# Guidelines for Behavioral Support:
# A Person-Centered Approach

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**CONTENTS**

## INTRODUCTION

The purpose of the following document is to provide guidelines to promote appropriate access to behavioral support. These guidelines are primarily intended for use within the OCDD system. Other systems, of course, are welcome to use the guidelines as a reference. Throughout the document references will be made to the persons or individuals who receive behavioral support services. For the purposes of these guidelines, this refers to individuals with developmental disabilities. Behavioral supports should be accessible in terms of the language used to describe them. Although technical jargon will be avoided when possible, the necessity of technical language to ensure accurate professional-to-professional communication is recognized. The following document strives to balance these considerations. The articulation of standards, as found in the following document, promotes peer review of supports and services provided. This ensures that we are held accountable to those we serve and support.

This set of guidelines acknowledges that the key to designing and providing optimal behavioral services and supports is for the individual being served to be the driving force behind programming and goal-making decisions. Behavioral services should emphasize positive supports, tailored to accommodate the individual's strengths and needs, that are person-centered and effective, foster caring and enriching environments and are comprehensive in scope and integrated with other support services. Behavioral services should also have the capacity for assisting an individual to improve his or her quality of life according to his or her personal goals.

While encouraging comprehensive planning and delivery for individuals who are in need of behavioral services, these guidelines acknowledge that not all persons with disabilities are in need of formalized behavioral support plans. Behavioral services can be used both in and outside of formal behavioral support plans. Behavioral support plans should be used to increase competencies and reduce problems primarily when the person asks for help and/or remains in jeopardy or distress secondary to unresolved problems or unrealized goals. Behavioral services should be provided in the following situations:

- The individual asks for services to enhance his or her quality of life, increase his or her ability to function independently, or achieve his or her goals,
- The individual has a skills deficit that impedes his or her ability to function independently and achieve his or her goals, and/or
- The individual exhibits a challenging behavior that results or may result in injury to self or others or property damage, infringes upon the rights of others, or impedes his or her ability to function independently and achieve his or her goals.

Central to the development of a Behavioral Support Plan is the emphasis on positive programming and the understanding that a person's lifestyle must be meaningful and purposeful to be motivated by any treatment intervention.

Positive behavioral supports incorporate a comprehensive set of procedures and support strategies and include an ability to be flexible to accommodate a person's strengths and needs. In order to be effective, meaningful, and personally enriching, strategies should be selectively tailored to an individual's cognitive and communication functioning, in addition to his or her needs and preferences.

This set of guidelines endorses the notion that person-centeredness is central to the delivery of behavioral services. The input of the person and/or people of importance to the person is paramount; this input should drive the service delivery process and should include ongoing dialogue, with full consideration given to the person's perspectives, values and wishes. Services should revolve around the needs and goals of the individual, should be designed with the primary aim of benefiting the individual, and should acknowledge the importance of personal choice in the selection of services and the creation of supports. As such, person-centered planning is considered to be an important tool in this process. It is also recognized that, in conjunction with person-centered planning, behavioral service providers have an ethical obligation to favor

the use of strategies and interventions which have been empirically validated to be effective before using practices which are less-well tested.

The position of this set of guidelines is that there is no inherent conflict between person-centered planning and behavioral treatment. On the contrary, these approaches often naturally complement each other. The person-centered plan defines goals and outcomes valued by the individual, infuses the planning process with individual choice, and provides a direction for services. It establishes a road map for services and supports. Behavioral treatment is often the vehicle for accomplishing these goals; learning-based interventions often represent the most effective means for promoting new skills and achieving personal outcomes. A person-centered plan that defines desired outcomes but fails to provide the means for achieving these outcomes does little to serve the individual. Behavioral technology that results in measurable changes in behavior but which fails to gratify a person or improve quality of life is also of little real benefit to the individual. The real goal should be to put the full weight and power of empirically derived, statistically validated, effective, structured teaching approaches at the disposal of individuals with disabilities on their way to achieving life goals, learning new skills, and achieving independence and community inclusion. Interventions can and should be both clinically effective and personally enriching.

It is also the philosophy of this set of guidelines that individuals are best served in caring environments in which services are directed towards maximizing growth and independence. A principal focus of behavioral services, therefore, should be the fostering of therapeutic, enriched environments, including social environments. Behavioral service providers should be keenly aware of how the settings in which we live and work can impact behavioral issues and psychological well being, both positively and negatively. An understanding of the reciprocal interactions between persons and their environments (how our environments shape us and vice versa) is at the forefront of many of the most widely used behavioral assessments (e.g., functional analyses, eco-behavioral analyses and skills assessments) and interventions. Adaptive behavior does not occur in a vacuum. Competence can vary considerably as a function of the environmental and social supports available to us. Behavior service planning and delivery must be sensitive to contextual issues, including living environments, educational and vocational environments, and social and recreational environments.

It is the intention of these guidelines to encourage behavioral services that are comprehensive in scope. This usually entails a focus on multiple life domains (e.g., social, leisure and vocational), spanning multiple service areas. As a result, all behavioral support planning should occur in the context of the interdisciplinary team (IDT). The IDT represents all major areas of service providers (speech therapy, occupational therapy, physical therapy, recreational therapy, educational services, vocational services, medical services, etc.) as well as the individual and others who know the individual best (family, direct support professionals, friends). During the planning process as an individual's goals are reviewed and steps for achieving those goals are delineated, overlap across service areas should be discussed. Treatment planning should reflect the overlap and coordination of services (e.g., Behavior Support Plans to assist with mealtime behavior should incorporate input from nutritional support staff where appropriate. Replacement behavior training programs involving communication skills should be constructed and coordinated with speech therapy staff where appropriate. Behavior Support Plans focusing on job skills issues should most often represent joint efforts by behavior support staff and vocational trainers, etc.) Behavioral support plans should flow naturally from the overall planning process and should reflect how multiple team members are working together to aid individuals in achieving their goals. Comprehensive services require integration of services.

Services should be able to offer some assistance or support to a person in whatever area of life he or she has dissatisfaction or unmet goals. Assessments and treatments of any kind should be used as a means of evaluating and enhancing the individual's quality of life and ability to function as a contributing member of society. Goals of treatment should reflect what the individual would like his/her life to be like in the future. Given the scope of this task, services must have the capacity to be broadly focused and comprehensive.

More specifically, goals in the planning process may address:

- participating in community life,
- gaining and maintaining satisfying relationships,
- making choices,
- having opportunities to fill respected roles and live with dignity, and
- continuing to develop competencies.

To be comprehensive, to serve the whole person, behavioral interventions may include 1) skills acquisition training programs to improve the individual's academic, personal care, domestic, social or vocational skills; 2) behavior support plans to decrease challenging behaviors and increase competing replacement skills; and 3) treatment aimed at alleviating or minimizing psychopathological symptoms.

Behavioral service planning should always take place in the context of weighing the anticipated risks and benefits of services/procedures to the individual. Individuals should be aware of these potential risks and benefits. A risk/benefit analysis of treatment options should take place at the outset of service planning, as a preliminary step. (See guidelines 2 for further discussion of this topic).

Services and supports would include the provision of the treatment aspects already mentioned as well as educating family members, friends and staff as to what things can be changed or added to the environment to allow the individual opportunities to broaden his or her experiences and function more independently. Focuses should be on changing those things that limit the person's opportunities for satisfactory social relationships and presence in the broader community setting. Quality behavioral services should always result in a change in the individual's quality of life, not just a reduction in behaviors others find bothersome or an increase in some isolated skill. If molecular skill development is a component of the plan, the provider should always be cognizant of how this component fits into the broader scheme of the person-centered plan. The delivery of comprehensive services involves working so that people have many ways to be a part of community life.

**NOTE: OCDD is aware that by necessity this set of guidelines is technical in nature. It is OCDD's position that behavioral support services are just one part of many in a person-centered endeavor.**

## GUIDELINES 1: PROVIDERS

**1.1 Providers of behavioral support have available at least one licensed psychologist and as many more licensed psychologists as are necessary to assure the quality of services provided. For those persons receiving psychotropic medication, providers of behavioral support have available at least one licensed, board-certified psychiatrist and as many more licensed, board-certified psychiatrists as are necessary to assure the quality of services provided.**

The intent of this guideline is to ensure appropriate human resources, in the quantitative sense, in the provision of behavioral support. It is essential that there are as many psychologists and psychiatrists necessary to meet these Guidelines. It is also intended to ensure appropriate human resources, in a qualitative sense. The psychologists involved in the provision of behavioral support meet the level of training and experience of a licensed psychologist as specified in the psychology practice act of the State of Louisiana. These psychologists should also be competent in the provision of behavioral support. When a licensed psychologist is not available on a full-time basis, a licensed psychologist is retained on a regular part-time basis to supervise behavioral supports provided. The licensed psychologist is vested with the functional authority necessary to assume professional responsibility and accountability for behavioral supports provided. These guidelines assume that the appropriate professional for provision of psychopharmacologic support is a licensed, board-certified psychiatrist with competence in developmental disabilities.

**1.2 Providers of behavioral support who do not meet requirements as a professional psychologist and/or psychiatrist are supervised, directed and evaluated by the appropriate professional. Tasks assigned to these providers are in keeping with their demonstrated areas of competence**.

Primary providers of behavioral support are licensed psychologists (when an individual is also receiving psychotropic medication, the psychiatrist is considered a primary provider of behavioral support as well). Other providers of behavioral support require supervision by a primary provider of behavioral support. Providers of behavioral support requiring supervision are supervised, directed and evaluated by a licensed psychologist to the extent required by the tasks assigned. Tasks assigned are in keeping with demonstrated areas of competence. Level and extent of supervision is consistent with requirements found in the Psychology Practice Act of the State of Louisiana.

Providers of behavioral support may include the following groups.

- Those responsible for behavioral assessments, development of behavioral support plans or recommendations, and evaluating effectiveness – These individuals may include the licensed psychologist, licensed board-certified psychiatrist (if a medication regimen is required), the associate to a psychologist, or other individuals with specific education and training in applied behavior analysis.
- Those responsible for training direct support professionals or families to implement behavioral support services – These may include the licensed psychologist, associate to a psychologist, or other individuals trained to competence by the licensed psychologist or associate to a psychologist.
- Those responsible for the direct provision of behavioral support services – These may include the direct support professionals, family members, other IDT members, the licensed psychologist or associate to a psychologist.
- Those responsible for monitoring behavioral support services – These may include the licensed psychologist, licensed board-certified psychiatrist (if a medication regimen is required), the associate to a psychologist, or other IDT members trained to monitor specific components of a behavioral support plan.

**1.3 A licensed psychologist is responsible for planning, directing, and reviewing the provision of behavioral support services**.

Final responsibility for behavioral support services should rest with a licensed psychologist.

**1.4 When behavioral support services are provided within an organizational setting, professional psychologists seek, whenever appropriate and feasible, to bring their education, training, experience and skills to bear upon the goals of the organization by participating in the planning and development of overall operations.**

The psychologist who holds final responsibility for behavioral support services is obligated to advocate for appropriate organization and management support to ensure successful and effective delivery of behavioral supports.

**1.5 Primary providers of behavioral support attempt to maintain and apply current knowledge of scientific and professional developments that are directly related to the services they render. This includes knowledge relating to special populations.**

**1.6 Providers of behavioral support limit their practice, including supervision, to their demonstrated areas of professional competence.**

**1.7 Primary providers of behavioral support are encouraged to develop and or apply and evaluate innovative theories and procedures, to provide appropriate theoretical or empirical support for their innovations, and to disseminate their results to others.**

## GUIDELINES 2: ASSESSMENT

Assessment is a process of problem solving, decision-making and evaluation. The primary goal of assessment is to gather information that will lead to quality of life enhancement for the person being assessed. The individual, teachers, family members, friends, advocates, support professionals, speech, occupational, and physical therapists, psychologists and medical professionals may be actively involved in assessing the life goals, strengths and weaknesses of a person. Thus, best practices mandate that the assessment be a multifaceted, person-centered, team process whereby professionals, laypersons, and the person work cooperatively toward meaningful solutions to any areas of concern.

**2.1 Systematic assessment precedes behavior support development and moves toward building hypotheses.**

An on-going dialogue is opened with the person, the family, and other significant support people to gain a better understanding of the individual and to provide a holistic description of the person's life goals, strengths, and challenges. Assessment is an ongoing, interactive process that uses a variety of materials and individualized techniques in multiple settings across many time periods. For those individuals exhibiting behavioral challenges, the assessment process categorizes behaviors into levels of seriousness or risk that have implications for whether or not a behavior support plan will be required. The team reviews the assessment data with the person to determine if the challenging behavior is no risk (present but not currently presenting any problems for the individual), low risk (interferes with a person's life goals), moderate risk (infringes on the rights of others), or high risk (is dangerous to the person or others). Through this process, a determination about the necessity of a skill acquisition program, behavior support plan or alternative programming is made. In some instances simple environmental modifications will be indicated by the assessment results.

**2.2 Initial assessments should be comprehensive in scope.**

Numerous assessment methods are available to examine a multitude of issues. It is a generally accepted standard of practice that initial assessments systematically look at all areas of functioning to determine if and where additional assessment and/or support may be needed. A comprehensive assessment should include some basic components at a minimum. Those components are listed in guidelines 2.2.1 through 2.2.8. Assessments designed to evaluate treatment progress and/or those completed to answer a specific referral question (e.g., a suicide evaluation) may be more limited in scope and only include some of the components listed below.

**2.2.1 An interview with the person and her or his family and/or other significant support persons is conducted**.

The individual, her or his family and support network will generally be the best providers of general information about that person. The information gathered would provide a historical context within which to place the current situation, an overall picture of the person's life at present, as well as a foundation of goals toward which the individual is working.

**2.2.2 A record review is conducted to collect and organize current and historical information about the person and past and current attempts to increase skills and address the behavior challenges and/or psychopathological symptoms.**

Information is collected on developmental milestones, previous psychotropic medications and behavioral interventions, clinical history, adaptive, cognitive, academic, and communicative functioning, and educational/employment history. This information (along with the interview

information above) provides an overall picture of the individual's life. It helps to verify information derived from the interview, as written documentation is less subject to errors than memory. It also allows for comparison of support techniques that have been used in the past and establishment of trends with regard to skill acquisition, behavioral challenges, and psychopathological symptoms.

**2.2.3 A health assessment or review is conducted to rule out any health issues impacting the behavior or the individual's life.**

Health issues may impact numerous life areas (e.g., increased behavior challenges while ill, increased depression while ill, or increased anxiety in the presence of medical procedures). Thus, accurate diagnosis and support planning with regard to these issues is an important component in the overall assessment and support planning process. It is necessary to rule-out medical factors that may be related or causing behavioral issues prior to the development of a support plan. Each individual is entitled to a medical examination with the physician present to address such issues. Examples include referrals to an occupational therapist for a fine motor assessment, and ENT consults for SIB.

**2.2.4 Assessments will be needed to evaluate/determine current cognitive and mental status.**

Current cognitive and mental status assessments allow for delineation of basic functioning level. Cognitive assessments denote specific areas of strength and weakness with regard to skills and abilities. Mental status examinations incorporate the assessment of such areas as the individual's orientation to and understanding of the environment, attitude and interaction with others, appearance and mood, and judgment and insight into issues. These assessments are particularly useful for documenting changes in functioning across time and during different phases of illness (e.g., a person may be less cooperative, unaware of surroundings and/or depressed while ill; those same factors, along with lack of judgment and insight, may be apparent in acute phases of some mental disorders).

**2.2.5 Routine screening for psychopathology will be conducted for each person.**

Rates of psychopathology are higher in persons with developmental disabilities. However, diagnostic issues are often clouded by the communication and interaction difficulties associated with such disabilities. Thus, it is essential that routine screening is conducted to rule-out psychopathological symptoms. When present such symptoms can be associated with decreased skill level and increased behavioral challenges. Any assessment and support planning process designed to target skill acquisition and/or behavior reduction would necessarily include information related to any psychopathological symptoms present at the time or in the past.

**2.2.6 Data should be collected on operationally defined challenging behaviors, and should be made through direct observations of the person and her or his environment for the purposes of establishing a pretreatment baseline.**

Data are collected with regard to three areas: a) challenging behavior frequency, duration, and/or intensity; b) some measure of adaptive functioning (task engagement, task completion, social interaction); and c) frequency, duration and/or intensity of psychopathological symptoms. Methods may include time samples and interval and frequency recording; however, data collection is an ongoing process that allows for repeated measures that facilitate pre-treatment assessment, intervention development and treatment implementation.

**2.2.7 An adaptive behavior assessment is conducted to select relevant areas that would benefit from training and more socially appropriate replacement behaviors for the challenging behaviors.**
Adaptive behavior assessments involve examining such areas as activities of daily living, social skills, communication skills, domestic skills and community orientation skills. These assessments help to

identify skill levels in certain areas, which aids in delineating where treatment strategies may begin and to select meaningful targets for increase. As replacement behaviors are chosen, a thorough adaptive behavior assessment also aids in design of methods for training such behaviors. It is important to know if the individual has an appropriate behavior in his repertoire that he may simply increase with assistance or if skills will need to be taught.

