POLICY STATEMENT: Individualized Planning

Adopted by the Board of Directors 06/25/2015

It is the policy of Open Options UCP to provide coordinated, individualized, person-centered plans of service to persons served with the purpose of supporting individuals in achieving their desired goals and ensuring their needs are met. The plan shall be constructed to facilitate support for the individual served based on his/her strengths and abilities, needs and desires, individual values and preferences and their cultural/familial background. The organization regards education, coordination, and support toward achieving interdependence as its primary services.

Formal learning and support activities shall be carefully planned and coordinated through the framework of an individualized plan as authorized by the person served, his/her guardian and his/her support team. The plan shall define desired outcomes and a plan of action that reflect the unique needs and preferences of the person served. The plan should focus on integration of the person into the community and other support systems, including addressing any social barriers to inclusion. The person centered plan is a continuously evolving document, changing as individual's needs and desires change. Implementation of the plan shall be coordinated and periodically reviewed so that services remain relevant and are satisfactory to the person served, are delivered in a timely fashion and the results are measurable. Person served input shall be utilized in determining the effectiveness of the plan.

Procedures shall be implemented to meet accreditation standards and contract requirements of funding sources as applicable. As the requirements of funding sources may change, procedures shall be kept current in order to clearly state staff responsibilities in the process.

INDIVIDUALIZED PLANNING

PROCEDURE – Community Living Programs

The organization utilizes a "Person-Centered" approach to planning supports and services to individual persons served. Person-Centered Planning is the cornerstone of a person-centered approach to supporting people to live meaningful lives. A number of planning formats are available to use in planning, and these will be selected on an individualized basis. The goal of Person-Centered Planning is to a) understand the individual receiving services, and b) to deliver supports and services in a manner which assists the individual in meeting his or her life

goals. This will include the coordination of services and ongoing supports and opportunities for the individual to learn new skills and to participate in a variety of life experiences. In adherence to our philosophy, all employees of the organization will contribute to the process at varying levels of responsibility.

Duties for the preparation of the annual planning meeting, coordination of the meeting itself, and the completion of documents following a meeting are managed differently based on whether a person served has a county or state Support Coordinator. In all cases, Open Options UCP employees attend the meeting with information on progress of past year and recommendations for the coming year, including information gathered through the completion of assessments as well as informal conversation with the person served. Once the Person-Centered Plan is received, Open Options UCP is responsible to implement and document in areas where the plan assigns responsibility. The procedures described herein reflect the roles most commonly assumed by Open Options UCP and the Support Coordinator, and where "…or designee" is indicated it may be an Open Options UCP employee in many cases.

Scheduling the Planning Meeting

The planning process is complex and requires preparation time, therefore the meeting date should be set approximately 60 days prior to the implementation date. The planning meeting is scheduled and coordinated by the person served, with the support of the Support Coordinator or their designee. Annual implementation dates are within a timeframe determined by the Missouri Department of Mental Health (DMH). Initial meeting dates for those entering into Open Options UCP services should be held within 30 days after admission and should be scheduled as soon as practical after the person begins services. The Support Coordinator or designee will assist the person and/or their guardian to determine the specifics of the meeting, e.g. who to invite, when (day/time), where to hold the meeting, and who will facilitate the meeting.

The support team members chosen to attend the Planning Meeting are selected by the individual and/or his or her guardian. The support team participants are usually people whom the individual likes and trusts and who knows them well. Some options of support team members include friends, family, neighbors, church members, nurse, current or prospective service providers, and advocates. The ideal support team will include a variety of paid and unpaid people who know and care about the person and who can contribute to the overall

effectiveness of the planning process. The guardian, Support Coordinator and Quality Enhancement Coordinator are always invited to the Planning Meeting. The Support Coordinator generally leads the meeting, but the focus person may decide to facilitate their own meeting, or choose another member of the support team to do so. The Support Coordinator should work with the person/guardian to determine who will facilitate the Planning Meeting.

In determining when and where to hold the meeting, the Support Coordinator will help the focus person and/or their guardian to identify the best date and time for the availability of all invitees to attend to ensure participation. In deciding where to hold the meeting, the Support Coordinator should encourage a place that is most comfortable for the person that allows the needed privacy and space to carry out the meeting.

The Support Coordinator or designee will assist the person served to send invitations or otherwise notify support team members of the meeting date, time and location.

Information Gathering

The Support Coordinator will lead and oversee the planning process as outlined. The typical roles and assignments are described below, though the Support Coordinator may choose to designate employees other than those listed as warranted. Open Options UCP will identify and use assessments and interview processes that assist in defining supports for the coming year. Assessments and interviews with the focus person should be conducted in a private, comfortable atmosphere suitable to the preferences of the individual.

The Quality Enhancement Coordinator is responsible for coordinating the completion of the reports needed for the Person-Centered Plan. The following reports or assessments should be compiled at least two weeks prior to the planning meeting:

- Current physical and/or other related health assessments
- Vocational/Day Program - written or verbal report of progress and goals
- Toxic Substance, Water Temperature Evaluations
- Financial Information & Money Management Assessment
- Levels of Supervision Assessment
- Review of Individual Rights - verbal report of any identified rights training needs
- Verbal report of interviews with the focus person or family members

- Written report from employees and others as applicable
- Updated personal inventory form
- Missouri Quality Outcome Survey

During the planning process, the action plan from the past year should be reviewed, and the person served will be given the opportunity to state his/her satisfaction with the progress made, and determine whether this is a goal to be continued. The support team will discuss any plans for the future as identified in the reports, assessments or interviews. The Support Coordinator will review the individual's desires for topics to be discussed at the meeting and assist him/her in preparing to share preferences, wants and needs.

The Planning Meeting

The facilitator of the meeting will guide the support team through the topics that are important to the person served, always encouraging the individual to participate in the process. Participants shall be prepared to discuss in detail the person served's strengths and needs, progress and satisfaction regarding goals during the past year, identified preferences, health status and support needs. The person served shall be supported in leading his or her own meeting as much as possible. Reports and assessments may be available for review as needed.

It is hoped that the presence of a family member or guardian will provide additional assurances that the person served's interests are represented. If the guardian or a relative of the resident are not able to attend the meeting, the involved employees shall make extra efforts to speak toward issues of concern to the person served, including those discussed during preference interviews prior to the meeting, and advise the team of the person served's views. Input from the person served, or input made in the person served's behalf, shall be incorporated into the individual's plan.

Key themes will be identified through the planning process. These may be identified as roles or values that we can support for the person served. For each area, a defined "outcome" will be identified, and a plan will be identified to attain the outcome. This will include specific, measurable steps to take in order to reach the person served's goal, and will define and designate persons responsible with timelines for completion.

During the planning meeting, key principles of Person-Centered Planning shall be utilized.

These include but are not limited to:

Focus on the individual - including the person's interests, talents, and a process that works for the person.

a) Focus on the positive and minimize the negative.
b) Focus on relationships and building connections.
c) Focus on action and outcomes - developing supports that make sense based on the person's choices and preferences.
d) Focus on problem solving - including willingness to confront difficult realities (e.g. choice vs. risk) and figuring out how to support people in a lifestyle that they define.
e) Focus on any identified barriers and how they might be overcome.
f) Focus on what the person wants or needs, not what is available from the current service system.
g) Focus on a desirable future for the person as he or she defines it.

As the action plan is developed, encourage the person and support team to develop goals in three areas: support goals for team members, skill building goals to minimize dependence on others, and goals that enhance an individual's personal interests.

