

Behavior Support Policy 2011

Delaware County Board of Developmental Disabilities

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(A) Origin and Development of Regulation

(1) Review of Regulation

The Behavior Support Committee and Human Rights Committee review the Behavior Support policy at least annually in March. The policy is then submitted to the superintendent and Delaware County Board for review and approval by the April Board meeting.

(2) Authority

This policy, which originated in August 1986, is based on Ohio Department of Developmental Disabilities Rules and the following legal documents:
5123:2-1-02 Ohio Administrative Rule

(3) Professional Qualifications

Professional staff developing or implementing behavior support plans shall be those who meet the qualifications of their employing agency for personnel requirements.

(4) Purpose

This regulation shall serve to formulate policy and general procedural guidelines regarding the provision of behavior support services to clients of the Delaware County Board of Developmental Disabilities, and/or contracting agencies and a provider as defined in ORC 5123:2-1-02(J)(1)(e).

For the purpose of this policy client of the Board refers to individuals that are receiving residential services and/or adult services. **In the educational setting (preschool or school age) educators** shall follow the student discipline guidelines of the Ohio Department of Education (Division of Early Childhood Concept Paper on the Identification of and Intervention with Challenging Behavior and Division of Special Education, Technical Assistance for Implementation of the Behavior Intervention Process) and the educational setting in which they are served. **Early Intervention providers shall** follow the guidelines of the Ohio Department of Health. Aversive interventions will not be permitted with children in Early Intervention.

Behavior support policies are intended to promote the growth, development and independence of individuals, promote individual choice in daily decision-making, and emphasize their self-determination and self-management. To the extent possible, behavior-support plans will be formulated with the individual's participation. Behavior Support policy is available to all staff, individual's parents of minor children, legal guardians and providers.

(5) General Statement of Policy

Behavior support techniques are an appropriate and useful tool in the education and training of people including individuals who have developmental disabilities. The focus is on positive teaching and support strategies and encourages use of the least restrictive environment and least intrusive forms of services. Behavior support shall be utilized as an integral part of ongoing training programs. Positive and natural consequences of behavior are the most desirable and always have the best long-term effects. Aversive techniques shall be used only after positive interventions have proved unsuccessful. Aversive techniques should be understandable to the individual and should be applied only to behaviors that are subject to the individual's voluntary control. Aversive consequences should be the least restrictive and least intrusive possible. Abusive, demeaning, or retaliatory actions are not behavior support techniques and are contrary to human rights. No aspect of this policy shall be construed to deny any individual full protection under the Board's Civil Rights Plan and the "Bill of Rights" set forth in Ohio Senate Bill 322. Behavior Support Plans are not to be used for staff convenience or discipline or as a substitute for an active treatment plan.

(6) The Climate for Behavioral Support is characterized by:

- (a) The identification of the underlying cause for the behavior and the development of plans to proactively address and fulfill the identified need; not solely focusing on the reactive intervention strategies alone;
- (b) Interactions and speech that reflect, dignity, and a positive regard for the individual;
- (c) The setting of acceptable behavioral limits for the individual;
- (d) The absence of group punishment;
- (e) The absence of demeaning, belittling or degrading speech or punishment;
- (f) Staff speech that is even-toned made in positive and personal terms and without threatening overtones or coercion;
- (g) Conversations with the individual rather than about the individual while in the individual's presence;
- (h) Respect for the individual's privacy by not discussing the individual with someone who has no right to the information; and
- (i) The use of people-first language instead of referring to the individual by trait, behavior or disability.

(B) Prohibited Interventions

The County Board recognizes the inherent dignity and worth of each individual. Therefore, the following abusive interventions are prohibited: Prohibited actions are reported as a Major Unusual Incident to the Delaware County Board of Developmental Disabilities' MUI Coordinator.

- (1) Any physical abuse of an individual such as striking, shoving, spitting on, paddling, spanking, scratching, pinching, corporal punishment, or any other action to inflict pain.
- (2) Any sexual abuse of an individual.
- (3) Medically or psychologically contraindicated procedures.
- (4) Any psychological/verbal abuse such as threatening, ridiculing, or using abusive or demeaning language.
- (5) Placing an individual in a room with no light, unless it is for scheduled nap periods in a school setting, for individuals under the care of a program nurse, or other periods of rest or sleep.
- (6) Subjecting the individual to damaging or painful sound.
- (7) Denial of breakfast, lunch or dinner.
- (8) Squirting an individual with any substance, as a consequence for behavior.
- (9) Time out in a time out room exceeding one hour for any one incident and exceeding more than two hours in a twenty-four hour period.
- (10) Placing an individual in a time out room that is key locked, inadequately lighted or ventilated, or does not provide a safe environment for the individual, or where the person is unable to lay down in any direction or stand up fully.

- (11) Placing an individual in a time out room and leaving him/her unsupervised.
- (12) Use of behavioral restraints except when displayed behaviors are destructive to self or others or part of a behavior support plan.
- (13) Use of psychotropic medication unless it is prescribed and supervised by a licensed physician involved in the interdisciplinary planning process. (“Involved in the interdisciplinary process” does not mean that the physician must attend IP meetings. It means that the program and physician must communicate on a regular basis about medical and behavioral issues. This could be in writing or by telephone).
- (14) Non-contingent (custodial) use of mechanical restraints
- (15) Use of noxious and/or unpleasant substances or stimuli including contingent electric shock.
- (16) “Standing” or “as needed” (PRN) programs.
- (17) One individual disciplining another.
- (18) Group punishment
- (19) Emergency placement of an individual in a time-out room without an approved behavioral plan.
- (20) Use of any aversive behavior support method for the purpose of retaliation, staff convenience or as a substitute for active treatment programs.
- (21) Use of prone restraints. Prone restraint is defined as a face-down restraint and may cause suffocation.

(C) Crisis Intervention

Crisis management is the process which utilizes methods to help an individual reduce the intensity of a crisis behavior and to enable him/her to regain composure, safety, and control.

(1) When is a situation considered a crisis?