**2.2.8 Reinforcer or preference assessments are conducted to determine items and activities that will enhance the person's life and can be included in behavior acquisition and reduction procedures.**

Information about preferred activities is important in creating positive, proactive behavior supports and interventions that include meaningful and stimulating, reinforcing environments, teaching strategies and peer models, successful experiences and conventional human contact. Discovering what is reinforcing to a person is vital to the success of any behavioral support treatment. There are at least six classes or types of reinforcers (edible, tangible, exchangeable, activity, social, and sensory). A good assessment evaluates across classes of reinforcers and takes into account the sensory and motor deficits of the person. For example, for people with profound deficits, preference may be operationally defined as reaching or turning toward or touching an object or change in activity level in the presence of the item. Because there are potential difficulties in identifying reinforcers for people with physical or developmental disabilities, assessment methodologies are needed to determine what is reinforcing for a person.

**2.3 For those individuals who exhibit challenging behaviors, behavioral problem solving and effective behavioral support programs are based upon functional and ecological assessments that facilitate a better understanding of the structure and function of the challenging behavior.**

Functional and ecological assessments examine the person's environment, activities, social interactions, and interpersonal relationships to identify factors that might contribute to the challenging behavior. The goal is to gather specific information over time in as many settings as possible from people who know the person well. A comprehensive behavioral analysis is conducted to identify the functions or consequences (functional assessment) of the challenging behaviors as well as any settings or events that precede those behaviors (antecedent analysis). A functional assessment may include the following steps.

An Indirect Analysis is a functional assessment method that relies on structured interviews, questionnaires and rating scales.

Descriptive Analyses are designed to identify naturally occurring behavior rates and to evaluate naturally occurring antecedent and consequent events.

Probe Analysis or treatment probes involve working directly with the person in his or her natural environment for short periods of time and systematically presenting or removing stimuli to determine the effects on the challenging behavior. It is used when indirect, structural, and/or descriptive analyses fail to generate a hypothesis or piloted interventions based on these procedures are not successful.

Experimental Analysis is designed to identify environmental events that maintain challenging behaviors.

These steps are carried out in hierarchical fashion with increases in intrusiveness and skill level required to use the procedure as one moves from indirect analysis to experimental analysis. If satisfactory results are achieved with earlier levels of assessment, then the additional analyses may not be completed. For detailed information regarding functional assessment see appendix A.

**2.4 Individuals receiving behavioral support services will receive a comprehensive assessment annually.**

At least annual review/assessment of all life areas should be conducted for those individuals receiving behavior support services. This review/assessment should highlight any changes during the past year and should be used to drive any changes or additions to goals or support plans. Other assessments and/or updates to previous assessments should be done as needed throughout the year. For individuals not receiving behavior support services assessments will be conducted as needed.

**2.5 Behavioral Support Plans will be assessment driven.**

Assessment information aids in the development of hypotheses regarding problematic areas and recommendations regarding support planning. Based on this information, the following decisions will be made: a) skills training should target identified areas that if increased would aid in increasing the individual's ability to function independently in relevant situations for him or her; b) support plans for behavioral challenges will address the identified function (maintaining variables) identified in the assessment process; and c) psychopathological symptoms identified will lead to diagnosis which will in turn lead to identification of clinically driven treatment procedures.

**2.6 A risk analysis will be conducted prior to the completion and implementation of the behavior support plan.**

In choosing among behavior support options, the professional developing the behavioral supports must select a protocol that achieves the most reasonable balance between likely benefits and potential risks. A risk analysis involves systematic examination of the costs of the intervention weighed against the cost of continued exhibition of the challenging behavior(s). In conducting this analysis the IDT should examine the level of probable harm to self, others and property, current staff support required to stop the behavior(s), the person's general response style following intervention, community tolerance of the challenging behavior(s), and the person's goals. A risk analysis should include at a minimum the following components:

- Identification of risks of the behavior,
- Identification of risks of the proposed intervention(s),
- Review and consideration of alternatives to the proposed intervention, and
- Determination that the risk of the behavior continuing outweighs the risk of the intervention.

For an example of a risk analysis see Appendices B and C.

## GUIDELINES 3: TREATMENT

### INTRODUCTION

This section addresses issues related to design and delivery of behavioral interventions and treatment relevant to behavioral issues. The first section discusses the important issue of consent to treatment by persons with developmental disabilities. The section on Generalization provides a brief overview of strategies to enhance generalization and discusses guidelines for incorporating generalization programs into larger behavior support plans. The Unrestricted Procedures section discusses behavioral strategies used to promote adaptive skills and decrease non-dangerous maladaptive behaviors; it describes an array of positive behavioral approaches and structured teaching approaches and includes guidelines for using these procedures. The Restricted Procedures section discusses strategies which are used to treat behaviors which are dangerous to an individual or others or which involve some measure of intrusiveness; guidelines for the safe, appropriate and ethical use of these interventions, as well as procedural guidelines for approved usage within agencies are discussed. The Psychotropic Medication section provides basic guidelines for the use of psychotropic medications in the context of behavior support plans.

Prior to the development and implementation of any support program, the individual's living environment must be considered. Singh (1997) notes that "current professional standards of care and federal law require that individuals with developmental disabilities be provided with an effective treatment environment to ensure an acceptable quality of life." In determining if the individual's living environment is "effective" or "acceptable", Singh recommends that the following areas be considered and addressed.

- Is it an engaging environment? (i.e., How well do the individuals actively participate in the activities provided in the environment?)
- Are functional skills taught and maintained (i.e., Does the environment provide the context for individuals to learn skills and functionally improve their independence and general quality of life?)
- Are occurrences of behavioral problems reduced or preempted? (i.e., How effective is the environment in actively and successfully treating behavioral problems, as well as, in providing an environment that preempts the occurrence of such problems?)
- Is the environment the least restrictive alternative? (i.e., How normalized is the living environment?)
- Is the environment stable? (i.e., How consistent are the personnel, interactions, and activities in the lives of the individuals?)
- Is the environment safe? (i.e., Are the individuals safe from physical and psychological harm as consequences of their own behavior or the behavior of others in their living environment?)
- Is the environment the one in which the individuals choose to live? (i.e., Would individuals choose to live in this environment?)

If the above-mentioned factors are considered and addressed prior to the development and implementation of a formal plan, in many cases a formal plan may not be necessary. A formal program is not needed to ensure that all individuals served by an agency are provided with as "normalized", "effective" and "acceptable" an environment as is possible.

### CONSENT

Services that acknowledge the importance of person-centeredness must be concerned with the issue of personal consent. The consent of the individual, legal status of the individual, legal issues regarding consent and organizational/agency policies regarding consent and individual choice are important considerations in service planning.

The issue of consent and persons with developmental disabilities is complex. Developmental disabilities can have an impact on factors such as capacity, information and voluntariness relevant to determining ability to consent. As stated, a person-centered philosophy must value the importance of obtaining the consent of the individual, who drives the service planning and service delivery process. Obtaining consent becomes increasingly complicated as an individual's ability to make his wishes known and truly understand his/her options diminishes. In many cases, communication and cognitive limitations can impact a person's ability to truly give consent. Because of this, family, friends, staff, teachers, and other concerned caregivers (and in cases of interdiction, a curator) must often play a more important role in this process.

In some cases, the personal wishes of the individual come into conflict with mandates or responsibilities of a parent, caregiver or organization to provide services necessary to ensure basic safety and well-being of an individual or others and to protect an individual with disabilities from exploitation and abuse. These conflicts are not always easily resolved.

In other cases, as members of society, the personal wishes of an individual, while critical, must be balanced with the rights of others and with community laws and standards. When consent of an individual to treatment is not granted and a behavior in question places the individual in danger or violates the rights and/or safety of others, therapeutic interventions can, in some cases, be incorporated into plans of care without the individual's consent. These interventions can be implemented, however, only after the agency has followed clearly established due process procedures.

To restate, balancing personal choice with safety and societal standards, in the context of cognitive and/or communication limitations and with the input of the multiple persons who form a circle of support, can be difficult. Nevertheless, at its most basic element, consent and an organization's/service provider's value and mindful pursuance to obtain consent to the fullest degree possible constitute the chief protection of an individual's rights and personal freedom. It is central to the right to self-determination of individuals with developmental disabilities. This section is not intended to resolve the consent issue. However, it is intended to offer thoughtful consideration of issues relevant to consent and to offer guidelines, that, if followed, take substantial steps toward promoting personal choice and consent to treatment services.

**Guidelines for Obtaining Consent of Persons with Developmental Disabilities:**

**3.1 Consent for treatment services must be obtained in accordance with:**

- **a) a program's or agency's policies and procedures,**
- **b) state law (which currently includes the right of individuals with mental retardation or developmental disabilities to refuse specific modes of services unless contrary to the health, habilitation or medical needs of the individual) , and**
- **c) Title XIX guidelines (which currently include directives to obtain consent for any program or practice that could abridge or involve risks to individual protection or rights).**

**3.2 The individual should be present at meetings and during decision-making regarding service planning, if at all possible. Service providers and decision makers are obligated to attempt to consult with the individual with the disability.**

The fullest possible efforts should be made to understand the wishes of the individual and to obtain consent for services that constitute the plan of care. Making "the fullest possible efforts" to understand the wishes of the individual might include, but should not be limited to, making multiple attempts to obtain information from the individual if necessary, obtaining information under circumstances which an individual is most likely to be able and willing to provide it, and utilizing assistance of others who know the individual best and

are best able to solicit accurate information from the individual and interpret the true meaning of an individual's responses.

**3.3 Attempts should be made to have several persons who know the individual best present at service planning or decision-making meetings**

This might include family, staff or others. Meeting composition should take into consideration requests by the individual regarding persons he/she would like to be present. In cases where an individual is a minor, is interdicted, or needs assistance in making decisions, family members should be involved in service planning. In cases where an individual does not need assistance in making decisions, the individual's expressed wishes and values should supercede the wishes of family members.

**3.4 At service planning or decision-making meetings, someone should be present whose primary role is to serve as an advocate for the individual and the individual's wishes. Advocates should meet with the individual and obtain information regarding the individual's wishes prior to actual service planning meetings.**

This guideline is not intended to limit who might serve as an advocate. Advocates might include anyone who can impartially assist the individual during service planning in representing their needs and wishes.

**3.5 The person assisting in the role of advocate should use substituted judgment rather than a best-interest standard**

That is, the advocate should speak to what the person's wishes are or what is believed the person's wishes would be, rather than what is thought to be in the individual's best interest or for his or her own good.

**3.6 In instances where persons considered critical to assisting in making decisions cannot be present, efforts should be made to solicit their input prior to the decision-making**

**3.7 Treatment planning (pharmacological, behavioral, educational, habilitative, etc.) should always be undertaken in the context of risk analyses weighing potential risks and benefits of treatment vs. no treatment vs. various treatment alternatives.**

Risk analyses are discussed in more detail in a separate section of this set of guidelines. (See section on Assessment - Guideline 2.6).

**3.8 As the critical nature of the decision increases, the discussion of services, taking consent into account, becomes more important.**

Highest scrutiny should be given to high-risk decisions that are unclear or inconsistent with a person's known values and interests. Lowest scrutiny should be applied to low-risk decisions that are clear or consistent with a person's known values or interests. Moderate scrutiny should be given to high-risk decisions that are consistent with a person's known values or to low-risk decisions that are inconsistent with known values (Dinerstein, 1999, citing Sundram, 1994).

**3.9 Informed consent implies the fullest possible efforts are made to present information using language commensurate with the individual's level of communication abilities to facilitate understanding to the greatest degree possible.**

The purpose of this guideline is to promote respect of the individual and a person-centered approach, to encourage appropriate input from the individual, and to remain sensitive to a person's cognitive and communication functioning. If an individual is capable of understanding the proceedings to some degree, efforts should made to facilitate understanding even if the person has substantial communication or cognitive deficits. If a person has profound language deficits and is unable to understand the proceedings in any meaningful capacity, decision-making should include the advocate and, if possible, might still take place in the presence of the individual. By the same token, when seeking consent from a person's guardian, medical and other technical jargon should be replaced by readily understandable everyday terminology.

**3.10 Following the presentation of information, the individual's understanding of the information should be assessed and additional clarifications should be made as warranted.**

**3.11 In presenting the proposed use of a treatment, the information given should include targets to be changed and how they will be monitored; expected benefits; probability of success; how long it should take these benefits to occur; the expected duration of use; specific and clear information about the intervention itself; potential side effects and the likelihood of occurrence of side effects; feasible alternatives; the right to refuse treatment; the time-limited nature of consent; that consent can be withdrawn at any time (except in cases referenced above in which consent of a person was overridden); and procedures for withdrawal of consent.**

**3.12 In seeking consent, efforts should be taken to ensure consent is truly voluntary.**

Voluntariness extends beyond simple lack of coercion. Coercion can be subtle. Persons working with individuals with developmental disabilities must take power differentials into account. Substantial efforts should be undertaken to ensure that individuals are aware of their choices and that they are free to disagree with recommendations without fear of retaliation. These issues should be taken into consideration both in terms of the manner in which information is presented and in terms of selecting the individuals best-suited to convey information.

**3.13 Efforts to assist an individual in making informed decisions and/or to obtain assent or concurrence from an individual should be undertaken in situations in which a person cannot give consent and/or has a curator or guardian who is responsible for the actual consent to treatment procedures.**

In some situations, an individual may be able to make an "informed decision" even if he/she lacks the ability to give "informed consent," (i.e., meeting a legal definition for consent). In other situations in which a person is unable to truly consent to treatment due to a lack of capacity, efforts should still be undertaken to obtain the individual's assent to treatment.

**3.14 In situations in which an individual does not consent to a proposed service or intervention, the fullest possible efforts should be taken to resolve this issue, with full consideration given to:**

- **a) the rights and wishes of the individual**
- **b) program or agency obligation to obtain consent**
- **c) program or agency obligation to ensure safety**
- **d) rights of the individual vs. the rights of others**
- **e) risk analysis**
- **f) possibility of obtaining a second opinion through a peer consultation or some other process prior to overriding the individual who does not give consent.**

In some cases, treatment should be withheld under these circumstances in keeping with the individual's

wishes. In other cases the wishes of the individual may be overruled due to safety and protection issues or secondary to the need to protect the rights of others. In these cases, due process as outlined in the agency's policies and procedures (e.g., BIC approval and HRC approval) in keeping with Title XIX guidelines and in keeping with state law must be followed. In these cases, there is additional accountability on the part of service providers to implement treatment judiciously, to continue to assess the efficacy and the necessity of the intervention, and to deliver treatment according to the individual's wishes, to the greatest extent possible. Service providers should also continue to attempt to obtain consent, remaining sensitive to the issue of voluntariness discussed above.

**3.15 The process of obtaining consent from the individual should be documented.**

**3.16 Each facility should have a policy to address consent that takes into consideration the above guidelines. Given the magnitude of this issue, each facility should also be responsible for monitoring system-wide the manner in which consent is addressed at that facility.**

A person-centered philosophy obligates facilities to continue to evaluate their consent policies on a regular basis and to continue to take steps toward improving consent policies.

## GENERALIZATION

In many cases, the skills taught in behavior support plans are important in multiple life domains. A behavior support plan may initially focus on *acquisition* of a skill, that is, helping an individual to acquire and use a new skill under specific circumstances or conditions. In most cases, however, *generalization* of the skill is an equally desired outcome for the individual. Generalization refers to the transfer of a behavior that occurs under specific conditions to other situations or conditions. A behavior can generalize across settings (for example, an individual who learns to place an order for food at a facility canteen may also have little difficulty ordering in a fast food restaurant.) Behaviors can generalize across individuals or trainers (for example, an individual who has been practicing conversation skills with direct support staff may later demonstrate improved ability to converse with peers). Generalization can occur across many other conditions as well (for example, an individual who has learned to employ a relaxation exercise when he gets anxious at work may apply the same relaxation strategy when he gets anxious on a social outing and find that the strategy is equally effective). Generalization basically connotes widespread change across diverse conditions (Stokes & Osnes, 1988). Most learned behaviors targeted in behavioral support plans are potentially valuable to individuals across many different areas of their lives. Adaptive behaviors which occur only under very limited conditions may have limited utility in an individual's life. Whether or not an acquired skill generalizes often determines whether it is truly meaningful to the person.

**3.17 Generalization programming should be incorporated into behavioral support plans of individuals whenever it is important for target skills or adaptive behaviors to occur in multiple settings or circumstances.**

### 3.17.1 Planning for generalization should take place at the outset of behavioral support planning.

Generalization of an adaptive behavior beyond specific training conditions often fails to take place unless there are active attempts to program or train generalization. There is general consensus among behavioral practitioners that plans for generalization should be identified and built into the educational/training program from the outset. The persons, places, and procedures used to teach a new skill can have a great deal to do with determining whether the skill is later displayed under very limited circumstances or results in widespread and meaningful change. Since generalization goals may alter the way that a new skill should be taught, the time to plan for and promote generalization is at the beginning of training, not after acquisition has already occurred in specific training conditions.

**3.17.2 Behavioral support planners should be mindful of the multiple situations in which an individual may want to or may be expected to use a target skill. Behavior support plans should be designed to assist an individual to use the target skill across these multiple circumstances, circumstances in which using the skill will result in the greatest benefits to the individual. (i.e., Generalization programming should be systematic.)**

Relevant generalization goals should be identified at the outset of the plan by the individual and the IDT. The plan should take into consideration and include strategies to achieve the specific desired generalization outcomes.

**3.17.3 Simple guidelines for promoting generalization include: 1)Take advantage of natural reinforcers; 2)Train loosely and diversely and in diverse natural settings; and 3)Incorporate mediators into training–physical stimuli, social stimuli, and behaviors that will be common to training settings and generalization settings** (Stokes and Osnes, 1986).

