities, medical/psychiatric issues, family/ residential history, educational/vocational history, and previous behavioral interventions.

7. Behavioral Assessment

   - See the preceding section on Behavior Assessment; a thorough assessment is an essential component of the BSP.

8. Informed Consent

   - Per State of Ohio Behavior Support Rule (OAC 5123:2-1-02(J)(2)(o), informed consent from the individual/guardian is the first of several approvals required prior to the implementation of the BSP. Please see Chapter Three for a more detailed discussion of informed consent.

   - As part of the informed consent process, a plan which includes restrictive and/or aversive interventions must clearly identify previous positive, though unsuccessful, approaches that preceded the decision to incorporate the restrictive/aversive intervention.

9. 30 Day Summaries

   - Per the State of Ohio Behavior Support Rule (OAC 5123:2-1-02(J)(2)(p), plans which incorporate aversive interventions must be reviewed at least every 30 days. A thirty day review summary and documentation form is included as part of the CCBDD BSP outline. See IDT responsibilities in Chapter Three for a more detailed discussion of this requirement.

10. Training, including medication review

   - Forms for completion of required training are included in the BSP outline; see Chapter Three "Training and Medication Review Guidelines" for more detailed discussion.

Behavior Support Plan Documents

Behavior Support Plan

The Behavior Support Plan includes two separate but related components: the outline of targeted behaviors and related interventions as well as the supplemental documentation required for behavior support plans as identified by the State of Ohio Behavior Support Rule.

Transportation Vest Plan

A separate outline has been developed for use with transportation vest plans. This document outlines the necessary information related to assessment, history, and intervention guidelines as well as providing for appropriate training and review for such plans.

These forms are found on the following pages.

Cuyahoga County Board of Developmental Disabilities
Behavior Support Plan (BSP)

BSP Implementation	**Start Date:**		**End Date:**	
Name:			DOB:	
Residence:			Day Site:	
Implementation:	Home [ ]	Day Program [ ]	Guardian:	

How does this Behavior Support Plan relate to the overall goals of the ISP?

Targeted Behaviors to DECREASE:	**Description**
Positive Replacement Behaviors to INCREASE:	
Aversive/ Restrictive Intervention(s):	**Used For:**

PROCEDURES

A. *Skill Development for Positive Replacement Behaviors*

B. *Proactive/Preventative Strategies (including preventative restrictive interventions)*

C. *Reactive Strategies (from least to most aversive/restrictive)*

IF	**THEN**
IF	**THEN**
IF	**THEN**
IF	**THEN**

NOTE: The complete behavior support plan including the supporting documentation is on file with plan coordinator and at all site(s) where plan is to be implemented with the identified individual. The plan coordinator or identified party is responsible for reviewing the complete plan with implementers at all applicable sites and ensuring that appropriate individuals (including substitute staff) are trained on using the plan.

Cuyahoga County Board of Developmental Disabilities
Behavior Support Plan (BSP)
Supporting Documentation

Name: **Start Date:**
End Date:

Plan Approval Information:					
[ ] Initial Review		**[ ] Periodic Review (Initial BSP:)**			
[ ] Positive			**[ ] Aversive/Contingent Restriction**		
Individual:			Individual:		
Guardian:			Guardian:		
IDT:			IDT:		
			OT/PT:		N/A [ ]
			BSC:		
HRC: (if restriction)			HRC:		
			DODD:		N/A [ ]
Training completed: list dates of training for all settings as applicable					
HOME:	BSP: N/A [ ]	NVCI: N/A [ ]	Med Review: N/A [ ]		
DAY SITE:	BSP: N/A [ ]	NVCI: N/A [ ]	Med Review: N/A [ ]		

Responsibility	**Name/Title of responsible person**
A. Initial Plan Writer (date)___________________	
B. Plan Currently updated by:	
C. Plan Coordinator (responsible for the following): 1. Obtaining required approvals from the individual, guardian, team, RBSC, and HRC (as needed) 2. Ongoing evaluation/adjustment of the plan 3. Completing 30 day reviews and sharing with team 4. Documentation that 30-day reviews have been shared with the person/guardian/parent, SA, and the residential provider. 5. Medication review and documentation of training 6. Obtain OT/PT evaluation if needed 7. Original documents filed at _________________ (location)	
D. Annual Training on general plan	
E. Annual training on NVCI techniques (if applicable)	
F. Debriefing on aversive interventions to be completed by (if applicable):	
G. Substitute Training (documentation of both behavior support plan and NVCI training required for all substitutes prior to their implementing BSP)	
H. Administrative Oversight of plan:	

I. BEHAVIORAL DATA:

A. Behaviors of Concern:
Original Baseline Data Summary
Baseline Data collected from to . (Dates of baseline data)

Targeted Behaviors	Frequency	Time Range (hours/location)

B. Recent or Current Data:

YEAR:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Targeted Behaviors:												
Positive Replacement Behaviors:												
Aversive/Restrictive Interventions:												

C. Team needs to reconvene if the following circumstances occur:

D. Plan of fade: The IDT will consider each aversive/restrictive procedure for fade individually. The team will discuss fading a procedure after there have been 0 uses of that procedure for one (implementation span) year.

II. INDIVIDUAL HISTORY

A. BASIC INFORMATION ON THE INDIVIDUAL

1. Cognitive Functioning (mental age/developmental age):
2. Communication (mode, language receptive/expressive):
3. Motor Development (skills/ limitations, fine/gross motor):
4. Sensory System (skills/limitations):
5. Relevant medical information (known medical conditions and/or concerns; sleep problems; psychiatric diagnosis if known; psychiatric hospitalizations; medications, side effects, etc.).

6. Have there been any changes to the individuals medical condition or to the hands on procedures in this plan that require an updated OT/PT (Occupational Therapist or Physical Therapist) evaluation:

YES (updated evaluation attached): **NO:**

B. MEDICAL

Date of last medical appointment (month/year):____________
Source/informant:_____________

Psychotropic Medication (current within 40 working days of BSP date)	Dosage/ frequency as of	Purpose

If plan contains use of chemical restraint the name of the Physician and person responsible for communication with the Physician: **Physician: ____** **Contact person:_____________________Relationship or Title:___________**

C. CASE HISTORY (needs to be updated yearly):

1. Relevant family/residential history (past and present):

2. Relevant educational/vocational history:

3. History of behavioral interventions:

III. BEHAVIOR ASSESSMENT SUMMARY:

A. Environmental Features: (Detail the persons, places, activities, types of interactions etc. that appear to be relevant to the occurrence of the behavior problem. Describe where, when, and with whom the behavior is most likely and least likely to occur).
B. Relevant Factors: (Describe the medical, psychological, physiological, educational, communicative, and/or skill factors that may be relevant to the occurrence of the behaviors.)
C. Functions of the Behaviors: (Discuss the potential functions that the behaviors appear to be serving. Include the reinforcers and/or consequences that may be maintaining the behavior).

IV. EXPLAIN THE NEED FOR EACH AVERSIVE/RESTRICTIVE PROCEDURE INCLUDING:

A. Why positive programming was not enough

B. Risks and benefits of the action, treatment and/or services

C. The acceptable alternatives to such action, treatment, and/or services

D. The consequences of not receiving such action, treatment, and/or services

V. APPROVALS

Name____

INDIVIDUAL/GUARDIAN/PARENT/ADVOCATE/CAREGIVER REVIEW

I have received a copy of the behavior support program with implementation dates of___________ to _____________ and had it 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 (see Section IV). I was able to ask questions and have them answered. I know that the program 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 and decide that I no longer want to accept this plan. If I change my mind at any time 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.)

____

____

INTERDISCIPLINARY TEAM APPROVAL / INDIVIDUAL BEHAVIOR SUPPORT TEAM
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

Name____

_____________________________________REGIONAL BEHAVIOR SUPPORT COMMITTEE REVIEW

DATE ____

ACTION TAKEN:
[ ] APPROVED on ____
(date) RBSC chairperson's signature

[ ] NOT APPROVED on__________________
(date)

[ ] TIME LIMITED APPROVAL WITH CHANGES LISTED. MUST BE REVIEWED AGAIN BY__________ (for periodic reviews only)

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

____

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____

[ ] PROJECTED IMPLEMENTATION DATE: ____

PROJECTED REVIEW DATE: _________________ or under the following circumstances:

____

____

____

Person responsible for filing final approved plan: _________________________________.
Name

SIGNATURE	POSITION	DATE

* = RBSC voting member

Name_______________________________________

HUMAN RIGHTS COMMITTEE REVIEW – DATE - ___________________

Check one: [ ] CCBDD HRC [ ] ICF/MR HRC [ ] Other HRC

ACTION TAKEN:

[ ] APPROVED

[ ] NOT APPROVED

[ ] TIME LIMITED APPROVAL WITH CHANGES LISTED. MUST BE REVIEWED AGAIN BY_______

PERIODIC REVIEW BY HRC REQUESTED: [ ] YES WHEN:___________________
[ ] NO

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

____

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AUTHORIZED REPRESENTATIVE'S SIGNATURE DATE

Monthly Behavior Support Plan Summary

Name: **Month/Year:** **# of days in attendance:**

Team needs to reconvene if the following circumstances occur:

Targeted Behaviors to DECREASE:	**Number of times 2 months previous**	**Number of times 1 month previous**	**Number of times current month**	**Increase, Decrease, or Same**
Positive Replacement Behaviors to INCREASE:				
Aversive/Restrictive Intervention(s) Outlined in BSP				

Recommend team reconvene? YES NO

SUMMARY COMMENTS:

1. Please describe any reported problems with the implementation of the plan, including injuries and the review of any major unusual incidents and or unusual incidents.

2. What have you learned about this individual that helps them to feel confident and supported in their home and/or workplace and relationships?

Copy of Review Sent	**Yes/No/NA**	**Date sent**
To Individual		
To Guardian		
To Residential		

If you have any questions or concerns about the program please contact one of the following persons:

Staff Name (print) Signature Title Phone # Date

Habilitation Supervisor (print) Signature Phone # Date

cc: Guardian/Parent/Caregiver
Residential Provider
Support Administrator
Habilitation Manager
Original to client file
Behavioral Outcomes Administrator (if plan includes restraint or time out)
**** Attach copies of current data sheets**

Confirmation of Medication Review
CUYAHOGA COUNTY BOARD OF DEVELOPMENTAL DISABILITIES

I have read the attached information on the intended action and potential side effects of the following medication(s) prescribed for ______________________ (name of individual) in conjunction with the Behavior Support Plan dated ____________ to ____________.

List Medications:

________________________ ________________________

________________________ ________________________

________________________ ________________________

Staff Signature	Title	Date

Confirmation of Behavior Support Plan (BSP) Training

BSP

CUYAHOGA COUNTY BOARD OF DEVELOPMENTAL DISABILITIES

The complete Behavior Support Plan was trained on this date_____________ for the approved strategies to be utilized in the Behavior Support Plan dated_________ to _________as developed for ______________________.
Name of Individual

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

PRINT Name	Staff Signature	Title

____

Instructor/Supervisor Signature/Date

REFER TO THE INDIVIDUAL'S BEHAVIOR SUPPORT PLAN FOR SPECIFIC DETAILS.
ORIGINAL FORM IS ATTACHED TO THE CURRENT BEHAVIOR SUPPORT PLAN.

CC: Consumers File
Program Manager
Support Administrator

Confirmation of Nonviolent Crisis Intervention Training Specific to a BSP

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 Plan dated________ to _______as developed for ___________________________.
Name of individual

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.

PRINT Name	Staff Signature	Title

Certified CPI Instructors Signature/Date **Certified CPI Instructors Signature/Date**

REFER TO THE INDIVIDUAL'S BEHAVIOR SUPPORT PLAN FOR SPECIFIC DETAILS.
ORIGINAL FORM IS ATTACHED TO THE CURRENT BEHAVIOR SUPPORT PLAN.

CC: **Consumers File**
Program Manager
Support Administrator

INDIVIDUAL NAME: ______________________ MONTH/YEAR: ______________

Procedures:

EXAMPLE DATA SHEET

Write down appropriate number daily for each category below.

OBJECTIVE		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 Behaviors to Decrease	Verbal Aggression																															
	Self-Injury																															
	Physical Aggression																															
Positive Behaviors to Increase	Practiced coping skills																															
	Used appropriate communication																															
	Followed staff guidelines																															
Aversive Interventions Outlined in BSP	CPI Team Control Position																															
	Duration																															
	Time Out																															
	Duration																															
	Initials																															

STAFF SIGNATURE ______________ INITIALS ______ STAFF SIGNATURE ______________ INITIALS ______

STAFF SIGNATURE ______________ INITIALS ______ STAFF SIGNATURE ______________ INITIALS ______

STAFF SIGNATURE ______________ INITIALS ______ STAFF SIGNATURE ______________ INITIALS ______

Cuyahoga County Board of Developmental Disabilities

Transportation Vest Behavior Support Plan

BSP Implementation	**Start Date:**	**End Date:**	
Name:		DOB:	
Residence:		Day Site:	
Implementation:	Transportation [X]	Guardian:	

I. GOALS AND PROCEDURES OF THE PLAN:

To prevent, reduce, and effectively manage the following behavior(s) which constitute a risk during transportation:	**Description**	**Location: Bus, Site, Both**
Positive Replacement Behaviors to INCREASE:		
Restrictive Intervention: Use of Transportation Vest for prevention of behaviors listed above	• The vest will be applied prior to boarding of vehicle • Duration of use: __ minutes door to door • Vest will be removed upon arrival at the site/residence. • On all community-based outings, the individual will only wear the vest on the transportation vehicle for the length of the time spent on said vehicle. The vest will be removed prior to disembarking the vehicle.	