<u>After the Meeting</u>

The Quality Enhancement Coordinator will update the Person Served Information Sheet and file all assessments and reports used for the planning process. The Quality Enhancement Coordinator will direct and oversee any follow-up actions required as determined in the planning meeting.

If any restrictions or limitations are identified in the planning process, the Quality Enhancement Coordinator will begin the approval process as identified in the Person Served Rights section of this Policy & Procedure manual.

<u>Construction of the Written Plan</u>

The responsibility for producing the written plan will be determined by the support team. For individuals receiving Support Coordination through Jackson County, the Support Coordinator is most often the point person in constructing the plan. For those plans to be written by Open Options UCP, it is the responsibility of the Quality Enhancement Coordinator in conjunction

with the support team to develop the written, measurable outcomes and action plans to address the service, support, and training needs of the person served, and when applicable, teaching plans to meet the objectives. This may be delegated in part to qualified employees.

The Open Options UCP Person-Centered Plan shall meet all requirements of the Department of Mental Health for planning. The plan should include specific goals and action steps toward achieving outcomes. The outcome describes an annual goal, something to be accomplished in the coming year. This may be an end in itself, or it may be a step toward a long-range goal. The goal shall be defined in measurable terms, and the person served along with others on the support team shall have input in determining the criteria for measuring the completion of the outcome.

Each goal and list of action steps will be identified and included in the plan with the overall outcome described as one of the Missouri Quality Outcomes. Action steps will identify a course of action for completing the outcome. Action steps will include target dates and an assignment of responsibility for completing the step. Action steps may be designated for the person served, organization employees, family members, or others on the support team.

The plans written by Open Options UCP shall be submitted to the Kansas City Regional Office (or Jackson County) Support Coordinator 30 days prior to implementation. The Support Coordinator ensures the person served and/or the guardian has the opportunity to review the plan before giving consent. A copy of the plan will be provided to the person served by the Support Coordinator once the plan is officially approved.

<u>Plan Implementation and Documentation</u>

The Quality Enhancement Coordinator assigned to the Person-Centered Plan shall determine the means of documentation of the goals and supports outlined in the plan. The Quality Enhancement Coordinator or designee will create data sheets or identify other methods of documenting supports and goal progress.

The Quality Enhancement Coordinator is responsible for the initial training and orientation of employees to the plan. Upon completion of the written Plan, the Quality Enhancement Coordinator will schedule employees for training on the plan and the documentation required. The Quality Enhancement Coordinator shall orient employees to the total plan, including the desires, goals, and general support needs of the person served. Training will be recorded on

the Person-Centered Plan Training Record. After this initial training, it is the responsibility of the Quality Enhancement Coordinator to train employees not in attendance as well as any future employees (including contracted temporary employees). Under the direction of the Quality Enhancement Coordinator, the Manager is designated responsible for the overall supervision of plan implementation for each person served in the home. The Quality Enhancement Coordinator is responsible to spot-check implementation as they review data and make routine observations in the home.

Planning Timeline Summary

a) Schedule the meeting 30 days prior to meeting date.
b) Assessments and interviews completed 15 days prior to the meeting date.
c) Meeting date 60 days prior to implementation date.
d) Plan finalized and sent to Regional Office 30 days prior to implementation date

Plan Review and Monitoring

Under the direction of the Quality Enhancement Coordinator, each person served's Person Centered Plan shall be formally reviewed at least monthly. To complete the monthly review, the reviewer shall:

a) Read the progress notes for the previous month.
b) Review and calculate progress on goals.
c) Read all health care notes, nursing notes, seizure chart, vital signs and physician reports.
d) Review the employee logs, activity calendars, event reports, personal fund ledgers.
e) Review any documentation from the work or day program.
f) Recall any personal observations from the previous month.
g) Review documentation or recall any family or friend interactions.

When this list is completed, the reviewer will have the required information to complete a thorough monthly review on the appropriate Monthly Review form. Once completed, the report shall be reviewed with the person served. The person served shall be encouraged to provide input and questions to determine if revisions in the plan are needed. Comments shall be noted on the face sheet of the review. The monthly review shall be signed by the person served and the reviewer(s). If the persons served's signature is illegible, employee (or guardian/advocate) shall sign as "witness." The monthly review will be completed by the due date on the Open Options UCP planning calendar.

Prior to the 15th of the following month, the Quality Enhancement Coordinator will assess whether any changes need to be made to the person centered plan, if any follow-up action is needed with direct support employees, or if other action is required. The Quality Enhancement Coordinator will then read and review the monthly nursing assessment and any physician visit forms.

Revisions to the Plan

The Person-Centered Plan document should always contain current information, with the identified supports and services occurring as outlined in the plan. Based on person served input and/or the identification of support needs, plans may be revised after they are implemented. In some cases, action steps may be added, revised or deleted to better meet the needs of the person served. Significant changes to the plan will require a written addendum with the involvement of the support team. When needed changes are identified, the Manager or designee will alert the Quality Enhancement Coordinator who will consult with the person served (or guardian if applicable) and Support Coordinator to determine the necessary modifications and levels of approval.

If addendums are required for plans that are written by county Support Coordinators, the Quality Enhancement Coordinator will alert the Support Coordinator. If addendums are required for plans written by the Quality Enhancement Coordinator, the Quality Enhancement Coordinator will write and submit them to Director of Quality Enhancement for approval before then sending to the Support Coordinator.

Coordination of Outside Agency Services

The Quality Enhancement Coordinator will ensure the coordination and integration of support services received outside of the organization. Open Options UCP employees will communicate with support services to promote continuity. Contacts with other agencies and progress on services rendered shall be documented as follows:

a) Person Centered Plan Action Plans - referral to outside services and ongoing coordination of services shall be documented as part of the regular review of the plan. Whenever possible, outside supports should be included as specific action steps to a desired outcome, however, if this is not the case, progress shall be documented in progress notes and under general

comments of the monthly review.
b) Medical Services - documented in the person served's medical file as healthcare notes along with filed assessments or doctor visit forms.
c) Employment/Employment Training/other day programs - contacts and progress notes shall be documented on the Training/Employment Contact Log.
d) Other Outside Support Services, shall be entered on the monthly review of the Person Centered Plan as general progress notes/comments. When ongoing support coordination is anticipated as the result of additional support services, the Plan may be modified to indicate this.

COMMUNITY MEMBERSHIP

PROCEDURE - All Programs

Open Options UCP recognizes that persons and families receiving services bring with them their own values, beliefs and attitudes regarding such issues as culture, age-appropriateness, gender roles, sexual orientation, spiritual beliefs, socio-economic status, and communication style. These are all factors to be considered in supporting individuals to participate in and to become active members of their communities.

In order to facilitate opportunities for persons with disabilities to participate in their communities, the following guidelines will be utilized on an individual basis. The ultimate goal is to assist people in becoming members of their communities, with consideration given to individual choices, attitudes, and preferences. These guidelines consist of five broad goals, with suggestions that may be implemented on an individualized basis through the mechanism of the Person-Centered Plan and in daily activities. The five goals are:

1. Persons served in all program locations will become active participants in the community where they live through:
- Participation in leisure activities which are age appropriate,
- Participation in cultural events, arts, and ethnic life,
- Participation / support in appropriate hygiene & grooming standards,
- Participation and support in acquisition of skills accepted by the community,
- Physical support or environmental adaptations for acceptance,
- Use of assistive devices,
- Identification of barriers in the community and advocacy for reducing or eliminating these

barriers,
- Use of typical transportation services and methods.

