Behavior Policy Guidelines

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Introduction

Individuals with Intellectual and Developmental Disabilities sometimes present with challenging and intrusive behaviors. Often, these behaviors are perceived as being inappropriate or unacceptable by others in their environment. Historically, behavior modification programs for individuals with Intellectual and Developmental Disabilities have been unacceptably intrusive, focused primarily on punitive consequences, and designed to suppress behaviors without taking into consideration that behavior may serve an important function for that person.

Research indicates that effective interventions for challenging and interfering behavior can be reached without resorting to aversive and intrusive strategies. Monadnock Developmental Services (MDS) supports the use of non-aversive, positive approaches that increase safety, independence, and overall well-being, while promoting the development of adaptive skills. In the past, MDS' Human Rights Policy supported only the use of Gentle Teaching strategies to be used as intervention for challenging behaviors. However, as an agency, we recognize the needs of the individuals we support are broad, complex, and highly individualized; thus, we support a variety of approaches, including Gentle Teaching strategies, Positive Behavioral Supports, Applied Behavioral Analysis, and trauma-informed care, in order to better meet the behavioral and clinical needs of all individuals we support. The purpose of this behavioral policy is to outline how MDS and its contracting providers should safely support individuals who may engage in challenging behaviors to live as independently as possible in the least restrictive environment.

Region-Wide Adherence to Policy

This policy shall be distributed to all provider agencies that are under contract with the Area Agency. Each agency under contract shall be able, if requested, to describe in writing, the following:

1. Methods for ensuring client's rights
2. Training and authorization for staff who utilize the techniques and strategies described herein
3. Review mechanisms for the behavior plans used in a program subcontracted by the Area Agency, including timelines for the review of the plan and what data will be submitted to the Human Rights Committee
4. A statement that suspension or termination of services is a team decision and part of a client's service agreement, and may not be based solely on a single incident of maladaptive behavior. Termination shall comply with He-M 503; and
5. Methods for obtaining necessary written approval prior to implementation as specified in this policy.

Variation From This Policy

Each subcontracted agency/program shall have policies and procedures containing all elements listed in this region-wide policy. Any agency may adopt this policy verbatim and use it as their own. If, on the other hand, an agency decides to modify any part of this policy, such agency shall submit to the Area Agency, a written copy containing all of the modifications. The Area Agency Executive Director and Human Rights Committee (HRC) shall review and jointly approve such modified policies prior to their implementation. Until the Area Agency Executive Director and Human Rights Committee approve any modified policies, this policy shall be in effect.

MDS Behavior Plan Policy

Plan Development

A Behavior Support Plan shall be developed to support an individual in any of the following circumstances:

1. An individual exhibits behaviors that pose a threat to his or her health and safety, or the health and safety of others
2. An individual's behavior interferes, limits, or prohibits the individual from engaging in daily activities including community integration
3. When the use of any restrictive control is indicated for the individual.

Standards.

1. All Behavior Support Plans, regardless of degree of restriction, will be developed based upon assessment, to include functional behavioral analysis, observation, and/or file review.
2. All plans will be designed to:
    a. Enhance individuals' opportunities for community integration
    b. Meet the individualized needs of the person
    c. Provide the individual with opportunities for choice and decision-making
    d. Result in sustained behavioral changes
    e. Promote a positive image of the individual.
3. Prior to the development of any behavioral program, the following environmental and/or physical events will be considered, and a plan made to address the following:
    a. Staff-to-client ratio
    b. Medical issues
    c. Boredom
    d. Sensory issues such as temperature, noise level, etc
    e. Provocation by others
    f. Frustration
    g. Fear, and
    h. Staff training needs.

Components of a Behavior Support Plan.