II. BEHAVIOR ASSESSMENT SUMMARY:

Importation safety issues to know about this person relevant to the need for a transportation vest:

Relevant Medical Information (known medical information and/or psychiatric diagnosis):

Does the individual understand that the behaviors listed above could constitute a risk to health and safety?
[ ] No [ ] Yes: Explain ______________________________

Other relevant factors to know about the Individual:

Case history relevant to the need for a transportation vest:

Years worn vest: [ ] unknown [ ] <2 years [ ] 2 – 3 yrs . [ ] >3 yrs.

Individual has had trial period without vest [ ] No [ ] Yes When?__________________

Is there any documentation of the behavior including reaction to the transportation vest?
[ ] No [ ] Yes - attach documentation

Does this person have a Behavior Support Plan other than for a transportation vest?
[ ] No [ ] Yes - **Please refer to BSP in individual's file/folder.**

III. INFORMED CONSENT INFORMATION

EXPLANATION OF VEST PROCEDURE:
The transportation "vest" is a harness made of nylon and secured with a back zipper that is used in order to maintain the health and safety of some individuals riding in transportation vehicles. The vest has a simple "H" design similar to the harnesses found on child safety seats and some wheelchairs. The vest comes in various sizes and is designed to fit snuggly over outside clothing. The vest allows for full range of movement of the arms and head. The legs are not affected. The vest has four metal loops that are secured at the shoulders and hips to two seat straps by way of metal clip fasteners. When the vest is secured the individual can move forward approximately 6 inches, but cannot get up nor can the individual slide down. The vest is used for transportation only. (Picture attached)

LESS RESTRICTIVE OPTIONS:
Explain WHY this is the least restrictive option available to keep this person/ others safe:
____
____

DISCOMFORTS AND RISKS (reasonable, to be expected): If the vest is too tight, may cause discomfort and pressure.

BENEFITS: Individual will be protected from their own behaviors that would put their health/safety at risk. Individual will be prevented from causing a health/safety risk to others on the vehicle.

ACCEPTABLE ALTERNATIVES: If not approved, other forms of transportation may be considered, alternative program placement may be considered if transportation can not be safely completed

CONSEQUENCES OF NOT APPROVING TRANSPORTATION VEST: Possible need to change programming, identification of alternative transportation options

IV. Staff members involved in the implementation of this plan (name, title):

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Plan Author (original): _____________________________________ (name, title)
Person responsible for current update: __________________________ (name, title)

- Staff members will be observed during the initial application of the vest by the site Occupational Therapist or RN as needed. The OT or RN will also assess the fit of the vest and provide training to staff as needed.

V. DATA, DATA PROCEDURES, TRAINING, and MONITORING:

Is baseline data available?
[ ] Yes, summary: ____
[ ] No, due to length of time individual has worn a vest
Approximate date this behavior was last observed: ______________________________

Annual Data Summary (identify any reports of unusual behavior related to the transportation vest as identified in monthly data reports): ____
____

30-day reviews will be completed in order to indicate continued need or to institute a fading or removal procedure. Staff will share the 30-day review with the individual/guardian and support administrator and will document that this has occurred.

Training: Staff at residence/site will be trained by plan coordinator as well as OT/RN on fit and application of vest; transportation providers will receive training on appropriate implementation of the transportation vest in their vehicles

Approvals/Dissents:

Individual/Parent/Guardian:

I have received this copy of the Transportation Vest Behavior Support Plan for ____________________________
dated ________ to ___________, and had it explained to me by ____________________(phone)_____________
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 program 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 and decide that I no longer want to accept this plan. If I change my mind at any time 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 (for one-year) ____
Signature Date

I DO NOT Approve ____
Signature Date

Relationship ____
(Name) (Phone)

Witness ____

Interdisciplinary Team/Individual Behavior Support Team:

Date: _______________ ______ **APPROVED** ______ **NOT APPROVED**

Signature Position Signature Position

____

____

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

____

____

[ ] **Multipurpose Committee signatures** or [ ] **Regional Behavior Support Committee signatures**

Date: ______________________

______ **APPROVED** ______ **APPROVED WITH CHANGES LISTED** ______ **NOT APPROVED**

Signature Position Signature Position

____

____

____

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

____

____

Human Rights Committee Signatures (only needed if we do not have a Multipurpose Committee review):

______ **APPROVED** _______**APPROVED WITH CHANGES LISTED** ______ **NOT APPROVED**

____ ___________________________

Authorized Representative's Signature Date

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

____

____

DAILY PROGRAM DATA SHEET FOR E-Z ON VEST **MONTH/YEAR**____________________

NAME: ______________________________ Reviewed and approved: DEPARTMENT #: TSC

CLIENT#: ______________________________ ROUTE # AM:______

ROUTE # PM:______

PROGRAM AREA: Behavior Support Original Implementation:____________________

FREQUENCY OF REVIEW: Monthly FREQUENCY OF IMPLEMENTATION: Daily 2X's DURATION: Bus ride to/from day program

OBJECTIVE: To ensure safety while in transit, _____ will wear an EZ on vest daily to/from the day program.

SERVICE PROVIDERS
INITIALS / SIGNATURES / TITLES

____

____

____

____

CODES: Y = YES
N = NO
A = ABSENT

CHECK DAILY: AM DATE:	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
1. Wears Vest?																															
2. Agitated?																															
3. Physically aggressive?																															
4. Attempted to get out of seat?																															
INITIALS:																															

CHECK DAILY: PM DATE:	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
1. Wears Vest?																															
2. Agitated?																															
3. Physically aggressive?																															
4. Attempted to get out of seat?																															
INITIALS:																															

- Please submit data sheet to the Transportation Unit Supervisor at the end of each month. Copies are then sent to the Habilitation Supervisor and the Transportation Safety Manager
- **If necessary, follow up any unusual incident with an Unusual Incident Report (UIR).**

Chapter

3

Levels of Review

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

Review Requirements

Behavior Support Plans (BSPs) and Individual Service Plans (ISPs) may require levels of review beyond individual consent when they contain restrictions to an individual's rights or aversive interventions.

1. The following strategies may be incorporated into the consumer's Individual Service Plan and do not require the development of a Behavior Support Plan:

- Rights Restrictions not related to behavioral supports. These may be restrictions imposed by external factors such as the courts, medical prescriptions (see the discussion of Chemical Restraints in Chapter 1), or factors of the environment. Rights restrictions require HRC review and approval

- Behavioral Guidelines intended to promote the maintenance or development of positive behavior. These are often considered preventative in nature.

    - Guidelines are not considered to be treatment and do not require documentation of specific behavioral incidents, responses to strategies, or specific monitoring of the procedures. Specialized training is not required.

    - If guidelines include restrictive procedures, these restrictions must be identified as such in the ISP and receive HRC review and approval.

2. Behavior Support Plans are intended to both promote the development of positive behavior (skill development) and reduce the frequency, intensity, or duration of maladaptive behaviors. They may include positive, restrictive, and aversive interventions.

- Behavior Support Plans are treatment and prescribe specific responses to negative or maladaptive behavior; they are intended to result in a measurable impact on the individual's behavior.

- BSPs require data collection procedures to assess 1) the impact of the intervention on the frequency/intensity/duration of the behaviors and 2) the frequency of the implementation of the interventions

- BSPs which rely solely on proactive strategies and interventions based on reinforcement strategies (positive and negative reinforcement) and do not involve restrictions require individual/guardian and IDT approval only.

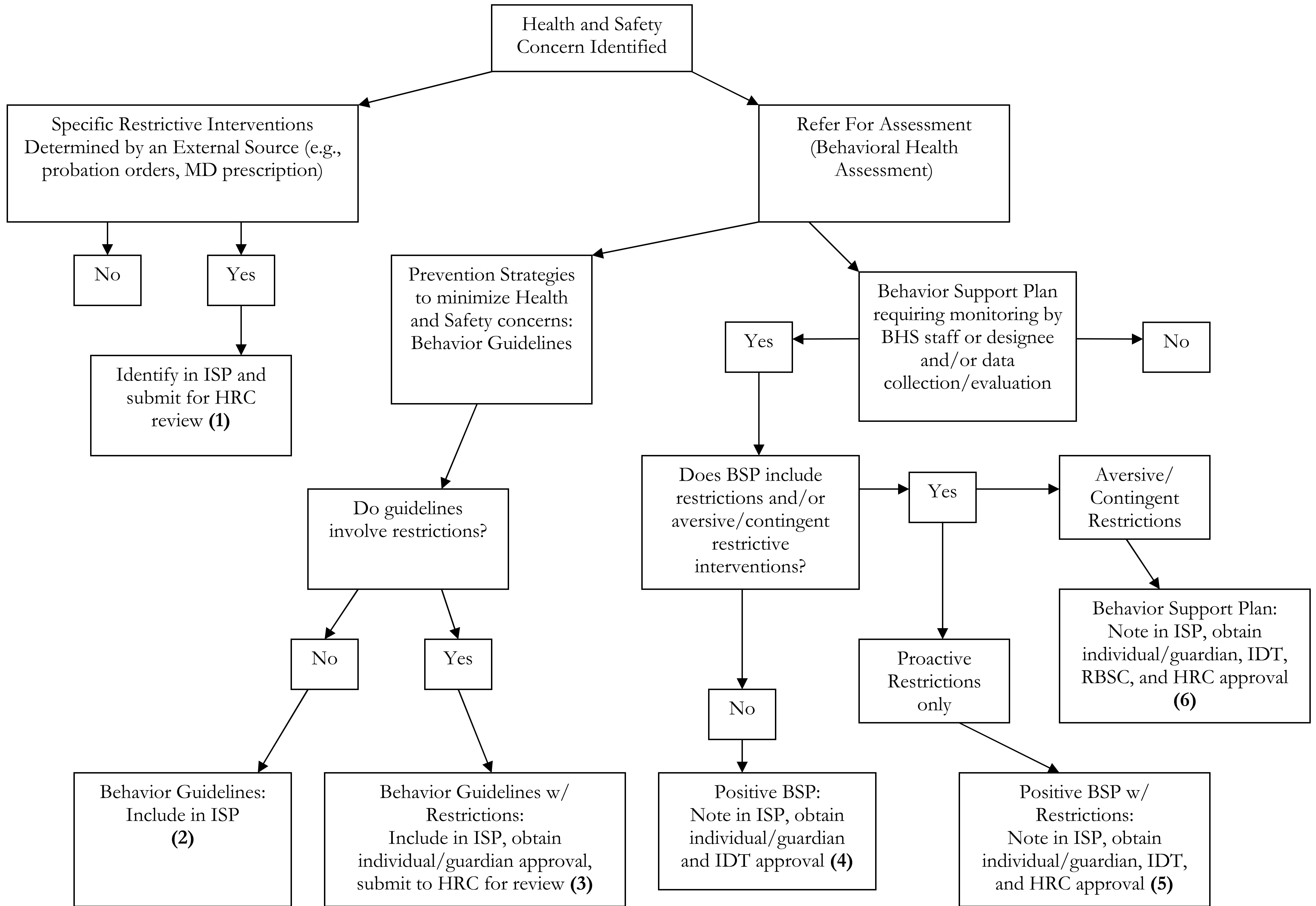
- BSPs which include non-contingent restrictions intended to prevent target behaviors or promote the development of adaptive skills may not require RBSC review/approval but will, due to the rights restriction, still require HRC review/approval.

- BSPs which include the use of proactive strategies, contingent restrictions (such as response cost), and aversive interventions require individual/guardian, IDT, behavior support committee, and human rights committee approval.

It should be noted, however, that any intervention even if generally viewed as non-aversive should be brought to the RBSC and HRC Committees for review, if the individual or another member of the team perceive the intervention to be aversive to the individual.

The following table and flow chart graphically summarize the review requirements for plans which may contain restrictive or aversive interventions.

	Individual Service Plan (ISP)					
		Guidelines		Behavior Support Plan		
				Positive		
	Rights Restrictions not related to behavioral supports	Without Restrictions	With Restrictions	without restrictions	with restrictions	Aversive/ Contingent Restrictions
Purpose:	To address concerns related to health and safety of consumer	Promote maintenance or development of positive behaviors	Prevent risks to health and safety due to history or current behavioral concerns	Treatment to develop positive behaviors and reduce behaviors that are dangerous or present a risk to well-being of self/others Dependent on collection of data to determine effectiveness of interventions		
Includes:	Prescribed practices from physicians. Orders of parole or probation. Environmental controls based on consumer/setting variables	Proactive strategies; recommendations for staff response	Proactive strategies AND Restrictions to the rights/freedoms of consumers in order to minimize health and safety risks	Proactive and Reinforcement Strategies (positive/ negative)	Proactive strategies, reinforcement AND non-contingent restrictions to prevent target behavior or promote skill development	Proactive / reinforcement strategies AND Interventions contingent on target behavior that have potential to be undesirable to the consumer or as required by BSP rule
Monitoring and Review Requirements	Individual Guardian IDT HRC	In ISP	Individual Guardian IDT HRC	Individual Guardian IDT	Individual Guardian IDT HRC	Individual Guardian IDT BSC HRC If applicable: OT/PT DODD notification
Training Requirements	Training as required by provider for staff education and supervision	Training by appropriate personnel (BHS Staff) on recommended guidelines and practices		Training by appropriate personnel (BHS Staff, Provider Management) as outlined in BSP Documentation pages To include medication review as applicable		Training as outlined in BSP Documentation pages including NVCI and medication review as applicable
Flow Chart	1	2	3	4	5	6


Health and Safety Concern Identified
Specific Restrictive Interventions Determined by an External Source (e.g., probation orders, MD prescription)
Refer For Assessment (Behavioral Health Assessment)
No
Yes
Identify in ISP and submit for HRC review (1)
Prevention Strategies to minimize Health and Safety concerns: Behavior Guidelines
Behavior Support Plan requiring monitoring by BHS staff or designee and/or data collection/evaluation
Yes
No
Do guidelines involve restrictions?
Does BSP include restrictions and/or aversive/contingent restrictive interventions?
Yes
Aversive/ Contingent Restrictions
Behavior Support Plan: Note in ISP, obtain individual/guardian, IDT, RBSC, and HRC approval (6)
No
Yes
No
Proactive Restrictions only
Behavior Guidelines: Include in ISP (2)
Behavior Guidelines w/ Restrictions: Include in ISP, obtain individual/guardian approval, submit to HRC for review (3)
Positive BSP: Note in ISP, obtain individual/guardian and IDT approval (4)
Positive BSP w/ Restrictions: Note in ISP, obtain individual/guardian, IDT, and HRC approval (5)

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 a behavior support plan containing aversive or restrictive measures. These rules also require that informed consent must be updated on an annual basis, if the same behavior support plan is still being implemented.