A crisis situation is one or more of the following:

- (a) Danger to others: physical acting out behaviors that seem likely to cause bodily harm
- (b) Danger to self: self-abuse that seems likely to cause bodily harm
- (c) If there is evidence of past threats leading to any of the above mentioned behaviors, then it should be noted that threatened abuse toward others or self can be considered a “crisis” situation. If a “crisis” behavior occurs the team will meet to address the crisis and develop intervention strategies if necessary.

(2) When is a situation no longer considered a crisis and a plan must be written?

If a target behavior occurs and the team can make a reasonable predication, based on past threats and behaviors, that the behavior will occur again, then this justifies the reason to develop a plan.

(3) Crisis Intervention Strategies

In order to deal with a crisis of an individual's behavior in an effective and humane manner, a hierarchy of techniques beginning with the least intrusive should be utilized.

- (a) Alteration of environment ➤ Moving materials, objects, furniture, people, etc. to end the behavior.

(b) Non-physical intervention ➤ Distraction through gestured redirection, calling an individual's name, use of a loud noise to interrupt, etc. to end the behavior. Redirection, calming or relaxation procedures, problem-solving, and establishing boundaries are also non-physical interventions or reducing the staff/individual ratio.

(c) Manual restraints ➤ A hands-on method that is used to control an identified behavior by restricting the movement or function of the individual's head, neck, one or more limbs or entire body, using sufficient force to cause the possibility of injury. Generally only used after other less restrictive procedures have been tried or if an unanticipated but immediate threat to the safety of others is reasonably judged by staff. This must be an employer approved physical restraint technique.

(d) Emergency relocating of services ➤ A person may have services relocated but may not be removed from county board services. For students placed by the LEA, suspension procedures under IDEA (Individuals with Disabilities Education Act) apply.

(4) Reporting Crisis Events

All incidents involving crisis intervention or that meet the MUI rule (OAC 5123:2-17-02) must be reported to the County Board of DD within the time frames specified in the MUI rule.

(D) Positive Support Strategies

(1) What is a Positive Support Strategy?

Positive Support Strategies are systematic programs, which only use consequences that are pleasant and non-aversive.

(2) When to use Positive Support Strategy

(a) Planned positive reinforcement procedures shall be a part of the program of each individual served by the County Board for whom a behavior plan exists. These procedures will be designed to increase desired behaviors as identified in the individual's program plan. Plans shall be written to include training of an alternate, appropriate behavior to replace a problem behavior.

(b) Use positive support strategies when behavior support plans include aversive interventions. Positive and less aversive teaching and support strategies are demonstrated to be ineffective prior to the use of more intrusive procedures.

(c) Occasionally, consequences designed to increase a desirable behavior may need to be combined with a plan to reduce or eliminate a problem behavior. Contrived contingencies may need committee approval or at least committee interpretation. Any behavior plan, which includes Aversive Intervention, must also include Positive Support Strategy, designed to increase alternative appropriate behaviors to replace challenging behaviors.

(3) Incorporating General Support Strategies into an Individual Support Plan (ISP)

(a) Simple positive support strategies, where an on-going analysis of the target behavior is not required, may be incorporated into the individual's ISP if the behavior is not a threat to the health and safety of the individual and/or others, and the team defines the alternate behavior as desirable, rather than critical; a BSP is not required.

(b) Simple support/motivational strategies typically should not violate any of the Client Rights listed in Section 5123.62 Bill of Rights of the Ohio Revised Code. When an individual's rights are violated due to health and safety issues, this may be an indication

that the alternate behavior is critical rather than desired and a full behavior support plan may be needed. If a simple support/motivational strategy violates any of the individual's rights, the strategy must be approved through the Human Rights Committee.

(c) The Behavior Support Committee and Human Rights Committee members are available to assist teams with making this determination by request.

(4) Recording of Data on Positive Support Strategies

Data should be kept on all behavior strategies that reduce or increase a target behavior and shall be maintained in the documentation section of the client records even though committee approval is not necessary. The team will develop necessary documentation forms.

(5) Examples of Positive Support Strategies include but are not limited to:

- (a) Positive reinforcement
- (b) Errorless learning
- (c) Shaping/fading/planned ignoring/extinction
- (d) Modeling/imitation

- (e) Token economy without response cost
- (f) Self-management techniques e.g. having the individual record his/her own behavior frequency
- (g) Contracts with positive consequences
- (h) Participating in a chosen activity
- (i) Interval Schedules of Reinforcement
- (j) Ratio Schedules of Reinforcement
- (k) Redirection
- (l) Rule Reminders
- (m) Simple Self-Correction
- (n) Time Away (This is different from time out)
- (o) Satiation

(E) Aversive Interventions

(1) What is an Aversive Intervention? /How Aversive Interventions Work

An Aversive Intervention is a technique, which employs unpleasant, intrusive or uncomfortable stimulus. This intervention has the purpose and effect of decreasing a target behavior. These strategies employ behavioral consequences that a person would work actively to avoid. Manual restraints are utilized to stop the target behavior and protect the health and safety of all those involved.

(2) Safeguards when using Behavior Support methods - Aversive Interventions

Aversive strategies should be used with great caution. Positive and natural consequences of behavior are the most desirable and have the best long-term effect. Aversive techniques shall be

used only after positive support strategies have proved unsuccessful. Aversive techniques should be understandable. Behavior support methods must be employed with sufficient safeguards and supervision, to ensure that the safety, welfare, due process, and civil and human rights of the individual receiving county board services are adequately protected. [DODD 5123:2-1-02(j)(2)(f)]

Critical components in determining whether appropriate safeguards exist include :(these components must be included in both positive and aversive plans)

- (a) Written, informed consent has been obtained.
- (b) All of the individual's rights have been adequately protected in accordance with the DD Bill of Rights.
- (c) There are no medical contraindications to the planned procedure.
- (d) There has been strict adherence to requirements of all levels of review.

(3) When to use Aversive Interventions

Aversive strategies shall be used as a part of a person-centered planning process only after positive and general strategies have been demonstrated to be ineffective or the risk to health and safety requires an aversive intervention.