2. Persons served in all program locations will have positive relationships with people who are not paid providers by:
   - Supporting persons served to develop and/or sustain positive friendships,
- Supporting persons served to re-establish or sustain relationships with family members,
- Establishing opportunities for social contact with the same group(s) of people,
- Supporting opportunities for persons served to invite guests to their homes or to invite guests on special outings,
- Supporting responsible/consenting and intimate relationships with others.

3. Persons served in all program locations will have the opportunity to contribute to their community by:
- Having the opportunity to join or assume roles in various community organizations, including religious organizations of choice,
- Having the option to volunteer,
- Having the opportunity to help their neighbors and friends.

4. Persons served in all program locations will have the opportunity to have communications recognized, responded to, and supported by:
Use of supports and/or services which enhance functional communication,
- Availability of alternative communication devices for use at all times and in all environments,
- Use of alternative communication methods, for example sign language,
- Ensuring that individuals' suggestions, opinions, and other communications are recognized and receive a response,
- Promoting a physical environment that is conducive to communication and positive interaction, including encouraging the individuals to include in their environment accessories and personal possessions which promote conversation.

5. Persons served in all program locations will have opportunities to interact in a manner which promotes inclusion in community life by:
   - Participating in a supportive environment where most individuals engage in positive, acceptable interactions,
   - Being assured continued and varied access to the community,

- Opportunities for a variety of program strategies for teaching and learning appropriate adaptive behaviors.

SUPPORT COORDINATION AND REFERRAL

PROCEDURE – Family Support, Targeted Case Management

At the time of admission or intake to Targeted Case Management Services, a Support Coordinator is chosen by the person served or designated to ensure the coordination of all services and supports. The Support Coordinator shall ensure that all admission procedures are carried out, including orientation of the person served to the organization and to the specific services offered, documenting and gathering information for the establishment of the Person Served Case Record, initiation of procedures for the Person Centered Support Plan, and all other admission procedures.

The President/CEO will designate a secondary Support Coordinator contact to provide services and facilitate continuity when the primary Support Coordinator is not available.

Support Coordination may include the following:

a. Provision of information and referral to existing support systems within the community, with routine follow-up and additional referral as indicated. This will be documented in the person served file.

b. Coordination of information and input for the Person Centered Support Planning process, including but not limited to: information about the preferences, needs and desired outcomes of the person served (and family members, as applicable); coordination of assessments and/or questionnaires which promote the input of persons served and their significant others; coordination of the Planning Meeting; development of the written Plan, Follow-Up Services to the person served and family and Monitoring of the Plan throughout, including times of transition for the person served.

c. Identifying, in conjunction with the person served and/or family members, targeted results or outcomes of service and identifying resources or actions to achieve these outcomes.
d. Implementation and documentation of the Plan, including data collection, reviews of progress, and arranging for addendum or modifications to the plan when the person served's

needs or level of satisfaction indicate such a need.
e. Coordination and integration of supports and services, including links to community resources, natural supports (such as support from family members, neighbors, etc.,) health related services, and any other services which are reasonable and necessary to meet the basic needs of the person served. Use of outside services shall be documented on the appropriate organizational form and included in the monthly review of the Plan. Whenever possible, coordination of outside supports shall also include opportunities for the person served to learn skills to access and use the services as independently as possible, and to make informed choices about the services selected.
f. Ongoing review of the person served's financial situation to ensure the person served has access to all appropriate government and generic benefits, such as SSI/SSA, Medicaid, Medicare, Food Stamps, and utility assistance. The Support Coordinator will gather appropriate financial information, make appropriate referrals, and document responses in the Person Served Case Record.
g. Ongoing assessment of the person served's need for advocacy - The Support Coordinator will provide informal advocacy as appropriate, including opportunities for the person served to engage in self-advocacy, and makes referrals for formal advocacy when needed. Formal advocacy is available through community agencies such as Kansas or Missouri Protection and Advocacy, the Community Developmental Disability Organization or Families Together, Inc.
h. Ongoing support and coordination of community membership opportunities, including opportunities to enhance social and natural support networks in the individual's community.
i. When applicable, coordination of supports for crisis assistance, which may be met through a rotating schedule of the Support Coordinators.

The frequency of contact and intensity of service provision for all of the above services may be identified in the case notes for each person served casefile, or in the Individualized Person Centered Support Plan.

POLICY STATEMENT: Behavioral Support
And Restrictive Procedures
Adopted by the Board of Directors 06/25/2015

It is the policy of Open Options UCP, that assisting persons served in acquiring behaviors that will maximize community integration is an integral part of our service. Employees are trained in strategies to identify and provide supports to help persons served reduce social barriers. We further believe that approaches to changing behaviors should be positive, of the least

restrictive nature possible, and that positive approaches to changing behavior must be employed before utilizing restrictive procedures. Behavior support and intervention methods shall preserve the dignity and personal safety of persons served at all times.

Any plan, contract, procedure, or staff action taken which significantly alters or limits a person served's freedom of movement, use of leisure time, use of property, or exercise of normal privileges is considered a "restrictive procedure or intervention." Any "restrictive procedure or intervention" is required to meet the level of review, consent, data collection and authorization required by the Missouri Department of Mental Health (or other authorizing organizations), and Open Options UCP internal procedures, including the consent of the person receiving services and/or his/her guardian. Intervention procedures are designed to identify target behaviors and replacement behaviors, and attention is given to environmental factors that may contribute to the target behavior. Corporal punishment, aversive conditioning, seclusion, physical/verbal/ psychological abuse, or any other procedure which would violate abuse and neglect policies and regulations or be considered personally degrading are specifically prohibited.

In some instances, rules for the common good, and program expectations designed to serve the organization's mission may act to limit freedom of people served. These rules may be instituted only with the written approval of the Director of Community Living, and are subject to review of the Human Rights Committee and/or Department of Mental Health. Expectations and rules must be applied equally to all persons served in a program or program location, and communicated to the person served, guardian, and funding source upon admission and at subsequent revisions.

BEHAVIOR SUPPORT – General

PROCEDURES – Community Living Programs

Behavior support is a broad term encompassing employee actions / reactions and plans and agreements with persons served which are designed to: help the person learn behaviors to reach their own personal goals; help the person learn to make responsible personal choices, and minimize behaviors which put the individual and others at risk. Our procedures describe three types of support – preventive, positive, and reactive – which are all aimed at building or reducing the incidence of actions by a person served where there is agreement that these actions or behaviors interfere with a person's goals or jeopardize health and safety.

Human beings are each unique, and being different does not in itself necessitate change. Before any intervention, we must first question what we want to change and why we want to change the behavior. Some questions we might ask about the behavior: is it harmful to the person? Is it harmful to others? Is it disruptive to the person's daily life? Does it limit them or cause problems with relationships? While a person may display some behaviors that are not typical, there may not be a substantial rationale for seeking change.

During the implementation of behavior support strategies, positive approaches to understanding and changing the behavior must be utilized and the results documented prior to the implementation of restrictive procedures. It is intended that these processes be used successively, that is, that preventive and positive strategies will be applied in order to support individuals in developing positive behaviors and coping skills prior to the use of more intensive strategies. When preventive and positive strategies are not effective in supporting the individual, or when the problematic behaviors are of a greater severity, reactive supports, which may include a full functional analysis of the behavior, will be developed. Except in rare situations, restrictive strategies will be considered only after positive strategies have been utilized and documented, and this will involve a level of more intense review and authorization.