1. All Behavior Support Plans will include the following components:

    i. Personal profile, to include:
        i. Name of individual
        ii. Birthdate
        iii. Diagnoses
        iv. Legal Status including guardianship or 171-b, if applicable
        v. Person-centered/whole description of the individual
        vi. Historical overview which relates to the need for plan/protocol
        vii. Description of current services including type and site of programming
        viii. List of medications

j. Rationale for Plan, to include:
    i. A description of target behaviors identified in observable, measurable terms
    ii. Baseline data
    iii. Hypothesized function of target behavior, based upon assessment
    iv. History of other approaches attempted
k. Strategies and techniques, to include:
    i. Proactive techniques to support the individual
    ii. Replacement/desirable behaviors and strategy to teach
    iii. Antecedent and precursor behaviors
    iv. Reactive strategies or techniques
    v. Expected immediate response to dangerous behavior
    vi. A description of all environmental adaptations or restrictions, if applicable
    vii. Psychotropic PRN protocol incorporated into plan, if applicable.
l. Monitoring, to include:
    i. Data collection on target behaviors
        1. Physical restraint documentation must include, at minimum, the antecedent, duration, description of restraint, response of individual, and debriefing (if appropriate).
    ii. Expected monitoring of plan, to include:
        1. Frequency of monitoring (minimum of quarterly)
        2. Person responsible for monitoring
        3. Description of monitoring
    iii. Criteria for revising the plan, to include:
        1. Fade or termination criteria
        2. Transition plan or fading procedure to less restrictive interventions
        3. Explanation as to when a team review or meeting would be necessary
        4. Any planned reductions to restriction should be clearly outlined
    iv. Expected training of staff
        1. Frequency of training, including statement that training must occur prior to working with individual
        2. Person responsible for training
        3. Expectations pertaining to any additional training requirements
m. Formatting expectations, to include:
    i. Footer on each page containing page number and total number of pages
    ii. References to other sections of the document are clearly labeled
    iii. Include plan author, revision author, edit date, and level (if applicable).
    iv. Submission of HRC Cover Sheet with all required signatures, included in submission packet.
    v. If MDS template is not being used, a checklist of all required items and page numbers must be included.

Prohibited practices.

1. No Behavior Support Plan may provide for a program of treatment that denies the individual adequate sleep, a nutritionally sound diet, adequate bedding, access to bathroom facilities, adequate clothing, or any other basic living needs including preferred or comfort items.

2. Only those interventions that are, of all available interventions, least restrictive of the individual's freedom of movement and most appropriate given the individual's needs, or least intrusive and most appropriate, may be employed.
3. The following interventions are prohibited:
    a. **Aversive Interventions:** Any intervention designed to inflict pain, discomfort, and/or social humiliation; or any intervention as perceived by the person to inflict pain, discomfort, or social humiliation in order to reduce behavior, shall not be used. Examples of aversives include, but are not limited to, electric skin shock, liquid spray to one's face, or strong, non-preferred taste applied to the mouth.
    b. **Seclusion:** Any procedure in which the individual is isolated or confined alone in a room or space that they are physically prevented from leaving, such as being locked in a room alone without a key, is prohibited.
    c. **Denial of nutritionally adequate diet:** The intentional removal of readily available nutritious foods, shall not be used as a punishment for behavioral challenges. Individuals must have food readily available at all times.
    d. **Overcorrection:** A procedure in which the individual is required to engage in repetitive acts as a penalty for behavior. Overcorrection is used as a punishment and thus is not an approved intervention.
    e. **Corporal punishment:** the intentional use of physical force to cause bodily pain or discomfort as a penalty for behavior, is never allowed. Corporal punishment includes any action that causes discomfort such as spanking, hitting, slapping, shoving, etc.
    f. **Experimentation:** Any treatment, device, or procedure (not the standard of care), which may be unapproved or unauthorized, and lacks wide recognition from the scientific community as a proven and effective measure of treatment, may not be used.
    g. **Mechanical Restraints**: Any physical device used to involuntarily restrict the movement of an individual, or the movement or normal function of the body, shall not be used. This includes devices such as handcuffs, straightjacket or camisole, or shackles. *This does not include devices specifically ordered by a physician for medical purposes such as bedrails or adaptive seatbelts.*
    h. **Any procedure which limits the individual's ability to breathe**: Any method of physical restraint in which physical pressure is applied to the individual's body that restricts the flow of air into the lungs, shall not be used.
    i. **Medications used as behavior management**: Psychotropic medications may not be used as a way to control mood or behavior without a written protocol outlining under which specific conditions the medication is to be administered. All written protocols outlining use should be signed by a nurse and submitted for HRC review.