When a behavior support plan containing aversive measures is proposed for a person aged 18 or above and that person does *not* have a guardian, the following assessment protocol should be administered.

Other decisions about when to administer the protocol can be made on a case-by-case basis. For example, it may be appropriate to administer the protocol to a competent person when there is a suspicion that cognitive deterioration has occurred, or when steps have been taken to improve a person's competency to make informed decisions.

Annual Update of Informed Consent

1. If a person has been determined to be incapable of providing informed consent during a previous assessment of the capacity to consent to aversive behavioral interventions, the assessment does not need to be repeated as it will generally be assumed that the incapacity persists. Rather, guardianship should have been pursued or the aversive should have been discontinued.

2. If a person was determined to be capable of providing informed consent during a previous assessment, the assessment does not need to be updated <u>unless</u>:

    a. The behavior plan has changed significantly, meaning that a new aversive has been added, OR

    b. The person's condition has changed or is suspected to have changed, so that there is a concern that the person may no longer be competent to provide consent.

In addition, several other considerations apply:

1. Any service coordinator may request a re-assessment of the person's ability to provide informed consent if there is a concern or a need

2. <u>Disclosure</u> of the nature of the procedure, risks, benefits, etc. should be provided on an annual basis to <u>all</u> persons (or guardians) receiving aversive behavioral interventions on an annual basis, or more often if procedures change significantly during the course of the year.

Process for Determining BSP Consent

See form on next page.

PROCESS FOR DETERMINING BEHAVIOR SUPPORT PLAN CONSENT FOR THE INDIVIDUAL SERVED

Individual served by the plan: ______________________________________

Date of plan: __________________

I. **DISCLOSURE INFORMATION** (prepared by members of the referring team)

   A. Use page 1 of the Behavior Support Plan and attach.

   B. In addition, complete the following information:

Goals/objectives/benefits of the plan (the goal can be referenced on the BSP):

How will effectiveness be evaluated (methods can be referenced on the BSP, e.g. data collected daily, and summarized monthly; Habilitation Supervisor/Specialist will review monthly, IDT will review semi-annually)?

What are the alternatives? (Include pros and cons of each)

What if nothing is done?

II. SELECTION OF INDIVIDUALS TO COMPLETE THE DISCLOSURE/INFORMED CONSENT PROCESS.

(A member of the Behavioral & Health Supports and Assistive Technology departments should be involved and two other individuals may be involved who are considered supportive, trusted by the individual, and do not have a primarily authoritarian relationship with the individual. Behavioral Health and SLP staff will consult with individual and referral source to identify how to proceed with selection of these individuals.)

Describe the individual's input in selecting the individuals to present the Disclosure/Informed Consent Process.   **In what ways were these persons the best choice for presenting the issues in terms of enhancing the voluntariness of consent?** (ALL TEAM MEMBERS *to ask themselves: what is my role with this person, perceived authority, level of comfort to assess, involvement in the development of the plan, what stake do I have in the consent/approval process?)*

III. A. CAPACITY/COMPETENCE

(This section is completed to document the findings of the Disclosure/Informed Consent Process with the individual)

Describe the individual's limitations and strengths in communication and choice-making. **( ) Check here and end assessment if no symbolic mode is present.**   **Adaptations/methods of presentation to enhance comprehension:**   **Describe the individual's response to the presentation?** (affect, engagement, general demeanor: this section may provide indicators of voluntariness)

In what ways did the individual demonstrate, or fail to demonstrate, that he/she understood the issue presented? (Ask questions like "Tell me in your own words…what did ____tell you about ____?" Use quotes.)

Target Behavior(s) (What behavior(s) does your team want you to change?)

Procedures? (What will your staff do if you_____?)

Benefits? (Why do your staff think this is a good idea? Why are your staff suggesting this?)

Risks/complications/discomforts? (Might you be uncomfortable or hurt if staff do this?)

Pros and cons of alternatives?

If nothing was done?

In what ways did the individual demonstrate that he/she appreciated, or failed to appreciate, the issue presented? (Relevant information would be that the individual recognizes that he/she has a problem and need a plan to address it, and that he/she understands why the specific intervention is recommended. Look for the individual's ability to relate to the plan directly, statements recognizing one's problem and need for plan to address it, "I" statements, "if…then" statements. Look for more than just factual grasp of the information…matters of belief rather than knowledge. Use quotes.)

Benefits?

Risks/complications/discomforts?

Pros and cons of alternatives?

If nothing was done?

III. B. VOLUNTARINESS (this section is completed to document the findings regarding the voluntariness of the consent)

Describe the evidence that the individual made a voluntary decision. (Consider personality style, affect, mental state, diagnosis, as well as statements. Ask if it's okay for them to say "no.")

Manner of presentation reflects absence of:
( ) coercive language
( ) language that judges the individual's decision
( ) unfair threats or consequences
( ) judgmental body language

Site evidence that the individual understood that supports will continue from CCBDD no matter what their decisions ("What will happen if you decide not to go along with your staff's recommendation?)

<u>What concerns do you have about the voluntariness on the decision?</u>

Is there a remedy to address these concerns?

III. C. CONCLUSIONS OF THE INDIVIDUALS COMPLETING THE DISCLOSURE/ INFORMED CONSENT PROCESS:

What is the conclusion regarding the individual's ability to provide informed consent on this issue?

CHECK ONE:

____ Demonstrates competence to consent, voluntariness and consents to the interventions. Have individual sign the consent portion of the Behavior Support Plan and attach this completed document.

____ Demonstrates competence to consent, voluntariness and rejects the following interventions
(identify those interventions which were not consented to):

____ Does not demonstrate competence to consent.

Comments:

Dissenting opinions:

III. D. SIGNATURES OF INDIVIDUALS COMPLETING DISCLOSURE/INFORMED CONSENT PROCESS:

____ .
Signature Relationship/Title Date

____ .
Signature Relationship/Title Date

____ .
Signature Relationship/Title Date

____ .
Signature Relationship/Title Date

____ .
Signature Relationship/Title Date

FULL TEAM'S DECISION (this includes members of the individual's IP team: significant family, friends, advocates, day program, residential, etc.):

Step One (Check all that apply):

____ Proceed with RBSC review.
____ Modify plan to conform with individual's decision, make additions/deletions to the BSP and get signatures, update page 6 of this form, and proceed with RBSC review.)
____ Due to health and safety issues it is recommended that all interventions remain in the plan.
Describe health and safety issues:

Step Two (Check all that apply):

____ The following measures will be taken to ensure proper advocacy for the individual:
___ Pursue family/advocate/caregiver approval.
___ Assist individual in pursuing due process.
____ Refer for administrative review and decision.
____ The plan will not be implemented until consent issues are resolved.
____ Pursue guardianship options:________________________________
____ Develop a plan to develop competency:________________________
____ Other: ____

Comments:

___ Dissenting opinion(s):

SIGNATURES:

______________________________ SELF ______________________________ .
Signature Date

____ .
Signature Relationship/Title Date

____ .
Signature Relationship/Title Date

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Signature Relationship/Title Date

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Signature Relationship/Title Date

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Signature Relationship/Title Date

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Signature Relationship/Title Date

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Signature Relationship/Title Date

Interdisciplinary Team

Purpose of the Interdisciplinary Team (IDT)

The IDT is composed of the individual and/or his/her guardian, the plan coordinator, 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 a specific behavioral plan to address these issues. At this point an Individual Behavior Support Team may be formed to assist the individual in addressing these behavioral issues.

Behavioral health staff may be called in as part of the Individual Behavior Support Team to assist in the development of these plans.

IDT Composition

The team members may include:

- The individual
- Their guardian if applicable
- Support Administrator
- QDDP if the individual lives in an ICF/MR
- Other staff and friends that the individual wishes to have involved in the planning process.
- People with a role in behavioral support
- Specialty Services Providers (e.g.: behavioral health staff, SLP, OT/PT, nurses)

IDT Responsibilities

The IDT members will be responsible for compliance with the following:

1. Completing a behavior of analysis if there is a behavior problem.
2. Ensuring that positive interventions are identified to support the individuals needs.
3. Developing proactive and, as necessary, reactive behavioral strategies to address any problems identified.
4. Obtaining informed consent from the individual or their guardian.
5. Seeking guardianship if the individual is unable to provide informed consent for restrictive/aversive behavioral interventions.
6. Obtaining a referral for an OT/PT assessment under the following circumstances:
    - Plans coming for their FIRST review:

  - All new behavioral support plans that include the use of any manual/mechanical restraint. This would include (but not limited to) plans using a physical restraint or hold, a helmet or a splint for behavioral purposes.
  - The OT/PT evaluation must be requested and completed prior to the RBSC meeting.
- Review for plans that are NOT new: an updated OT/PT evaluation is needed when there are changes to the individual's physical/medical status, a new manual/mechanical restraints are added to the plan, or every four years. Examples may include:
  - A significant change in the medical diagnosis or a new diagnosis is added within the last year.
  - The previous OT/PT evaluation report made recommendations for an annual OT/PT evaluation.
  - There is a doctor's order for precautions.
  - There is an adaption to a standard manual restraint.
  - **If the OT/PT evaluation is over 3 years old, an updated OT/PT evaluation is required**.
- If unsure whether to refer to the OT/PT for an assessment consult with the OT/PT staff for clarification.
- Upon receipt of the OT/PT Evaluation Report, the plan writer will electronically add the report to the BSP document.

7. Taking all behavior support plans involving aversive or contingent restrictive interventions to the Regional Behavior Support Committee (RBSC) for review. (Submitted plan must include team signatures of approval and evidence of informed consent).
   - The date of the BSP should be consistent with the individual's ISP span period. BSPs should be submitted to the RBSC well in advance of the implementation date, ideally 45 days before the start of the span period.
8. Plans must be submitted to the RBSC Chairperson *no later than one week* prior to the scheduled RBSC review. Submitted plan should include copies of approval signatures and training records.
9. Once approval is received from the RBSC the plan must be taken to the Human Rights Committee (HRC) for their approval.

- For plans that involve preventative/proactive restrictions but do not include aversive or contingent restrictive interventions, the IDT must submit the plan to HRC for their approval. Such plans do not require RBSC review.

10. Implementing the plan after all approvals are obtained.

11. Reviewing plans containing restrictive/aversive procedures every 30 days and adjusting plans when needed.

12. The IDT is responsible for sharing the Monthly Behavior Support Plan Summary with the individual or their guardian, SA, and residential provider (if applicable), and documenting that this has occurred. Monthly summaries of plans involving aversives must also be forwarded to the Behavioral Outcomes Administrator.

13. The IDT is responsible for bringing approved plans back to the RBSC for updated approvals annually.

    - Plans with proactive/preventative restrictions, and no aversive or contingent restriction interventions, must be reviewed by HRC on an annual basis.

14. If the plan has been discontinued prior to the renewal time the IDT needs to notify the RBSC/HRC of the discontinuation

15. The IDT will identify a plan coordinator(s) who will facilitate and oversee the completion of the IDT's responsibilities relating to the BSP.

    Each IDT must identify an individual, or in the case of joint plans two individuals, who will serve as plan coordinator(s) for the BSP. The plan coordinator is the designated person responsible for assuring that IDT tasks related to the development and ongoing implementation of a behavior support plan are completed in a timely manner and in compliance with the practices outlined in this manual. The coordinator, typically a staff person with direct involvement in the individual's care planning and delivery of services, is a critical element of an effective behavior support plan as the coordinator can ensure that plans reflect the individual's current functioning and are implemented and documented as necessary, scheduled for review, and trained as required. Plan coordinators also have the responsibility to ensure that complete documentation of the behavior support plan is maintained and filed in the individual's permanent record.

Plan Coordinator Checklist

- o Complete Behavior Support Plan and supporting documentation (initial plan)
- o Obtain approval of individual, guardian, IDT members
- o Submit plan (as required) to RBSC and HRC (at least one week prior to scheduled meeting)
    - ▪ Plans with aversive and/or contingent restrictive interventions require RBSC review prior to initial implementation and every year thereafter
    - ▪ Plans with aversive and/or contingent restrictive interventions require HRC review prior to initial implementation and every fourth year
    - ▪ Plans with proactive/preventative restrictions, and no aversive or contingent restriction interventions, require HRC review prior to initial implementation and every year thereafter.
- o Maintain ongoing evaluation/adjustment of the BSP (annually or as indicated by individual progress)
- o Complete Monthly Summary/reviews and distribution to required parties
    - ▪ Monthly Summaries are to be forwarded to the CCBDD Behavioral Outcomes Administrator if the plan includes restraint or time-out procedures
- o Document that Monthly Behavior Support Plan Summaries have been shared with individual, guardian/parent, SA, residential provider, and Behavioral Outcomes Administrator
- o Obtain OT/PT evaluation (initial) or review (every fourth year or as specified by OT/PT) as needed
- o Complete medication review and documentation
- o Obtain documentation of required BSP and NVCI training
- o File BSP, approvals, and monthly data sheets (original copies)

Record Keeping Guidelines

1. Plans implemented in CCBDD operated programs (DCs, AACs, Employment Services): Original copies of the plan, including signature sheets and training documentation, are to be filed in the individual's primary site-based file. Copies of the plan (including signature/consent and training documentation) should be forwarded to Support Administrator as well as added, electronically, to the individual's Gatekeeper profile.