BEHAVIOR SUPPORT - Preventive Strategies

PROCEDURES – Community Living Programs

Preventive Strategies: These activities are designed to prevent negative behavior from developing. These include:

a. Understand the individual**.** Through the mechanism of Person Centered Planning and through daily interactions, employees should develop an understanding of the desires, goals, strengths and needs of each individual in the program. Effective behavioral support requires that we recognize and respect each person served's unique routines and preferences to the greatest extent possible, and to assist persons served in obtaining the maximum amount of control over their daily routines, within responsible limits.

b. Structure living and learning environments in ways that make positive actions more likely and problematic actions less likely. When we understand the individual, we can adapt the

environment in the most positive way to eliminate or reduce factors that cause stress, frustration and potentially negative actions or behaviors. The environment may include physical surroundings (e.g., amount of light, noise, people, etc.), daily routines/schedules, and availability of adaptive equipment if applicable. Within reasonable limits, the environment should be structured in such a way as to promote positive behaviors and coping skills among all persons served in the program. Employees will enrich the environment with comfortable temperature, available activities, respectful and positive conversation with individuals that allows for choice and individuality.

c. Consistently reward and promote positive behaviors. Employees shall model appropriate actions as a method of teaching. In order to promote positive behaviors, employees should identify the positive things the person served is doing which will help him/her reach personal goals. Employees should also identify things which the person served finds rewarding. Sincere praise, communicated verbally or non-verbally (smiles, "thumbs up"), is an effective and often under-used reward. When shaping behaviors in an effort to reduce negative actions, rewards must be given frequently and consistently for positive actions. Gradually, after negative actions have diminished, external rewards can be faded and replaced with natural positive consequences, such as reaching personal goals.

d. Avoid rewarding negative or problematic behavior**.** Experience suggests that some people find attention rewarding, even negative attention. It is important to pay more attention to positive actions/behaviors, no matter how small, than to negative actions/behaviors. Not all undesirable behavior, however, can be ignored. This balance must be carefully maintained. If a person served's actions pose an immediate and imminent threat of harm to themselves or to others, including causing distress to others who live in the home, the actions cannot be ignored and employees must intervene. Employees must be aware that providing negative feedback for undesired behavior is not considered a preventive strategy.

BEHAVIOR SUPPORT – Positive Strategies

PROCEDURES – Community Living programs

If it is determined that behavior support is needed, the cause or function of the behavior must be considered prior to intervention. Before any intervention, the support team should define the specific behavior that needs to change and complete an informal analysis of the circumstances surrounding the identified behavior. This might include determining when the

behavior occurs, where the behavior occurs, possible motivators for the behavior or if the behavior is a related to a medical issue. From there, the team will develop strategies to support the person, using positive measures before implementing restrictive procedures whenever possible.

In keeping with Open Options UCP's policy regarding behavior support and restrictive procedures, positive approaches to changing behavior must be utilized and the results documented prior to the implementation of restrictive procedures. It is intended that these processes be used successively. That is, Preventive Strategies are utilized on an individual or group basis to guide behaviors. Informal counseling and training are used to support the person served in developing positive responses when a negative action or ineffective behavior is identified. More formal strategies may be implemented under the direction of the Support Coordinator, utilizing positive methods, through short-term contracts, action plans, or positive behavior support plans. If this fails to influence a person served's behavior, restrictive procedures may be enacted through reactive strategies (see next section) which include more stringent approval and review requirements. Through these successive steps, employees shall prevent premature use of procedures which are more intrusive than absolutely necessary to influence the behavior of a person served.

Positive Strategies include:

a. Informal Counseling and Training occurs with the provision of feedback, suggestions, and instructions without any stated or implied negative (imposed) consequences. These are daily interactions between employees and persons served on a spontaneous and casual basis. When these interactions occur, employees should engage in open, active communication with the person served, including genuine listening and responding. Responding includes letting the person know we've heard them and responding with empathy to the level of urgency that they are feeling. Whenever possible, the person served should be encouraged to generate solutions for their problems, weigh the advantages and disadvantages of each solution, and select a course of action. Employees should provide support and counseling to reach a positive solution, and arrange for a time to "follow-up" on the solution to see how it is working. Informal counseling offers opportunities for employees to teach positive behaviors by using the following sequence:

(This sequence is modified from *The Teaching Family Model*; Braukmann, Ramp, Tigner & Wold, 1982.)

- Describe, demonstrate, or explain the positive action (what to do or how to do it.) This includes giving a specific description, giving examples, and explicitly modeling the desired action or behavior. Employees should be specific and break down complex behaviors into smaller components. Employees should encourage persons served to express their ideas for "how to handle" a situation and to express positive alternatives for problem-solving.
- Discuss reasons for doing something or for doing it in a certain way. Persons served and employees together should discuss rationales for certain behaviors that are reasons/advantages for the action that are meaningful and desirable to the person served.
- Supervise opportunities for practicing certain behaviors. Practice is critical for the teaching of new skills because it allows the staff person to support and coach the consumer in refining and becoming comfortable with the skill. It also allows the employee to be sure the person served understands the skill being taught.
- Provide positive feedback including praise. Employees should be constantly aware that rewarding (reinforcing) behavior increases the likelihood that the behavior will be repeated. The use of positive feedback in teaching new skills not only increases the likelihood that the skills will be used; it also helps make the teaching interaction more pleasant.

Employees will document informal counseling and training in the progress notes.

b. Behavioral Support Action Plans / Behavior Shaping Plans

New skills, including alternative behaviors and "coping skills" may be developed through consistent teaching methods. For behavioral support, an outcome and action plan may be included in the Person Centered Plan. The action steps should include specific strategies to teach positive behaviors and coping skills.

When a maladaptive behavior is targeted, a positive program provides for a reinforcement or reward when the positive "replacement" behavior is demonstrated. "Rewards" should be negotiated with the person served to ensure that they are powerful and meaningful to the persons served.

At times, a short-term contract or behavior shaping plan may be developed without a formal addendum to the person centered plan. These short-term plans must use only positive

behavior support strategies and must be approved by the support team. When Positive Behavioral Supports are included in the Person Centered Plan, and/or a short-term plan is utilized, the strategies may include:

1) **Antecedent and setting-event modifications**, also known as short-term prevention strategies. Once the team identifies specific events that trigger problem behavior, they can be eliminated or modified to prevent problem behavior from occurring. Antecedent modifications provide the opportunity to teach alternative skills and build supportive environments, instead of reacting to individuals in crisis. Second, antecedent modifications avoid the problems and negative consequences often associated with reactive interventions. Five common setting event modifications are:
    a. Remove a problem event (avoid taking the person to crowded areas, avoid exposing the person to long delays, etc.)
    b. Modify a problem event (change your voice intonation when communicating, modifying/revising a boring schedule, using suggestive rather than directing language, treat a person's physical illness)
    c. Intersperse difficult or unpleasant events with easy or pleasant events (schedule non-preferred activities (cleaning) among preferred activities (leisure), proceed prompts for non-preferred activities (brushing your teeth) with easily followed prompts (opening the cabinet, choosing your favorite toothpaste)
    d. Add events that promote desired behaviors (schedule preferred activities in daily routine, involve the person in planning their schedule to increase predictability, provide the person with a rich variety of activities from which to choose, provide increased opportunities for social interactions)
    e. Block or neutralize the impact of negative events (provide opportunities for rest and relaxation when the person is tired or ill, provide time alone or time to regroup after a negative experience)

The success of antecedent and setting-event modifications often depends on a carefully arranged environment. In the event that employees cannot prevent problem situations, or the person goes to another setting in which modifications are not in place, challenging behaviors are likely to recur. Longer lasting results are achieved by helping people learn the skills they need to control their own environment (alternative skill training) and by creating long-term supports to maintain and generalize new skills and enhance their quality of life.