Planning for generalization of adaptive skills and behavioral improvements is often a complex process. The discussion of this subject in the current text will of necessity be brief and fairly general. Nevertheless, some basic strategies for promoting generalization and relevant factors for consideration, taken from the published literature, are listed below.

In their seminal and often cited article, Stokes and Baer (1977) discussed several strategies for promoting generalization. Each is discussed briefly below. (Stokes and Baer's strategies have in some cases been renamed in an attempt to reduce technical jargon.):

In a **Sequential Training** approach, training of the target skill is conducted in multiple settings, under different circumstances, or with different trainers, as required, *one at a time*. After acquisition occurs under one set of circumstances, it is trained in another and then another, sequentially . This represents a step-by-step approach. (Example: An individual practices making appropriate requests at home with support staff. Later training of the same skill occurs with teachers in a classroom setting.)

Generalization from a training setting to natural untrained settings may be facilitated by reinforcing the target skills during training with **Naturally Occurring Reinforcers** (and/or other Contingencies). Utilizing natural reinforcers that will occur in real life settings can reduce reliance on more contrived reinforcers which may be less available in naturalistic settings. (Example: If a social skill is likely to be reinforced and maintained in a natural setting by a social reinforcer, it may be more appropriate to reinforce the skill during initial training with that same social reinforcer as opposed to a tangible reinforcer).

In Sequential Training approaches (above), generalization is specifically trained to occur in every setting in which the skill is desired to occur. In contrast, generalization to many settings may occur by **Training Under a Variety of Circumstances** as opposed to training in every circumstance. (Example: Generalization of a social behavior to many persons may occur if the individual is taught to appropriately display the behavior with two or three persons vs. with just one trainer. In some cases, training under two or three situations may be sufficient to promote generalization when one is not.)

With a **Train Loosely** model, little control is exercised over training stimuli (e.g, props), the training environment, and the correct responses allowed. In doing so, the target response becomes less dependent on specific conditions or the specific training environment. Because it is more difficult to discriminate the training environment from other environments, the target skill is more likely to occur in multiple environments.

Similarly, a target skill is more likely to generalize to settings in which it will not be reinforced if it is difficult for the individual to discriminate in which settings the skill will be reinforced or will not be reinforced (this is called using **Indiscriminable Contingencies)**. If an individual is fully aware that she is only going to be reinforced for displaying a skill under a very specific circumstance, she is more likely to display the behavior only in that circumstance. If it's hard to tell when reinforcers are or are not available, the behavior may be more likely to generalize.

Utilizing a **Programming Common Stimuli** approach, stimuli common to both the training and the generalization setting are purposefully incorporated into training. (Example: Teaching someone to choose the correct restroom by reading "Men" vs. "Women" would be an example of this since these words will probably be displayed on most restrooms the individual will encounter.)

**Generalization** can be **Mediated** by teaching a chain of responses that includes a specific skill likely to be exhibited in multiple situations. The specific skill may mediate generalization of a whole chain of responses, of which it is a part. (Example: If an individual has impulsive behaviors, impulsive aggression, impulsive verbal aggression, etc., teaching the individual to stop and count to ten before acting can serve as the initial response in a chain of adaptive behaviors.)

Finally, generalization itself can be considered a response which can be reinforced in individuals.

**3.17.4 In the written behavior support plan there should be evidence of a systematic and planned approach to programming generalization. This includes specifying how generalization will be assessed.**

The specific structured teaching approaches being used to facilitate generalization should be identified in the written behavior support plan. In cases in which it is intended that a skill should be trained in a natural setting, the setting should be specified. In cases in which it intended that training will occur in a series of settings, the series of settings should be identified. Plans should denote who, how, and where training should occur, if these factors are relevant to promoting transfer of the skill to multiple life areas. Documentation of these factors supports a systematic approach to generalization.

Generalization has to be assessed to determine whether it's occurring. This entails giving an individual meaningful opportunities to use the skill under different circumstances. Data collection systems should accurately gather information critical to determining whether a skill is being meaningfully employed by a person in relevant life situations, whenever this is a desired outcome of the plan. How this data should be collected (type of data, format, frequency of data collection and locales) should be specified in the behavior support plan. This supports a systematic approach to generalization.

**UNRESTRICTED PROCEDURES**

Behavior supports should primarily be concerned with helping individuals to achieve their goals. In many cases this entails not only providing individuals with opportunities for goal attainment but affording them the skills needed to meet their goals and desires. Without the necessary skills (communication skills, social skills, vocational skills, etc.), opportunities may be considerably limited. Moreover, the bolstering of prosocial skills and other adaptive behaviors can eliminate problematic interpersonal behaviors. The reduction of these problems can, in turn, reduce obstacles to the achievement of happiness, independence, and personal goals.

A range of empirically supported behavioral strategies and structured teaching approaches may be employed to facilitate the acquisition of adaptive skills. Most of these are nonintrusive and do not require the use of punitive methods or other procedures that restrict the rights of individuals. Some approaches simply require

careful assessment, problem solving and the initiation of an appropriate environmental change. Others require the training and shaping of skills over a period of time. This manual will outline minimal guidelines for any unrestricted procedure as well as providing a matrix for denoting differences in requirements across all categories.

**3.18 Unrestricted procedures shall be used in a planned, competent manner.**

Because the risk to the individual is minimal, when these interventions are used to treat non-dangerous behaviors, they are generally regarded as "unrestricted". (In contrast, more *restrictive* techniques are termed *"restricted"* in this manual because of the restrictions governing their usage). However, "unrestricted" does not imply that competence is unnecessary on the part of those utilizing these methods. A haphazard or inconsistent use of unrestricted procedures is likely to result in treatment failure and the erroneous conclusion that more intrusive approaches are called for. Moreover, when unrestricted procedures are inappropriately applied an actual *worsening* of behavior problems may occur.

As a result, all those involved in the development, implementation, and monitoring of habilitation or behavior treatment plans are required to have competency based training in the basic principles of behavior support. Basic techniques and procedures and the requirements for their usage are outlined in this section of the manual. It should be further understood that some methods may require a more advanced level of training.

**3.19 When the target behavior poses risk to the individual or others, the behavior support program will require a higher degree of scrutiny and expertise, even if the procedure would ordinarily be regarded as "unrestricted."**

The seriousness of the behavior should be taken into account. In such instances of high risk behavior such as aggression or self- injury, the involvement of a highly trained professional (e.g., a psychologist experienced in working with self-abusive individuals) is mandated.

**Adaptive Skills Training**

The development of effective methods for teaching adaptive skills to persons with developmental disabilities ranks among the greatest advances in the area of applied behavior analysis. With positive programming approaches, the teaching of new skills (academic, self-help, social, communication, vocational, etc.) is emphasized. Such skill development is accomplished to meet the dual objectives of life enhancement of the person and reduction of severe behavior problems. Utilizing effective training programs, individuals acquire the ability to achieve levels of independence not previously possible. Individuals who once communicated by striking out can now express their needs/desires appropriately. Incontinent individuals become continent; chronically disheveled individuals become well groomed. A similar combination of specific skills training and support has enabled many individuals to achieve competitive or semi-competitive employment. Integration into the community at large is feasible via training in social competence skills in tandem with formal individually tailored support systems and informal circles of support.

The "good news" of positive behavior programming, however, must be tempered with the admission that gains are typically hard earned. Progress can be slow and tedious. Considerable time and investment are required on the part of the trainers, professional staff, and the individual who is attempting to learn new skills.

**3.20 Adaptive skills training programs must be carefully crafted, effectively monitored and evaluated, and fine-tuned on a regular basis.**

A high level of precision is essential if programs are to be useful and effective. Data collection must be sufficient to determine whether target skills are being obtained, whether the program is truly serving the needs of the individual, and if the program may be in need of revision. Forethought will be important in the development of programs. For example, without programming specifically designed to promote generalization, training may not carry over (i.e., generalize) to multiple settings.
Tools for accomplishing adaptive skills training are listed in this manual as either "Basic Behavior Support Procedures" or "Advanced Training Procedures". The advanced procedures include those that ordinarily require a greater degree of technical sophistication. In no case should either basic behavior supports or advanced procedures be used randomly or without appropriate competence on the part of the staff. Usage may be in the context of a highly specialized behavior treatment plan or as part of a general habilitation plan, depending on the nature of the behavior and the results of a comprehensive assessment.

**Behavior Support Procedures**

.Behavior Support Procedures include:

1. Reinforcement,
2. Planned ignoring of selective maladaptive behavior,
3. Modeling,
4. Shaping,
5. Fading,
6. Interruption and redirection,
7. Simple Correction,
8. Corrective Verbal Feedback, and
9. Non-contingent reinforcement.

All individuals who have the designated responsibility of carrying out habilitation training or behavioral programming shall be taught Behavioral Support Procedures. Those involved will learn how to observe and record behavior accurately and appropriate methods for delivering positive procedures for modifying behavior

**Advanced Behavior Support Procedures**

Some skill acquisition programs require a higher degree of proficiency in order to ensure proper implementation. Examples of Advanced Behavior Support Procedures include:

1. Differential Reinforcement,
2. Differential Reinforcement of Other Behavior (DRO),
3. Differential Reinforcement of Incompatible Behavior (DRI),
4. Differential Reinforcement of Low Rates (DRL),
5. Backward Chaining,
6. Forward Chaining,
7. Total Task Training,
8. Desensitization,
9. Generalization Training (SEE SECTION ON GENERALIZATION - Guideline 3.1), and
10. Extinction.

Staff using the procedures listed in this section shall be trained in the application of these techniques.

**Treatment Procedures for Specific Disorders**

It is increasingly recognized that individuals with developmental disabilities are subject to a full range of

DSM-IV disorders[1]. Consequently, simple training procedures may not suffice. Instead, more complex behavioral teaching interventions, supported in the empirical literature, may be required.

**3.21 Persons involved with behavioral support programming are responsible for assessing individuals for the presence of specific DSM-IV disorders and for incorporating appropriate state of the art treatment components. Proposed treatment strategies should be supported by the applied research literature.**

Treatment should be matched to the disorder on the basis of a preponderance of the existing research regarding that disorder. For example, exposure with response prevention may be the behavioral treatment of choice for individuals with obsessive compulsive disorders. Similarly, habit reversal may be indicated for Tourette's Disorder or trichotillomania. A comprehensive delineation of such treatment-disorder "matches" is beyond the scope of this manual. However, it is essential that empirically supported interventions, validated to be effective treatments for the target disorder, be employed whenever possible. Examples of treatments used with a developmentally disabled population include but are not limited to:

1. Systematic Desensitization,
2. Exposure with Response Prevention,
3. Cognitive Behavioral Treatments,
4. Habit Reversal,
5. Stimulus Control Interventions, and
6. Anger Management Training.

**Replacement Behavior Training**

It is recognized that maladaptive behaviors can sometimes be treated by focusing entirely on skill acquisition. Replacement Behavior Training (RBT) differs from other adaptive skills training only in that the program is developed in relation to a specific maladaptive behavior or set of behaviors. That is, there is an attempt to eliminate or decrease certain maladaptive behavior by the acquisition of and maintenance of specific functionally equivalent adaptive skills (i.e., replacement behaviors). Programs aimed at bolstering replacement behaviors are intended to produce desirable behavior changes and may be used in conjunction with other procedures.

**3.22 With Replacement Behavior Training programs, the replacement behaviors should compete with and provide an appropriate, functionally equivalent alternative to the problem behavior**.

The objective of behavioral programming is to teach adaptive skills to individuals so that their own goals for independence and life satisfaction can be met. Replacement Behavior Training programs will be designed with such goals in mind, with the understanding that the ability to more effectively cope with one's environment can maximize the probability for success.

As with other behavioral interventions, precision on the part of the program designer is essential. For example, it should not be assumed that *any* positive adaptive behavior will result in reduction of a given problem behavior. Instead, the replacement behaviors should be chosen with at least reasonable expectation that the behavior is likely to compete with or provide alternatives to the inappropriate behavior of concern. Moreover, the concept of functional equivalence should be borne in mind. That is, the replacement behavior should allow the individual to continue to meet essential needs and to gain appropriate reinforcers that were previously being met/gained by the maladaptive behavior. For example, an individual might be trained in a

[1] Sometimes also referred to as "mental disorders", "psychiatric disorders" or "mental illness."

functionally equivalent vocal response that serves the same escape function as screaming. Thus, the replacement behavior expands the response class to which the maladaptive behavior belongs. The goal of intervention is to add alternative adaptive responses that will become the most probable among response options, yet produce the same effect on the environment. The following considerations should guide selection of replacement behaviors:

- The replacement behavior should be relevant to the community (i.e., social validity) and to the individual,
- The replacement behavior should be functionally equivalent to the challenging behavior,
- Selection of replacement behaviors should be based on Functional Assessments,
- The reinforcement value of the replacement behavior should exceed that of the maladaptive behavior, and
- In some cases, it is helpful if the replacement behavior chosen is already minimally in the person's repertoire.

**Prevention and Management**

Prevention and management includes strategies initiated prior to or concurrent with the onset of a maladaptive behavior. Prevention focuses on providing environments that are conducive to facilitating socially acceptable behaviors and avoidance of maladaptive behavior via environmental adjustments. Management strategies focus on preventing increased duration, intensity, and frequency of maladaptive behavior.

Prevention

Some general categories of prevention strategies include:

- eliminating/minimizing specific stimulus conditions that are likely to instigate problem behaviors,
- presenting specific stimulus conditions that increase the probability of competing social behaviors, and
- presenting or emphasizing specific stimulus conditions that inhibit the occurrence of specific maladaptive or problem behaviors.

**3.23 In the development of behavior support plans, it is essential that the individual's overall environment be considered. Individuals should have ample opportunity to practice appropriate skills in a setting in which there is contingent and non-contingent access to activities of choice. Natural contingencies should be in place such that appropriate behavior is reinforced.**

Creating a positive, meaningful, enriched environment is of supreme importance for effective behavioral programming and simply to enhance quality of life. In the context of a positive environment (appropriate levels of stimulation, ready access to preferred activities, access to and inclusion in desired social opportunities, a setting in which basic needs are provided for and there are opportunities for personal growth), problem behaviors are less likely to occur and strategies developed to decrease problematic behavior are more likely to be effective. Anticipating, preventing and working around maladaptive behavior problems is generally preferable to dealing with such problems after the fact. A preventive approach can resolve difficulties more rapidly and can avoid the use of more intrusive or restrictive measures. Preventive approaches often should begin by assessing whether an individual's environment is serving his or her needs. Additionally, BSPs should attempt to make full use of naturally occurring reinforcers. When more contrived reinforcers are initially used in the plan to promote acquisition of adaptive behaviors, attempts should be made over time, whenever appropriate, to fade the more contrived reinforcers and move to more naturally occurring, ecologically valid reinforcers.

**3.24 When utilizing prevention strategies, manipulation of antecedents for problem behavior should follow from a comprehensive antecedent analysis.**

The alteration of major aspects of an individual's life should not be taken lightly. Random manipulation of variables based upon simple speculation can be needlessly and inappropriately disruptive to an individual's life. Instead there should be data (e.g., based upon a thorough antecedent analysis and input from the individual) to suggest that such changes will have a positive impact.

Prevention and management might also involve manipulation of obvious consequences. Caution is offered in this connection since an extinction paradigm might initially lead to an increase in problem behavior. Again, there should be data to support such manipulations.

Examples of prevention strategies include:

- reducing the noise level for individuals who become agitated when ambient noise level is high,
- providing preferred activities or environments in which the individual has responded well in the past,
- reminding the individual that a contingency is in effect,
- providing a preferred reinforcer when an individual is doing an exceptionally hard task, and
- adjusting task demands to a level the individual can tolerate.

Preventive procedures often serve to remove antecedents and/or contingent reinforcers that serve to maintain maladaptive behavior. Environmental engineering involves identification of events that set the occasion for or precipitate problem behavior. Effort is then made to eliminate these antecedents or manipulate the environment so that the maladaptive behavior is less likely to occur. Poorly arranged environments may set the stage for increases in maladaptive behavior, whereas well-designed environments engender socially acceptable work, leisure, and interpersonal behavior. Simple changes in the environment can sometimes have profound effects on an individual's behavior. Environmental engineering, in keeping with sound behavioral programming practices and person-centered planning, should give utmost consideration to the individual's needs, preferences, and desires.

Examples of environmental engineering include:

- assigning individuals with a history of intense conflict to different work areas,
- making training groups compatible,
- redesigning daily schedules,
- reassigning staff who are abrupt, less sensitive, or lack the skills necessary to adequately deal with the individual, and
- reducing the noise level in living areas.

The precursors for problematic behavior may not be readily apparent. Thus, a careful functional analysis may be a requirement for environmental engineering strategies.

Management Procedures

Management procedures are behavioral procedures following the onset of a specified behavior designed to quickly and safely stop the behavior or to prevent increased duration, intensity, or frequency. These procedures may also be designed to help an individual to calm or alter his or her responses in other ways. It is important that management strategies are clearly described to ensure proper implementation and monitoring of the strategy and to avoid misuse. Management procedures may include various methods for dealing with maladaptive behaviors, including:

- Problem solving,
- Environmental changes (contingent), and
- Relaxation.

**Behavior Programs Using Prevention and Management**

**3.25 Prevention and management procedures alone do not always produce durable behavior change. Prevention and management techniques are therefore often incorporated into replacement behavior training programs or other programs designed to teach adaptive skills.**

Prevention and management procedures may be included with replacement behavior training programs and, therefore, conditions for implementation are outlined in the replacement behavior training section of this manual. Exceptions exist in cases where the IDT has determined that the behavior to be treated is injurious to the individual or others. (See Prevention and Management in the section entitled Mildly Restricted Procedures, when injurious behaviors have been identified.)