2. Plans implemented in non-CCBDD operated day programs: Original copies of the plan, including signature sheets and training documentation, are to be filed in the individual's file at the provider agency. Copies of the plan (including signature and training documentation) should be forwarded to the CCBDD liaison for the provider agency (to be filed in the contract agency file) and Support Administrator as well as added, electronically, to the individual's Gatekeeper profile.

3. Plans implemented in residential settings (licensed group homes, supported living environments): Original copies of the plan, including signature sheets and training documentation, are to be filed in individual's primary provider agency file. Copies of plan (including signature and training documentation) should be forwarded to Support Administrator as well as added, electronically, to the individual's Gatekeeper profile.

4. Plans implemented in multiple settings (residential and day program): When a joint plan is implemented in multiple settings, original forms and signature sheets should be maintained in the Support Administration file with full copies maintained in the files of both the CCBDD program and the external provider agency. Copies of the plan (including signature and training documentation) should be forwarded to the CCBDD liaison for the provider agency if applicable (to be filed in the contract agency file) as well as added, electronically, to the individual's Gatekeeper profile.

Document Filing Checklist

- Behavior Support Plan Document including original signatures of individual, guardian, IDT, RBSC (if applicable), and HRC (if applicable)
- Training Documentation including BSP training, NVCI Training (as needed), and Documentation of Medication Review (as needed)
    - If joint plans, training documentation for each site should be maintained at the provider agency location.
- Informed Consent Assessment Documentation (if applicable)
    - For individuals who are their own guardians, the Informed Consent Assessment should be attached to the BSP at the time of initial review and a copy filed with each subsequent year's plan.
- OT/PT Evaluation Report for a Manual/Mechanical Restraint (if applicable)
    - For plans involving manual or mechanical restraint, the OT/PT Evaluation Report should be attached to the BSP at the time of initial review and a copy filed with each subsequent year's plan.
- On a monthly basis:
    - Original data sheets
    - Monthly Behavior Support Plan Summaries
- Copies of the plan, including signature and training documentation, should always be forwarded to the individual or guardian for their personal record keeping.

Training and Medication Review Guidelines

Training Requirements

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

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

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

Forms for documenting BSP and NCPI training are attached to the behavior support plan; see the BSP outline included in Chapter Two of this manual. These completed forms must be maintained in the individual's file along with the other elements of the behavior support plan.

Procedures for Documentation of Medication Review

Individuals who have behavior support plans and who are also taking medications need to have the medication side effects documented as part of their plan so that staff and caregivers who work with the individual will be able to recognize whether there are any side effects to the medication occurring. The plan coordinator will attach copies of the patient-counseling sheet for each of the medications listed in the behavior support plan along with the Documentation of Medication Review Form as an appendix to the behavior support plan. The Documentation of Medication Review Form contains the signature of staff who work with the individual indicating that they have read the patient-counseling sheet on the intended action and potential side effects of the medications prescribed for that individual.

There are several ways in which the patient-counseling sheet can be obtained.

1. When an individual is prescribed medication, by law, the dispensing pharmacist is required to provide patient counseling. This counseling is most often supplied by giving the individual a patient counseling sheet. When a county board staff

or provider is notified that an individual has been prescribed a medication the worker will request a copy of the pharmacy supplied patient counseling sheet.

2. If there is no patient counseling sheet available the patient medication information sheet may be obtained through CCBDD Behavioral & Health Supports staff including nurses and behavioral health staff. Alternately, the information may be obtained via web-based medication information resources.

The following web-based resources, among others, can be used to obtain medication information sheets:

- www.medlineplus.com (website of the National Institutes of Health)
- www.epocrates.com

All staff working with the individual are then required to review this information and document the completion of their review on the attached "Documentation of Medication Review" signature page. The original copy with the signatures will be attached to the Behavior Support Plan and will remain in the individual's permanent record. This should be completed prior to the plan going to the Regional Behavior Support Committee for review.

If there are any additional questions concerning the medication information a County Board nurse is available at all times for consultation.

Regional Behavior Support Committee

Purpose of the RBSC

The role of the RBSC is to do a technical and clinical review and approve plans that contain a restrictive or aversive intervention or other interventions that the IDT recommends for RBSC review. The State of Ohio Behavior Support Rule mandates that a behavior support committee reviews and approves or rejects all plans that incorporate aversive methods, including restraint and time-out. The RBSC will review any plans that meet these criteria that occur within the geographical area of the region. This will include plans that originate at day programs, school programs, and residential programs for individuals living within the region. The RBSC may at times be asked to review plans from outside the geographical region when there is an urgency to review a plan from another geographical region and their meeting is coming up before that region's regularly scheduled meeting.

Per the State of Ohio Behavior Support Rule, county boards are ultimately responsible for the review of plans that contain rights restrictions, or restrictive/aversive interventions. CCBDD operates multiple committees to ensure that plans receive the necessary review. In the event that a provider elects to establish an external review committee, CCBDD approval would be required to ensure that the requirements of the state rule are met. Per the rule, a CCBDD representative would be a required member of an external committee.

In the event that concerns arise regarding a specific plan, CCBDD can require that the plan be submitted for review by CCBDD committees.

RBSC Committee Composition

The committee members shall include persons knowledgeable in behavior support procedures but not those people who are directly involved with the plan under review.

The committee members will include at least one member from each of the following groups:

- CCBDD Behavioral Health representative
- CCBDD Direct Care Staff (Habilitation Specialist, Workshop Specialist, Program Specialist, Teacher, Teacher's Aid).
- CCBDD Administrative representative (Habilitation Manager, Habilitation Supervisor, Principal, Assistant Principal)
- Residential representative (Coordinator, Manager, QDDP)

Adjunct members to the committee include health care (CCBDD or residential), SLP, OT/PT representatives. The health care and SLP representatives will do a paper review of all plans and the OT/PT representative will do a paper review of all plans containing manual/mechanical restraints.

If an adjunct member of the committee does a paper review and does not have any comments or concerns about the plan all they will need to do is to sign off that they have reviewed the plan. If after doing a paper review there is any input they wish to provide in person or if they have concerns about a particular plan they should attend the meeting when the committee reviews the plan. Adjunct members who attend the committee meeting will be functioning as a full committee member and will have the same power as the rest of the committee members to agree or object to endorsing the plan.

The minimum quorum for holding a meeting would be a behavioral health representative, the direct care staff representative and an administrative representative.

The individual's Support Administrator will attend the meeting as an advocate for the individual to ensure that the individual's human rights are protected.

RBSC Chairperson and Responsibilities

The RSBC chair will be responsible for:

1. The Chairperson will set an agenda for the meeting and notify presenters of plans where and when they will be presenting.
2. The Chairperson will facilitate the meetings.
3. The Chairperson will assign someone to take minutes.
4. The Chairperson will be responsible for obtaining all necessary signatures and returning forms to the IDT.

5. The Chairperson or their designee will be responsible for receiving and distributing plans to committee members for review prior to the meeting.

6. The Chairperson or their designee will be responsible for completing the RBSC Quality Assurance Checklist as part of the review of the plan.

7. The Human Rights Committee will notify the RBSC within one working day of their approval of any plans. Once this occurs the RBSC chairperson or their designee will be responsible for

   a. Filling out and sending the Five Day Notification Form to the Ohio Department of Developmental Disabilities (DODD) within five working days of the approval to Columbus.

   b. Sending a copy of the notification form along with a copy of the plan to the Behavioral Outcomes Administrator for record keeping.

   c. Notifying the IDT that the plan has been approved by all necessary committees and can now begin implementation.

8. The Chairperson or designee will be responsible for notifying the IDT and appropriate administrators when plans have failed to return to the committee for the necessary annual review that they are now out of compliance and cannot continue using the plan until approval is renewed.

It will be the responsibility of the IDT to take the plan to the Human Rights Committee if necessary once the RBSC approves it.

> **Note**
>
> An RBSC Quality Assurance Checklist is included in the appendices of this manual as a tool to assist committees in their review of behavior support plans. Use of this checklist is optional.

Schedule of RBSC Meetings

Each of the six Regions will have a RBSC meeting once a month. The meetings will be staggered so that there is at least one RBSC meeting each week of the month. In the case of an emergency a behavioral support plan can be brought up to next meeting scheduled regardless of regional boundaries.

Submission of Behavior Support Plans for Review

Submission of the Behavior Support Plan through the review process is an administrative function. Therefore, the staff responsible for this function will be habilitation managers or program managers, depending upon the setting for implementation. They will be responsible for assuring that deadlines for the review process are met. Behavior Support Plans for an individual will be submitted to the RBSC for the region in which they reside. If there is an immediate need to have a plan reviewed before the next scheduled meeting of that region then another RBSC that is meeting sooner may be utilized depending on that team's schedule. Behavior Support

Plans need to be submitted to the RBSC chairperson no later than one week before the scheduled meeting date. Someone from the IDT needs also to be present at the meeting to present the plan and to facilitate incorporation of suggested changes.

Guidelines for Where Joint Plans Need to be Reviewed

In general, most plans will go through CCBDD RBSC unless the Residential Provider requests that their review committee take over the responsibility. If an ICF/MR is involved, the QDDP is the service coordinator and the plan should be taken through the Residential Behavior Support Committee. The exception to this would be when the plan consists solely of interventions for the day program or if the IDT decides that the plan should go through CCBDD RBSC instead of the Residential Behavior Support Committee.

OT/PT Regional Committee Reviews of Behavior Support Plans

- OT/PT will review only plans with manual/mechanical restraints.
- The RBSC chairperson or designee will forward the plans to be reviewed to the OT or PT assigned to the regional committee prior to the committee meeting. The chairperson or designee is encouraged to forward the plans to the therapist at least 2 weeks prior to the scheduled meeting.
- The therapist who completed the OT/PT Evaluation Report for a Manual/Mechanical Restraint cannot review the plan at the regional level. In this situation, the evaluating therapist should forward the plan to another OT/PT serving on a regional review committee.
- The OT/PT will review the entire plan as a part of the regional behavior support committee. The OT/PT must review the OT/PT Evaluation Report for a Manual/Mechanical Restraint or evaluation report from a non-CCBDD therapist. The evaluation report from the non-CCBDD therapist must indicate that the assessment recommendations are in relationship to the specific Manual/Mechanical Restraint to be used in the BSP.
- If the OT/PT approves of the Behavior Support Plan, he/she will sign and date the bottom of the Regional Behavior Support Committee Review sheet and may add comments under the comment section as needed.
- If the OT/PT does not approve of the Behavior Support Plan or the OT/PT Evaluation Report for the Use of a Manual/Mechanical Restraint is not attached, the OT/PT will specify the problem in the comment section of the signature sheet and sign and date the comment section. Do not sign the bottom of the signature sheet.
- Forward the signature sheet to the chairperson or designee prior to the RSBC meeting. If signature sheet is received by OT/PT after the date of the RBSC meeting, sign and date the form with the date the plan was originally reviewed.

OT/PT Evaluation Report For A Manual/Mechanical Restraint

Evaluation of potential safety concerns regarding use of a manual/mechanical restraint as part of the behavior support plan.

NAME: ________________________ DOB: _________ EVAL DATE: ______________

THERAPIST: ___________________________________ TITLE: ____________________

TYPE OF MANUAL/MECHANICAL RESTRAINT

EVALUATION SUMMARY
Behavior Reported Observed:

Sensory:

Posture:

Muscle Tone/Strength:

ROM:

Mobility:

Balance:

RECOMMENDATIONS:
[ ] Based on the aforementioned assessment observations, there appears to be no observable contraindications to the use of the behavior interventions.

[ ] Based on the OT/PT evaluations and observations, concerns and precautions have been identified as follows:

[ ] Based on the assessment, the following recommendations for further evaluation are being made prior to implementing the monitored procedure:

Signature and Title Date

(copy of original evaluation report is electronically signed in BAGG)

****COPY OF THIS REPORT IS TO BE INCLUDED AS AN ATTACHMENT WITHIN THE ELECTRONIC FORM OF THE BSP** **11/10**

Human Rights Committee

Purpose of the HRC

The role of the Human Rights Committee (HRC) is to review and approve all behavior support plans that contain restrictive or aversive interventions or an intervention determined to be a rights violation as noted on the ISP. The State of Ohio Behavior Support Rule mandates that the HRC reviews and approves or rejects all plans that incorporate aversive methods, including restraint and time-out as well as those that involve potential risks to the individual's rights and protections. The HRC shall ensure that the rights of individuals are protected. It is not the role of the HRC to engage in a clinical review of behavior support programs as that is the role of the Regional Behavior Support Committee. Once a plan has been approved by the Regional Behavior Support Committee and meets the above criteria it will be sent to the HRC for review and will not be implemented until the HRC gives the plan their approval.

HRC Committee Composition

The committee members will include at least one member from each of the following groups:

- Parent of a minor or guardian of an individual eligible to receive services from a county board.
- Staff member from CCBDD or the Provider convening the committee
- Individual receiving services from CCBDD
- Qualified persons who have either experience or training in contemporary practices to support behaviors of individuals with developmental disabilities
- Someone with no direct involvement with CCBDD's programs

One committee member may serve more than one category.