2) **Teaching alternative skills.** Typically, people engage in challenging behaviors because (a) they do not have the skills (or are not fluent in the skills) to meet their needs or (b) they have learned that these behaviors can bring about desired results (e.g., shouting to get something is often more effective than appropriately asking). Alternative skill instruction can be categorized into three distinct approaches:
    a. Replacement skills – one-to-one replacement skills that serve the same function as the problem behavior (Teach the person to communicate to replace head banging to escape difficult tasks). If the replacement skill does not produce the same result in the same or shorter amount of time as does the problem behavior, it will not be effective for the individual.
    b. General skills – broad skills that alter problem situations and prevent the need for problem behaviors (teach organizing/planning skills to prevent the individual from becoming frustrated when faced with multiple tasks, teach the individual to self-initiate activities to prevent boredom)
    c. Coping skills – skills that teach individuals to cope with or tolerate difficult situations (help the person learn to relax during stressful events, teach the person to self-soothe to accept medical examinations or tolerate fire drills). Consider providing extra incentives or rewards for the person when he or she is coping through difficult events, and be sure to provide strong words of encouragement and praise for a job well done.

3) **Consequence interventions** – teaching the person that (a) alternative skills are a better strategy for bringing about desired results, and (b) problem behaviors are ineffective, inefficient, or a socially undesirable means for achieving goals. Examples of consequence strategies:
    a. Increase the use of an alternative skill (respond quickly to an appropriate verbal request to discontinue an activity, praise the person for problem-solving an issue)
    b. Reduce the outcomes of problem behavior (redirect the person to another activity or prompt him or her to use an alternative skill)
    c. Crisis management (at first signs of crisis engage the person in a calming/preferred activity). Crisis management does not contribute to the teaching aspect of the plan. It is purely an emergency procedure used to protect the individual and/or others from harm to de-escalate crisis situations should other approaches in the support plan fail to prevent dangerous

behaviors from occurring.

4) **Long-term supports – geared toward the long-term prevention of problem behaviors.**
    a. Lifestyle interventions – general improvement of the person's quality of life. A person's poor quality of life (limited opportunities for choice and control, loneliness, exclusion) or dissatisfaction with daily events may contribute directly to the problem behavior.
        - Help the person develop a peer network.
        - Incorporate daily opportunities for choice in activities and routine.
        - Help the person maintain existing friendships.
    b. Maintenance and generalization strategies – allow for ongoing, long-term support of the individual.
        - Teaching other persons in a setting how to make specific accommodations for the individual.
        - Teach the support team to reinforce the use of alternative skills over time and in other settings (generalization).
        - Help the person practice and praise the use of new skills in different settings.
        - Help the person set and monitor goals.

Sources:Designing Positive Behavior Support Plans –Second Edition. Linda M. Bambara and Timothy P. Knoster

http://jan.ucc.nau.edu/~jde7/ese425/cog/punishment.html; Mandt System Trainer Manual (revised January 2010)

For some individuals, the most "powerful" rewards could have potentially negative health effects. For example, food, candy, and tobacco products may be highly desired by a person served as a "reward" or reinforcer for positive behavior. Employees must be cautious about the type of "rewards" selected. Positive behavioral support programs which use reinforcers with potentially negative health effects shall be used ONLY when alternative reinforcers have proven ineffective, the programs are time-limited, and the program is not medically, psychologically, or nutritionally contraindicated. Such programs shall be designed and monitored with input from appropriately qualified professionals, and must be approved by the support team.

BEHAVIOR SUPPORT - Reactive Behavioral Support Strategies

PROCEDURE – Community Living programs

As the term implies, Reactive Strategies include a specified reaction by employees in response to the presentation of a defined behavior. When designing Reactive Strategies, the goal is to understand the nature of the problem behaviors before intervening. This type of support involves the use of multiple strategies, and may or may not include the use of restrictive procedures. (See also procedure for use of restrictive procedures below.) Reactive support strategies are developed by the Quality Enhancement Coordinator in conjunction with the Manager with input from the person served, employees, and whenever possible, from the guardian, family members, or other advocates of the person served. Reactive support strategies and plans involving the use of any type of "negative consequences" must be reviewed and approved by the support team. Any behavior plan using restrictive procedures must also be reviewed by either the organization's Human Rights Committee or the Kansas City Regional Center's Human Rights Committee. Following approval, the Reactive Support plan will be integrated in the person served's Person-Centered Plan. Employees will be responsible for recording data as specified in the plan.

Plans/Outcomes involving Reactive Support Strategies shall include review of the following factors. Each step of review need not be documented separately, but an overall summary or description of the issues shall be included in the Person Centered Plan.

a. Review environmental factors and previous interventions which were determined to be ineffective. Consideration should be given to other problems which may be a factor in the behavior, such as medical conditions, medication side effects, psychiatric conditions, and other life stressors (e.g., death in the family, recent move, changes in employees, etc.) Treatment for some of these issues may be in the hands of other professionals, but as support providers it is our obligation to give thorough review to these issues. Factors reviewed and related supports provided shall be documented in the Person Centered Plan.

b. Examine the problem behavior (Functional Assessment). The purpose of the functional assessment is to determine the function of the behavior (what purpose does it serve) and identify patterns and possible strategies for changing the behavior. Information may be gathered through simple observation, data collection, structured interviews, and record reviews.

- In as specific terms as possible, define the "problem behavior." This should be done in objective, observable terms, including a description of the behavior/action and what is its impact on the individual.
- Define the individual's strengths, interests, and skill deficits.
- Give consideration to the individual's general health and well-being, including medical, pharmacological, and psychological issues.
- Give consideration to the person's quality of life (participation in meaningful activities, opportunities for self-determination, relationships, etc.) Identify relationships between the person's life experiences (or lack thereof) and the problem behaviors.
- Give consideration to events that are associated with the behavior, including events which precede and follow the behavior, and information about frequency, intensity, duration.
- Identify specific settings, activities, or situations in which the behavior is likely to occur.
- Give consideration to the function(s) of the behavior (i.e., what is the individual trying to get or avoid?)
- Give consideration to other specific variables which may be contributing to the behavior, such as skill deficits or physical condition.

c. Determine Reactive Strategies. Multiple intervention strategies may be used in the context of reactive behavioral support. These include:

- Antecedent/Environment Strategies - changing or eliminating the circumstances that cause the behavior to occur.
- Alternative Skill Training - opportunities to learn new skills which give the individual more control in more appropriate ways.
- Consequence Strategies - designed to strengthen alternative or desirable behaviors through reward/reinforcement; and/or to weaken the effectiveness of the behavior through ignoring, redirection, or decelerative interventions.
- Long-Term Prevention Strategies - address quality of life factors in an effort to build long-term supports.
- Emergency Strategies - designed to protect the person and others from harm should a crisis arise. (See also Behavior Management Emergency Strategies Procedure.)

<u>Plans for Evaluating the Effectiveness of the Intervention</u>**.** The behavioral support outcomes and action plan shall be reviewed at least monthly through the Person-Centered Plan Review. The plan should indicate outcomes (decreases in negative behaviors, increases in alternative

positive behaviors, reduction in use of emergency strategies, etc.) which will be measured to determine the success of the plan and the need for subsequent revisions. The plan shall prescribe a data collection system for measuring these outcomes.