Emergency Conditions, Procedures, and Protocols

Duty to Protect from Harm

All staff and agents have the responsibility to protect all individuals and staff from physical injury. Emergency restraint may be used only after the failure of less restrictive alternatives, and that such alternatives would be ineffective under the circumstances and only for the period of time necessary to accomplish its purpose.

Emergency shall mean that a reasonable person would observe one or more of the following:

1. The present occurrence of serious self-injurious behavior
2. The present occurrence of serious physical assault
3. The imminent threat of serious self-injurious behavior or behavior which is likely to lead to self-injury, where the individual has engaged in any action which indicates a present intention or inclination to carry out such behavior immediately
4. The imminent threat of serious physical assault, where the individual has engaged in any act, which indicates a present intention or inclination to carry out such assault immediately. The occurrence or imminent threat of property damage is not an emergency unless such damage is also likely to lead to the serious self-injury of the individual or to the serious harm of those present.

Staff Training and Monitoring

Providers utilizing physical restraint shall train all direct care staff in the safe and appropriate use of such restraint. Training shall include techniques which deal with the prevention and management of potentially violent behavior, as well as health and safety precautions for the individual during restraint (Physical intervention management programs include: Mandt, Management of Aggressive Behavior or MOAB, Safety Care, Crisis Prevention Institute or CPI, etc). As a component of the Behavior Support Plan, Provider Agencies are required to keep updated training records and certifications. As changes in personnel occur, provider agencies are expected to keep verification of ongoing training on file.

If using a specific crisis intervention program (like Mandt, Management of Aggressive Behavior or MOAB, Safety Care, Crisis Prevention Institute or CPI, etc), vendor agencies must choose one specific nonviolent crisis intervention program, which will be specific to each individual. So, if Mandt techniques are chosen to be used with Individual A, all staff must be Mandt trained. Staff who may have had training in Safety Care may not work with Individual A until they are trained in Mandt. This is to ensure consistency and quality of care for the individual, and to prevent confusion and/or disorganization which may result if different providers are trained in differing or opposing methods.

Whenever an individual is in physical restraint, all staff persons are to be trained to understand an individual's emotional and physical reactions to restraints, and shall continuously monitor the individual's response to ensure comfort, body alignment, and circulation.

Staff will ensure a verbal conversation and visual physical review (as appropriate) with the individual to identify if anywhere on their body hurt, as well as verbal processing of the incident including the individual's feelings. Follow-up as appropriate where medical treatment is indicated.

Documentation Requirements

Incident reporting guidelines. An incident report will be completed and filled out according to MDS Incident Reporting Guidelines.

Emergency incidents. Emergency Incidents – Severity Level 1 – include incidents which present cause for immediate concern and notification. This includes:

1. Hospitalization (either ER visit or unplanned admittance)
2. Incidents involving police or emergency personnel involvement
3. Injury requiring medical intervention
4. Causing injury to another
5. Removal from residence
6. Discontinuation of program

7. Human rights violation that threatens harm to the individual
8. PRN administration due to behavioral incidents.

Emergency physical restraints. The Vendor agency will ensure that an Emergency Restraint form is completed on each occasion when an individual is placed in emergency restraint. The completion of the form will conform to Area Agency standards.

The completed emergency physical restraint form shall include the following:

1. Type of incident
2. Identify each person involved in the restraint
3. A description of less restrictive alternatives which were attempted prior to the utilization of a restraint
4. Document all examinations and other safety checks made of the individual in restraint
5. Identify the type of safety/monitoring checks and the name of the person who conducted such examinations or checks.
6. The date and time the individual was released from restraint (duration), and
7. Staff follow-up section

Post-Emergency responsibilities and protocol.