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

HRC Chairperson Role

1. Reviews the HRC Checklist with the committee and gains consensus from the committee on approval/disapproval and recommendations
2. Ensures that the signature sheet is signed and records comments from the group

HRC Facilitator's Role

1. Collects and distributes packets one week prior to the scheduled meetings.
2. Maintains a log of cases reviewed and dates of the review
3. Maintains copies of the program and signature sheets
4. Faxes the signed approval form to the RSBC chairperson the next day after the meeting and follows that up with sending the original approval form through the mail.

5. Sets time frames for review of each case and facilitates the process of keeping the meeting on track.

6. Chairs business (non-client related) portions of the meeting.

7. Sets up meeting dates and place.

8. Notifies RBSC of HRC approval of plan within 24 hours of the HRC meeting.

Schedule of the HRC

There are three HRCs, one on the East Side of the county, one on the West Side, and a third that focuses on review of ISP rights restrictions. They each will meet monthly in a staggered schedule so that there will be at least one HRC meeting scheduled every two weeks in the county. In general, plans originating on the East Side will go to that committee and visa versa. However, plans that require urgent review may be submitted to the committee that is meeting next regardless of the site of origin.

HRC Review Process for Behavior Support Plans

Once a plan has been submitted to the RSBC and approved it will be up to the IDT/Plan Coordinator to submit the plan to the HRC for approval prior to implementation.

Plans must be submitted to the HRC facilitator no later than one week prior to the scheduled meeting date.

It is expected that the plan coordinator or their designee attend the HRC meeting or be available by phone in order to answer any questions about the plan.

Following approval of the plan, the HRC Facilitator will notify the IDT of the committee's recommendations.

Behavior Support Plans including aversive or restrictive interventions will be reviewed by HRC prior to initial implementation. Annual review of the BSP by the HRC is not required; however, a second review by HRC will be mandated if an individual has required the use of aversive or restrictive interventions for four years. A new HRC review is required every four years.

Note

Behavior Support Plans are not considered to be in effect until they have received Human Rights review and approval.

HRC Review Process for ISP Rights Restrictions

Overview

If a consumer's ISP includes an entry in the Rights Restriction section, then that plan needs to be forwarded to the Human Rights Committee for review and approval.

Restrictions identified in the ISP should be based on:

- a completed safety assessment (Supervision/Support; Substance Abuse; Behavioral Health; Safety at Home and Community; Assistive Technology/Adaptive Equipment; Fire Safety; Human Sexuality) with resulting recommendations for necessary restrictions.

  OR

- a Behavioral Health Assessment (or other external assessment, e.g. medical report or forensic report) that has identified the need for specific restrictions

Note

Restrictions based on "house rules" or provider policy are not acceptable as restrictions for the purposes of health and safety protection are individualized and based on consumer-specific needs and concerns.

The presence of an entry in this ISP Rights Restriction section requires the following action:

1. At least 75 days before the span date (after the annual ISP meeting), notify the HRC coordinator (currently Richard Rowlett, Ph.D.) via e-mail that the consumer's ISP contains a rights restriction and may require HRC review
   a. Attach the ISP to the e-mail
   b. Forward via e-mail or fax the supporting documentation (SA assessment, the clinical report, the physician's prescription) that demonstrates a need for or justification for the restriction
   c. PLEASE NOTE: HRC meetings are held 1-2x/month; timely notification is key
2. After receipt of this information, SA will be notified by the coordinator whether or not sufficient information is present to schedule review
   a. If additional information is needed, the coordinator will provide feedback on what is needed.
   b. If the information is sufficient, SA will be notified of the date/time of the review.

   c. SA will be asked to provide a phone number at which they can be reached at the meeting time in case of specific questions that the committee needs answered in order to complete their review and give approval (SA attendance at HRC is not expected or required).

3. Upon HRC review/approval

   a. SA will be notified of the approval

   b. Coordinator will upload a signature page/review attachment to the Core ISP in GK which will document the completed review of the rights restrictions for the ISP span.

4. Each year, the ISP (if the restrictions continue) will require HRC review.

5. If addendums to the ISP are created during the course of the span year and result in the addition of rights restrictions, the following action is required:

   a. Upon guardian and team approval of the addendum/rights restriction, SA will notify HRC coordinator of the new restriction and provide a copy of the addendum.

   b. The restrictions included in the addendum should not be implemented by the team until HRC approval is obtained, typically within 30 days, unless:

      i. If there is a clear threat to health and safety which is directly addressed by the rights restriction, the restriction may be implemented upon verbal acknowledgement by HRC coordinator. If there is a clear risk, 30 day temporary approval will be given to implement the preventative restriction.

      ii. Evidence of the need for the rights restriction must be submitted to the HRC coordinator, for review by the HRC, as soon as possible.

   c. The HRC will review the addendum, and supporting documentation, within thirty days of notification. SA will be notified of approval and, at that point, the rights restriction may be implemented.

Human Rights Committee Review Checklist for Behavior Support Plans

Name:_______________________________________ Date: ___________________________

HRC Member signature:____

Responsibility of the Human Rights Committee: Review and approve/reject programs using restrictive methods, including restraint and time-out, and those that involve potential risks to the individual's rights and protections

- To ensure that the rights, health, and safety of the individual are protected within federal, state, and CCBDD guidelines.
  - To ensure that procedural guidelines are systematically followed to protect the individual's right to due process.

For their review the HRC will examine and discuss the following issues:

A. The proposed program should represent humane treatment. Risks to safety, civil and human rights (including limits to options), and health (emotional and physical well-being) are to be considered as well as the individual's response to the restrictive procedures.

Y – N 1. Does the proposed program reflect person-centered planning and significant positive and proactive programming?

Y – N 2. Does the proposed program address the individual's health?
Please review whether the proposed behavior program indicates that consideration was given to medical/physical needs which might impact on or affect behavior, such as sleep disorders, sensory or orthopedic needs, illness, allergies, medications. Are medical or physical needs being responded to in a timely manner?

Y – N 3. Does the severity of the behavior justify the procedure(s)?
Please consider whether the behavior poses a significant risk. Has the behavior resulted in serious harm or injury to self or others?

Y – N 4. Does the program indicate why less restrictive means would be ineffective or pose a nonacceptable risk to the individual or others?
Is there documentation to support the need for the use of each of the restrictive procedures? Have less restrictive procedures been tried and been demonstrated to be ineffective?

Y – N 5. Does the proposed program reasonably provide for the safety of the individual and others?
Does the restrictive procedure and program reasonably protect the individual and others from injury? Does the program employ sufficient safeguards and supervision to maximize the individual's safety during the implementation of the procedure? Is adequate supervision and staff training provided to maximize the individual's safety over time?

Comments/concerns:

B. Are the restrictive procedures acceptable to the community/general public?

Y – N 1. Will the procedure(s)/program avoid stigmatizing the individual or causing the individual to "stand out" in public or community settings? If not, do the benefits of the procedure outweigh the risk of stigmatizing the individual, and have attempts been made to "normalize" the appearance of the restrictive procedure?

Y – N 2. Will behavior changes result in social or otherwise significant improvement in the individual's life and/or environment, either directly or indirectly, or for significant others in the individual's life and/or environment?

Comments/concerns:

C. Was the consent/approval process followed to ensure the individual's right to due process?

Y – N 1. Are all needed approvals signed?

Y – N 2. Is there indication that consent was voluntary and informed? For individuals who are their own guardians, is there evidence that the individual was capable of providing informed consent?

Comments/concerns:

SUMMARY:

Y – N Do the benefits to the individual outweigh the potential risks to their rights, health, and safety? Do the benefits justify the risks?

Comments/concerns:

Human Rights Committee Review Checklist for ISP Rights Restrictions

Name: ____ Date: ________________________________

HRC Member signature: ____

<u>Responsibility of the Human Rights Committee</u>: Review and approve/reject ISP's that involve potential risks to the individual's rights and protections

- <u>To ensure that the rights, health, and safety of the individual are protected within federal, state, and CCBDD guidelines.</u>
- <u>To ensure that procedural guidelines are systematically followed to protect the individual's right to due process.</u>

For their review the HRC will examine and discuss the following issues:

Y – N 1. Is there sufficient justification for the implementation of potential rights restrictions in regards to maintaining the individual's health and safety?

Y – N 2. Are there any less restrictive ways to maintain health and safety?

Y – N 3. Was the consent/approval process followed to ensure the individual's right to due process?

Y – N 4. Do the benefits to the individual outweigh the potential risks to their rights?

Comments/Concerns:

Five Day Notification to DODD Procedures

The purpose of this section is to outline the procedure that Cuyahoga County Board of Developmental Disabilities will follow to notify DODD of behavior support plans that include the use of restraint or time-out room.

The Ohio Department of Developmental Disabilities requires that they be notified of any behavior support plans that include any form of restraint or the use of a time-out room. Restraint includes manual, mechanical, and chemical restraint. According to the State of Ohio Behavior Support Rule, the county board or the residential provider must notify DODD within 5 working days of the final approval of such plans.

CCBDD Notification Protocol

CCBDD Notification Protocol

1. When applicable, HRC shall notify the RBSC Chair that the plan has been approved. This notification should occur in a timely fashion, preferably within 24 hours.

2. The RBSC Chair is responsible for submitting the approved plan to DODD. At this point, DODD is not requiring that the plan itself be submitted, but rather a summary sheet (Five Day Notification to DODD form) should be sent. It is imperative that DODD receive notification of the plan's approval *within five working days*. Notification can be sent by facsimile or other electronic means.

Residential Provider Notification Protocol

Residential Provider Notification Protocol

1. Within 5 days of a Human Rights Committee approval of a behavior support plan that includes restraint or time-out room, the provider agency is responsible for submitting the Five Day Notification to DODD form to DODD directly.

2. Provider agencies must also notify CCBDD Behavioral Outcomes Administrator of the approval of the plan, as well as provide a copy of the plan and the Five Day Notification to DODD form.

Instructions for the Five Day Notification to DODD form

Individual's Name: Please give official name in the last name, first name format.

Date of Birth: Use format of mm/dd/yyyy

County: Name of county where the program is being implemented.

Type of Intervention: Check the box indicating all of the types of interventions that are being implemented in this program.

Maximum Duration: According to this program, what is the longest time an intervention can be applied for each time the target behavior is seen.

*Note: For chemical interventions please list the specific medications that are considered restraint instead of maximum duration in this section.

Target Behavior: Describe briefly the behavior that will lead to applying these interventions in the block under the designated intervention.

Baseline Frequency: Specify how often the target behavior has been seen prior to this intervention being implemented. Please give the frequency and in what period of time, i.e. 5 x's/month, 3 x's/week, 45 x's/day, etc.

Informed Consent: If the individual has a guardian, it must be the guardian who provides consent.

For all sections providing dates please use the mm/dd/yyyy format.

DODD is in the process of developing an electronic Time Out Restraint Notification system which will allow county boards and providers to submit five day notifications via a secure, online application. Training will be provided as this system becomes available and will, at that time, replace the procedures outlined above.

Five Day Notification to DODD
Ohio Department of Developmental Disabilities
Behavior Support Plan Using Restraint or Time-Out Notification Form

Individual's Name: ______________________ DOB: ______________ County: ______________

	Time-Out	Mechanical	Manual	Chemical
Type of Restraint	☐	☐	☐	☐
Maximum duration for one episode per program -the longest time an intervention can be applied for each time the target behavior is seen. *For chemical intervention, please list the specific medications instead along with the total daily dosage for each.				
Target Behavior for the restraint – Describe briefly the behaviors that will lead to applying these interventions				
Baseline Frequency of Target Behavior (Average per month- If you have more than one target behavior, add the frequencies of each, . But only include the numbers for the specific target behavior that leads to the intervention.				

Was informed consent obtained from the individual or guardian?	☐ YES	☐ NO

Date of Behavior Support Committee approval: ______________ Date of Human Rights Committee approval: ______________

Effective Date of Plan: ____________ Author of Plan: ______________________ Position: ______________

Notification submitted by: ______________________ ______________________ ______________
Name Agency & Title Phone

Date Notification submitted: ______________ Means of submission: Fax: ☐ Electronic Means: ☐

Submit to Ohio Department of Developmental Disabilities within five working days of local approval of behavior support plan (OAC 5123.2-1-01(J)(#)(f)
Email: behavior.support@list.dodd.ohio.gov **or fax: (877) 644-6671**
9/28/01, updated 4/1/10

Behavior Support Conflict Resolution Process

The following process is triggered when there is disagreement among team members about whether or not an aversive behavioral intervention is warranted, or when unusually high levels of risk or liability are thought to be present. This process may be activated:

1. When team members fail to reach consensus about the need for an aversive measure,

   OR

2. Team members do not necessarily disagree about the need for a procedure, but the procedure or the target behavior is thought to involve an unusually high level of risk or liability. In this instance, this process provides an independent expert review.

How to activate conflict resolution process

1. A team member calls CCBDD Chief Clinical Officer (216 736-2693) to request assistance

2. The Chief Clinical Officer or his designee will assess the situation and recommends either:

   a. adding resources (e.g., personnel) to the team or

   b. convening an ad hoc group

The first step will usually involve augmenting the team with additional resources. However, in circumstances where special expertise is required (e.g., regarding some forms of manual restraint), an ad hoc team of experts can be convened as a first step. In most cases, the ad hoc team will provide a second level of review if an issue cannot be resolved at the team level.

Personnel that can assist with conflict resolution

When there is an attempt to resolve the issue at the team level, the Chief Clinical Officer or his designee can assist the team by accessing CCBDD staff or staff drawn from a pool of residential providers. These independent *resources* should have the following characteristics:

1. They have some training in mediation or conflict resolution

2. They are impartial

When an ad hoc group is convened, members of the group should have expertise relevant to the content issues that require review. For example, this expertise may involve physical crisis intervention, medical, or legal issues. The Chief Clinical Officer or his designee will determine the composition of the team on a case by case basis.