Systematic planned aversive interaction shall be used only when:

- (a) Necessary to protect health, safety and property
- (b) The problem behavior is destructive to self or others.
- (c) The problem behavior is detrimental to the development of self or others
- (d) All other conditions required by the behavior support rule are met

(4) Restraint or time-out shall be discontinued if it results in serious harm or injury to the individual or does not achieve the desired results as defined in the behavior support plan

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

(6) Any use of restraint or timeout that results in an injury that meets the definition of a major unusual incident or an unusual incident shall be reported as such pursuant to DODD rule 5213:2-17-02 of the administrative code.

(7) Acceptable Aversive Interventions

All time limits listed below are within a 24 hour period beginning with the first application of the aversive intervention. The limits apply across all settings in which that aversive may be used. Minutes used must be added across settings within the 24 hour period.

- (a) Emerging methods and technologies: New methods of restraint or seclusion that create possible health and safety risks for the individual including methods or technology that were not developed prior to the effective date of this policy.
- (b) Financial Restitution: Individual is required to pay back owner of broken or damaged items.

(c) Overcorrection: Individual must restore environment, then repeatedly perform an appropriate substitute behavior. Example: Individual throws all clothes out of dresser. They are then required to fold clothes and put away and then repeat several time.

(d) Response cost: Removal of previously earned tokens, privileges or other reinforcers contingent upon target behaviors to be decreased.

(e) Restraint:

(i) Manual restraint: Individual must be released and allowed to move freely at least ten minutes during each two hours of restraint.

(ii) Mechanical restraint: Individual must be released and allowed to move freely at least ten minutes during each two hours of restraint.

(iii) Chemical restraint: Use of PRN medication to alter behavior and the use of psychiatric medication without a psychiatric diagnosis.

(f) Time Out: Confining an individual in a room and preventing the individual from leaving the room by applying force or by closing door or other barrier, including placement in such a room when a staff person remains in the room with the individual. A record of time out activities must be kept. Time out may not exceed one hour per use, nor two hours in a 24 hour period.

(g) Suspension: Refers to the prohibition of an individual from presence in his or her typical environment other than time out, with the exception of suspension when such suspension is consistent with the other agency policy.

(h) Withholding of routinely given items, materials or activities: Also referred to as loss of privileges. This involves the loss of an item, material, and/or activity that constitutes a part of the individual's normal school or work day. Loss of privilege involves the same basic behavior mechanics as Response Cost, except that it employs items, materials and/or activities that were NOT earned by the individual (in contrast to response cost when they were earned).

(8) Special Definitions which apply to Aversive Interventions

(a) A 24-hour period is defined as a "rolling" or "continuous" 24 hours, based on the time the first incident occurred.

(b) A record for all time-out activity shall be maintained and is defined as written documentation of the following three elements:

(i) Date and time in which a person was put into time out

(ii) The date and time the person was released from time out

(iii) The individual must be under supervision by staff at all times

(c) Time-out rooms shall not be key locked. Time out doors may be held shut by a staff member or by a mechanism that requires constant physical pressure from a staff person to keep the mechanism engaged. Time out rooms shall be adequately ventilated and free from hazardous conditions including, but not limited to, presence of sharp corners and objects, uncovered lights fixtures, or unprotected electrical outlets.

(9) Guidelines for Chemical Restraint

A behavior plan is necessary for all individuals who are chemically restrained. A chemical restraint exists if there is no valid DSM diagnosis for the corresponding medications.

Written documentation from the prescribing MD or DO (who is involved in the interdisciplinary process) of a valid DSM diagnosis must be on file at the board office. This information must include the name of the medication, dosage, reason for prescription/ diagnosis.

If team members question the diagnosis or do not find validation of the diagnosis, then a second opinion is in order. This is a medical issue, not a behavior support issue.

(10) Parent Delegated Discipline Strategies

The Delaware County Board of DD Behavior Support Committee recognizes that Behavior Support Policies and Procedures OAC 5123:2-1-02(J) does not differentiate between aversive behavioral interventions for adults and typical parental strategies for children. DCBDD has developed the following guidelines for addressing the use of these parental discipline interventions without need for a traditional behavior support plan.

(a) The only approved Parent Delegated Discipline Strategies are:

i. time out (within eyesight of the provider) when the child is physically blocked from leaving the timeout area. This is not a restraint, but physical encouragement to remain in time out.

and

ii. removal of routinely given materials or activities contingent upon inappropriate behaviors.

(b) These interventions are appropriate for children ages 3 -7 years old. Parents(either parent of the child, including an adoptive parent but not a foster parent) may delegate discipline strategies to independent providers only, not to provider agencies. At any time the team determines the need for other aversive interventions, the team will not implement these interventions without an approved and trained Behavior Support Plan. Any Crisis Intervention Strategies will be reported through the appropriate channels.

(c) The planning, approval and training process shall be completed by utilizing the appropriate Parent Delegated Discipline Strategy Checklist (Time Out or Removal of Routinely Given Materials or Activities) as a part of service planning. Teams will complete the checklist in its entirety and provide the necessary detail for the provider to implement the discipline strategy. Parents are responsible for the delegating and training of the approved strategies.

(d) The SSA and team are responsible for the monitoring of the discipline strategy at an interval determined by the team, but not to exceed three months.

(e) Documentation of the discipline strategies shall adhere to the Service Documentation Delivery Rule OAC 5123:2-9-05 and shall be submitted to the SSA at the agreed upon monitoring intervals.

(F) Process for Development, Approval, Implementation, and On-going Review of Behavior Support Plan.

(1) Development – Training and experience required for staff that develop behavior support plans are specified by the qualifications of their employer agency.

(a) Person-centered planning has occurred in behavior plans, which have been specified on the previous or current IP as a primary issue. Behavior Support methods are to be integrated into the individual's plan and provide a systematic approach to helping the individual learn new positive behaviors while reducing the undesirable behaviors.

(b) Required elements of the behavior plan are to be presented in a manner, which can be understood by the individual, parent or guardian. Behavior Support plans shall be developed according to the findings of the Behavioral Assessment.