**CRISIS INTERVENTION**

The purpose of crisis intervention is to interrupt an acute situation in which there is imminent danger that challenging behavior(s) will result in physical harm to the individual or others, or in major destruction of property. In other words, it involves ***unplanned*** interventions to address *unanticipated* challenging behaviors. Typically, these behaviors are not addressed in a Behavior Support Plan. Even if they are, crisis intervention may be necessary if the specific procedures contained in the plan prove to be insufficient to manage an unusually severe episode. Successful crisis intervention programs ensure ongoing safety by creating conditions that discourage violence**,** and by providing a quick, effective response when violence occurs.

**3.26 Each agency must have a crisis intervention policy(s) and a comprehensive procedure manual.**

All agencies must develop a crisis intervention policy and a detailed procedure manual in accordance with the policies and procedures ascribed to by OCDD and DHH. The crisis intervention manual should include specific techniques for avoiding problem behaviors (e.g., giving clear, concise and positive instructions to persons receiving support, and generous doses of positive reinforcement for appropriate behavior throughout the day), as well as identifying concrete strategies for decelerating a crisis situation (e.g., environmental engineering and other relevant techniques discussed in the *Unrestricted Procedures* section of these guidelines). In addition, the manual must clearly specify the interventions that staff may employ in crisis situations when prevention and/or de-escalation are not effective, and present a least-to-most restrictive hierarchy of these approaches. Specific approval and documentation requirements for the use of highly restrictive crisis interventions must also be addressed (one would expect prior authorization of "emergency" mechanical restraint, as well as documentation over and above an incident report). The narrative following Guideline 3.29 gives an example of a prior approval process for emergency restraints in crisis situations.

This procedure manual must be available for review (e.g., by individuals and/or their family members) upon request. Additionally, copies of the crisis intervention manual must be readily available to staff employed by the agency (i.e., a copy should be in all homes, program areas and departments).

**3.27 All staff who have contact with people receiving supports must demonstrate continued competence in crisis intervention procedures.**

All staff members who have contact with persons receiving support (Behavior Support Staff, Developmentalists, Habilitation Instructors, Direct Support Staff, QMRPs, Nurses, etc.) must be trained in the use of crisis intervention procedures prior to reporting to work. This training must include didactic as

well as demonstrative components. Staff members will be able to discuss and demonstrate crisis intervention components with 100% accuracy. Annual retraining and assessment of competence will be conducted at a minimum. Incident review procedures may be used to evaluate staff response to crisis situations with feedback**,** and booster training sessions provided as needed. Each agency must have a clearly defined procedure for training staff and assessing continued competence in crisis intervention procedures.

**3.28 Crisis intervention procedures are not a substitute for a behavior program.**

A Behavior Support Plan is a set of procedures designed to teach skills and/or decrease the frequency of the challenging behavior *and* to increase other competing, replacement skills. It is intended to lead to long-term behavior changes. Crisis intervention procedures**,** on the other hand**,** do *not* teach new skills and are *not* expected to result in long-term changes in behaviors. Instead, they are used to ensure safety and to minimize damage in emergency situations. Clearly, the use of crisis intervention procedures is *not* sufficient as a replacement for a Behavior Support Plan. But, the use of one of the more restrictive emergency strategies (i.e., personal, mechanical or chemical restraint) may well warrant a special meeting of the person's IDT to determine if the development of a Plan appears warranted. The crisis intervention procedure manual should include criteria and maximum time frames for convening such IDT special meetings.

**3.29 Each service provider must establish written guidelines for the emergency use of restraints.**

Acceptable crisis intervention methods for OCDD programs are outlined in the OCDD staff training curriculum. Each service provider is responsible for establishing guidelines and procedures designed to control the use of emergency procedures. These guidelines and procedures must be in accordance with the statewide policy regarding use of emergency procedures. They should minimally address the following issues:

- what constitutes a "crisis",
- what strategies may be used,
- decision tree for choosing between strategy options, and
- any authorization or notification process required.

**3.29.1 If an individual continues to behave dangerously (ie., over three emergency restraints in a three month period), the need for subsequent use of restraint should be anticipated by the IDT and a proactive plan formulated in an effort to maximize the protection to the individual and others.**

This plan should include behavior control procedures unless there is reason for the IDT to conclude that restraints will not be necessary again. This rationale should be clearly stated in the plan. Planning use of behavioral control procedures provides for safer use of them by addressing the following issues:

- individual needs,
- predictability of the behavior and need for use of such techniques, and
- guidelines for effectively treating/eliminating the challenging behavior in addition to behavior control techniques.

Additionally, if the individual is subject to emergency restraint procedures three times within a six month period, the IDT must meet to discuss information and revise the plan as necessary (although the revision may not necessarily include use of planned restraints).

**3.29.2 If emergency restraints are required in rapid succession and there is a high likelihood of the need for further restraint before the standard approval procedures can be followed, an interim approval procedure may be followed.**

Each service provider must develop written guidelines for the interim approval of behavioral programs. The following interim approval procedure outlines minimal standards for providing a proactive services plan for the protection of the individual and/or others.

a. The IDT will meet and weigh the potentially harmful effects of the behavior control procedure against the harmful effects of the dangerous behavior. The IDT's decision that the harmful effects of the behavior clearly outweigh any potential harmful effects of the procedure will be documented in the individual's record.
b. The IDT will consider the least intrusive, effective behavior control necessary to safely manage the individual's dangerous behavior. The procedure will be incorporated into a behavior intervention program which will become part of the individual's IPP.
c. The individual's physician will determine and document that the use of the procedure is not medically contraindicated.
d. Verbal consent is obtained prior to implementation.
e. The proposed plan will be submitted to the Chairperson(s) of both the BIC and the HRC or their designee(s).
f. These two chairpersons or designees and two members from each committee will review the proposed behavior control procedures and may grant temporary approval for implementation. The date of expiration of this temporary approval must be specified and may not exceed 30 calendar days.
g. The person's behavior support staff will train and qualify staff members in the proper implementation of the plan and monitor implementation.

**RESTRICTED PROCEDURES**

OCDD upholds ethical and moral principles that require the use of positive programming procedures, avoidance of the use of restricted procedures when possible, completion of a risk analysis prior to the use of restricted procedures, and minimization of adverse side effects when restricted procedures are deemed necessary. It is recognized that guidelines must closely regulate and monitor the use of intrusive procedures in order to protect the rights and dignity of individuals served. This section of the manual will describe restricted procedures that may be used and the criteria and approval that must be satisfied prior to their use.

Restricted procedures can be divided into two main categories: a) prevention and management techniques used for dangerous behaviors; and b) any procedure designed to suppress a response with some consequence that has some effect on daily routines, may be uncomfortable to the person served, and/or has some degree of intrusiveness beyond that associated with everyday life. The second category is further divided into mildly restricted behavior intervention techniques, moderately restricted behavior intervention techniques, highly restricted behavior control techniques, and highly restricted behavior intervention techniques. Each group of techniques is defined below.

**Mildly restricted behavioral intervention techniques** - Procedures designed to suppress the response with mild consequences. They have minimal effect on daily routines and are not uncomfortable to the person served.
**Moderately restricted behavioral intervention techniques** - Procedures designed to suppress the response with moderate consequences. They are more intrusive than mild procedures and should only be used when the behavior has been shown to seriously effect the safety of the individual or others and/or the rights of others.
**Highly restricted behavioral control techniques** - Those procedures used to deal with recurring "dangerous behaviors" that represent an imminent physical threat to the person and/or others in their proximity. They are used only in extreme situations and only after prevention and management procedures, replacement behavior procedures, and response suppression procedures have been carried out and failed to avert the dangerous behavior. They are used for protection from injury and are not designed to produce durable

behavior change nor as a substitute for habilitative strategies. These procedures must be evaluated to determine the most effective, but least intrusive restraint procedure possible for each individual. Because they are individualized to the person served, address predictable recurrences of dangerous behavior, and are part of a plan to improve behavior and eliminate restricted control techniques, these procedures are not emergency procedures.

**Highly restricted behavioral intervention techniques** - Procedures designed to suppress the response with a more severe consequence. They are highly intrusive in the daily routine of the individual and include a contingent stimulus which is unpleasant (but not physically harmful) to the individual. (Expressly prohibited procedures include corporal punishment, seclusion, verbal abuse, forced exercise, and any procedure which denies requisite sleep, shelter, bedding, food, drink and use of bathroom facilities.) These procedures should only be used under rare circumstances when the individual demonstrates severe, life threatening behavior that fails to remediate even with the most rigorous less intrusive intervention. In such extreme situations, failure to use knowledge of professionally sound therapeutic techniques, even though unpleasant, would be a disservice to the individual receiving treatment.

Use of any restricted procedure requires safeguards beyond those extended under ordinary circumstances of daily living. Guidelines for approving use of a restricted procedure, evaluating its use, and qualifications of the monitor and staff implementing the plan should be outlined by each service provider. This manual will outline minimal guidelines for any restricted procedure as well as providing a matrix for denoting differences in requirements across restricted categories.

**3.30 The program proposal must include a rationale and comprehensive functional analysis of the behavior identified for treatment.**

Programs using restricted procedures should be based on a hypothesis of the cause of the behavior whenever possible. Such hypotheses must be generated as the result of a comprehensive functional analysis (see the assessment section for a detailed description of what must be included in a functional analysis) which identifies the variables that maintain the challenging behavior(s). The treatment options should logically follow from the hypotheses that are generated. By targeting those variables identified in the functional analysis, the likelihood that the treatment will be effective increases and the techniques used will be largely positive in nature.

**3.30.1 The analysis must provide a detailed review of available information regarding behavioral strategies implemented in the past and the person's response to each.**

Review of previous strategies and the individual's response to each allows for determining which hypotheses have already been tested. Results of the review should then be used as part of the rationale for either continuing an existing strategy, modifying an existing strategy, or attempting new strategies altogether. For those strategies that have been tested and failed, the clinician must attempt to determine if the failure was due to ineffectiveness of the treatment or other problems with implementation. A review of all available reliability and treatment integrity information would be essential in making such a determination.

**3.30.2 It must include available history of any drugs for behavior support used and the person's apparent response to each.**

Providing a detailed review of medication history allows for examining effects and side effects of previous treatments in the same manner as guideline 1.1 allows for doing so with behavioral treatments. It is important to consider in this review the reasons each medication was prescribed. For those prescribed for behavioral reasons, the team should plan a gradual titration following implementation of effective behavioral strategies to determine if any additive benefits are noted with the medication or to discover optimal minimum dosage. Review of responses to each medication should address any increase or

decrease in adaptive skills as well as effect on challenging behaviors. For more information regarding medication usage and guidelines see the psychopharmacology section.

**3.31 The procedures must be incorporated into formal behavior support plans designed to teach the individual socially appropriate replacement behaviors.**

Restricted procedures should not be used staff unless they are a part of a comprehensive behavioral support program based on a functional analysis. Additionally, it is unlikely that suppressing the challenging behavior through preventive strategies and manipulation of consequence events will be maintained without also providing the individual with opportunities to acquire or strengthen appropriate behaviors that are functionally equivalent to the challenging behaviors and equally or more efficient in achieving the desired goal. The individual will likely fall back on the challenging behavior as a default (particularly since it has been effective in the past) in the following situations.

- The individual does not have an alternative means of achieving his or her goals and wants.
- The individual possesses appropriate skills, but those behaviors do not generally result in achieving goals and wants (not reinforced).
- The appropriate behaviors must be performed more often or longer than the challenging behaviors to achieve goals and wants (or require more effort to perform).

**3.31.1 The programs must be designed to lead to a less intrusive way of addressing the challenging behavior and ultimately to the elimination of the challenging behavior.**

The goal of any behavior support program should be to improve the individual's skills which will result in a decreased need to perform the challenging behavior and ultimately to the use of less restricted intervention methods (or no plan at all). Restricted programs should not be implemented over long periods of time with no change in the challenging behaviors and no increase in abilities. Plans that contain highly restricted behavioral intervention techniques (ie., restraint and time-out IV) should include steps to eventually fade the use of these procedures over time and/or should contain documentation that usage of the procedure has resulted in a decrease in the challenging behaviors, a decrease in the number of times the procedure is used and/or a decrease in the duration the procedure is used each time.

**3.31.2 Included in the program must be tentative provisions for the generalization and maintenance of therapeutic effects over time and across settings.**

Generalization and maintenance of treatment effects are imperative to prevent the need for future use of restricted strategies in other settings. Issues regarding the generalization and maintenance of treatment effects can be found in Guidelines 3.1.

**3.31.3 The program proposed should be supported by the applied research literature.**

Documentation from the empirical literature should be used to support the treatment team's decision. There are numerous behavioral strategies available for use by behavior support staff. Not all strategies work for all problems. Review of the empirical literature will guide staff in choosing strategies that have been shown to be effective for treating the presenting problem and in avoiding those that have consistently failed to produce effective results. Such guidance is helpful both in utilizing procedures in isolation and in combination with other strategies.

**3.31.4 Procedures used should always begin with the least intrusive, clinically indicated intervention.**

Movement to a more restricted procedure requires documentation that a less restricted intervention was attempted, was implemented correctly, and was properly evaluated as ineffective. Exceptions may exist only when it is urgent that a maladaptive behavior is reduced or eliminated quickly due to the severity of the behavior and to deny the program would be detrimental to the person. This must be strongly supported in the functional assessment. It is important to note that the least intrusive treatment guideline refers ONLY to those procedures shown to be effective for the presenting problem. If the team is able to present a rationale that a treatment has consistently failed to produce results for the presenting problem, then withholding effective treatment while "less intrusive" measures are attempted first would not be in the best interest of the individual being served.

**3.32 For those programs using physical holds, mechanical restraint and/or transports, the individual's physician has documented that the proposed procedure is not medically contraindicated.**

Release by a physician prior to the use of these procedures ensures the individual's safety. If use of a particular procedure is medically contraindicated, then alternative procedures must be explored and used.

**3.33 Restricted procedures are used only within programs designed and monitored by professionals with specialized training and experience in applied behavior analysis.**

Misuse of behavioral strategies can result in inadvertently reinforcing (and increasing) challenging behaviors or denial of appropriate and effective services. Thus programs utilizing restricted components must be developed and monitored by professionals with training and experience in applied behavior analysis. These staff members must also be provided with continual opportunities for further study in applied behavior analytic techniques to maintain competence in the area. Additionally, for those programs targeting symptoms of mental illness, the plan should be developed and monitored by individuals with specialized training and experience in the diagnosis and treatment of mental disorders. Again, continual training opportunities must be provided.

**3.33.1 If the professional is a psychological associate and/or behavior analyst, he or she must be supervised by a licensed psychologist.**

Provision of behavioral services must be supervised by a licensed psychologist as such services fall under the purview of "psychological services" according to Louisiana law. It is understood this psychologist has training in applied behavior analysis.

**3.34 Staff members responsible for carrying out restricted procedures must have adequate training.**

Just as training and experience is required for those developing and implementing behavioral programs, the staff members who are asked to carry out these programs must also be adequately trained to avoid misuse of the procedures outlined in any given plan. The staff members responsible for carrying out restricted procedures must have training in the following areas:

- Basic behavior support principles (as outlined in the staff training section),
- Crisis interventions procedures, and
- The specific techniques involved in the individualized program.

Such training should be conducted by individuals with training and experience in the above listed areas and, for c, the person responsible for the development and monitoring of the plan.

**3.35 All programs involving use of restricted procedures must receive all appropriate approvals.**

Federal and state regulations require the review and approval of behavioral programs by various groups/bodies depending on the level of restrictedness of the program. These processes are designed to ensure quality programs and protect the rights of the individuals being served. The process required for each level of restrictedness is outlined in the matrix at the end of the treatment section.

**3.36 Use of restraints must be documented immediately.**

Immediate documentation of the use of restraints increases the likelihood that the documentation received is accurate and shortens the time period from restraint application to restraint review. Use of restraints as a behavior control procedure must include the following documentation:

- Less restricted methods were attempted immediately prior to the application of restraints,
- Type of restraint used,
- Duration of the restraint, including time restraint began and time it ended,
- Authorization and justification for the procedure,
- Safety and well-being of the individual and adequacy of the restraint method was checked promptly after the restraint was begun and at least every thirty minutes thereafter ( A nurse should be notified when the restraint is initiated and should check the individuals vital signs within 15 minutes of the initiation. The nurse should return to check the individual at the end of the restraint period or at least once per hour - whichever is shorter.),
- That an attempt was made to release the individual from restraint for a minimum of 5 minutes at least every hour with an opportunity provided for motion, exercise, liquid intake, and toileting, and
- If a mechanical device is used, documentation indicated that the device has been inspected prior to each use to ensure that it remains in good repair and free from tears or protrusions that may cause injury.

Use of restraints as part of a highly restricted behavior intervention program requires documentation of b-g above.

When protective equipment is used, the plan must specify the parameters of use and the procedures for fading its use.

**3.36.1 The behavior support staff responsible for the monitoring of the plan must receive notification of the use of restraints within 24 hours.**

Since restraints are considered highly restricted procedures and carry risk of harm to the individual, use of these procedures must be carefully monitored. To ensure appropriate use of restraint and evaluate effectiveness in a timely manner, the staff responsible for the development and monitoring of the plan must receive notification within 24 hours of its use. The staff is then obligated to assess the appropriateness of the application of restraint in that situation and note any needed modifications within the plan.