Responsibilities for Approving Behavior Support Plans for Persons Residing in ICF/MR Facilities

In a technical sense, Ohio Administrative Code 5123:2-1-02(J), the State of Ohio Behavior Support Rule, does not apply to persons residing in ICF-MRs, as ICF-MR rules and standards take precedence over county board rules. However, a number of these persons receive aversive or high risk behavioral interventions in either home or day settings (or both), and there has been considerable confusion about the responsibilities of both residential and day providers in these circumstances. The following guidelines have been developed in an effort to clarify the issue. It is recognized that the ICF-MR does have the ultimate authority in these circumstances. It is also recognized that the long-term system-wide goal is to develop a single behavior support plan that is implemented across settings, though this goal has yet to be fully realized.

Therefore, in instances where there is disagreement, high risk, or liability concerns, a dual review by both residential and county board behavior support committees may be recommended. Liability concerns are especially likely in instances where high-risk interventions are being proposed or implemented.

The recommended guidelines are as follows:

- If an aversive/restrictive procedure for a person is implemented in one setting only (residential or day setting), that setting's behavior support and human rights committees will be responsible for reviewing and approving the procedure. For example, if time out were implemented at work but not at home, then county board committees would be responsible for conducting the review and approval. *It should be emphasized, however, that when committees operated by one setting review and approve the procedure, then representatives from both residential and day settings should be invited to participate in these meetings.*

- If an aversive/restrictive procedure is implemented across both residential and day settings, by default the behavior support committee and/or the human rights committee of the ICF-MR will be responsible for review and approval of the plan.

- Under some circumstances, there can be an exception when an aversive/restrictive procedure is implemented across both residential and day settings. More specifically, if there is dissent regarding an aversive intervention or if the intervention is deemed to be controversial or to pose high risk, then review and approval by behavior support and human rights committees in both settings is recommended. If there is a conflict that cannot be resolved via this dual review and approval process, then the conflict resolution procedures described elsewhere in this manual will be implemented.

Chapter

4

Appendices

Board Policy

1. CCBDD Policy Manual

9.10 Behavior Supports

The CCBDD shall formulate and follow procedures for the use of aversive and restrictive techniques that conform to procedural requirements of the Ohio Department of Developmental Disabilities (DODD) rules. This includes a specification of low risk strategies that may be used without formal approval by the required review committees, as well as the stipulation of a hierarchy of aversive interventions.

An appropriately constituted behavior supports committee shall review and approve or reject the use of all monitored procedures requiring oversight. For purposes of this policy, monitored procedures are defined as those techniques classified as aversive or restrictive in the State of Ohio Behavior Support Rule and the CCBDD Behavior Supports Procedures Manual.

The behavior support committees shall be comprised of persons knowledgeable in behavior support procedures, including administrators and direct service providers.

A human rights committee shall review and approve or reject all behavior support plans using aversive and restrictive procedures to ensure that the rights of individuals are not violated.

In the case of a person living in an ICF/MR residential facility, the behavior support committee and the human rights committee that reviews the plan may be either those formed by CCBDD or those formed by the provider of ICF/MR residential supports. In this situation, representatives of CCBDD and the ICF/MR residential provider shall be involved.

9.10.1 Crisis

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.

9.10.2 Suspension

All due process procedures governing the suspension of handicapped school children 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.

Non-crisis use of suspension for adult enrollees may be part of a behavior support plan to instill appropriate conduct. A suspension of services may occur in order to put in place a support plan to protect the health and safety of the individual, other individuals served and staff members

2. Administrative Regulation for Complaints/Informal Grievance

Cuyahoga County Board of Mental Retardation/Developmental Disabilities

Administrative Regulation

Administrative Resolution of Complaints/Informal Grievance Process for Individuals/Representatives

Purpose:

This regulation establishes general requirements and responsibilities of the CCBMR/DD for implementation of an informal grievance process and a formal administrative process for resolving complaints of consumers and/or their authorized representatives.

Citations:

ORC 5123.041
ORC 5123.043
OAC 5123:2-1-12
Board Policy 9.8

Informal Grievance Procedure:

Consumers/representatives may choose to file a complaint under the informal grievance process. In this process, the Superintendent/designee will appoint one or more persons to hold an informal hearing to attempt to resolve the issue within 30 calendar days of the complaint being filed. The consumer/representative does not have to use the informal grievance procedure before filing a complaint under the administrative resolution of complaints procedure. And the consumer/representative may file a complaint under the administrative resolution of complaints procedure at any time even though they have pursued the informal grievance process.

Following the informal hearing, the person(s) conducting the hearing will advise all concerned regarding the outcome of the hearing and the status of the issue.

Responsibility:

Procedures have been developed for implementing ORC 5123:041, ORC 5123.043, OAC 5123:2-1-12, the board's policy and this administrative regulation. A training curriculum enabling CCBMR/DD staff members to be aware of their role in this process and to respond appropriately to complaints from individuals and/or their representatives will continue to be a priority for the agency, as well as systems that enable the agency to collect, store and monitor documentation of the implementation of the procedures.

Each department director/general manager will assure that staff members in his/her department receive training in the procedures. In addition, each director/general manager may develop and implement internal monitoring procedures for his/her department. However, such departmental procedures do not preclude the collection, storage and monitoring of documentation done by the agency.

Each employee of the CCBMR/DD shall respond in a positive manner to the complaints of individuals and/or their representatives. Staff members are expected to encourage individuals/representatives to voice concerns over services and supports. Staff members shall listen to concerns and attempt to do whatever is within their role to address the concerns. Additionally, staff members will assure that no retaliation or loss of services occurs as a result of making a complaint.

Staff members shall give (or cause to be given) information to the individual/representative about both the informal grievance process and the administrative resolution of complaint process. Staff members will assist the individual/representative in filing an informal grievance or an appeal for administrative resolution of complaint if the individual/representative wishes to do so.

__*Terrence M. Ryan*________

Terrence M. Ryan, Ph.D., Superintendent

Date: 8/9/04

Effective date: 9/1/04

Revised: 5/26/09

RBSC Quality Assurance Checklist

Instructions:

Completion of the Quality Assurance Checklist may be assigned to an RBSC member for completion. This member should not have direct involvement with the plan being reviewed. Use "NA" for any item "not applicable". If completed, the Quality Assurance Checklist should be filed with the RBSC minutes.

NAME: ______________________________ **SITE:** ____________________

RBSC Committee: ______________________________

Completed by (Signature/position): ______________________ **Date:** ______________

A. IDENTIFYING INFORMATION AND GOALS OF ISP: Are Sections I & II below complete?

( ) No Concerns

( ) Concerns: ______________________________

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I. Identifying Information – is information complete?
A. BSP Implementation Dates
B. Consumer Information (Name, DOB, Programming Location, Guardianship status)
C. Implementation Location (Home/Day Programming)

II. How does this BSP relate to the overall goals of the ISP?
Is there a reasonable statement as to the relevance of behavior support goals within the comprehensive Individual Service Plan?

B. BEHAVIORAL GOALS/SUMMARY: Is this section completed following the format in the model below?

( ) No Concerns

( ) Concerns: ______________________________

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A. Targeted Behaviors to Decrease: The first section refers to "excess" behaviors that the plan aims to decease. Each target behavior should be described in terms of its topography (what it looks like) and its intensity.
B. Positive Replacement Behaviors to Increase: The second section refers to "deficit" behaviors and/or replacement behavior/skills that the plan aims to strengthen.
C. Aversive/Restrictive Interventions: The third section should list specific procedures and the behavior or situation that triggers the implementation of that intervention.

The examples below illustrate how target behaviors/interventions can be described:

Targeted Behaviors to DECREASE:	Description
Self-Injurious Behavior	XXX will attempt to engage in head banging (walls, floors), head butting, or face slapping. Individual episodes may last from 10 seconds to 5 minutes. An episode is considered over when he has not attempted continued self-injury for 60 seconds.
Physical Aggression	XXX will engage in head butting, scratching, biting, or hitting towards peers and staff. He will strike out purposefully and with great force. Aggression has a short duration, typically lasting less than 60 seconds.
Positive Replacement Behaviors to INCREASE:	
Communication of wants/needs	Staff will reinforce XXX's efforts to appropriately and effectively communicate his wants/needs through vocalization, gesture/sign, or use of his communication device.
Social Interaction Skills	XXX will be offered opportunities for social interaction/interactive play at least twice time per day, response to be documented.
Aversive/ Restrictive Intervention(s):	**Used For:**
CPI Team Control Position	Continued engagement in self-injurious behavior following unsuccessful verbal redirection or attempts at aggression; XXX will typically not support own weight when restraint is implemented and the following strategy may also be necessary
CPI Team Control Position Seated Floor Position	Continued engagement in self-injurious behavior following unsuccessful verbal redirection or attempts at aggression

Target behaviors are defined in measurable terms. This includes but is not limited to the following:

- Specifying if "attempts" are counted.
- Determining whether counting "episodes" of behavior or every occurrence of the behavior is more meaningful. An "episode" of behavior is a behavior that occurs in "clusters" within a relatively short time. (For example, in the case of an individual who strikes out 15 times on the way to the T.O. area, it can be more meaningful to count this as one episode of physical aggression.)
- Defining the behavior or giving examples, which reflect the severity (intensity/dangerousness) of the target behavior. The severity of some behaviors, for example self-injurious behavior, may be defined by more than one dimension of behavior (frequency, topography, intensity).
- Distinguishing physical aggression towards people from physical aggression to property (in terms of definitions and data).

C. PROCEDURES

( ) No Concerns

( ) Concerns: ____________________

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A. Skill Development for Positive Replacement Behavior

- Is there a clear connection between the function/motivation of the target behavior to be decreased and the replacement behaviors included in the plan? Will the enhancement of the skill/replacement behavior likely lead to a decrease in the behavior targeted for decrease?
- Are procedures described to allow for consistent implementation?
- Are data collection procedures identified? Are these instructions clear?

B. Proactive/Preventative Strategies

- Are there positive, proactive, and preventative strategies that can be utilized with the individual in the plan?
- When you finish reading the plan are you left with the impression that the plan is very positive? Does the plan include a substantial amount of positive/preventive strategies?
- The plan is a good fit for the individual. Interventions are developed taking into consideration such things as the individual's physical characteristics, lifestyle, and personality. The plan (including the IEP/IP/IFSP) supports an enhancement of quality of life. That is, the plan addresses the wishes, desires, and preferences of the person.
- If preventative strategies involve restrictive procedures (restricted access, limited schedules, belongings or activities, specific staffing patterns), is there clear justification as to the potential risk of the behavior and the expected preventative benefit of the restrictive procedure or practice?

C. Reactive Strategies (from least to most restrictive)

- Are there strategies specific to each target behavior listed under the Behavior Goals section?
- Procedures are specifically described to allow for consistent implementation.
- There are appropriate and sufficient resources (materials; staff ratio; staff skills) to implement the procedures, and if not, these are noted and being arranged for.
- If there are problems on the bus, have strategies been developed for use by transportation staff?
- Are data collection procedures identified? Are these instructions clear?

D. TRAINING AND MONITORING/REVIEW INFORMATION IS COMPLETE:
Identification of individuals by name and title is necessary.

( ) **No Concerns**

( ) **Concerns:** ____

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E. BEHAVIORAL DATA

( ) **No Concerns**

( ) **Concerns:** ____

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- Original baseline data (identified by dates of collection, location of collection, and hours during day when data was collected (i.e. 9am-4pm, Monday-Friday)
- Recent or Current Data: past 12 months, current level of behavior under existing conditions
- If this is a periodic review, previous data is included.

- Data should be submitted for the first three years that the individual has a written behavior support plan.
- After the first three years, data should be presented for the current year and the two most recent prior years.
- Data is meaningful, can be compared over time. Target behaviors are measurable and specifically defined.
- The time and setting for data collection is specified.
- If plan is for multiple settings, is data for both settings reported?

- Criteria for team to reconvene – is a specific, objective criteria identified?

- Plan of Fade: Is the plan appropriate to the interventions?

F. HISTORY AND ASSESSMENT: This section should contain any information that assists you in understanding the individual.

( ) No Concerns

( ) Concerns: ____

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A. Basic Information on the Individual: Is the information reasonably complete and current?

1. Cognitive functioning (name/date of most recent I.Q. test optional)
2. Communication (receptive language level; expressive language level; functional communication mode.)
3. Motor Development (skills/limitations, fine/gross motor);
4. Sensory System (skills/limitations)
5. Relevant medical information (known medical conditions and/or concerns; sleep problems; psychiatric diagnosis if known; psychiatric hospitalizations; medications, etc.)
6. Have there been any changes to the individual's medical condition or to the hands on procedures in this plan that require an updated OT/PT (Occupational Therapist or Physical Therapist) evaluation.

B. Medical:

1. Updated medical information including date of most recent medical, current psychotropic medication along with dosage/frequency and prescribed purpose
2. Chemical Restraint: If applicable (as listed under Aversive/Restrictive Interventions), is this completed?

C. Case History: A brief summary of the social history of the individual including – to be updated yearly:

1. Relevant family information (past/current)
2. Relevant educational/vocational history
3. History of behavioral interventions

D. Behavior Assessment Summary: Is the information complete and current?

1. Environmental Features: Are there details about the person, places, activities, types of interactions, etc. that appear to be relevant to the occurrence of the behavior problem? Examples of factors that might influence the person-environment fit are level of noise, crowding, level of light, staff, peers, and family. Are the demands that are being made of the individual (both explicit and implicit) appropriate in terms of the degree of challenge (intellectual, attentional, emotional) that they present to the individual? Have the demands being made been carefully considered in regards to their fit with the individual's preferences and abilities? How strong is the justification for what is being required of the individual – is the justification mostly about fixed expectations of a program or organization or are they linked in a thoughtful and reasonable manner to the needs of the individual

2. Relevant Factors: Is there a description of the medical, psychological, physiological, educational, communicative, and/or skill factors that may be relevant to the occurrence of behaviors? Is there a description of where, when, and with whom the behaviors are most and least likely to occur?