(c)The Behavior Support Plan must include the following required elements:

- (i) Name of Behavior Consultant (person responsible for overseeing the elements of the plan, the approval process and implementation of the plan and represents the plan at BSC & HRC meetings)
- (ii) Summary of behavioral concerns
- (iii) Background information (case history including medical information, which clarifies physical or medical issues associated with the behavioral difficulties, list of diagnosis, and list of medications with associated diagnosis.)
- (iv) Target behavior: (to be decreased)
- (v) Target behavior: (to be increased or alternate behaviors to be taught)
- (vi) Baseline data (and program data if applicable) of target behavior to be decreased
- (vii) Baseline data (and program data if applicable) of target behavior to be increased if available.
- (viii) Behavioral Assessment (who, what, when, where, why, and how). Address all environments where the target behavior(s) occur(s), including times when the individual is transported in a vehicle.
- (ix) Least restrictive measures tried, including dates, and results
- (x) Behavioral Objective for target behaviors to be increased and decreased. Behavioral objectives must be listed in measurable terms.
- (xi) Positive plan and established schedule of reinforcers
- (xii) Aversive plan (if applicable)
- (xiii) Possible complications of applying aversive techniques (if applicable)
- (xiv) Data collection process (data sheet) All documentation must meet the requirements of OAC 5123:2-9-05 **HCBS waivers – waiver service documentation requirements for services provided to individuals.**
- (xv) Persons responsible for implementation
- (xvi) Documentation of how and when staff will be trained on the behavior plan
- (xvii) Documentation of complete staff training (may be submitted after HRC & BSC review the plan but must be submitted prior to final approval).
- (xviii) Evidence of team involvement developing the plan
- (xix) Team members consent to use of the plan (see sample signature page)
- (xx) Dissenting opinions documentation (see sample signature page)
- (xxi) Completion of Informed Consent-see form
- (xxii) Evidence of how and when an individual reviewed his/her plan, and a record of his or her response, even if he/she was not the consent giver (see sample signature page)

(xxiii) Evidence that a copy of the Administrative Resolution of Complaints procedure has been reviewed and given to all members of the team. (County board staff, providers, individuals, parents of minor children, guardians.)

(d) Informed Consent

To determine if an individual can give informed consent, he/she must be able to identify target behaviors, risks and benefits of the plan, acceptable alternatives of the plan, consequences of not implementing the plan, and the right to refuse the plan. Documented informed consent must be obtained prior to plan implementation.

The Informed Consent form must be completed by:

- (i) Parent or guardian of a minor (under 18 years of age)
- (ii) The individual, if he/she is his/her own guardian, and the team determines he/she can give informed consent.
- (iii) Guardian of the individual regardless of the individual ability to give informed consent.
- (iv) Parent or Advocate for an individual who can not give informed consent and has no guardian.
- (v) Human Rights chairperson in the event the individual can not give informed consent and has no guardian, parent, or advocate.

(e) Team Consent

Consent of the person's team is obtained. For the purpose of behavior support program approval, each team member's opinion must be considered.

- (i) In the event that a team member does not agree to the plan or whether or not a person can give informed consent, the team member may submit, in writing, a dissenting opinion.
- (ii) In some cases when consensus cannot be reached, the team must have an objective, independent, interested party from the Human Rights Committee to determine the appropriateness of the program.

(f) Team Review of Behavior Support Plan

- (i) Team will utilize the Team Review of Support Plan form (See attached) as a check and balance to assure all elements of the plan have been addressed. This is for team use only, not to be turned into the Behavior Support Committee.

(2) Behavior Support Committee and Human Rights Committee Approval

(a) Process for Behavior Support Committee approval of Aversive Plans.

Aversive behavior plans must be approved by the Behavior Support Committee and Human Rights Committee prior to implementation. In addition to the initial approval, aversive plans must be approved at annual resubmission corresponding with the ISP date and any time there is a major revision.

- (i) Teams should submit plans in entirety 8 working days prior to a scheduled Behavior Support Committee meeting.
- (ii) Behavior Consultant or alternate is required to attend the Behavioral Support Committee meeting when the plan is reviewed.

(iii) The Behavior Support Committee evaluates all required parts of the plan.

(iv) The Behavior Support Committee approves the plan and Behavior Support Committee Chairperson forwards the plan and the Behavior Support Review Form to Human Rights Committee, OR

(v) If not approved, the Behavior Support Committee outlines its concerns in writing and returns the plan to the individual's Team for reconsideration, revision, and re-submission.

(b) Process for Human Rights Committee approval of Aversive Plans:

(i) The Human Rights Committee will review the behavior plan and behavior support committee review form forwarded from Behavior Support Committee.

(ii) All Human Rights Committee decisions will be forwarded to the Behavior Consultant and Behavior Support Committee. In the event the Human Rights Committee does not approve the behavior plan The Human Rights Committee will outline its concerns in writing and return the plan to the Behavior Consultant for reconsideration, revision, and re-submission.

(c) Positive Behavior Support Plans

(i) Can be submitted to Behavior Support Committee and Human Rights Committee for review upon team request.

(ii) All behavior plans that involve a potential risk to the individual's rights and protections must be submitted to Human Rights Committee for their approval prior to implementing the plan.

(d) Emergency Approval

(i) The Committees recognize that emergency situations arise; therefore, emergency approval can be obtained. The behavioral consultant will submit the plan to the BSC or HRC Chair for approval. The committee recognizes that due to the urgent need for the plan, the plan may not contain all required elements. In the event there are required elements missing from the plan, the consultant will provide an explanation for the omission(s). However, DCBDD will not approve plans on an emergency basis without informed consent, proof of team involvement and proof of training.

(ii) The Chairperson or designees of the Behavior Support Committee or the Human Rights Committee, with concurrence from the superintendent or designee may provide emergency short-term approval for plan implementation. This short term approval is not to exceed the date of the 2nd BSC meeting scheduled after the plan has been approved for emergency approval. There may be an extension of the short-term approval in extenuating circumstances at the discretion of the committee.