All behavioral support plans shall adhere to the guidelines and procedures of the Department of Mental Health.

BEHAVIOR SUPPORT - Use of Restrictive Procedures

PROCEDURE - All Programs

Definition - "Restrictive Procedures" are actions taken by staff and /or rules enacted in response to a consumer's inappropriate, maladaptive, or unsafe behavior. Restrictive procedures are actions which alter, limit, or restrict a consumer's freedom of movement, use of leisure time, use of personal or agency property, exercise of other normal rights, or participation in normal routines of life. Restrictive procedures in this context do not include mechanical, chemical, or physical restraints which are described and addressed in other procedures.

“Decelerative Strategies” are behavioral interventions which are intended to reduce problem behaviors by making them less effective. Decelerative strategies, including any “negative consequences or other loss of freedoms are restrictive procedures, and can only be implemented under the guidelines in this procedure.

As the level of restrictiveness and intrusiveness of a procedure increases, so must the level of required approval and the frequency of the review. Restrictive procedures shall be implemented only in accordance with DMH guidelines and shall never be implemented unless their use has been previously delineated in writing through one of the two processes below:

a) Reactive Behavior Support Strategies

Restrictive procedures may only be implemented through a behavior support plan which is included in the Person Centered Plan and shall be reviewed monthly. At this point in the process, DMH guidelines are to be consulted. (See also procedure for Reactive Behavioral Support.)

Any negative consequences utilized must:

- Appropriately address the function of the behavior,
- Be the least intrusive, but most effective strategy,
- Be appropriate for the person's age.

The support team should assess any individual contraindications to the proposed restrictive procedure. Whenever possible, the guardian, family member, or other advocate should be involved in the development of the plan. All plans involving restrictive or decelerative interventions must be approved at appropriate level, and the informed consent of the person served (or legal guardian) must be obtained prior to implementation of the plan. All employees involved in the implementation of the plan shall be oriented to the procedures and methods prior to initiation.

b) "Basic Expectations" are guidelines that assist persons served in getting along with peers and community members. Infractions of "Basic Expectations" do not typically receive "negative consequences." However, Basic Expectations (or other similar guidelines) are considered a restrictive procedure IF a negative or restrictive consequence is defined for infractions. If rules, expectations, or guidelines with consequences are instituted it shall be done only as follows:

1) Adopted by a majority vote of persons served in the home or program at a meeting where all persons served are present, and similarly adopted annually, OR
2) Instituted by the Division Director to protect physical safety or promote person served independence,
AND
3) Approved by the Director of Community Living, and/or Human Rights Committee (i.e., rules with consequences can develop through (a) and/or (b) but must always be approved by an additional administrative employee.)
4) The rules and expectations as well as consequences for violation if applicable, must be in writing, and distributed to all persons served.

Any person served who does not agree with restrictive procedures implemented in accordance with the above guidelines, or who believes the guidelines have not been observed, may file a grievance as described in the Grievance Procedure. If a grievance is filed, implementation of the restrictive procedures at issue shall be suspended until the grievance is settled. All new persons served shall be informed of these procedures at the time of admission.

Any restrictive procedures utilized shall be explained and discussed with the person served

and/or the legal guardian in language that is easily understandable. Signed informed consent and acknowledgment shall be obtained when restrictive procedures are utilized through reviewing the plan with the person served/guardian and obtaining consent signatures within the plan.

(See also Procedure for Person Served Rights and Limitations.)

BEHAVIOR SUPPORT - Emergency Behavioral Support Strategies

PROCEDURE - All Programs

When an individual is at imminent risk of harming themselves or others, that situation is considered an emergency. Emergency situations are not "teaching moments." The goal of emergency strategies is simple - to end the emergency situation as soon as possible, without anyone getting hurt. Emergency strategies are generally adequate for the temporary control of a challenging behavior - to interrupt and discontinue an otherwise dangerous or unmanageable situation.

Examples of situations which "threaten immediate safety" include: pounding on windows or other glass, physical assault of another person served or employee, elopement or situations that pose imminent danger to the person served, self-injurious behavior, throwing objects which would cause injury.

If a standard response or consequence for a specific behavior or action is stipulated in a behavioral support plan or in the Person Centered Plan, employees should follow those procedures precisely. If no response is stipulated, employees should assess the situation and determine at what crisis cycle level the individual is at. Employees should provide the appropriate response depending on what level of the crisis cycle the person is in. The employee response for each phase of the crisis cycle:

1) Stimulation Phase – Trigger:
   In the stimulation phase (warming up), something has happened to make the person begin to feel emotionally and/or physically uncomfortable or distressed. There may begin a gradual or rapid increase in the person's blood pressure, pulse, breathing, muscle tension, adrenaline, and endorphins. This is a transitional behavior between baseline and incident. The person is asking for help through his/her behavior.

Employee Response:

▪Stay calm. Watch your own physical and emotional responses. Breathe slowly and evenly to relieve your own tension and to maintain a calmer tone of voice.

▪Treat the person with fairness, consistency, dignity, and respect.

▪Search for the person's trigger mechanisms. Is the stress internal or external?

▪Watch for physical, cultural, environmental, interpersonal, or medical indicators.

▪Use reflection. Try to find out the real problem. Could the behavior be a response to fear, embarrassment, shame, frustration, sadness, etc.?

▪Give clarification and/or apology to the person if necessary; use please and thank you.

▪Remove the stress from the person or help the person get away from the stress.

▪Be an active and non-judgmental listener. Try to understand what the person is feeling. You must be responsive to the person's stress whether or not you agree with the validity of the cause of the stress.

▪Involve the whole team: staff, volunteers, family members, etc.

▪Try nonverbal strategies to give the person other things to do beside escalate. Listen with your eyes and ears. Maintain eye contact (when appropriate). Be aware of personal space and the individual's comfort and discomfort zone. Use slow and small hand/arm gestures.

▪Verbal strategies: Use clam, softer voice tone. Call the person by name. Try problem solving or active listening. Note: avoid questions or statements that begin with the word "why." This may cause the person to be defensive about her or his actions. Typically, when people are asked why they engaged in certain behavior, their first response is to justify the behavior. Use "who-what-where-when" questions instead.

▪If you can rectify the environment or communication which has caused the stress, do so to de-escalate the person.

2) Escalation Phase:

In the escalation (going up) phase, the person is starting to show increased signs of discomfort or distress. There may be an increase in breathing, muscle tension, color of skin, etc. The person's blood pressure and pulse will increase and the body will begin to produce more than normal amounts of adrenaline and endorphins. Some things may decrease, such as hearing, reasoning skills, compromising skills, self-management, and the ability to choose appropriate words: the person may use the language of fear and pain (vulgarity). The person may pace, rock, or talk faster and louder; he may move faster or may seem slower and more deliberate.