3. Functions of Behavior: Is there a statement as to what are the potential functions that the behaviors appear to be serving? What are the reinforcer and/ or consequences that may be maintaining the behavior?

G. **EXPLAIN THE NEED FOR EACH AVERSIVE/RESTRICTIVE PROCEDURE**

( ) **No Concerns**

( ) **Concerns**____

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- There is a compelling reason justifying the use of <u>each</u> aversive or restrictive procedure/intervention.
- This section indicates why less restrictive means would be ineffective, less effective, or pose an unacceptable risk to the individual or others. The severity of the behavior should justify the procedure(s). The benefits should justify the risks. Justification can include other factors such as:
  - lifestyle interventions alone may not improve every problem;
  - there may be deeper issues such as psychiatric problems or biopsychosocial issues that make positive programming alone difficult;
  - there may be research (in the literature) or data on this person that do not support a non-aversive approach; <u>Specific example</u>: The CPI transport technique is necessary to maintain safety because John starts hitting someone, he will not stop, no matter who is trying to deescalate him, no matter what options are offered him during an aggressive incident. UIRs indicate that when staff has tried blocking him, he has become more aggressive. He has injured one staff member and one peer in the past year (one of these times he broke someone's nose). Fortunately, John immediately stops aggressing and calms as soon as he is placed in the CPI transport.
- Identification of alternative interventions and any relevant implications of said alternatives
- Informed Consent: does the plan identify risks and benefits of the plan so as to educate the individual on these issues? Are acceptable alternatives identified? Are the consequences of not implementing the behavior plan identified?

H. **APPENDIX:** These should be attached to the plan. May not be available prior to meeting date

( ) **No Concerns**

( ) **Concerns:** ____

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A. Any documentation of behaviors over the last 12 months should be attached (may include UIR's, data sheets)
B. Pictures/drawings of each manual and mechanical restraint/control used.
C. Current behavior support plan at home/residence if present.
D. OT/PT evaluation (required for all plans containing a restraint procedure)
E. Copy of 30 day summary form
F. Patient Medication Sheets for each prescribed medication listed in plan
G. Completed Documentation of Medication Review Signature Sheet
H. Completed BSP and NVCI (If applicable) Training Sheet(s)
I. Sample data collection form - A sample data form should be attached.

State of Ohio Behavior Support Rule

OAC 5123:2-1-02(J) as of 11/1/10

(J) Behavior support policies and procedures

(1) Purpose

(a) The county board shall develop and implement written policies and procedures that support and assist individuals receiving services from county board programs to manage their own behaviors.

(b) These policies and procedures shall acknowledge that the purpose of behavior support is to promote the growth, development and independence of those individuals and promote individual choice in daily decision-making, emphasizing self-determination and self-management.

(c) The county board superintendent shall appoint a committee to implement paragraph (J) of this rule through the development of behavior support policies and procedures.

(d) The county board shall develop and implement written policies and procedures which shall:

(i) Focus on positive teaching and support strategies and encourage use of the least restrictive environment and least intrusive forms of services;

(ii) Specify a hierarchy of these teaching and support strategies, ranging from most positive or least intrusive to least positive or most intrusive, including approvals and review procedures; and

(iii) Be developed in accordance with department guidelines and relevant local, state and federal statutes and regulations.

(e) As used in paragraph (J) of this rule, "provider" refers to all persons and entities that provide specialized services, as defined in section 5126.281 of the Revised Code, and that are subject to regulation by the department, regardless of source of payment, including:

(i) A contracting entity of a county board, as defined in section 5126.281 of the Revised Code.

(ii) A provider licensed under section 5123.19 of the Revised Code. For the purposes of paragraph (J) of this rule, "provider" does not mean an intermediate care facility for the mentally retarded (ICF/MR) certified under Title XIX of the "Social Security Act."

(iii) A provider of supported living under section 5126.431 of the Revised Code.

(iv) A provider of respite care certified under sections 5123.171 and 5126.05 of the Revised Code.

(v) A provider approved to provide medicaid services under home and community-based services waivers administered by the department.

County Board Responsibilities

(2) The county board shall ensure that:

(a) Medical factors are considered in the development of behavior support plans.

(b) A behavior assessment is completed prior to implementation of any written behavior support plan to help identify the causes for a behavior and to determine the most appropriate teaching and support strategies. The behavior support plan shall be developed to follow the findings of the behavior assessment.

(c) Behavior support methods are integrated into individual plans and are designed to provide a systematic approach to helping the individual learn new, positive behaviors while reducing undesirable behaviors.

(d) Restraint and time-out, as defined in paragraph (J) of this rule, are only used with behaviors that are destructive to self or others and only when all other conditions required by paragraph (J) are met.

(e) Policies and procedures, including administrative resolution of complaints procedures in accordance with rule 5123:2-1-12 of the Administrative Code, are available to all staff, individuals receiving services from the county board, parents of minor children, legal guardians, and providers.

(f) Behavior support methods are employed with sufficient safeguards and supervision to ensure that the safety, welfare, due process, and civil and human rights of individuals receiving county board services are adequately protected.

(g) Aversive behavior support methods are never used for retaliation, for staff convenience, or as a substitute for an active treatment program (interdisciplinary team developed and approved per individual plans).

(h) Positive and less aversive teaching and support strategies are demonstrated to be ineffective prior to use of more intrusive procedures.

(i) Standing or as needed programs for the control of behavior are prohibited. A "standing or as needed program" refers to the use of a negative consequence or an emergency intervention as the standard

response to an individual's behavior without developing a behavior support plan for the individual as required by paragraph (J) of this rule.

Behavior Support Committee

(j) A behavior support committee reviews and approves or rejects all plans that incorporate aversive methods, including restraint and time-out, and reviews ongoing plans that incorporate aversive methods, including restraint and time-out. The committee shall include persons knowledgeable in behavior support procedures, including administrators and persons employed by a provider who are responsible for implementing behavior support plans, but not those directly involved with the plan being reviewed. The authors of the behavior support plan may attend committee meetings to provide information and to facilitate incorporation of suggested changes.

Human Rights Committee

(k) A human rights committee reviews and prior approves or rejects all behavior support plans using aversive methods, including restraint and time-out, and those which involve potential risks to the individual's rights and protections. The human rights committee shall ensure that the rights of individuals are protected. The committee shall include, at least, one parent of a minor or guardian of an individual eligible to receive services from a county board, at least one staff member of the county board or provider convening the committee, an individual receiving services from a county board, qualified persons who have either experience or training in contemporary practices to support behaviors of individuals with developmental disabilities, and, at least, one member with no direct involvement in the county board's programs. One human rights committee may serve more than one county board or provider.

(l) The behavior support committee and the human rights committee, which reviews the plan, is either those formed by the county board or those formed by the provider. In this situation, representatives of both agencies shall be involved. A county board or provider may establish one multi-purpose committee to fulfill all functions of the behavior support committee and the human rights committee. County boards and/or providers may jointly establish and share the operation of a behavior support committee, a human rights committee, or a multi-purpose committee.

Requirements for behavior support plans

(m) A behavior support plan includes a case history (including medical information), results of a behavior assessment, baseline data, behaviors to be increased and decreased, procedures to be used, persons responsible for implementation, review guidelines, and signature/date blocks including space for dissenting opinions.

(n) Training and experience required for staff who develop behavior support plans and for all persons employed by a provider who are

responsible for implementing plans are specified and required training is documented.

Informed Consent

(o) Prior documented informed consent is obtained from the individual receiving services from the county board program, or guardian if the individual is eighteen years old or older, or from the parent or guardian if the individual is under eighteen years of age. When informed consent cannot be documented in writing at the time it is obtained, such consent shall be documented in writing within three days of implementation. This written informed consent shall be updated at least annually. Any revisions to a behavior support plan requiring behavior support committee approval shall require written informed consent from the individual receiving services from the county board program, or guardian if the individual is eighteen years old or older, or from the parent or guardian if the individual is under eighteen years of age. "Informed consent" means an agreement to allow a proposed action, treatment or service to happen after a full disclosure of the relevant facts. The facts necessary to make the decision include information about the risks and benefits of the action, treatment or service; acceptable alternatives to such action, treatment or service; the consequences of not receiving such action, treatment or service; and the right to refuse such action, treatment or service. The behavior support plan shall be presented in a manner that can be understood by the individual or parent of a minor or guardian.

(p) A regular review of all behavior support plans is held, at least, in conjunction with individual plan updates. Plans that incorporate aversive methods, including restraint and time-out, shall be reviewed as determined by the interdisciplinary team but at least every thirty days. Status reports on a plan that incorporates aversive methods, including restraint and time-out, shall be provided to the individual receiving services from the county board program, or guardian if the individual is eighteen years old or older, or the parent or guardian if the individual is under eighteen years of age. Additionally, for individuals who receive services from a provider, status reports shall be provided to the provider.

Prohibited Actions

(q) Prohibited actions are reported as major unusual incidents in accordance with rule 5123:2-17-02 of the Administrative Code. Prohibited actions shall include the following:

(i) Any physical abuse of an individual such as striking, spitting on, scratching, shoving, paddling, spanking, pinching, corporal punishment or any action to inflict pain.

(ii) Any sexual abuse of an individual.

(iii) Medically or psychologically contraindicated procedures.

(iv) Any psychological/verbal abuse such as threatening, ridiculing, or using abusive or demeaning language.

(v) Placing the individual in a room with no light.

(vi) Subjecting the individual to damaging or painful sound.

(vii) Denial of breakfast, lunch or dinner.

(viii) Squirting an individual with any substance as a consequence for a behavior.

(ix) Time-out in a time-out room exceeding one hour for any one incident and exceeding more than two hours in a twenty-four hour period. Use of a time-out room requires the additional oversight specified in paragraphs (J)(3) and (J)(4) of this rule and the following safeguards:

(a) A time-out room 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.

(b) The room must be adequately lighted and ventilated, and provide a safe environment for the individual.

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

(d) The individual must be under constant visual supervision by staff at all times.

(e) A record of time-out activities must be kept.

(f) Emergency placement (i.e., without a written plan) of an individual in a time-out room is not allowable.

(x) Systematic, planned intervention using manual, mechanical, or chemical restraints, except when necessary to protect health, safety, and property and only when all other conditions required by paragraph (J) of this rule are met.

(xi) Medication for behavior control, unless it is prescribed by and under the supervision of a licensed physician who is involved in the interdisciplinary planning process.

(r) Behavior support policies and procedures adopted by the county board or the provider:

(i) Promote the growth, development and independence of the individual;

(ii) Address the extent to which individual choice will be accommodated in daily decision-making, emphasizing self-determination and self-management, to the extent possible;

(iii) Specify the individual's conduct to be allowed or not allowed;

(iv) Be available to all staff, the individual, parents of minor children, legal guardians, and providers;

(v) To the extent possible, be formulated with the individual's participation; and

(vi) Ensure that an individual must not discipline another individual, except as part of an organized system of self-government.

(s) The climate for behavior support is characterized by:

(i) Interactions and speech that reflect respect, dignity, and a positive regard for the individual;

(ii) The setting of acceptable behavioral limits for the individual;

(iii) The absence of group punishment;

(iv) The absence of demeaning, belittling or degrading speech or punishment;

(v) Staff speech that is even-toned made in positive and personal terms and without threatening overtones or coercion;

(vi) Conversations with the individual rather than about the individual while in the individual's presence;

(vii) Respect for the individual's privacy by not discussing the individual with someone who has no right to the information; and

(viii) The use of people-first language instead of referring to the individual by trait, behavior, or disability.

(3) Requirements for restraint and time-out

(a) The use of restraint and time-out, because of their possible adverse effects on health and safety, shall require additional oversight by the department. As used in paragraph (J) of this rule, the following definitions shall apply:

(i) "Restraint" means any one of the following:

(a) "Chemical restraint," which means a prescribed medication for the purpose of modifying, diminishing, controlling, or altering a specific behavior. "Chemical restraint" does not include the following:

(i) 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);

(ii) Medications prescribed for treatment of a seizure disorder.

(b) "Emerging methods and technology," which means new methods of restraint or seclusion that create possible health and safety risks for the individual, including methods or technology that were not developed prior to the effective date of this rule.

(c) "Manual restraint," which means a hands-on method that is used to control an identified behavior by restricting the movement or function of the individual's head, neck, torso, one or more limbs or entire body, using sufficient force to cause the possibility of injury.

(d) "Mechanical restraint," which means a device that restricts an individual's movement or function applied for purposes of behavior support, including a device used in any vehicle, except a seat belt of a type found in an ordinary passenger vehicle or an age-appropriate child safety seat.

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

(b) Prior approval from the director must be obtained before using the following methods of restraint:

(i) Any emerging methods and technology designated by the director as requiring prior approval; or

(ii) Any other extraordinary measures designated by the director as requiring prior approval, including brief application of electric shock to a part of the individual's body following an identified behavior.

(c) Restraint or time-out 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 plan.

(d) Any use of restraint or time-out in an unapproved manner or without obtaining required consent, approval, or oversight shall be reported as a major unusual incident pursuant to rule 5123:2-17-02 of the Administrative Code.

(e) Any use of restraint or time-out that results in an injury that meets the definition of a major unusual incident or an unusual incident shall be reported as such pursuant to rule 5123:2-17-02 of the Administrative Code.