1. Guardian(s) and Service Coordinator (or on-call Service Coordinator) must be contacted and informed of the incident expediently. The Service Coordinator or on-call Service Coordinator and Guardian should be contacted within 3 hours of the incident.
2. Per incident reporting guidelines, an Incident Report (and Emergency Physical Restraint form, if applicable), must be completed and sent to MDS and Service Coordinator within 24hrs.
3. The Service Coordinator shall review the Incident Report, including Emergency Physical Restraint form, if applicable, and determine whether a team meeting is required at this time. The Service Coordinator may consult with the Director of Service Coordination in order to make a determination about whether a team meeting is necessary.
4. If a team meeting is required, the individual's team of providers must meet to review the emergency using the Incident Report Form. The team meeting should focus on debriefing of the incident, as well as developing strategies (behavioral or otherwise) which will reduce or prevent future incidents. The Service Coordinator should document this meeting in Service Logs along with notation of who is responsible for which step.
5. Notify MDS Human Resource Officer or Bureau of Developmental Services Complaint line within 24hrs if an investigation is needed or suspected of being needed.

Human Rights Committee Review

One of the purposes of the MDS Human Rights Committee is to review, approve, and monitor programs of intervention to support those individuals who need assistance in addressing challenging behaviors.

The format for review by the committee will include the following steps:

1. An opportunity for individual HRC members to receive and review the written description of the program as proposed by the plan author.
2. An opportunity to formulate a series of questions to clarify areas of concern or ambiguity.
3. An opportunity to receive a verbal presentation by the program author or service agency representative, if desired, and
4. An opportunity to have the formulated questions answered.

Following a review of the plan, as described above, the committee may take one of the following actions:

1. Approval of plan. If time-limited, this parameter will be specified on an approval form, which is signed by a committee representative.
2. Approval of the program pending the receipt of an addendum or modifications to the plan. Such modifications may be requested for review at a following meeting or referred to as required prior to implementation and documentation at the Area Agency.
3. Approval of the plan with follow-up reporting to the HRC.
4. Rejection of the plan. The committee representative will describe the reasons for rejection with recommendations for alternatives, specification of additional criteria that must be met, and/or an invitation for further discussion with the committee.

On an annual basis, this Behavior Policy will be reviewed by the Human Rights Committee, to ensure that it continues to meet the needs of the individuals we support. Review will take place in the month of July.

Definitions

Aversive Interventions: Interventions designed to inflict pain, discomfort, and/or social humiliation; or any intervention as perceived by the person to inflict pain, discomfort, or social humiliation in order to reduce behavior. Examples of aversive interventions include, but are not limited to, electric skin shock, liquid spray to one's face, or strong, non-preferred taste applied to the mouth.

Applied Behavioral Analysis (ABA): A specific behavioral treatment approach. ABA is a way of understanding behavior. This approach assumes that all behavior serves a purpose, and that desired behaviors can be taught through a system of rewards and consequences. ABA clinicians use direct observation, objective measurement (ie, taking data), and evaluation of interventions to ensure the desired outcome is reached. ABA is often referred to as the "gold standard" of treatment for autism, and research has shown that it can be effective, particularly at young ages (Linstead et al, 2017). Historically ABA used aversives as punishments, and though this is rare today, ABA still faces criticism for teaching individuals to engage in neurotypical behaviors and "hide their autism" in order to "earn" equal treatment.

Behavior: An observable and measurable action of an individual. May be described in terms of duration, intensity, and frequency.

Corporal Punishment: The intentional use of physical force to cause bodily pain or discomfort as a penalty for behavior.

Emergency Physical Restraint: Any limitation of movement by direct bodily contact with the individual. Physical force is used to overcome the active resistance of the individual. This could include "escorting" an individual on an involuntary basis. Physical Restraint can only be implemented in response to an emergency situation.

Environmental Adaptations/Restrictions: Any device, tool, or measure that is used to control or adapt the environment or physical space around the individual. Such measures should only be used in order to ensure the individual's health and safety. Such adaptations are broad and applied in response to medical and behavioral challenges. Environmental Restrictions may include: alarms or chimes on doors, locked sharp objects and/or chemicals, as well as medically-necessary bed rails, adaptive seatbelts, or anything else that may impede free movement within an individual's home or personal space.

Experimentation: A treatment, device, or procedure (not the standard of care), which may be unapproved or unauthorized, and lack wide recognition from the scientific community as a proven and effective measure of treatment.