Employee Response:

▪Stay calm. Remember your goal is to de-escalate and manage yourself so you can help the other person to de-escalate.
▪Offer appropriate options but avoid "either/or" choices. Use the self-reinforcing or self-soothing behaviors from baseline phase. Give the person the opportunity to save face and regain dignity. Then set some expectations; people need to know that you will protect them.
▪Keep your R.A.D.A.R. on.
▪State positive and negative consequences of his decision and allow the person to choose. If you give a person a choice, you must accept what he chooses from your list of options.
▪In the early phase of escalation people may still be able to make decisions and use reasoning; offer options early. As escalation increases, this ability diminishes. Set expectations in the later part of the escalation phase.
▪Empower the person to exercise his personal freedoms and rights. If it is you who are upsetting the person, back off. Stop and rethink the situation.
▪Communicate understanding. This is another way of saying, "I don't know exactly what you are going through, but others have experienced or expressed similar feelings."
▪If setting expectations, do so by "cueing the positive replacement behavior." If someone is raising his/her hand, ask the person to put his/her hand down, please. If someone is about to throw papers off the desk, ask him/her to step back. Ask them to do something that is incompatible with the behavior you do not want to see. If you just say, "don't…" the person probably will….
▪Use diversion and/or distraction. If you use humor as a diversion, it should be focused on the situation rather than the individual. If you use distraction, be sure to come back and address the issue of anger when the other person is calmer. Distraction doesn't resolve the anger; it only avoids an inappropriate expression of it.
▪Channel feelings into a positive direction or into a creative activity, such as music, exercise, games, art, etc. Choose an activity that is effective for that individual.
▪Assist in problem solving. This allows the person to save face, to be validated in her feelings, and to self-manage.
▪For people who communicate non-verbally, take extra steps to ensure staff who knows the person and their communication preferences an styles, is present to assist and support them.

3) <u>Crisis Phase:</u>

In the crisis phase, the person is now showing major signs of discomfort or distress.

There are very noticeable chances in breathing, muscle tension, color of skin, facial expression, body language, etc.: in addition, the person's blood pressure, pulse, adrenaline, and endorphin levels have reached their maximum. The language of fear and pain (vulgarity), if used, is now at its maximum. Also the person's reasoning skills, compromising skills, and self-management are at their lowest or even nonexistent. It is important to note that the person while in the crisis phase may use only verbal aggression and may not display any physical aggression. On the other hand, that same person, if pushed enough either verbally or physically, may become physically aggressive to self and/or others.

Employee Response:

Stay calm, take a deep breath, and don't overreact; this is evidenced by your physical presence, tone of voice, choice of words, and body positioning; stay out of reach.

Keep your R.A.D.A.R. on.

If there is no threat of injury to the person or others, re-evaluate.

Get some assistance, use the team approach, and don't try to be a "hero."

The safety of all individuals is the most important thing. Only the least restrictive interaction needed to adequately protect the person or others, should be used.

Physical interactions/interventions should only be used for the purpose of protection, and should not be used for the purpose of changing behavior in situations where no protective need is present.

4) De-escalation or Recovery Phase:

In the de-escalation (going down) or recovery phase, there will be a decrease in blood pressure, pulse, breathing, muscle tension, adrenaline, and endorphins. Physical and/or emotional discomfort or distress is still present and the person may still use the language of fear and pain (vulgarity). This is very similar to the escalation phase, and it will take some time for the person's reasoning skills and compromising skills to return to normal. Recognize that two people need time to de-escalate, you and the other person. Allow time and space for this to happen.

Employee Response:

▪Structured cooling off with removal of or from the upsetting stimulus and stress. Time is on your side; don't rush it. After the individual has made their preference known about how they would like to cool off, invite yourself to participate as part of the relationship you have built with them in the baseline phase.

▪Be non-judgmental. This is not the time to express displeasure or disappointment in the person's actions, nor to coach for apologies.

Offer appropriate options but avoid "either/or" choices. Empower the person to save face and regain dignity. Then set some expectations; people need to know that you will protect them.

▪Be aware of your goal. You do not want to re-escalate the situation by stating consequences of behaviors. Do not do or say anything that will cause the person to re-escalate.

▪Communicate understanding. This is another way of saying, "I don't know exactly what you are going through, but I have experiences similar feelings."

▪Use diversion and/or distraction. If you use humor as a diversion, it should be focused on the situation rather than the individual. If you use distraction, be sure to come back and address the issue of anger when the other person is calmer. Distraction doesn't resolve the anger; it only avoids an inappropriate expression of it.

▪Channel feelings into a positive direction or into a creative activity, such as music, exercise, games, art, etc. Choose an activity that is effective for that individual.

▪Use reflection. Try to find out what the real problem is. Could the behavior be in response to fear, embarrassment, shame, frustration, sadness, etc.? Note: avoid questions or statements that begin with the word "why." This may cause the person to be defensive about her or his actions. Typically, when people are asked why they engaged in certain behavior, their first response is to justify the behavior. Use "Who-what-where-when" questions instead.

▪For people who communicate non-verbally, take extra steps to ensure staff, who knows the person and their communication preferences and styles, is present to assist and support them.

▪If the individual escalates to the point of physical aggression, physical crisis intervention techniques (blocking or restraint) may be used by appropriately trained and certified staff members to prevent a threatening resident from causing immediate injury to himself/herself or others. Such restraint must be the minimum necessary to protect those threatened and there must be clear and compelling reason to believe that an immediate threat is present.

5) <u>Stabilization Phase:</u>

In the stabilization phase, you are welcoming the person back into the relationships and environments (work and home) that are normal and usual for the person. The person's physical and/or emotional discomfort or distress has been reduced. The person has been empowered to regain some dignity and self-management. The blood pressure, pulse, and breathing return to normal; tense muscles are beginning to relax; and

adrenaline and endorphin levels are decreasing. Reasoning skills, compromising skills, and the ability to choose more appropriate words are also returning to normal for that person. Allow time and space for this to happen.

Employee Response:

▪Use good nonverbal and verbal skills; be an active and non-judgmental listener.

▪Involve the whole team: staff, volunteers, family members, etc.

Keep your R.A.D.A.R. on.

▪Give the person reassurance; often he/she will forget the event quickly.

▪Re-establish contact; convey caring and concern for the person; make sure there's no "leftover" hostility or anxiety influencing your behavior toward the person. Structure an opportunity to mend relationships. Do not require apologies if the person does not have the cognitive or developmental ability to understand his/her actions.

▪Use reflection. Try to find out what the real problem is. Could the behavior be a response to fear, embarrassment, shame, frustration, sadness, etc.? Avoid questions or statements that begin with the word "why." This may cause the person to be defensive about her or his actions. Typically, when people are asked why they engaged in certain behavior, their first response is to justify the behavior. Use "Who-what-where-when" questions instead.

▪Assist the person in post-crisis problem solving. Identify situations, options, and other strategies that could have been employed. Have the person communicate possible consequences of behaviors exhibited.

▪Communicate with the rest of the team, other shifts, etc. This person may need time to rest or time away from structured events or routines.

▪For people who communicate non-verbally, take extra steps to ensure staff, who knows the person and their communication preferences and styles, is present to assist and support them.

▪At this phase, you may need to find ways to re-integrate the person back into the environment. The higher they went in the crisis cycle, the greater the likelihood that their behavior was a stimulus or trigger for others. Using side or cross dialogue may be a way of telling the person and others that you as the staff person will make sure everyone is safe.

▪The team must process and evaluate the events as well as feelings: What went well, and what could be done differently to avoid a repeat situation? Make sure that information and care plan changes are communicated to everyone involved with the person's care.

▪Document the incident. If any physical interactions were used, they must be

documented.