(iii) Once the plan designee receives emergency approval, a copy of the plan and approval will immediately be forwarded to the Behavioral Support Committee for committee records.

(iv) Plans, initially submitted for emergency approval, once submitted for regular committee approval require new informed consent, team involvement and staff training.

(3) Implementation

- (a) Training & experience required by staff implementing Behavior Support plans are specified by the qualifications by their employing agencies.
- (b) Once the Behavior Support Committee and Human Rights Committee have given final approval of the plan, the team may implement the plan.
- (c) Team must collect data for the purpose of determining plan effectiveness and ongoing use of aversive procedures by reviewing the following, but not limited to... objectives, previous month's data, current data, medication changes, environmental changes, life changes and developing team recommendations. A Behavior Support Committee Progress Review Form (see attachment) is then completed for Behavior Support Committee.

(4) On-going Review of Plans

(a) Monthly

- (i) Plans that incorporate aversive methods shall be reviewed as determined by the team, but at least every thirty days.
- (ii) Team collects and summarizes data for review per section (F)(3)(c) of this policy and Behavior Consultant submits the completed Behavior Support Program Plan Progress Review form to Behavior Support Committee for review at least monthly (this form is to be turned into Behavior Support Committee 8 working days prior to Behavior Support Committee's regularly scheduled meeting- Refer to BSC calendar).
- (iii) Behavior Consultant provides status reports to the person receiving services, or his/her guardian if the person is over 18 years of age, or parent or guardian if the person is under 18 years of age. Also, if the person receives community services under contract with the board, status reports shall be provided to the contracted provider. As well, the contracted provider will provide status reports to the other affected board programs. Other team members may request a copy of this report.

(b) Annual and Major revision plan review

- (i) A regular review of all behavior support plans is held in conjunction with individualized plan updates. Behavior Support plans must be submitted to the Behavior Support Committee for review a minimum of 60 days prior to the Individual Support Plan start date. Attach approved Behavioral Support Plan to ISP and address this need in the body of the ISP.
- (ii) All behavior plans are in effect for a maximum of one year and must be reviewed by the team and resubmitted in its entirety to Behavior Support Committee and Human Rights Committee for review and approval prior to the expiration of the behavior plan.
- (iii) Any major revision to a plan must be resubmitted in its entirety to the Behavior Support Committee and Human Rights Committee for review and approval prior to the implementation of the revised behavior plan. A major revision may include but is not limited to an addition or change in a target behavior for which an aversive intervention is applied or a change in the aversive intervention applied for an existing target behavior. All required elements of the plan must be submitted.

(G) Behavior Support Committee

(1) Purpose

The Behavior Support Committee provides objective, technical, review as well as approval or rejection of all behavior programs support plans using aversive procedures or involving potential risks to an individual's rights or protections. This may include positive procedures for self-injurious behavior resulting in tissue damage.

(2) Members

The members of the Behavior Support Committee will be appointed by the Superintendent or designee. The term of membership on the committee shall be a minimum of three years with no more than two consecutive terms. Appointees must be individuals who are knowledgeable in behavior support procedures as specified by the qualifications of their employing agency for personnel requirements. Membership should be representative of as many board programs as possible. The committee will be composed of no less than five members and no more than nine members appointed. Representation will include members of varying levels of position and must include on representative from each of the following areas:

- (a) Direct service personnel
- (b) County Board employees
- (c) At least one representative of a contract agency

**If a committee member also participated in the development of a submitted plan, then that member may not participate in the Behavior Support Committee approval process.

(3) Chairperson Rotation

Chairperson changes in July every year. Chairperson shall be someone who has at least served 1 year on the committee.

(4) Behavior Support Committee Responsibilities

- (a) Meets according to policy guidelines or as determined by the chairperson. Members should not have more than 3 absences per calendar year in order to preserve the integrity of the committee.
- (b) Provides initial reviews for new behavior programs using aversive procedures or involving potential risks to an individual's rights or protections to assure accountability and necessity for use of an aversive procedure. Also ensures that all elements of the plan have been addressed as listed in Section F (1)(c) of this policy.
- (c) Provides ongoing review for existing behavior plans.
- (d) Provides emergency approval upon request following the guidelines listed in Section F (2)(d) of this policy.

(H) Human Rights Committee

(1) Purpose

The Human Rights Committee provides an objective review of all behavior programs using aversive procedures or involving potential risks to an individual's rights or protections to ensure that an individual's rights are protected. The committee is also to review and prior approve/reject

all behavior programs using aversive methods or support plans involving potential risks to the individual's rights and protections.

(2) Membership

(a) Members

The Superintendent or designee will appoint the members of the Human Rights Committee. The committee will be composed of at least five members appointed from the areas listed below. At least one of the five members will serve as a qualified person(s) who has either experience or training in contemporary practices to change behavior of persons with developmental disabilities. The committee shall be no more than nine members. The term of membership shall be a minimum of three years with no more than two consecutive terms.

- (i) At least one County Board employee.
- (ii) At least one parent of a minor or a guardian of a person eligible for county board services.
- (iii) At least one interested citizen with no direct involvement in the program.
- (iv) At least one person receiving services from the county board.
- (v) At least one person from a community agency or contract agency that provides services to people eligible for county board services.

(b) Selection Process for New Committee Members

The standing committee may make recommendations for new committee members to the Superintendent for appointment. The standing committee will consider the following areas, but is not limited to:

- (i) Any recommendations
- (ii) Advertise in Perspectives, newspaper or other local newsletters
- (iii) Letters of invitation
- (iv) Consumer recommendations from staff (must be in written form)

(c) Requirements for Members

- (i) Receive written recommendation for admittance to join committee
 - (ii) Receive written approval of membership from Superintendent
 - (iii) Receive Human Rights orientation training within six months of joining committee.
 - (iv) Read and sign the Bill of Rights from Ohio Revised Code Section 5123.62
 - (v) Read and sign a Statement of Confidentiality
 - (vi) Attend meetings to receive Behavior Support Training at least once a year.
- (iv) All members fulfilling the role of eligible individual will complete the following in addition
- Participate in monthly meeting as applicable
 - Be assigned a mentor for questions and help
 - Sign Statement of Intent

(3) Meetings

- (a) Face to face committee meetings are held at least twice per year where plan reviews will occur as needed along with training that will be offered.
- (b) Monthly meetings will occur via electronic mail if a face to face meeting is not occurring. This is determined by plans reviewed by the Behavior Support Committee the previous month.
- (c) Teams may submit positive support strategies that do not require a behavior support plan in full to the human rights committee for review. These plans will be approved/disapproved as they occur.
- (d) Emergency meetings are scheduled as needed and all meetings are subject to change.