**3.37 The use of a time-out room requires adequate documentation.**

**3.37.1 Prior to use of a time-out room there must be documentation that the room and its use will meet safety standards.**

Use of a time-out room as part of a highly restricted behavior intervention program requires documentation of the following prior to implementation to ensure safety:

- Physical arrangements are made for continuous observation of the individual to ensure intervention

of staff to prevent injury to the individual
- Rooms are ventilated and well-lighted
- Rooms are free from safety hazards
- The door to the room is held shut by staff or a mechanism requiring pressure from a staff member to keep the mechanism engaged

**3.37.2 Use of a time-out room must be documented immediately.**

As with restraints, documentation of use of a time-out room immediately increases the likelihood of accurate documentation and decreases time between use of time-out room and review of its use. The following items must be documented after each incident of use of the time-out room:

- The individual was removed from a potentially positive, reinforcing activity,
- The procedures of the program to shape incompatible adaptive behaviors were being followed by persons assigned responsibility for them,
- Safe transporting techniques were used in the implementation of the program,
- The individual was in the time-out room for a period not to exceed 30 minutes, and
- The time use of the room began and the time it ended

**3.37.3 The behavior support staff responsible for monitoring the plan should receive notification of the use of time-out room within 24 hours.**

Reasons for notification within 24 hours and obligations of staff are the same as those presented in guideline 3.36.1.

**3.38 All programs utilizing restricted procedures must be evaluated in a timely manner and appropriate documentation must be maintained.**

Restricted procedures should be monitored regularly and at intervals frequent enough to avoid prolonged use of ineffective procedures (for specifics regarding requirements see matrix at the end of the treatment section). Data should be collected as outlined in each plan (based on assessment results) and analyzed AT LEAST monthly by professionals responsible for the development and implementation of the plan. Documentation should include the following:

- raw data,
- copies of reliability and treatment integrity checks and results,
- graphic representation of data,
- notations of any program or life changes,
- documentation of initial and interim staff training and any additional feedback provided as needed,
- written summary of progress and recommendations at least monthly, and
- documentation to verify completion of recommendations.

**PSYCHOTROPIC MEDICATION**

A psychotropic medication is any drug prescribed to stabilize or improve mood, mental status or behavior. Of the interventions discussed in this Chapter, it is generally considered to be the most restrictive.

The use of psychotropic drugs with persons with mental retardation and other developmental disabilities persons has been a focus of concern among parents, advocates, policy makers and professionals for several decades. Contributing factors cited by Reiss (1998) include the frequency with which they are prescribed (surveys have reported that 30% to 50% of the individuals residing in developmental centers and 25% to 40% of their counterparts in the community take psychotropic medications on a daily basis), the fact that

they are often prescribed indefinitely with no specified endpoint to treatment, the vulnerability of many of the individuals supported (e.g., limited verbal skills which preclude their ability to report side effects), and the relative paucity of physicians trained to serve people with dual diagnoses.

The following guidelines are based upon, and in several cases taken verbatim from, those presented by Kalachnik, et al (1998) in *Psychotropic Medication and Developmental Disabilities: The International Consensus Handbook.* While "best practices" for the use of psychotropic drugs will continue to evolve as new research findings come to the fore, these guidelines reflect the current "best thinking" of a broad cross-section of experts in the field.

**3.39 Psychotropic medication shall not be used excessively, as punishment, for staff convenience, as a substitute for meaningful psychosocial services, or in quantities that interfere with an individual's quality of life.**

Much of the controversy and litigation involving psychotropic medications has its roots in the historical misuse of these agents in both mental retardation and mental health facilities (e.g., the "A 'good patient' is a 'quiet patient' " philosophy of decades past). A scrupulous approach to employing these drugs is thus both warranted and critical to the welfare of the person.

Psychotropic medications cannot be used as a substitute for less intrusive, appropriate treatment procedures. Furthermore, they should ordinarily be used only after other less restrictive techniques have been implemented and have failed to achieve the outcome desired by the individual's interdisciplinary . This does not preclude the use of psychotropics as a first line intervention in those instances where there is substantial empirical support suggesting that medication usage is a necessary intervention, the most likely effective intervention available, or there is consensus among the scientific community that medications are an appropriate initial treatment for the condition in question (e.g., the use of neuroleptics for the treatment of schizophrenia). However, the acceptable first line introduction of a psychotropic medication does not eliminate the need to use other appropriate procedures [e.g., while an individual with profound mental retardation may present with clear symptoms of a depressive disorder (frequent crying, loss of appetite, anhedonia, etc.), this by no means precludes the concurrent introduction of a behavior intervention plan designed to positively address behaviors associated with depression].

Many psychotropic medications have non-selective effects; that is, they do not selectively act on the particular behavior for which they are being prescribed. Historically, psychotropic medications with sedating effects have often been used to suppress maladaptive behaviors in persons with mental retardation at the expense of adaptive functioning. In persons with developmental disabilities, careful attention should be given to adverse medication effects on adaptive functioning, as well as adverse effects which impact an individual's ability to benefit from and enjoy learning-based habilitation programs and recreational/leisure activities. Pharmacological approaches which result in global reductions in maladaptive and adaptive behavior are generally *not* considered best practice. Risks vs. benefits of medications on quality of life and functioning in different life domains should considered.

**3.40 Psychotropic medication use must be reviewed within a coordinated interdisciplinary plan of care designed to improve the individual's quality of life.**

Decisions about medication usage, as with all treatment procedures, should take place within the context of an interdisciplinary team process, with special consideration given to the recommendations of medical and other psychopharmacological experts. All team members should be made aware of the intended therapeutic effects, as well as potential adverse effects.

As with all interventions, the overarching consideration is to assist the individual in achieving his or her

personal goals, and to improve the person's quality of life. In most instances, psychotropic medications are employed in conjunction with other interventions (e.g., educational, behavioral and psychosocial) designed to address behavior problems or mental disorders. As a result, the team must pay special attention to the possible interactive effects of medications with these other treatments/therapies. This necessitates interdisciplinary team evaluation to determine treatment efficacy.

**3.41 The selection of psychotropic medication should be based on a DSM-IV diagnosis,a labeled use for treating the presenting behavior, or a behavioral/pharmacological/ biochemical hypothesis supporting the use of the medication for the presenting behavior based on published empirical and/or theoretical literature.**

Decisions to employ medications and decisions regarding the specific drug(s) to be used should be assessment/diagnosis-driven. The assessment should include the gathering of information regarding clusters of symptoms displayed by the individual; the degree to which symptom profiles meet DSM diagnostic criteria and categories; behavioral hierarchies/behavioral chains; the chronicity of the problems/time lines of problems; patterns of the occurrence of behavior problems/symptoms of mental disorders; and, the degree to which problems covary with environmental events including antecedents, consequences and setting events. A comprehensive functional assessment is a key element in the diagnostic process. Since that approach is discussed in Assessment, this section will focus on several considerations in making a DSM-IV diagnosis.

At the outset, it is important to note that a specific DSM-IVdiagnosis may *not* be appropriate in every case of aberrant behavior, including some cases of severe aggressive and self-injurious behaviors. Diagnosis of a mental disorder is often complicated by the language skills and deficits, cognitive functioning level and presentation of many people with mental retardation and other developmental disabilities. Szymanski., et al (1998), note that these complexities may require that the diagnostician employ the DSM-IV "Not Otherwise Specifiфed" (NOS) subcategories (e.g., Psychotic Disorder NOS when the individual's verbal skills preclude identifying the positive symptoms of schizophrenia). These authors also offer valid cautionary considerations involved in applying common diagnoses to many of the persons whom we serve (e.g., Oppositional Defiant Disorder is not equivalent to noncompliance, and Obsessive Compulsive Disorder is not warranted for an individual who exhibits ritualistic behavior unless the behavior is performed to prevent or reduce anxiety/neutralize obsessional thinking). In some cases, the diagnostic process can be facilitated by the use of rating scales specifically designed for individuals with mental retardation and other developmental disabilities [e.g., the Aberrant Behavior Checklist (Aman & Singh, 1986, 1994), the Reiss Screen for Maladaptive Behavior (Reiss, 1988; Reiss and Valenti-Hein, 1994) and the Diagnostic Assessment of the Severely Handicapped (Matson, Coe, Gardner & Sovner, 1991).

Once the comprehensive assessment is completed, there are several possible sets of circumstances under which it is appropriate to consider the use of psychotropic medication: (1) the individual has a DSM-IV diagnosis, and the drug being considered is FDA-approved for treating that disorder; (2) the individual does not meet criteria for a DSM-IV diagnosis, but exhibits a problematic behavior for which a drug is labeled as being an effective treatment (e.g., while such circumstances are few and far between, treatment of aggression is one of the labeled uses of Stelazine); and (3) although DSM-IV diagnostic criteria cannot be met and there is not a drug labeled for use with the behavior in question, there is a behavioral/pharmocologial/biochemical hypothesis supporting the use of the medication for the presenting behavior based on published empirical and/or theoretical research [e.g., Baumeister and Frye (1985) hypothesis that some self-injurious behavior may be mediated by dopaminergic systems, suggesting that dopamine antagonists may be appropriate in reducing the sib in these cases]. In the absence of any of the above circumstances, the prescription of psychotropic medication is generally *not* appropriate, and may be tantamount to "chemical restraint."

**3.42 Informed consent must be obtained from the individual, if competent, or the individual's guardian before the use of any psychotropic medication and must be periodically renewed.**

Informed consent implies that the fullest possible efforts are made to present information using language commensurate with the individual's level of communication abilities to facilitate understanding to the greatest degree possible. This holds true even if an individual has substantial communication or cognitive deficits. By the same token, when seeking consent from a person's guardian, medical and other technical jargon should be replaced by readily understandable, every day terminology.

In presenting the proposed use of psychotropic medications, the information given should include diagnosis, signs or symptoms to be changed, and how they will be monitored; expected benefits, probability of success, how long it will take these benefits to occur, and the expected duration of use; specific and clear information about the drug itself; potential side effects and their respective likelihood of occurrence; feasible pharmacological and behavioral alternatives; the right to refuse treatment; the time-limited nature of the consent, and procedures for withdrawal of consent at any time.

Once consent has been obtained, appropriate agency committees (e.g., the Behavior Intervention and/or Human Rights Committees) should review and approve the use of the medication before drug therapy is initiated.

**3.43 In order to monitor efficacy of psychotropic medication, specific index behaviors and quality of life outcomes must be objectively defined, quantified and tracked using recognized empirical measurement methods.**

Prior to the introduction of the medication, the target symptoms and the specific methods for measuring them should be operationalized in the plan. Data may include measures of frequency, duration and/or severity of target behaviors. Attempts should be made to use more than one measure of a target symptom when it is thought that multiple measures will provide additional or corroborative data useful in determining efficacy. Where appropriate, standardized measures of maladaptive/adaptive behavior or [e.g., *The Diagnostic Assessment of the Severely Handicapped* (Matson, Coe, Gardner & Sovner, 1991), and *The Reiss Screen for Maladaptive Behavior* (Reiss, 1998)]should be considered as one source of information.
The use of objective, quantifiable, observable samples of behavior does not preclude the use of subjective reports of efficacy. An individual's subjective distress pre- and post-medication, and his or her general satisfaction with treatment should be periodically assessed and considered along with the subjective impressions of staff and others involved in care. However, determination of efficacy must be based upon empirical data in addition to individual satisfaction (i.e., subjective impressions of efficacy, or self-report of alleviation of symptoms or perceived distress.)

Assessment of medication effects should include analysis of specific index measures of adaptive behaviors to determine whether medications are resulting in unwanted losses in communication, social functioning, or other adaptive functioning domains.

**3.44 The individual must be monitored for side effects on a regular and systematic basis using an accepted methodology that includes a standardized assessment instrument(s) where appropriate. If antipsychotic or other dopamine-blocking drugs are prescribed, monitoring must include assessments of tardive dyskinesia and other extrapyramidal symptoms.**

Many people served by OCDD are at increased risk for unrecognized side effects due to their limited communication abilities [e.g., as noted by Wilson, et al (1998) the anticholinergic side-effects of lower-potency antipsychotics are hard to identify in the absence of self-report by the individual]. While laboratory tests are necessary components of the monitoring plan for some psychotropics, they do not assess functional side effects (e.g., tremor, irritability and orthostatic hypotension). It is thus vital that a systematic, objective procedure for monitoring and reporting side effects be established, and that direct support and professional

staff are trained in its use. Possible monitoring tools include standardized scales or scales developed by the agency's staff to assess side effects of specific drugs or families thereof. Side effect assessment should also take into account effects on the individual's adaptive function and ability to benefit from habilitative and behavioral interventions.

Given the history of widespread use of traditional neuroleptics in programs for individuals with developmental disabilities and the risk of negative side effects, the introduction of any neuroleptic should be undertaken with careful consideration of risks vs. benefits and due consideration of the relative efficacy of other pharmacological and non-pharmacological treatment. If anti-psychotics and other dopamine-blocking medications are used, the individual must be regularly monitored for tardive dyskinesia symptoms before, during drug treatment and for several months thereafter. Widely used tardive dyskinesia scales include the Abnormal Involuntary Movement Scale (Guy, 1976), the Dyskinesia Identification System Condensed User Scale (Sprague & Kalachnik, 1991), the Tardive Dyskinesia Rating Scale (Simpson, Lee, Zoubok, & Gardos, 1979) and the Texas Research Institute of Mental Sciences Dyskinesia Scale (Smith, Allen, Gordon, & Wolff, 1983).

**3.45 Psychotropic medication must be reviewed on a periodic and systematic basis to determine whether it is still necessary and, if it is, whether the lowest optimal effective dose is prescribed.**

Prior to the introduction of a new agent, the individuals's interdisciplinary team should be made aware of the parameters of a reasonable medication trial (range of therapeutic doses and likely time period by which a response should have occurred). Clearly, this information should be taken into account in determining review intervals.

**3.46 Frequent drug and dose changes should be avoided.**

Attempts should be made to introduce new drugs or change doses one agent at a time, and changes in behavior intervention programs and changes in drugs should generally not be made concurrently. Many persons with developmental disabilities are very sensitive to even minor medication changes. This should be taken into consideration in determining increments for increases and reductions.

**3.47 Keep psychotropic medication regimens as simple as possible in order to enhance compliance and minimize side effects.**

Every possible effort should be made to employ the fewest number of medications possible and the smallest effective doses.

**3.48 The agency must have written policies and procedures which outline a stringent review process regarding the use of chemical restraints.**

It is recognized that situations may arise in which a psychotropic medication must be prescribed and administered on an "emergency basis" to calm an individual who has become extremely upset during a behavioral episode. This is a highly restricted intervention, sometimes referred to as "emergency chemical restraint", and should only be used to control severely aggressive or self-injurious behavior that places the individual, other people or staff in real and immediate danger, or involves major destruction of property. In these instances, prior approval by the team and Human Rights Committee and prior informed consent are clearly not feasible.

Procedures for chemical restraint should be incorporated into the agency's policies and procedures for dealing with unanticipated problem behaviors. On the one hand, it is recognized that the prescribing

physician has ultimate professional and legal *responsibility* for the chemical intervention. However, the *decision* to employ chemical restraint should be jointly made by medical (e.g., a physician or nurse) and non-medical (e.g., psychology personnel or, in their absence/unavailability, identified program personnel) staff. Minimally, the procedures should require that medical and non-medical staff observe the individual and consult with each other regarding what constitutes the appropriate treatment intervention before emergency chemical restraint is put into play.

The procedures should also limit the period of chemical restraint to no more than 72 hours after the initial administration of the medication. The person's interdisciplinary team should meet within 72 after the chemical restraint began to determine if a behavior intervention program should be developed or an existing program modified, and if additional psychotropic medication should be considered. Finally, procedures should stipulate that treatment plan reviews include the review of emergency medication use to determine the effectiveness of existing strategies and whether additional and/or alternative approaches are required to reduce emergency situations.

**3.49 Caution: Consider alternatives to the following practices to the degree possible: long-term use of benzodiazepine anti-anxiety medication such as diazepam; use of long-acting sedative-hypnotic medications such as chloral hydrate; long-term use of shorter-acting sedative hypnotics such as temazepam; anticholinergic use such as benztropine without signs of extrapyramidal side effects; long-term use of anticholinergic medication; and, use of phenytoin, phenobarbital and primidone as psychotropic medications.**

While some of these practices are not uncommon, the *Handbook* from which these guidelines were drawn and other sources include similar cautionary notes. They should thus be taken into consideration in determining and evaluating medication use. In the final analysis, the psychopharmalogical interventions chosen should be those which have the greatest empirical support for treating the disorder in question.

**3.50 Efforts should be made to establish a system of external review of psychotropic medication prescribing that incorporates a mechanism for flagging cases of greatest concern.**

Reviewers should include individuals with strong backgrounds in psychopharmacology and behavioral interventions. As deemed appropriate by the IDT**,** agencies should seek second opinions from qualified peer reviewers or psychopharmacological consultants in cases that are diagnostically complex, non-responsive to standard pharmacological regimens, multiple episodes of emergency chemical restraints.

## ESSENTIAL COMPONENTS OF A BEHAVIOR SUPPORT PLAN

A Behavior Support Plans, in most instances, at a minimum, should include a number of essential components.