6) Post-crisis Phase:
In the post-crisis phase, the person, because of emotional and/or physical intensity as well as the length of time in the crisis phase, may drop down below his/her normal level or "Baseline" before returning to his/her usual or normal behavior. The person may appear withdrawn or depressed, and may actually be sleepy and require rest.
Employee Response:
▪Give the person some time for proper grooming, i.e., a warm bath and clean clothes.
▪Rest and quiet time should be given; the person may feel drowsy or tired.
▪Offer appropriate options but avoid "either/or" choices. Allow the person to save face and regain dignity. Then set some expectations; people need to know they will be protected.
▪Give the person reassurance; often she will forget the event quickly.
Re-establish contact; convey caring and concern for the person; make sure there's no "leftover" hostility or anxiety influencing your behavior towards the person. Make sure the person has an opportunity to mend relationships. Do not require apologies.
▪Communicate with the rest of the team, other shifts, etc. This person may need time to rest or time away from structured events or routines.
The team should continue to process and evaluate the event as well as feelings: What went well, and what could be done differently to avoid a repeat situation? Make sure that information and care plan changes are communicated to everyone involved with the person's care.
▪Document the incident. If any physical interactions were used, they must be documented.
▪Telephone the supervisor (or on-call person) for instructions if the crisis is not defused. No employee should telephone the police without prior instructions unless danger is imminent.

If acute depression or pre-suicidal behavior is displayed, employees must take action to ensure the prompt evaluation of the individual. If the person served is receiving ongoing psychiatric treatment, his/her psychiatrist shall be notified of the behaviors, and the recommendations of the psychiatrist shall be followed. If the person served is not currently receiving psychiatric services, the Division Director (or on-call person) shall be immediately notified to arrange for a psychiatric evaluation and/or counseling services. If the evaluation results in hospitalization, procedures for hospitalization of a person served shall be followed. Following any psychiatric

evaluation, employees shall notify the appropriate placing agency (e.g. Regional Office) the legal guardian if applicable, and parents/family members as designated by the person served.

An Event Report Form must be completed by the employee observing the incident any time that physical crisis intervention techniques, including blocking and restraints are utilized; and any time that suicidal behavior (incl. verbal statement) is displayed. The event report and progress note should be written to include the following information:

a) what was occurring prior to the emergency strategy,
b) a description of the behavior that necessitated the intervention,
c) the less restrictive interventions that were attempted,
d) the emergency strategy that was used,
e) the date and time the reactive strategy was implemented and the time it was terminated, and
f) the person who initiated, applied, authorized and terminated the reactive strategy.

The Division Director must review and sign the emergency strategy event report within 24 hours and evaluate the situation and take steps to decrease the likelihood of the emergency strategy being needed again.

If emergency strategies are utilized to address a person served's behaviors two or more times in a two-month period or three or more times within a six-month period a behavioral support plan shall be developed. If one is already in place, new assessment and planning will ensue with revisions to the current strategy.

Processing After Emergency Behavior Intervention

Team Processing

Within 24 hours of the use of emergency behavioral support strategies, the support team should process all of the information regarding the incident:

a. Identification of what led to the incident.
b. Determination of whether the person's plan was followed.
c. Assessment of alternative interventions that may have avoided the use of the emergency intervention.
d. Determination of whether the person's physical and psychological needs and right to privacy were appropriately addressed.
e. Consideration of counseling or medical evaluation and treatment

for the person and staff for any emotional or physical trauma that may have resulted from the incident.

f. Consideration of whether other persons served and employees who may have witnessed or otherwise been affected by the incident should be involved in the debriefing activities or offered counseling.
g. Consideration of whether the legally authorized representative, if any, family members or others should be notified of and/or involved in debriefing activities.
h. Consideration of whether additional supervision or training should be provided to employees involved in the incident.

Participant Processing

Within 24 hours after a person has had an event where emergency behavioral strategies have been used, they should have the opportunity to process what occurred with the Division Director or designee. Information to ask the person served includes:

a. General comment on the episode.
b. Circumstances leading to the episode.
c. Employee actions that could have prevented the incident.
d. Person served actions that could have prevented the incident.
e. Description of the intervention used.
f. Any physical or psychological effects they may be experiencing.

Safety Assessment

As part of a behavior plan for any individual that has a history of needing emergency behavioral intervention, whereby reactive strategies such as the use of restraint or medication must be used to manage behavior, the safety of the individual must be considered through the review of:

a. A physician's report of medical conditions or physical limitations that would place the person at risk of physical injury during restraint or otherwise preclude the use of certain reactive strategies.
b. Documentation of any history of trauma such as a history of physical or sexual abuse.
c. Medical conditions that might create a risk, which include but are not limited to:
   - obesity
   - cardiac conditions
   - pregnancy
   - asthma or other respiratory conditions
   - impaired gag reflex

- back conditions or spinal problems
- seizure disorders
- deafness / blindness
- limitations of range of motion
- osteoporosis / osteopenia
- hemophilia

The following safety components must be included in the plan. This must include:

a. Definition of the target behavior and situations in which the identified reactive strategy may be used.
b. Definition of steps to be taken before the reactive strategy is used.
c. Statement of review of relevant medical conditions.
d. Interventions that cannot be used with this person.
e. Any precautions for interventions that can be used.
f. Any recommendations from the physician regarding the use of the intervention.

BEHAVIOR SUPPORT - Prohibited Techniques

PROCEDURE - All Programs

The following procedures are expressly forbidden in all Open Options UCP programs, facilities, and service locations:

a. Seclusion/Seclusionary Time Out - Placement of a person alone in a locked room or any room or area which he or she cannot leave at will. This includes forcing a person served to go to any room as a negative consequence for behavior or for any specified period of time. (This does not include self-initiated temporary removal from a stressful situation. Self-initiated temporary removal may occur when a person served chooses to go to his or her room or a quiet place to "cool off." This situation may be suggested by employees, but ultimately is based on the choice of the person served; there is no negative consequence for not making this choice, and there is no time limit set for the "cooling off" period.)
b. Withholding of a nutritionally adequate diet - should a person served not eat during the normal time, provisions must be made to ensure that food is offered at a later time.
c. Mechanical restraints - any device, instrument or physical object used to confine or otherwise limit a person served's freedom of movement (except when necessary for medical or orthopedic purposes, or for temporary safety during transportation.) This

includes the use of belts, scarves, enclosures or any devices which would restrict a person served's movement.

d. Chemical Restraints - use of any behavior-modifying or psychotropic medication for employee convenience, as a substitute for effective supports, or as punishment.
e. Behavioral techniques administered by other persons served or persons who are being supported by the agency.
f. Use of any procedure, including restraints, time out, temporary removal, medication, or any other procedure as punishment, for employee convenience, or as a substitute for effective support strategies.
g. Use of any physical restraint technique which has not been approved by the Department of Mental Health, Division of Developmental Disabilities, and for which the employee has not received Division-approved training.
h. Corporal punishment, overcorrection (requiring the performance of repetitive behavior), and aversive conditioning (including subjecting the person served to noxious stimuli, discomfort, or extreme sensory stimulation).
i. Any other procedure or treatment of a derogatory or humiliating nature; or any treatment which would violate the organization's policy on abuse and neglect.
j. Any treatment, procedure, technique or process prohibited elsewhere in organizational Policies and Procedures, or prohibited by federal or state statute, rule or Departmental Operating Regulations of the Missouri Department of Mental Health or other applicable placing agencies.

Any employee who utilizes - or who fails to report the use of prohibited techniques shall be subject to disciplinary action, including immediate termination, and may be subject to abuse and/or neglect charges. Use of prohibited techniques shall be reported immediately to the Director of Community Living, and an investigation of the incident will be initiated to ensure that appropriate follow-up actions are taken.