(4) Responsibilities of the Human Rights Committee

- (a) Review and approve/not approve plans/positive support strategies ensuring the following:
 - (i) Confidentiality of the person is maintained
 - (ii) Individual's rights are not needlessly violated
 - (iv) Informed consent process has been followed appropriately
 - (v) The team has addressed that the proposed program is the least restrictive for the individual
 - (vi) Severity of behavior justifies the use of an aversive procedure
 - (vii) Skills or positive support strategies are intended to replace inappropriate behaviors
 - (viii) Notation of any possible side effects addressed in the plan

(I) Reporting Responsibilities to DODD

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

(2) Upon approval of the Delaware County Board of Developmental Disabilities Behavior Support Committee and Human Rights Committee, the Behavior Support Chairperson will forward all Behavior Support plans that use the following methods of restraint for the purpose of prior approval from the director:

- (a) Any emerging methods and technology designated by the director as requiring prior approval; or
- (b) Any other extraordinary measures designated by the director as requiring prior approval, including brief application of electric shock to a part of the individual's body following an identified behavior. Note: Electric shock is prohibited in Delaware County.

(J) Conflict Resolution

(1) Within the Team Process

Concerns regarding behavior support issues within the team process shall be resolved in the same manner as other program issues. If there is a major objection to a behavior support issue the team may request policy clarification by the Behavior Support Committee through the conflict resolution procedures.

(2) Between the Team and Behavior Support or the Human Rights Committee:

The author of a behavior support plan should attempt to address any issues and changes recommended by the Behavior Support and Human Rights committees through the team process. If the Human Rights or Behavior Support committees disapprove a plan or recommend changes

that are not acceptable to the team, then the team is to formally appeal the decision back to the committee that denied the plan or recommended changes. If resolution cannot be made at this meeting, the conflict will be forwarded to the Directors of the agencies involved for resolution. If still no resolution is met, the Superintendent will hear the issue or appoint a hearing officer and resolve the conflict.

(K) Due Process

The subject of a behavior support program or their parent or guardian may object to any part or all of a behavior support plan. Such objections should first be addressed to the team, the Behavior Support Committee and the Human Rights Committee. Should the subject of the plan not be satisfied with the plan, they may follow the due process prescribed for their program service.

DEFINITIONS
*(*Indicates Aversive)*

ADAPTIVE FUNCTIONING ➤ Adaptive functioning refers to the individual's ability to act independently in their environment.

ANTECEDENT ➤ Measurable or observable stimuli which occur immediately prior to a behavior or event.

AVERSIVE INTERVENTION ➤ A technique which employs unpleasant, intrusive or uncomfortable stimulus. This intervention has the purpose and effect of decreasing a target behavior. Interventions are to be written in detail for consistency in implementation.

BASELINE ➤ A measure of the behavior before an intervention is started. Should have at least five "data points" (i.e. one day of behavior, one instance of behavior).

BEHAVIOR ASSESSMENT ➤ The process of collection information to identify the causes for a behavior and determines what the behavior looks like and why it happens. The assessment includes the written description of the target behavior in observable behavioral terms, which is easily identifiable. It also includes the written description of the function of the behavior detailing what happens before, during and after the identified behavior. Identification of common factors and themes such as location, people, times of day... and possible reasons why the behavior occurs. (Think of it as who, what, where, when, why)

BEHAVIOR CHAINS ➤ A procedure that involves teaching a complete sequence of behaviors that must be performed in a particular order.

- a. **Backward behavior chain** ➤ a procedure that involves teaching a complete sequence of behaviors that must be performed in a particular order, starting with the last step and working backward to the first.
- b. **Forward behavior chain** ➤ a procedure that involves teaching a complete sequence of behaviors that must be performed in a particular order, starting with the first step and working toward the last.

BEHAVIOR OBJECTIVE TO INCREASE AND TO DECREASE ➤ (Target behaviors to increased and decreased) ➤ A statement of criteria that measures the success of the program, which includes three elements: target behaviors to be increased or decreased, reduction level or level of increase, and time frame. Here's an example: (↓) Sally will spit no more than three times per week for five consecutive weeks. (↑) Sally will use her communication word to get attention (rather than spit) 60% of the month for two consecutive months.

BEHAVIOR SUPPORT ➤ The use of systematic behavioral strategies that manipulate factors including, but not limited to, antecedents, consequences, stimuli, environments, and/or reinforcers in order to increase or decrease a targeted behavior.

BLOCKING ➤ Physically stopping (blocking) an individual from performing an incorrect or undesired behavior by interrupting the behavior and then redirecting to a desired response. The block is only enough physical contact to prevent the contact of the hit or a second occurrence of a hit. The use of response interruption should always be paired with the training of appropriate activity and/or an incompatible activity.

BRIEF CONTINGENT REMOVAL OF MATERIALS➤ The materials that serve as stimuli and/or reinforcers that are a part of an activity in which the individual is involved, are removed for a brief time (up to 5 minutes) to disrupt or punish a behavior.

***CHEMICAL RESTRAINT**➤ Giving a prescribed medication for the purpose of modifying, diminishing, controlling or altering a specific behavior and/ or medication given without a DSM diagnosis.