**3.51 A Behavior Support Plan, in most instances, at a minimum, should include (1) a rationale, (2) specification of target behaviors, (3) specification of procedures, (4) specification of data collection strategies, (5) plans for evaluation of supports, (6) a consideration of due process issues, and (7) identification of persons responsible for the supports.**

The rationale should explicate the thinking behind the plan. Providing a rationale of this sort is an essential first step in the process of securing consent. The provider needs to be able to explain the "why" of the supports before asking the person (or their representative) to agree to the supports. The rationale statement is also necessary to facilitate any reviews that may be required. Target behaviors should be sufficiently operationalized to allow reliable assessment of occurrence versus nonoccurrence. The provision of behavioral supports is an assessment-intensive set of procedures. Failure to define the target behavior clearly

compromises the reliability of all other assessment efforts. Support procedures need to provide step-by-step instructions on how to carry out the supports. Procedures should also include scheduling of the procedures, criterion for mastery, and the projected date of completion. Appropriate data collection strategies should be detailed. Plans for evaluating the supports should include how often the licensed psychologist responsible for the plan systematically evaluates its effectiveness and continued appropriateness. Due process issues such as consent and review should be discussed in sufficient detail to ensure that the person's rights have been protected. Persons responsible for the supports should be specifically named.

**BEHAVIORAL SUPPORT PROCEDURE MATRIX**

| Procedural Step | Unrestricted | Mildly Restricted Prevention and management | Mildly Restricted behavioral intervention | Moderately Restricted behavioral intervention | Highly Restricted behavioral control | Highly Restricted behavioral intervention | Medication |
|---|---|---|---|---|---|---|---|
| **Procedures** | 1. Any procedures designed to increase or teach a skill<br>2. Replacement Behavior training<br>3. Any prevention or management technique used for non-dangerous behaviors a | 1. Any prevention or management technique used to reduce a dangerous behavior) (ie., blocking for self-injurious behavior | 1. Time-out I<br>2. Time-out II | 1. Response Cost<br>2. Restitution Over-correction<br>3. Positive practice<br>4. Time-out III | 1. Personal Restraint<br>2. Mechanical Restraint (includes use of helmets, mittens, and other protective equipment)<br>3. One-on-one staffing (only when used for controlling behavioral challenges) | 1. Time-out IV<br>2. Unpleasant Stimuli<br>3. Physical Restraint Conditioning Procedure | 1. For diagnosis that is labeled indications<br>2. For behavioral problems that are labeled indications<br>3. For unlabeled uses if based on rational scientific theory, a research-based pharmacological hypothesis, or controlled clinical trials |
| **Approval** | • IDT<br>• BIC (if part of formal behavior program)[1] | • IDT<br>• BIC<br>• HRC | • IDT<br>• BIC<br>• HRC | • IDT<br>• BIC<br>• HRC<br>• Consent | • IDT<br>• BIC<br>• HRC<br>• Consent<br>• Medical release (restraint) | • IDT<br>• BIC<br>• HRC<br>• Consent<br>• Medical release (restraint)<br>• Administration | • IDT<br>• BIC<br>• HRC<br>• Consent |
| **Process Evaluation** | 1. Observed and evaluated[2] at least monthly be behavior support staff[3] and QMRP<br>2. Revised as clinically indicated | 1. Observed and evaluated at least monthly by behavior support staff and QMRP<br>2. Revised as clinically indicated<br>3. BIC and HRC review at least annually or following revisions. | 1. 1.Observed and evaluated at least monthly by behavior support staff and QMRP<br>2. Revised as clinically indicated<br>3. 3.BIC and HRC review at least annually or following revisions. | 1. Observed at least weekly and evaluated at least monthly by behavior support staff and QMRP<br>2. Revised as clinically indicated<br>3. BIC and HRC review at least annually or following revisions. | 1. Observed at least weekly and evaluated at least monthly by behavior support staff and QMRP<br>2. Revised as clinically indicated<br>3. BIC review every 6 months<br>4. HRC review every 6 months | 1. Observed daily and evaluated at least monthly by behavior support staff<br>2. Revised as clinically indicated<br>3. Reviewed by BIC and HRC every 6 months for time-out and every 4 weeks for other procedures<br>4. Not to exceed implementation for 1 month with no reduction without explanation from licensed psychologist | 1. Individual monitored daily and evaluated at least monthly by behavior support staff<br>2. Revised as clinically indicated<br>3. Monthly graphs that reflect symptom presentation if medication is for DSM-IV diagnosis (specifics derived from assessment results)<br>4. Reviewed by BIC and HRC every 6 months |

1. Providers of behavioral support may elect to wave BIC review for BSPs to skill acquisition. Behavior support staff should include supervisory staff along with psychology staff and QMRPs
2. Observations include watching the treatment or training procedures in the plan being implemented across settings. Documentation that allows for checking reliability of data and accuracy of treatment implementation should be kept. Evaluations include assessing effectiveness of the plan by reviewing current data, reliability checks, and integrity checks (i.e., behavior drills or actual observations of plan being implemented). Graphs depicting daily behavioral rates and/or symptom presentation should be included unless clinically contraindicated

## GUIDELINES 4: STAFF TRAINING

An outline of information/areas that should be covered in a behavior support services training curriculum is provided in Appendix B. The outline is broken down into several sections: a) general behavior support training for direct support staff; b) person specific training; and c) training related to professional staff. Training of direct support staff is emphasized since direct support staff are most often with the individual and will be most immediately responsible for carrying out any behavior support strategies. Professional staff are also important "players" in the provision of behavior support; defining the scope of the knowledge and skills they must possess is essential.

Guidelines for staff training are included here. Prior to beginning work, each employee will participate in an orientation course which provides a general overview of the areas in the outline. All major areas noted in the Appendices must be covered in this orientation course. Supplemental training will provide in-depth coverage of key elements in the outline. The manual should provide guidance regarding these issues, but allow for some flexibility across service providers.

**4.1 Staff will receive general behavioral training during orientation (prior to reporting to work).**

Topics to be covered in general training are included in Appendix D. In addition, supplemental training must be provided depending on the specific needs of persons being supported. Additionally, each facility will be required to develop some mechanism for providing review or retraining on an annual basis. Terminology and definitions used during the general behavioral training must be consistent with the terminology provided in this manual and must be consistent with the terminology the behavioral support services staff will use in plan development.

**4.2 Training regarding a specific behavior program will occur following approval of the plan and prior to implementation.**

Staff responsible for behavior support services will use procedures for monitoring and supporting implementation of plans to continue to provide training and feedback with regard to specific procedures in a behavior support plan (see Guideline 5).

**4.3 General behavior support training should be conducted by a professional staff member who has received training in behavioral support techniques and has experience writing and implementing behavior support plans.**

Staff members should be provided with information in written format in addition to the didactic and demonstrative training provided (steps described below). The person(s) responsible for providing the general behavior support training will also be responsible for assessing competence in each area of training.

**4.4 Specific behavior support plan training should be conducted by the professional responsible for the plan development and/or a residential supervisor who has been trained to competence by the professional responsible for the plan development.**

Procedures for specific behavior support plan training may vary across service providers. If the professional responsible for the plan conducts the training, it may occur in numerous individual sessions (training staff one at a time) or in group session(s). It is also acceptable to provide the didactic training in group format and assess skill competence on an individual basis. If the training is provided by someone other than the staff member responsible for the plan, it is the responsibility of the person developing the plan to ensure that any other staff conducting training are competent and equipped to do so. Staff being trained should be provided with a summary of the plan, cue sheets/cards with prompts for all aspects of the plan, and copies/examples of the data sheets to be used, and/or other written materials that will facilitate plan implementation. Monitoring and support of the plan implementation should be conducted by the person responsible for the plan development in conjunction with supervisory personnel such as residential supervisors, home managers, etc. (see Guideline 5).

In most cases, training should include the following components:

- didactic training - verbal and written presentation of material (for general behavior support training this should be followed by a verbal or written test of knowledge in the area(s) covered)'
- demonstration by trainer - trainer should demonstrate each skill/technique staff are required to master,
- observation of staff practicing the skills/techniques - trainer should observe each staff member practicing each skill/technique he/she will be required to master, and
- feedback provided regarding performance - trainer should provide feedback in either written or verbal form regarding each staff member's performance on knowledge based tests and observation of skill/technique usage. Feedback should begin with a focus on the positive aspects of the performance/test and then constructively address any problem areas. The goal of the feedback process should be to provide information or identify methods for improving the person's performance/knowledge.

**4.5 Staff competence with regard to general behavioral support and person-specific strategies will be assessed utilizing verbal/written tests and demonstration of particular strategies.**

A criterion (not to be below 80% for general support strategies and 100% for person-specific strategies) will be set and all staff testing above the criterion will be considered competent to use the skills or implement the program. All staff testing below the criterion will need to be retrained in the area of deficiency. Behavior support skills and knowledge must be an important part of the performance evaluation for the direct support staff and supervisors. These skills and knowledge must also be an appropriate part of the performance evaluation for professional staff. Each service provider will be required to develop a procedure outlining the number of opportunities each staff member will be provided to master a given area/plan and the mechanism by which behavior support services staff will alert supervisory/administrative staff that someone has not mastered an area/plan within the given opportunities. Behavior support professionals are responsible for the development and approval of techniques to assess competence.

**4.6 Professional staff will actively maintain and upgrade their skills to insure that they are familiar with current best practice and new developmental in their field of expertise.**

## GUIDELINES 5: TREATMENT SUPPORT AND MONITORING

**5.1 Behavior Support Staff will spend a substantial amount of time in program areas to conduct direct observations of Behavior Support/Skill Acquisition Plans on their caseloads on at least a weekly basis, devoting this time to activities directly related to assuring appropriate Plan implementation.**

To provide the most effective services, Behavior Support Staff (people with knowledge of how to write, implement and adapt programs, as well as familiarity with specific details of individuals' programs) must be present in program areas, i.e. where services and supports are being provided. A participatory, hands-on interactional approach is essential for maximum program effectiveness. Behavior Support Staff must take an active role in assuring efforts of Direct Support Staff result in effective program outcomes.

During the time spent in program areas, activities of Behavior Support Staff will include observing the person's behavior and program implementation; listening to and problem solving with Direct Support Staff about observations, more effective approaches to interactions, explaining and clarifying behavior support plans, and identifying barriers to program success; talking to supervisors about subordinate staff performance, environmental and staffing issues, and barriers to reaching desired outcomes; modeling actions and interactions to increase effectiveness of programs; checking the reliability of data collection; discussing implications of data with staff, etc.

Activities which might occur in a program area but which do not meet the intent of this guideline include copying information and forms, discussions in conference rooms, writing new programs, gathering baseline data and individual skill assessments.

**5.2 Behavior Support Staff, QMRP's and Program Area Supervisors will take appropriate steps so that adequate resources are available for the implementation of Behavior Support/Skill Acquisition Plans, and that barriers to their implementation are removed.**

The most efficient attainment of program goals can happen only if Behavior Support Staff, QMRP's and Program Area Supervisors assure continuity of interventions and effective utilization of resources. For changes in behavior to occur, it is not enough for these staff members to be in program areas. To be effective, they must take direct action to achieve optimal resource utilization after needs are identified (e.g., by obtaining materials, making supplies and reinforcers available, or changing schedules to maximize staff presence in the area for targeted times).

Barriers to the implementation of Behavior Support/Skill Acquisition Plans may be identified by Direct Support Staff, QMRP's, Behavior Support Staff and/or Program Area Supervisors. They should work together to eliminate problems which negatively impact attainment of desired behaviors. Barriers may be addressed by the introduction of adaptive or augmentative equipment, a change in staff or program venue, changes in departmental or agency procedures, etc.. Sometimes staff must abandon a favored intervention when resources are not adequate or that strategy is not the most efficient.

When informed of barriers which subordinates could not effectively address, supervisory and administrative staff will assist in determining what actions could help in resolving the problems. All levels along the chain of command must take responsibility for assuring that meaningful active treatment is provided**.**

**5.3 Direct Support Staff will know the requirements of and implement Behavior Support/Skill Acquisition Plans of assigned person, and will pass audits with scores of 100%.**

Each Direct Support Staff member must competently answer questions regarding targeted behaviors, skills to be acquired/developed, prescribed intervention/training techniques, recommended reinforcers, replacement behaviors, etc. They must also demonstrate competency in identifying the targeted and replacement behaviors, the targeted skills, delivering reinforcers appropriately, implementing program strategies as written

and reliable data collection.

If, during an audit, a Direct Support Staff member does not answer questions correctly or demonstrate necessary competencies, the auditor (Behavior Support Staff, QMRPS, Program Area Supervisors, quality improvement staff, etc.) must review the correct answers/procedures with the employee. The staff member will be re-audited within 30 days, and the process will be repeated until 100% competency is attained. The auditor must report the score of each audit to the person being audited and to the supervisor of the program area responsible for the intervention program. All Direct Support Staff members must be re-audited at least quarterly to assure that 100% competency is maintained.

**5.4 Behavior Support Staff, QMRPs and program supervisors will be trained-and will maintain competency in reliable completion of audits of Direct Support Staff's knowledge of and ability to implement Behavior Support/ Skill Acquisition Plans.**

An agency must have a formal audit instruments to evaluate staff members' knowledge of, and demonstrated competency in implementing, Behavior Support/Skill Acquisition Plans. At a minimum, the instrument must assess the areas specified in the initial paragraph under 5.3, and also provide documentation of training provided and/or actions taken when deficits are identified.

In addition to training on how to correctly complete the audit tool, auditors must also understand program/training strategies, become proficient at assessing staff knowledge and skills, and be able to provide further training to staff when competency is less than 100%. Auditors should also be capable of recognizing when strategies aren't effective and to whom they should report these and other programmatic issues.

To assure competency, training of auditors must be documented. Some agencies may wish to adopt a formal certification model, including annual recertification of each auditor.

**5.5 Behavior Support Staff, QMRPs and Program Area Supervisors will audit the implementation of the Behavior Support/Skill Acquisition Plan and the reliability of data collection for a combined total of at least once per month per person being supported, or once per treatment phase per person (whichever is shorter).**

There must be a monthly audit of Behavior Support/Skill Acquisition Plans for each individual served. Agencies should have a system to coordinate audit assignments within the pool of trained auditors to assure that this occurs. The audit, which at a minimum assesses the areas cited in the initial paragraph under 5.3, focuses on three basic areas: (1) the employee's knowledge of the Plan, as evidenced by her or his ability to answer structured questions (e.g., regarding target and replacement behaviors; (2) observation of the staff member's ability to carry out the procedures (e.g., correctly delivering reinforcers); and (3) his or her ability to gather reliable data, as determined by the degree of correspondence with data gathered by the auditor during the session. The employee's performance is documented on the formal audit instrument, along with any corrective actions taken to address identified deficits.

It is important for Direct Support Staff to be audited by a variety of professionals, at different times, and on all aspects of each plan. In addition, the designation of which person's plan will be audited for each staff person must vary, and the program audited for a specific person should change from month to month.

Infrequently, the projected duration of an intervention strategy or training step (treatment phase) will be less than a month. In those instances, the agency must have a system in place to advise auditors of the necessity of auditing before the projected end date.

**5.6 Behavior Support Staff, QMRP's and Program Area Supervisors will be responsible for maintaining documentation of Behavior Support/Skill Acquisition Plan audits and sharing them as soon as possible with the appropriate persons, including Direct Support Staff and their supervisors.**

The purpose of auditing Behavior Support/Skill Acquisition Plans is to assure consistent implementation of the program techniques. This can be accomplished only if audit results are shared with all relevant parties (the Direct Contact Staff audited, the Program Area Supervisor, Behavior Support Staff responsible for the Behavior Support Program, the discipline responsible for the skill acquisition program, the QMRP, etc.).

It is the responsibility of the staff member completing the audit to provide feedback to the individual being audited as soon as possible.

Copies of the audit instrument, the names of all staff who were sent copies of the completed audit instrument, and any action taken by the auditor as a result of the audit must be maintained by the auditor for the period of time designated by the agency (but at least for one year).

**5.7 Data collected through audits will be reviewed on a monthly basis, documented, and resolution/action reported in the appropriate discipline progress notes or via other methods.**

The auditor must provide audit information to all supervisory staff who might have a need for the information. For example, if the program audited was one designed to reduce challenging behaviors, copies of the completed audit instrument should be given to the Direct Support Staff audited, and also sent to the supervisor of the program area in which the audit occurred, the supervisor of the Direct Support Staff audited (if different), and to the assigned Behavior Support Staff. If the audit revealed that a change in the person's plan might be appropriate, the completed instrument should also be sent to the QMRP.

Data review may be accomplished and used in various ways. The discipline responsible for the intervention might look at audits completed each month to determine the factors that may be contributing to a lack of progress, possible changes needed in intervention strategies, clarification of implementation instructions, etc. The supervisor of the Direct Support Staff should review all audits received during the year when preparing the employee's annual performance review. The Program Area Supervisor should consider audit information when purchasing equipment, determining staffing requirements, planning environmental changes, etc. The QMRP may find that audit information contributes to an understanding of changes in a person's behavior when other sources do not yield this information.

**5.8 Behavior Support Staff, QMRP, Program Area Supervisors and Direct Support Staff accomplishments in Behavior/Skill Acquisition Plan responsibilities will be reflected in their performance evaluations.**

Changing behaviors, by reducing challenging behaviors and/or by assisting people to acquire or improve skills, is mandated by the active treatment requirements of Title XIX. Behavior Support/Skill Acquisition Plans must be written competently, monitored regularly and implemented effectively if people are to achieve optimal personal growth.

Agencies must develop procedures for measuring staff members' success in meeting these assigned responsibilities, and for including data about each employee's level of success in annual performance evaluations.