Fading: The gradual removal of assistance/prompts as an individual becomes more independent in performing a skill.

File Review: Time in which a clinician spends reviewing the individual's file, including the individual's annual Service Agreement, monthly progress notes, any available Incident Reports, and copies of past evaluations or assessments.

Functional Behavioral Assessment: An assessment completed by a behaviorist in which the challenging behavior is defined, data is reviewed (ie, when and where is the behavior happening or not happening, what tends to happen right before or right after), a hypothesis is made about the reason for the behavior, and a plan is made to teach and encourage positive behavior.

Gentle Teaching: An approach to treating challenging behavior using relationship building to increase pro-social interactions and learning. This approach examines the behavior of the practitioner as well as the individual and uses strategies such as shaping, social reinforcement, visual cues, etc, to reduce maladaptive interactions and increase adaptive ones.

Intellectual/Developmental Disabilities (IDD): Having significant difficulties in both intellectual functioning (communication, learning, problem-solving), and adaptive behavior (social skills, living skills, daily routines).

Incident Report: A document used to inform management, supervisory staff, or any other appropriate staff of a serious injury or other event threatening the health and safety of the individual or staff.

Intrusive: Causing disruption or annoyance by doing something which is unwelcome.

Mechanical Restraints- A physical device used to involuntarily restrict the movement of an individual, or the movement or normal function of the body. This includes devices such as handcuffs, straightjacket or camisole, or shackles. This does not include devices specifically ordered by a physician such as bedrails.

Noxious Stimuli: Stimuli that are presumed to be aversive. Examples might include unpleasant smells such as ammonia, unpleasant sounds such as loud ringing bells, and unpleasant physical sensations including electric shock, pinching, watermist, etc.

Overcorrection: A procedure in which the individual is required to engage in repetitive behavior as a penalty for behavior. In particular, overcorrection requires that the individual, upon having committed an infraction, must repeatedly practice the correct or incorrect behavior.

Physical Restraints: Any manual (ie, hands-on) intervention, which restricts the individual's freedom of movement or reduces the individual's ability to move their torso, arms, legs, or head freely. Physical restraints are considered an emergency intervention to respond to an individual posing an immediate danger to themselves or others.

Positive Behavior Support: Positive Behavioral Support is an approach to treating challenging behavior that combines evidence-based practices from Applied Behavior Analysis (ABA). Like Applied Behavior Analysis, Positive Behavior Support focuses on identifying goals and behaviors of concern, gathering and analyzing information to identify patterns of behavior, selecting strategies to increase positive behaviors, and monitoring outcomes. Positive Behavior Support also focuses heavily on improving individuals' quality of life, and using proactive strategies as well as teaching acceptable replacement behaviors.

Psychotropic Medications: A medication, drug, or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior. Examples of psychotropic medications include antidepressants, antianxiety medications, stimulants, mood stabilizers, and antipsychotics.

Proactive strategies: Tools that are used to prevent or avoid problem behavior or dysregulation from occurring. Proactive strategies should be used before any challenging behaviors occur in order to help reduce the chances of them occurring.

Reactive Strategies: How a provider/staff person responds to challenging behavior when the behavior occurs. Reactive strategies are designed to ensure safety and restore calm as soon as possible.

Restrictive Control: Imposing limitations or conditions on an individual's activities or freedom. This can include physical controls such as restraints, environmental restrictions including alarms or

Seclusion: A procedure in which the individual is isolated or confined in a room or space that they are physically prevented from leaving. The definition of seclusion does not include a supervised/scheduled break or "taking space" while the individual is supervised or able to move freely between spaces.

Sensory Issues: Sensory issues may occur when an individual has a difficult time receiving and responding to information from their senses. Individuals with sensory issues may have an aversion to anything that triggers their senses, such as light, sound, touch, taste, or smell.

Target Behavior: Any behavior that has been chosen or "targeted" for change.

Trauma-Informed Care: A framework for human service delivery that is based on knowledge and understanding of how trauma affects people's lives, their service needs, and their service usage. Trauma-informed care recognizes the prevalence of trauma and its life altering impacts, and seeks to provide individuals with safety, choice, collaboration, trustworthiness and empowerment.