Five Day Notification to DODD

(f) Within five working days after local approval of a behavior support plan using restraint or time-out, the county board or provider shall notify the department by facsimile or other electronic means in a format prescribed by the department. Upon request by the department, the county board or provider shall submit any additional information regarding the use of the restraint or time-out.

(4) Department oversight of behavior support plans

(a) The department shall provide oversight of behavior support plans, policies, and procedures as deemed necessary to ensure individual rights and the health and safety of the individual.

(b) The department shall select a sample of behavior support plans for additional review to ensure that the plans are written and implemented in a manner that adequately protects individuals' health, safety, welfare, and civil and human rights. These reviews may be conducted by department staff designated by the director or by any qualified entity selected by the department.

(c) The department shall take immediate action, as necessary, to protect the health and safety of individuals served. Such action may include, as appropriate, the following:

(i) Suspension of any behavior support plan(s) not developed, implemented, documented, or monitored in accordance with paragraph (J) of this rule or where significant trends and patterns in data suggest the need for further review. When a behavior support plan is suspended, the department shall ensure that a new behavior support plan is developed and implemented in accordance with paragraph (J) of this rule.

(ii) Technical assistance in the development of a new behavior support plan.

(iii) Referral to the major unusual incident, licensure, or accreditation units of the department or to other state agencies or licensing bodies.

(d) The department shall compile information about the use of behavior supports throughout the state and share the results with county boards, providers, advocates, family members, and other interested parties. The department shall use the information to study and report on patterns and trends in the use of behavior supports, including strategies for addressing problems identified.

(e) By the effective date of this rule, the department shall establish a behavior support advisory committee made up of persons knowledgeable about behavior support and representatives of groups that have expressed an interest in the application of behavior support as specified in paragraph (J) of this rule. The behavior support advisory committee shall advise the department in the following matters:

(i) Trends and patterns in behavior support methods reported to the department;

(ii) Technical assistance needs throughout the state;

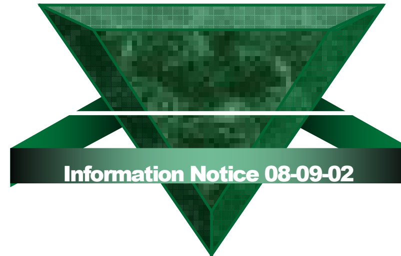
(iii) Behavior support issues raised by or referred to divisions or units of the department;

(iv) Plans for improving the quality of behavior support throughout the state;

(v) Any other pertinent issues related to implementation of this rule.

Positive Intervention Culture Information Notice

Ohio Department of Mental Retardation and Developmental Disabilities
Ted Strickland, Governor **John Martin, Director**



From: Michael J Rench, Deputy Director
Division of Community Services

Date: September 19, 2008

Re: Positive Intervention Culture

PURPOSE:

The purpose of this Information Notice is to recommend best practices regarding behavior supports with the goal of reducing and eventually eliminating aversive interventions, especially timeout and restraint, except where there is imminent risk to health and safety.

SCOPE:

This Information Notice applies to all providers of services to individuals with disabilities who receive funds directly or indirectly from the Ohio Department of Mental Retardation and Developmental Disabilities (ODMRDD) to provide a service or support to an individual eligible for County Board of Mental Retardation and Developmental Disabilities (CBMRDD) services.

INTRODUCTION:

The ODMRDD, in conjunction with the Statewide Behavior Support Advisory Committee, challenges those within the scope of this Information Notice to reduce and eventually eliminate aversive interventions. This Information Notice has been developed to provide guidance to individuals and organizations as they strive to meet this challenge, which will move Ohio toward creation of the Positive Intervention Culture. The Positive Intervention Culture is an ODMRDD initiative with an initial goal of eliminating timeouts and restraints, and an ultimate goal of an aversive-free approach to behavior supports. The Positive Intervention Culture is essential for building an environment that enhances the quality of life for the individuals we support and is supported by existing rules and regulations.

This Information Notice outlines the core strategies essential in successfully implementing the Positive Intervention Culture initiative and to provide guidance to individuals with disabilities, families, providers, advocates and CBMRDDs. This Information Notice does not eliminate the use of restraints as an emergency safety intervention.

The ODMRDD will provide awareness, education and support in the creation of the Positive Intervention Culture in all 88 Counties of Ohio. The Department will also continue to provide technical assistance and support through the Regional Behavior Support Committees, the Statewide Behavior Support Advisory Committee, the ODMRDD Behavior Support Consultants and any other means available. The recommendations in this Information Notice are considered by the ODMRDD to be best practices that will assist in the reduction of and eventual elimination of aversive interventions.

BACKGROUND:

The elimination of aversive interventions is a key factor in ensuring that individuals experience a quality of life that is in line with the Positive Intervention Culture. The Positive Intervention Culture centers on respect, trust and building relationships that are safe and healthy. The use of aversive techniques as behavioral interventions continues to be a concern in Ohio and nationally due to the risk of serious injury and death, emotional harm and trauma and the disruption of relationships with family members, peers and direct support professionals. The ODMRDD is dedicated to the reduction and eventual elimination of aversive interventions, again with the exception of extreme crisis where there is imminent risk to health and safety.

The ODMRDD supports statewide and national efforts to eliminate the use of aversive procedures. Alternatives that will eliminate the use of aversive interventions are needed to support and improve the quality of life for each person. Behavior supports are unique to each individual and will continue to be a chief component of each person's Individual Service Plan (ISP).

The ODMRDD encourages all providers of services and supports, on an individual and organizational level, to carefully examine the rationale for their use of restraint and timeout, along with their general approaches to positively support individuals with challenging behaviors.

PHILOSOPHY OF CARE AND SUPPORT:

Tenets of the ODMRDD's Positive Intervention Culture include:

- Supporting individuals
- Striving to meet the needs of individuals
- Working to understand individuals, regardless of their means of communication
- Empowering choice-making

- Assisting individuals to feel and be safe

Essential to this approach is the understanding that behavior is a form of communication. Facilitating the understanding of negative behaviors as communication and the use of alternate modes and methods of communication is an integral part of the Positive Intervention Culture.

The following value statements emphasize the importance of the Positive Intervention Culture and the need for it to spread through all levels of the MRDD service system:

- The individual is the central focus of the planning team.
- Create a safe and supportive person-centered environment where the individual has choices in matters affecting his/her everyday life.
- Staff understanding and incorporating the Positive Intervention Culture philosophies are critical at every level, from Direct Support Professionals to Administrators, in order to create a culture that supports positive approaches. All staff members should be knowledgeable in positive practices and in the use of any aversive procedure.
- Use positive practices that are known to be effective in helping the individual. There are various positive practice techniques that may negate the use of restraint or timeout. Promotion of positive practices should be integral in an organization's overall operations and training, as well as being explicitly evident in each ISP.
- Ensure that prevention and intervention as early as possible are critical parts of any plan to support the individual when reducing and eliminating restraints, timeouts and other aversive procedures.
- All staff members should be knowledgeable about the use of positive practices specific to the individual they support and be able to demonstrate them where needed. This includes the integration of behavioral and environmental supports that have proven effective for each person.
- Teach skills of self-monitoring and self-control to individuals receiving services, as well as to staff providing services.
- Create a culture of respect and ensuring ongoing training for staff that focuses on all forms of positive practices.

QUALITY EFFORTS:

The ODMRDD recommends that great effort be put forth by all persons involved in the MRDD service system to reduce and eventually eliminate aversive interventions. Each provider should review, assess and analyze the specifics of all aversive techniques in an effort to better understand the behavior and reduce the need for the aversive intervention in the future. Areas that public and private providers may consider in their quality efforts to safely reduce and eventually eliminate aversive techniques may include:

- Training

  - Acknowledging that there are providers that continue to serve and support individuals in a restraint-free environment and provide extensive training for their staff, these guidelines are viewed as minimal expectations to help support the individual and create a structure that prevents restraint and timeout.
  - Training should be ongoing for all staff and focus on overall supports for improving an individual's quality of life while maintaining his or her health and safety.
  - All staff should have documented, initial training specific to each individual prior to working directly with that individual. Training is expected to occur within every 12-month period.
  - Training in the application of restraints for those providers who utilize restraint as part of their operating procedures. The ODMRDD does not endorse any one curriculum; however below is a list of recommended curricula content for review and/or development of crisis programs and/or behavior support procedures:
    - Prevention strategies that include instruction on Person-Centered Philosophy (i.e., elaborate staff purpose and principles to guide practical affairs, knowing the person, knowing oneself in the role of staff, relationship skills and avoidance strategies in order to decrease the probability of problem behaviors arising).
    - Instruction on de-escalation strategies.
    - Instruction regarding intervention strategies that include judgment of when to use physical intervention, the safety issues involved and the possible risks when using physical restraints. This includes the proper application of restraints appropriate to the age, weight and diagnosis of the individual and possible negative psychological effects of restraint and how to monitor an individual's physical condition for signs of distress or trauma.
    - Definitions of restraint, policies on the use of restraints, the risks associated with the use of restraints and staff experiencing the use of physical restraint applied to themselves. This includes debriefing techniques with the individuals as well as the staff members.
- Policies and Procedures
  - Policies and procedures in place that address how people are supported in emergency situations where an individual's health and safety are at imminent risk, as well as outlining positive strategies.
- Risk Assessment
  - Each organization should have a Risk Assessment Policy and Procedure that includes:
    - Emphasis on the ongoing quality improvement efforts directed at the reduction and eventual elimination of the use of aversive interventions, especially timeout and restraint. The use of risk assessment processes to review and analyze aversive intervention use on an ongoing basis. A provider-specific plan to proactively address the prevention, detection, evaluation and correction of any environmental factors and/or triggers that may lead to the use of aversive interventions should also exist.

- Use of debriefing procedures that address the needs of individuals and staff directly following a restraint, as well as a more formal debriefing session where events and strategies are discussed in greater depth and detail. The debriefing sessions should work to address trauma and minimize the negative effects of the use of restraint while addressing the following components:
  - Thorough analysis of the events that occurred before, during and after each incident.
  - Strategies to prevent or decrease the time of future restraints.
  - Skills or methods to prevent a future crisis.
  - Appropriate revisions to an individual's ISP.
  - An internal review committee responsible for the review of post-emergency restraint and the outcomes of that follow-up.
  - An internal method for the collection of aversive interventions data required to be reported to the CBMRDD and/or the ODMRDD.

- Administrative Review
  - Each public and private agency provider should appoint a committee to analyze the organization's aversive intervention policies and procedures at least annually. This review will assure that they continue to meet the best practice standards established in this Information Notice and in the applicable rules and regulations established by ODMRDD in the area of Behavior Supports.
  - The ODMRDD Office of Provider Standards and Review will review each CBMRDD, licensed provider and certified provider's policies and procedures on behavioral supports, aversive procedures and restraint use in order to ensure that they comply with current ODMRDD rules and regulations.

REDUCING RESTRAINT AND AVERSIVE PROCEDURES:

As a way to reduce and eventually eliminate aversive techniques, it is recommended that providers consider the following standards are met before they use any restraint:

- Providers train their staff in appropriate positive intervention techniques, safety, de-escalation and crisis intervention techniques.
- Staff use only the restraint(s) for which they were trained.
- An internal method for data collection and monthly analysis of the use of aversive interventions is in place.
- Timeout and restraint are only used with behaviors that are destructive to self or others, and only when all conditions required by Administrative Rule 5123:2-1-02 (J) are met. Property destruction, where there is no imminent threat to any person's health and safety, is not considered to be destructive to self or others.
- Timeout and restraint are always last resort, emergency responses to protect an individual's health and safety.

- Individual and team involvement in a post-restraint debriefing should occur. It is critical to determine how future situations can be prevented. It is important, as part of the ongoing planning process, to review each occurrence of restraint. Information from the debriefing sessions should, at minimum, be included in the 30-day reviews. These discussions can be separate and distinct with the intended purpose of determining what could have been done differently to avoid the restraint. Any changes determined by the team as a result of these discussions will be documented in the ISP and/or Behavior Support Plan (BSP).
- Consideration should be given to the potential for trauma-related issues. A trauma assessment and training in trauma-informed care would be of great benefit in addressing future incidents.

It is recommended that all providers develop agency-wide policies and procedures for the reduction and eventual elimination of restraints and timeout. These policies and procedures should outline specific steps to be taken for the elimination of restraint components in any individual plan as well as general policies and procedures promoting the Positive Intervention Culture.

It is also recommended that within one year from the date of this Information Notice, person-centered strategies containing the following positive components be incorporated into all individuals' ISPs/BSPs. People that have experienced restraint in the past year should also have these positive components in their plans:

- The ISP should reflect an overall strategy to support and provide services for the individual without the need for restraint. If it is felt the individual exhibits behavior that may put them at risk of injury to themselves or others, the ISP should reflect strategies that will reduce the likelihood of aversive interventions and protect the individual.
- Information about undesirable behavior and what specific positive practices can be used to prevent future occurrences. This includes several suggested teaching strategies and intervention techniques that de-escalate or redirect the individual's behavior, as well as information regarding what positive components are currently effective.
- Justification that the proposed plan contains the most effective methods of helping the person deal with the negative behavior, while promoting the safety of the individual and others.
- Information regarding what procedures were unsuccessful in the past and what other positive alternatives might be incorporated in the future if the current alternatives are proven ineffective.
- A review of situations that could have potentially resulted in restraint but did not due to positive support strategies. These situations should be viewed as learning tools and communicated among the team.
- The types of procedures to be used in any situation where an aversive intervention may still be necessary.

Please contact Ginger Curtiss or Heidi Taylor, ODMRDD Behavioral Support Consultants, via email at behavior.support@odmrdd.state.oh.us for information on joining your local Regional Behavioral Support Committee or for further information on additional support in your area.

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, 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