**5.9 Behavior Support Staff will perform "spontaneous reliability checks" in addition to these conducted during formal audits, and will take appropriate corrective actions when deficiencies are found.**

As noted in 5.1, this is one of the activities that Behavior Support Staff are to undertake during time spent in program areas. When there are discrepancies in data gathering, the Behavior Support Staff will promptly take whatever action is necessary to address the problem (retraining staff, reviewing target and/or replacement behavior definitions to ensure that poor reliability is not a function of imprecise wording, follow-up with supervisors, etc.).

Documentation of the results of the of audit information and actions taken to resolve identified problems must be included in the appropriate discipline's records, and may also warrant inclusion in communications with other departments and minutes of team meetings, or result in modifications of task analysis and other intervention strategies.

**5.10 Each agency will develop written policies and procedures which address the documentation and analysis of the reliability of data collection and the accuracy and consistency of program implementation.**

Each agency must develop procedures for compiling,-analyzing and disseminating reliability data to produce a comprehensive picture of this aspect of service provision for individuals supported, within specific program areas, and across the agency. This information will be used in evaluating program area effectiveness, as well as progress toward meeting the person's training objectives and outcomes.

**5.11 Agency incident reporting procedures will assure that supervisors review and determine whether or not Behavior Support Program requirements were implemented in accord with the circumstances of the incident. If the Behavior Support Program was not implemented as required, appropriate and timely action will be taken by the supervisor.**

Agency procedures will require staff, when completing incident reports, to provide specific information about each challenging behavior exhibited by an individual and the staff member's exact response to each behavior (i.e., incident reports may not simply state behavior support plan was implemented).

Supervisors must review the specific information provided concerning behaviors and interventions, compare it to the person's Behavior Support Plan, and comment upon whether or not the Plan was correctly implemented. If discrepancies are noted, supervisors must take immediate action to include, but not limited to: assuring that the Behavior Support Plan is immediately and correctly implemented if the staff member did not initially do so, providing re-training on incident reporting procedures if the employee failed to give specific and other appropriate progressive action.

Supervisors will use information reflected in incident reports regarding an employee's implementation of Behavior Support Programs when completing performance evaluations.

**5.12 Agency incident reporting procedures will assure that behavioral information collected in incident reports is forwarded in a timely manner to the appropriate Behavior Support Staff person.**

Incident reports frequently include information about challenging behaviors targeted for reduction, or behaviors that should be considered for incorporation in a reduction program. These types of behaviors frequently have consequences that require incident reports to be completed (injuries, significant property destruction, endangerment of one or more individuals, etc.). In order for Behavioral Support Staff to develop and monitor plans to reduce these challenging behaviors, it is essential that this information be conveyed to them. Each agency must, therefore, have procedures to assure that behavioral information contained in incident reports is conveyed to appropriate Behavior Support Staff within two working days.

## GUIDELINES 6: EVALUATING PROGRESS

**6.1 Evidence of a behavioral support's effectiveness in achieving progress is partly to be found in a range of outcome variables that must be objectively defined, quantified, and tracked using recognized empirical measurement methods. This range of variables should include some index of contribution to quality of life.**

The trend of a problem target is not an acceptable index of the progress of a behavioral support. It is essential to monitor the progress of replacement behaviors or other adaptive behaviors. Ultimately behavioral support is about building resources and repertoires not eliminating excesses and deficits. Behavioral support is about learning more effective ways of achieving desired outcomes. But even this is not enough to index the value of a behavioral support. It must also be demonstrated that the new behaviors are socially valid and make a meaningful contribution to the quality of the person's life as assessed by the person.

All BSPs should include data collection plans for tracking problem targets, replacements and other adaptives, as well as Quality of Life indicators such as the range of personal outcomes espoused by the Council on Quality and Leadership in Supports for People with Disabilities.

**6.2 Evaluation of the progress of BSPs will be achieved via visual inspection of graphic data. An example of commonly accepted guidelines for constructing graphic displays may be found in Cooper et al, (1987).**

In most instances the data collected in the implementation of a BSP is most usefully represented in a graphic display. It is important to remember, however that the construction of a graphic display be driven by the question at hand. For example, a graph used to inform a psychiatric consultation will likely be different than a graph used to highlight progressive adaptive losses to inform a neuropsychological consult. A relevant, well-constructed graph is the most efficient means for transforming raw data into data meaningful to a clinician responsible for the design of behavioral supports.

**6.3 Inspection of graphic data is considered an essential component of clinical review of progress.**

Interpretation of graphic data should take into account changes in treatment procedures, changes in relevant psychosocial events, and measurement error as well as accuracy of data and trends and patterns in the data itself.

**6.4 Revision of BSPs will be undertaken as clinically indicated, as determined by the licensed psychologist OR as indicated by these Guidelines. All BSPs expire at one year.**

Revision of BSPs should be driven by clinical values versus bureaucratic deadlines. The one-year expiration date is intended to be a deadline that is not exceeded. The expiration date is NOT an invitation to wait a year before clinically indicated changes are made. The needs of the person cannot be scheduled as an annual affair.

**6.5 Evaluation of the progress of BSPs will be documented via progress note. A progress note will be registered once per month or more frequently when clinically indicated.**

## GUIDELINES 7: ACCOUNTABILITY

**7.1 The promotion of the person's welfare is the primary principle guiding the professional activities of all members of a behavioral support resource. Providers of behavioral support are accountable to the person.**

The value of a behavioral support is ultimately a judgement made by the person and his or her family or other primary support resources. A behavioral support used in pursuing goals is useful. Failure to make adequate behavioral supports available may deny the individual access or opportunities to achieve his or her goals.

We are most accountable to the person. This entails an ongoing obligation to respond in a positive and constructive manner to all the concerns and questions posed by the person and their primary support resources.

**7.2 Providers of behavioral support undertake periodic, systematic and valid evaluation of their service delivery system.**

This guideline requires evaluation of the overall behavioral support delivery system versus the effectiveness of a set of supports for an individual. A behavioral support delivery system should be evaluated, at a minimum in terms of:

- access to an appropriate level and quality of behavioral support providers,
- how well the supports provided comport with the standards found in these Guidelines, and
- measures taken to ensure providers are holding themselves accountable to the people they support and all other parties concerned with the delivery of behavioral support.

At a minimum**,** this evaluation of services should take place on an annual basis. It may be linked with the overall agency review system.

**7.3 Providers of behavioral support are accountable for all aspects of the services they provide and are appropriately responsive to those parties concerned with these services.**

In addition to the person, providers of behavioral support are also accountable to the full range of "players" within the delivery system. This includes, but is not limited to, review committees, surveying agencies, purchasers and administrative personnel (see Appendix E for statewide peer review protocol). Providers of behavioral support welcome questions as an opportunity to enrich the dialogue between the provider, the person and all others concerned with the delivery of high quality behavioral supports.

# GLOSSARY

Adaptive Skills Training: Training in skills important for independence as well as for successful social/emotional functioning.

Anger Management Training: Training in tactics for coping with anger. Such treatment involves helping the individual identify triggers for anger and practice alternative responses to such triggers (relaxed breathing, walking away, talking with someone, self-instruction, etc.). Repeated rehearsal is often required along with practice and prompting in multiple situations to promote generalization.

Aversive Conditioning: Refers to the application, contingent upon the exhibition of a maladaptive behavior, of extremely unpleasant, startling or painful stimuli that have a potentially noxious effect.

Backward Chaining: The development of specific sequences of behavior by initially reinforcing the last response in the desired sequence. Earlier responses are then added sequentially in a backward fashion so that the final link added to the behavioral chain is the first response in what would be the natural sequence.

Behavior Control Procedures: Those procedures used to deal with out-of-control behaviors that represent an immediate potential danger to the individual and/or others in the environment or involves major destruction of property. Control procedures include personal or mechanical restraint and are used only in emergency situations and only after behavior management and treatment procedures have been carried out and failed to avert the dangerous behavior.

Behavior Intervention Committee: Each agency in which behavior intervention programs are used will have a behavior intervention committee (BIC). This committee includes persons qualified to evaluate published behavior treatment research studies and the technical adequacy of proposed behavioral interventions.

Behavior Support Staff: Professional staff qualified by training to supervise the development and implementation of Behavior Support/Skill Acquisition Programs

Challenging Behavior: A recurring behavior exhibited by an individual that interferes significantly in training or daily living or infringes upon the rights of others.

Cognitive Behavior Therapy: Treatment strategies that use self-talk and thought/cognition to modify behavior and emotions. Such tactics are used in conjunction with other behavioral interventions to increase adaptive behavior and strengthen coping skills.

Conflict Resolution: Development of strategies to settle disagreements.

Contingency Contract (or Behavioral Contract): Goals and procedures of a behavior analysis program mutually agreed upon by the peson and modifiable by joint agreement. Restrictions applicable depend on the most restricted procedure within the contract.

Corporal Punishment: Application of painful stimuli to the body in an attempt to terminate behavior or as a penalty for behavior.

Counseling: Providing help or encouragement to an individual.

Desensitization: Techniques that are used to help individuals learn alternative responses to learned responses such as phobias. Identified reinforcer(s) or relaxation is paired with the "feared" (aversive stimulus) person, place, object or situation.

Differential Reinforcement: Refers to a reinforcement contingency for one specified behavior and an

extinction contingency for other forms of that behavior or other behaviors.

Differential Reinforcement of Incompatible Behavior (DRI): The regular delivery of reinforcement contingent upon the occurrence of a specified behavior which is incompatible with the occurrence of an unwanted behavior.

Differential Reinforcement of Low Rates of Behavior (DRL): The regular delivery of reinfrocement contingent upon low rates of the unwanted behavior.

Differential Reinforcement of Other Behavior (DRO): The regular delivery of reinforcement contingent upon the absence of unwanted behavior.

Direct Support Staff: Staff who have the day-to-day training/service responsibilities (Resident Training Specialists, Developmentalists, Habilitation and Rehabilitation Instructors, etc.)

Ecological Assessment: Also called Eco-behavioral Assessment or Antecedent Analysis. An assessment of a person's environment, most typically focusing on the identification of antecedents to specific adaptive and/or maladaptive behaviors. May focus on basic issues of whether the environment contains stimuli adequate for prompting, promoting, and supporting adaptive behavior.

Environmental Engineering: Involves the planning or alteration of the environment to minimize the emergence of challenging behavior and increase the probability of adaptive actions. Such tactics may involve the removal of distractions or provoking stimuli in order to prevent problematic incidents from occurring.

Environmental Enrichment: An antecedent strategy that increases the stimulation in a person's environment. Environmental enrichment is often accomplished through the provision of alternate sensory activities.

Errorless Learning: Training in a way that prevents failure at tasks. When tasks appear to be too difficult, they are broke down into smaller steps so that success can be achieved.

Exposure with Response Prevention: Treatment techniques based upon a classical conditioning extinction model in which the feared stimulus context is presented and the escape response is prevented. This treatment is often used to treat obsessive compulsive behavior. Thus, the individual is exposed to the situation in which the compulsive behavior would ordinarily occur (to reduce anxiety); however, such behavior would be prevented. The rationale is that the fear of not engaging in the compulsive behavior will ultimately extinguish. Note: such intervention must be developed carefully, following a comprehensive assessment.

Extinction Procedure: A procedure in which the reinforcer that has been sustaining or increasing an undesirable behavior is not given.

Fading: The gradual modification of antecedent stimuli or stimulus schedules so that a response that originally tended to occur only in the presence of one set of stimuli will be occasioned by a different set of stimuli.

Fading Assistance: The gradual removal of a prompt or guidance.

Forward Chaining: The development of specific sequences of behavior by initially reinforcing the first response in the desired sequence; later responses are added in a forward fashion so that the final link added to the behavior chain is the last response in the sequence. In this procedure, training usually proceeds to an established criterion before training is initiated on the next link in the chain.

Functional Analysis: To analyze (descriptively or experimentally) the variables of which an individual's behavior is a function.

Functional Equivalence: Refers to appropriate behaviors that serve an equivalent function to more challenging behaviors. This concept is usually considered in the context of replacement behavior training. (i.e., the replacement behavior produces the same effect upon the environment, but in a more acceptable form).

Generalization: Refers to widespread behavioral change across different conditions. The transfer of a behavior that occurs under specific conditions to other situations, settings, trainers, or conditions.

Habit Reversal: A method for reducing specific habits such as nail biting, hair pulling, and tics. With habit reversal, the individual practices actions that are the reverse of the habit. The person is taught awareness of the habit, monitors likely times for the habit to occur, and is reinforced (especially socially) for inhibiting the behavior.

Human Rights Committee: A Human Rights Committee must meet the following standards:

1) the Committee includes individuals served and/or their representatives;

2) at least one-third of the Committee's members are not affiliated with the agency;

3) at least one member of the Committee has training or experience with issues and decisions regarding human rights;

4) any member who otherwise has been involved in development, review or approval of a proposal or issue before the committee is excluded from the Committee's decision making relative to that proposal or issue;

5) the Committee ensures that each individual's rights are supported; and

6) each Committee member is given a statement of, and receives training in, the Committee's duties and responsibilities.

Informed Consent: The knowing consent of an individual or his authorized representative, so situated as to be able to exercise free power of choice without undue inducement or any element of force, fraud, deceit, duress or other form of constraint or coercion. The basic elements of information necessary to informed consent include the following:

1) a fair explanation of the procedures to be followed and their purposes, including identification of any procedures which are experimental,

2) a description of any attendant discomforts and risks reasonably to be expected,

3) a description of any benefits reasonable to be expected,

4) a disclosure of any appropriate alternative procedures that might be advantageous for the subject,

5) an offer to answer any inquiries concerning procedures, and

6) an instruction that the person is free to withdraw consent and to discontinue participation in the project or activity at any time without prejudice to the subject.

Maintenance: Refers to the continued display of an adaptive target behavior or continued absence of a maladaptive target behavior over time. Assessing maintenance is simply an assessment of whether a

behavioral change is maintained over time.

Management Procedures: Procedures following the onset of a behavior designed to prevent or minimize increased duration, intensity or frequency of the behavior.

Mechanical Restraint: The application of any physical device to the body of a individual for the purpose of restricting or suppressing the person's movement and preventing normal access to the body.

Natural Setting: The environment in which the individual generally spends his or her day. It may include their home, day program or work area, or any other area in which the individual spends a significant amount of time.

Non-contingent Reinforcement: Response-independent delivery of the stimuli that have been demonstrated to maintain the challenging behavior; these stimuli are typically delivered on a time-based schedule. These interventions are used to break up the connection between a challenging behavior such as self-injury and the reinforcing events (e.g., social attention). The advantage of non-contingent reinforcement over extinction procedures is the decreased risk for extinction bursts of the challenging behavior. Thus advantage is of particular interest when the challenging behavior poses risk for the individual or others.

One-on-One Staffing: Assignment of one staff member to be responsible for implementation of support planning and safety for one individual. That staff member is only responsible for that individual.

Over-correction: See positive practice or restitutional over-correction.

Personal Restraint: The application of body pressure to the body of an individual for the purpose of restricting or suppressing the person's movement. This does not include approved training techniques such as physical guidance, redirection, and escorts involving brief holds for less than 30 seconds in which no aggressive resistance is observed.

Physical Guidance: Directing an individual's movement using physical or manual force in a manner which is respectful. Aggressive resistance to the guidance should be followed by releasing any physical holding.

Positive Practice Over-correction: A moderately restricted procedure (punishment) that requires an individual to repeatedly practice a positive behavior.

Prevention Procedures: Those approaches that (a) eliminate or minimize specific stimulus conditions that are likely to instigate challenging behaviors, (b) present or emphasize specific stimulus conditions that increase the likelihood of competing pro-social behaviors, and (c) present or emphasize specific stimulus conditions that inhibit the occurrence of challenging behaviors.

Problem Solving: The process of guiding an individual's verbal or non-verbal communications from a unwanted challenging response to more acceptable alternative responses that can be reinforced.

Prompting: Providing a stimulus (such as verbal, visual, or physical cues) that increase the probability of a particular response.

Redirection: Directing a person's behavior from an unwanted response by providing stimulus conditions that evoke a wanted response to be reinforced.

Reinforcement: A stimulus or event following a behavior that increases the likelihood that the behavior will occur again.

Relaxation or Calm Down procedures: Providing opportunities to engage in behaviors which are conducive to achieving a greater state of relaxation. Examples might include going to a quiet place, sitting, lying down, closing eyes, deep breathing, leaving the immediate area, muscular relaxation. These procedures may be

introduced before or after the occurrence of a challenging behavior.

Replacement Behavior Training Procedures: Skill acquisition training intended to teach a skill incompatible with or replacing the occurrence of a challenging behavior.

Reprimand: A programmatic procedure involving the use of verbal or gestural consequences intended to interrupt decelerate or reduce the rate or occurrence of a response. It must be clear and concise. Loud, severe shouting is not considered a reprimand.

Response Cost: A procedure in which a specified reinforcer(s) is contingently withdrawn following an identified unwanted behavior. Usually these reinforcers are withdrawn from the person's reserve, as with loss of points, token fines, restriction of privileges, etc.

Restitutional Over-correction: A procedure requiring the restoration of the environment to a state vastly improved from that which existed prior to an act of disruptive behavior.

Restraint Conditioning Procedure: A highly restricted procedure involving the programmatic application of a physical restraint following a maladaptive behavior that is used specifically to reduce the frequency of maladaptive behavior. This is not to be confused with physical restraints used as behavior control procedures designed to be used only for the protection of the individual and/or others and applied only after other strategies to manage the behavior have been attempted.