- a. **PRN** - The County Board does not condone the use of PRN medications as chemical restraint but recognizes that, on extremely rare occasions, there will be a need for the use of PRN administrations of chemicals whose sole purpose is the restraint of behavior that is otherwise uncontrollable and/or violent/physically harmful to the client. PRN administration of chemicals for the sole purpose of restraining a client must be included, as a part of a behavior support plan considered aversive in nature. Medical orders from a licensed physician must be on record as a part of the plan to substantiate the management of the client's case by a medical doctor or a doctor of osteopathic medicine. Included in the doctor's orders must be a detailed description of those criteria required for the administration of PRN, including a detailed description of the behaviors exhibited by the individual which warrants the administration of the PRN and specific procedure of administration of the PRN including who authorizes the administration of the medication based on the observable criteria
- b. **Ongoing Use of Chemicals for Restraint** - A second form of chemical restraint exists when no DSM disorder is present that would warrant the use of the chemical prescribed. While the use of chemical restraints in such a manner is beyond the scope of the administrative structure of the DCBDD and its behavior support committee, the DCBDD strongly discourages the use of chemicals in this manner. Medications used for medical purposes (treat seizures, or mental health diagnoses) are not considered chemical restraints. In other words, there must be a psychiatric diagnosis for each psychiatric medication.

CONSEQUENCE➤ The stimuli that occur immediately after a behavior occurs. It is an environmental event that follows each occurrence of a behavior that has the effect of increasing or decreasing that behavior in the future.

CRISIS➤ An unexpected emergency which necessitates an immediate response to protect individuals from injury or prevent property damage.

DSM ➤Diagnostic Statistical Manual, most current Edition, published by the American Psychiatric Association used to diagnose mental illness. Examples are but not limited to Mood Disorders, Anxiety Disorders, and Psychiatric Disorders. If you have questions about what a diagnosis is, you may ask one of the psychology staff for assistance.

ERRORLESS LEARNING➤An instructional procedure that arranges stimuli and prompts so that only correct responses are emitted.

EXTINCTION➤ Discontinuing reinforcement of a behavior previously reinforced, resulting in a decrease or elimination of the behavior (e.g. planned ignoring or withholding of staff attention).

FADING➤ A procedure involving the gradual removal of prompts until the person is able to respond independently.

GENERALIZATION➤Display of a target behavior across situations, settings, activities, or with people other than primary trainers in training settings. Generalization could also refer to the continuation of intervention effects beyond the point of formal intervention.

***FINANCIAL RESTITUTION**➤ An aversive strategy involving full or partial financial payment for items broken or damaged as a result of a target behavior. This strategy is typically not used unless the value of money is understood by the person.

INCOMPATIBLE BEHAVIOR➤ A behavior that cannot be performed simultaneously with another behavior because they are functionally or physically incompatible. For example, sitting in a chair is incompatible with running out of the room.

INDIVIDUAL➤ indicates individual receiving services, guardian, or parent if child is less than 18 years of age.

LEAST RESTRICTIVE APPROACH➤ That intervention into the life of an individual with developmental disability that is the least intrusive and least disruptive to the individual, and that represents the least departure from normal patterns of living.

MAINTENANCE➤ Continuing the desired behavior over time by means such as gradually decreasing the reinforcers, altering reinforcement schedules and gradually fading artificial prompts.

MAINTENANCE PROCEDURES➤ Thinning reinforcers, altering reinforcement schedules and fading artificial prompts to promote the persistence of behaviors over time under more natural conditions.

***MANUAL RESTRAINT**➤ A hands-on method that is used to control an identified behavior by restricting the movement or function of the individual's head, neck, torso, one or more limbs or entire body, using sufficient force to restrict movement. Generally only used after other less restrictive procedures have been tried or if an unanticipated but immediate threat to the safety of others is reasonably judged by staff.

Examples:

- Staff hold hand of individual who is engaged in SIB hitting or throwing objects. The individual tries to get hand away and staff do not let go. The individual's movement is restricted.
- The individual is involved in aggressive behavior, the staff person uses a one person restraint to protect the individual and others. The person's movement is restricted until calm.

***MECHANICAL RESTRAINT**➤ A device that restricts an individual's movement or function applied for purpose of behavior support, including a device used in any vehicle, except a seat belt of a type found in an ordinary vehicle or an age-appropriate child safety seat. Generally only used after other less restrictive procedures have been tried and manual restraint is not appropriate. Use of contingent mechanical restraints as part of a planned behavioral program is permitted. Non-contingent use is not permitted. Use of mechanical restraints for staff convenience is prohibited.

MECHANICAL SUPPORTS➤ Items that are used only for the purpose of providing for an individual's physical safety, support, maintenance of optimal body alignment and protection, including preventing physically handicapped individuals from falling, supporting the individual during a prescribed diagnostic or medical procedure or transporting the individual by way of stretcher or wheelchair. These items can include wheelchair lap trays, splints, braces, adapted wheelchairs, sandbags, seat belts, helmets, soft ties, sheets, a sleeveless cloth jacket, and other orthopedic devices. Items, when used for mechanical support, are not considered restraints. Qualified therapists, together with medical professionals, shall prescribe within the (individual's plan) the mechanical supports and arrange for their provision.

MEDICAL RESTRAINT➤ The use of all items or measures to inhibit, control or limit the movement or normal function of any portion of an individual's body to permit treatment, promote healing, or prevent an

infection. Medical restraints are not considered behavior restraints. Medical restraints shall be prescribed by a physician.

MODELING PROCEDURE➤ Demonstrating desired response and individual imitates.

MONITOR➤ To examine an existing program on a regular basis to make sure it complies with applicable rules, policies, and procedures, and to take appropriate steps if compliance is not achieved.

NATURAL AND LOGICAL CONSEQUENCE➤ Those results of behavior which can be described as natural consequences because they are unplanned or necessarily follow the behavior and are its reasonable outcomes. Natural consequences are those that occur naturally in the environment such as the offensive odor that follow the smearing of feces. Logical consequences are those that are based on societal norms such as eviction when rent is not paid.