Satiation: The reduction of reinforcer effectiveness that occurs after a large amount of that type of reinforcer has been delivered.

Seclusion: Refers to the placement of an individual alone in a room or other area from which exit is prevented. This does not include placement in a time-out area or room for brief programmed time segments that is part of a behavior intervention program and meets all applicable standards.

Shaping: Reinforcing successive approximations of a "correct" terminal response.

Simple Correction : In contrast to Over-correction, a procedure in which an individual practices an adaptive response or replacement behavior once, following the occurrence of a maladaptive behavior. Unlike Positive Practice Over-correction, the individual practices the adaptive response only once. Unlike Restitutional Over-correction, the individual simply restores the environment to the state it was in prior to the occurrence of the maladaptive behavior.

Stimulus Control Interventions: Treatment methods that take advantage of the fact that certain behaviors may be performed in the presence of specific stimuli. Treatments may involve removal of the stimuli that set the occasion for challenging behavior and/or presentation of the events that are associated with desired behavior. Moreover, treatment might include a modification of the events associated with appropriate behavior. For example, appropriate behavior may occur only in the presence of a specific trainer . In this case, intervention might be developed to allow additional trainers to acquire stimulus control over these same desired behaviors.

Systematic Desensitization: Addresses fears and phobias by gradually exposing the individual to feared stimuli (in vivo or via imagery) while at the same time experiencing an incompatible state such as relxation.

Time-out-Type I: A mildly restricted suppression procedure in which the opportunity to gain a specific type of reinforcement is temporarily and briefly removed contingent upon an identified unwanted behavior. Time-out - Type I involves removing access to reinforcement and does not involve moving the person. This may also include blocking the line of sight.

Time-out - Type II: A mildly restricted suppression procedure in which the person is to move away from an

activity to observe others participating in and receiving reinforcement for an activity. This is sometimes referred to as contingent observation.

Time-out- Type III: A moderately restricted procedure in which the person is guided away from reinforcing environment and is not within sight (or hearing is sight impaired) of the activity to observe. In this procedure observation by staff is continuous and exit is not denied. Re-entry into the reinforcing environment is contingent upon the exhibition of specified appropriate behavior(s). This does not include procedures designed to teach an individual the advantages of leaving an area to calm down when upset if physical prompts are not employed.

Time-out - Type IV: Refers to an enclosed area (i.e. time-out room), in which the individual is placed contingent upon the exhibition of a maladaptive behavior, in which reinforcement is not available and from which exit is denied until an appropriate identified behavior occurs. The individual must be under the direct constant visual supervision of designated staff and the door to the room must be held shut by staff or by a mechanism requiring constant physical pressure from a staff member to keep the mechanism engaged.

Total Task Training: A method of teaching a sequence of behaviors by reinforcing responses at each defined link in the chain of responses from the first to the last.

Unpleasant Physical Stimuli: Procedures that include a contingent stimulus which is unpleasant, but not physically harmful to the recipient, and which functions as a consequence to reduce the future probability of occurrence of the behavior it follows.

Visual Blocking: Blocking, without any physical contact, an individual's line of sight to a specific task, activity, person, or other stimuli that would potentially lead to reinforcement, following the occurrence of a specific response by the individual. This is a Time-Out - Type I procedure.

Visual Screening: The application of an item, one's hand, a hood, a towel, or other devices over an individual's eyes contingent upon the exhibition of a particular behavior. This refers to procedures involving physical contact with the individual and not those that merely block the line of sight. This is a highly restricted procedure.

**Appendix A:**
**Functional Analysis**

## FUNCTIONAL AND ECOLOGICAL ASSESSMENT

Various assessment methods are employed to examine the interaction between behavior and its environment in an attempt to determine what conditions and contingencies may be maintaining it. These methods explore the possible functions the problem behavior serves and examine the challenging behavior in its ecological context

### TYPES OF FUNCTIONAL METHODS

Functional assessments fall within three methods that are not mutually exclusive and may be used sequentially with the information from one often serving as the basis for the next.

*INDIRECT METHODS* are convenient rating scales completed with a person familiar with the individual in the natural setting. Examples of indirect methods include:

- Structured interview (see below),
- Antecedent-Behavior-Consequent (A-B-C) Analysis, scatterplots (Touchette,MacDonald, & Langer, 1985),
- Questions about Behavior Function (Vollmer & Matson, 1996), and
- Functional Analysis Screening Tool (Iwata, 1995).

*DESCRIPTIVE METHODS* are direct observations of behavior and environmental events in natural settings to formulate hypotheses about the operant function of the challenging behavior provides estimates of natural schedules of reinforcement. An example is the PDC Maladaptive Behavior Record (Pinecrest Developmental Center)

*EXPERIMENTAL METHODS* are procedures to isolate and control contingencies that may maintain an individual's challenging behavior using standardized procedures that are analogues of naturally occurring situations provides direct identification of functional relations. Examples include:

- Analog functional analysis (Iwata, Dorsey, Sliver, Bauman, & Richman,1982/1994)
- Brief functional analysis (Northup et al., 1991)
- Natural setting functional analysis (Northup et al., 1999)

### CONDUCTING A FUNCTIONAL ASSESSMENT

*RISK ANALYSIS*

- made at time of referral to determine if assessment is warranted (see Appendix B)
- risk-to-benefit analysis made prior to intervention selection (see Appendix C)

*STRUCTURED INTERVIEW* – conducted with primary support providers, focusing on the following:

- specifying the behavioral topography,
- operationally defining the behavior,
- identifying hypothetical antecedent and consequent events,
- identifying current medical problems, allergies, and medications,
- identifying previously attempted interventions,
- identifying current self-help and communication skills and primary skill deficits, and
- identifying typical activities/settings in which the behaviors usually do or do not occur.

*NATURALISTIC OBSERVATIONS* of behavior in ecological context observations made by examiner and/or

support staff

- determine how behavior changes across different times, activities, social situations
- determine how antecedent and setting events impact on the behavior
- collect data on low rate behaviors with scatter plot and/or frequency chart
- collect data on high rate behaviors with time sample
- observe in situations behavior is likely to and not likely to occur
- observe interactions with peers, staff and when alone
- observe interactions in "demand" or "work", leisure and social situations
- collect data on intensity and duration

*BASELINE* (pre-treatment) rates of challenging behaviors determined

- stable or increasing baseline indicates intervention warranted
- unstable or decreasing baseline indicates intervention may not be warranted
- compare with behavior rates during treatment to determine intervention effectiveness
- compare with behavior rates across settings or trainers to determine generalization

*REINFORCER ASSESSMENTS* identify preferred, naturally occurring items and activities

- reinforcer surveys and checklists
- free operant preference assessments (Roane, Vollmer, Ringdahl, & Marcus, 1996)
- forced-choice reinforcer assessments (Fisher et al., 1992)

***HYPOTHESES ABOUT BEHAVIOR FUNCTION*** are generated by the assessment and used to develop function-based interventions.

- identified function and ecological context of the behavior used to formulate hypotheses
- hypotheses incorporated into treatment rationale
- includes preventive and reductive interventions that correct maintaining conditions
- multiple hypotheses may require more extensive functional assessments

**MORE EXTENSIVE FUNCTIONAL ASSESSMENTS**

Some challenging behaviors have multiple functions, or the function may vary across settings. Assessments of these behaviors may require more convincing information and data than indirect interviews or naturalistic observations. These more intrusive methodologies require a risk analysis, consent and examiners trained in behavior analysis.

*TREATMENT PROBES* test hypotheses in natural settings

- systematically provide and withhold suspected setting events/maintaining consequence
- intervention trials with data collection
- compare behavior rates during treatment to baseline
- incorporate most effective treatment components

*FUNCTIONAL ANALYSIS* - manipulation of events to determine role in altering probability of behavior occurring

- test operation of alternative reinforcement mechanisms (social and nonsocial) and corresponding stimulus events under simulated, controlled conditions
- conditions rotated in semi-random order (multi-element format)
- if data are unclear, consider using reversal design or systematically altering conditions

**REPORTING RESULTS OF FUNCTIONAL ASSESSMENT**

- Methods and results should be reported in the evaluation.
- Results and hypotheses should be noted in the rationale of the behavior support plan.
- Risk analysis should be reported in evaluation and behavior support plan.

**Appendix B:**
**Risk Analysis in Assessment**

## PRE-ASSESSMENT RISK ANALYSIS

The following behavior or behaviors have been identified by the team as causing concern to the individual, his friends and/or staff. The risk that the behavior places the person in or others in is assessed below.

**I. BEHAVIOR OF CONCERN:**

During this year, _____ (behaviorally defined) has occurred _____ times.

The behavior has a higher probability of occurring in the following settings:

❒ Home ❒ other (specify)

❒ Work setting

If at home, the behavior occur more often at which times?

❒ During Week ( ❒ Mornings ❒ Afternoons ❒ Evenings)

❒ Weekends ( ❒ Mornings ❒ Afternoons ❒ Evenings)

**II. LEVEL OF PROBABLE HARM TO SELF/OTHERS/PROPERTY** (Check one)

❒ 1. The behavior poses no harm to self/others or property.

❒ 2. The behavior poses minor harm to self/others or property. (Examples: Theft of property, pushing, shoving, grabbing, or physical assault with no medical intervention required, throwing property without harm to the item or self or others, self-imposed marks on skin, bites/scratches not requiring medical attention)

❒ 3. The behavior poses significant harm to self/others or property. (Examples: Physical assaultive behaviors, the willful damage to the property of others or the community in which the person lives to the extent that the property must be repaired or replaced, verbal threats to kill oneself or others, physical damage to self or others where medical care is needed and going into the community without proper supervision)

**III. STAFF SUPPORT REQUIRED TO STOP THE BEHAVIOR (Check one)**

❒ 1. The behavior typically does not require any intervention from staff.

❒ 2. The behavior is averted with environmental intervention or engineering.

❒ 3 Staff typically verbally redirect the person to interrupt the behavior.

❒ 4. Staff have to physically intervene and ask for assistance from other staff in order to interrupt the behavior.

**IV. INDIVIDUALS'S GENERAL RESPONSE STYLE AFTER INTERVENTION (check one)**

❒ Withdrawn ❒ Remorseful ❒ Indifferent ❒ Hostile

**V. COMMUNITY TOLERANCE OF THE BEHAVIOR**

Based on your knowledge of laws of the State of Louisiana and the people's willingness to accept or condone _____ (behavior), what is your opinion of the overall community tolerance for this type of behavior? (Checkone)

❒ Never ❒ Rarely ❒Sometimes ❒Often ❒ Always

Given the discussion and initial risk analysis of the behavior of concern, the team has determined the following: (Check appropriate items.)

❒ Additional behavior assessment and/or support is not warranted at this time.

❒ A formal functional assessment is warranted.

❒ Behavioral strategies should be considered for incorporation into his or her ILP

❒ A formal behavior support plan is warranted.

**Appendix C:**
**Risk Analysis in Treatment**

## TREATMENT RISK-BENEFIT ANALYSIS CHECKLIST

### I. DETERMINE TREATMENT GOALS, ENVIRONMENTS, AND PROCEDURES

| Yes | No | |
|---|---|---|
| ____ | ____ | Does an important performance discrepancy exist? |
| ____ | ____ | Has the challenging behavior been defined in clear, measurable terms? |
| ____ | ____ | Has a baseline level of behavior been determined? |
| ____ | ____ | Has the intensity and severity of the behavior been determined? |
| ____ | ____ | Have all necessary functional assessments been made? |
| ____ | ____ | Have all treatment environments been identified? |
| ____ | ____ | Have alternative functional skills or replacement behaviors been identified? |
| ____ | ____ | Has generalization of treatments across time and settings been planned? |
| ____ | ____ | Have all treatment materials been determined and provided? |
| ____ | ____ | Have all other ancillary resources (speech, O.T.) been determined and provided? |
| ____ | ____ | Has a historical analysis of the person been conducted? (Record, interview) |
| ____ | ____ | Has a previous behavior history been conducted? |
| ____ | ____ | Has a previous behavior treatment history been conducted? |
| ____ | ____ | Has a behavior function been determined? |
| ____ | ____ | Has the least restrictive, most effective, function-based intervention been identified? |
| ____ | ____ | Has a risk-benefit analysis been conducted? |

### II. STAFFING CONSIDERATIONS

| | | |
|---|---|---|
| ____ | ____ | Is there an adequate number of staff for safe and effective treatment? |
| ____ | ____ | Has a supervisor of program implementation been identified? |
| ____ | ____ | Have staff been assigned for monitoring and treatment integrity assessment? |
| ____ | ____ | Has a supervision and/or monitoring schedule been identified? |
| ____ | ____ | Have staff been assigned for data collection, analysis, and display? |
| ____ | ____ | Has a system of behavior drill and reliability checks been put in |

place?

**III. ONGOING EVALUATION OF PROCEDURES**

____ ____ Has criterion for determining effective treatment been determined?

**Appendix D:**
**Staff Training Outline**

## BEHAVIOR SUPPORT TRAINING FOR

## DIRECT CARE STAFF

I. The Role of Values In Formulating An Approach To Behavior Support.

a.) Identifying and listening to person "messages" (wants, desires, feelings, preferences, dislikes, etc.)

b.) Rights.

c.) Dignity, respect, tolerance.

d.) Choice - in the real world.
- Emphasize the difference between acceptable choices and noncompliance

e.) Responsibilities which accompany choice.

f.) Desire to promote growth and independence.

g.) Emphasis on positive Behavior Programming.

h.) Emphasis on self-regulating strategies

II. The Importance Of Creating A Meaningful Environment In Order To Support Appropriate Behaviors.

a.) Meaningful daily activities/fun things to do.

b.) Daily, weekly, monthly planning with individuals supported.

c.) Home and personal responsibilities for individuals supported.

d.) Methods for identifying person specific stressors and modifying the environment.

e.) Effective ways to determine the person's satisfaction.

III. Staff/Person Interactions.

a.) Issues that affect staff/person interactions.

1. relationship with the person.
2. personal characteristics of staff.
3. understanding one's own feelings and reactions.
4. understanding developmental disabilities and its effect on the person.
5. understanding DSM-IV disorders.
6. understanding physical limitations, medical issues and medication effects
7. the person's/staff's mood at the time of interaction
8. location of the interaction
9. "topic" of interaction

b.) What is behavior?

1. How is it defined?
2. How is it supported?
3. How is it reduced or extinguished?
4. How is it measured?

c.) Staff Interaction Skills.

1. Every interaction is a reciprocal learning opportunity.
2. Communicating with individuals who evince cognitive and language difficulties
3. Reinforce positive behaviors
4. Assist in problem solving
5. Assist in conflict resolution
6. When to ignore inappropriate behaviors?
7. Counseling of the person.
8. Interrupting inappropriate aggressive behaviors, self-injurious behaviors and/or property destruction.
9. Redirect.
10. Environmental engineering
11. Fading assistance (using least amount of assistance necessary)
12. Offering choices to encourage appropriate behavior

d.) Skill Acquisition

1. Informal training
   - Prompting/reinforcing skill the person already has in repertoire to increase use of skill
   - Share knowledge of how the world works
   - Model social behaviors
2. Formal Training
   - Objective identified in the plan
   - Training protocol/task analysis
   - Assigned generalization responsibilities
3. Prompting levels/strategies
   - Verbal
   - Gestural
   - Modeling
   - Physical Guidance

e.) Reducing Challenging Behaviors (To cover training in all reductive and prevention procedures in this manual)

1. Interventions staff can use "at will"
2. Intervention strategies which can only be used as part of a support plan or when authorized by a QMRP
3. Medication usage for behavioral control versus DSM-IV disorders

f.) Documentation (for Adaptive skills and Challenging behaviors)

1. Purpose
2. Types
3. Review of Forms

IV. Behavior Support Plans.

a.) Why we have plans.

b.) Overview of how specific intervention strategies are decided upon
- Staff role(s) in the process

c.) Overview of the due process procedures required for intrusive strategies and why

d.) How to read a plan.
1. Preventive measures
2. Reductive strategies
3. Replacement behavior training/skills acquisition
4. Behavior support medications

e.) What to do when you believe the plan's not working.

f.) What to do when you believe/know a particular strategy (not in the plan) really works

g.) Importance of implementing the plan as written

**PERSON SPECIFIC TRAINING**

1. Specific Behavior Support Plan

a.) Targeted behaviors

b.) Intervention strategies

1. Prevention
2. Reductive strategies
3. Replacement behavior training/skills acquisition

c.) Data collection

d.) Effective communication

e.) Plan monitoring/feedback

f.) Where cues/summary information will be kept

II. Specific Behavior Support Medications

a.) Specific medications prescribed

b.) Expected effects (to include identification of medication targets to be tracked)

c.) Side effects of medication

III Importance of notification when non-targeted significant behaviors emerge

**TRAINING RELATED TO PROFESSIONAL STAFF**

FOR EACH DISCIPLINE:

1. Overview of Behavior Support Fundamentals (to be determined based on the role of that discipline at the facility)

2. Role in provision of behavior support services

    a.) Plan development

    b.) Plan monitoring

    c.) Plan integration

III. How is BSP developed?

IV. What does BSP look like?

22. Where can completed BSPs be found?

VI. How does BSP integrate into other areas?

NOTE: Staff members responsible for the provision of behavior support services will be required to have expertise/knowledge in all areas described in this outline. Residential supervisors will be required to know and demonstrate competence in all areas in which their staff are required to know and demonstrate competence.

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