NEGATIVE REINFORCEMENT➤ REMOVING a consequence resulting in INCREASE in behavior. A behavior has been negatively reinforced if it increases due to the contingent removal or reduction of a stimulus. This procedure is sometimes referred to as escape conditioning. For example, when a child does as asked, the adult stops nagging. The child's behavior (doing as requested) has been negatively reinforced by the removal of the nagging.

NON-CONTINGENT (CUSTODIAL) USE OF MECHANICAL RESTRAINTS➤ (Prohibited by DCBDD) Restricting the movement or function of any portion of an individual's limbs, head, or body through mechanical means as part of a planned behavioral program.

***OVER CORRECTION**➤ A reductive procedure implemented following a behavior, which disrupts the environment. [It consists of] two basic components: 1) requiring the individual to restore the environment to a state vastly improved over one which existed prior to the behavior which disrupted the environment; and 2) positive practice, i.e., requiring to individual the repeatedly perform an appropriate substitute behavior. Over correction may involve the use of graduated guidance. It does not include simple self-correction. For example, an individual smears feces on the wall. He must then clean the entire bathroom, not just the soiled areas.

PROMPTING➤ A verbal, gestural or physical prompt to cue an individual. For example, if hands are blocked or redirected, but not held (i.e. hand of staff touching hand of individual, but individual can remove hand at any time), then is not restraint, it is simply guiding the individual and no way restricting movement to retreat or calm.. The amount of time the person is guided/blocked does not determine whether this is an aversive technique.

PLANNED IGNORING➤ Permit behavior to continue without responding, either verbally or non-verbally (i.e., no eye contact) in order to remove social reinforcement.

POSITIVE SUPPORT STRATEGIES➤ A systematic program for the purpose of increasing a target behavior which only uses consequences that are pleasant and non-aversive.

POSITIVE REINFORCER➤ GIVING a consequence resulting in INCREASE in behavior.

PROMPTED RELAXATION (NO PHYSICAL GUIDANCE)➤ A verbal or gestural prompt to cue an individual to display quiet, relaxed behaviors to replace the agitated, disruptive, or destructive behaviors he or she emits under certain conditions.

PROXIMITY CONTROL➤ A staff member moving closer to an individual whose behavior is disturbing. Proximity can also be achieved by having the individual bring something to the instructor.

***PUNISHMENT**➤ Any consequence that results in a decrease in behavior. Consequence may be given or removed.

REDIRECTION TO A MORE APPROPRIATE ACTIVITY➤ A procedure in which the individual is directed to a more appropriate task using cues or shaping. A reinforcer is given following the performance of a pre-specified appropriate behavior. The rationale for using this procedure to decrease behavior is that increasing a desired behavior may produce a simultaneous decrease in the targeted inappropriate behavior.

REPLACEMENT BEHAVIOR➤ The alternative appropriate behavior which needs to be taught to the individual. It is an appropriate behavior which achieves the same purpose as the inappropriate target behavior being treated for reduction, such as communication of boredom vs. a substitute for head-banging.

***RESPONSE COST**➤ Removal of previously earned tokens, privileges or other reinforcers contingent upon inappropriate behaviors.

RULE REMINDERS➤ Reminding the individual of rewards for desired behavior, and/or verbally explaining the negative consequences of specific behaviors. This should be done in a non-threatening, non-judgmental manner. Rule reminders call attention or restate previously discussed rules or expectations.

SATIATION➤ A procedure in which a reinforcer that has been maintaining a misbehavior is presented non-contingently in unlimited amounts in order to reduce that behavior. The individual becomes tired of the reinforcer and no longer exhibits behavior to get it.

SHAPING➤ The systematic, immediate reinforcement of successively closer approximations of the desired behavior until the desired behavior is established.

RESTORATION OF THE ENVIRONMENT➤ An individual is required to repair any damage that he/she did to the environment. This should not require the repair or cleaning of anything that the individual did not disrupt (i.e., no over correction is involved with simple self-correction). Also, physical prompts should only be to assist with the task if necessary, not to overcome resistance.

STANDING OR “AS NEEDED” PROGRAMS➤(Prohibited by DCBDD)_Use of a negative consequence or an emergency interaction as the standard response to an individual’s behavior without developing a behavior support plan for the individual.

***SUSPENSION**➤ Refers to the prohibition of an individual from presence in their typical environment other than time-out, with the exception of suspension when such suspension is consistent with other agencies policy (such as personnel policies or transportation policies).

TARGET BEHAVIOR➤ A behavior identified by the interdisciplinary team as needing to be increased or decreased by the use of a behavioral program.

THINNING➤ The reduction of a reinforcer’s frequency or intensity.

TIME AWAY➤ An interruption of regularly scheduled activities so that an individual can regain composure and be able to return to their regularly scheduled activities. Time away is usually determined

by the individual and is employed most often as an effective self-management strategy. The purpose of this procedure is to decrease inappropriate behavior by decreasing agitation, anxiety and frustration. Time Away should not have the effect of significantly producing avoidance of habilitative programming. The individual is free to leave at anytime.

***TIME OUT** ➤ Removing attention from individual. Includes verbal and non-verbal attention. Appropriate for use when behavior is attention seeking. Individual is removed from an area to a room and prevented from leaving by application of physical force or by closing a door or other barrier, including placement in such a room when a staff person remains in the room. (Time-Out Room, sending individual to a bedroom, etc.)

TOKEN REINFORCER ➤ An object that is given when an appropriate target behavior occurs and which can be exchanged at a later time for a reinforcing item or activity.

***WITHHOLDING OF ROUTINELY GIVEN ITEMS, MATERIALS, OR ACTIVITIES** ➤ Also referred to as loss of privileges. Involves the loss of an item, material, and/or activity that constitutes a part of the individual's typical environment. Loss of privilege involves the same basic behavior mechanics as Response Cost, except that it employs items, materials and/or activities that were NOT earned by the individual (in contrast to response cost when they were earned).

Type of Plan:

	Positive		Home
	Aversive		Work/day program
			Transportation

Behavioral Consultant:

Plan Status:

	New
	Renewal
	Revision
	Emergency

Start Date of Behavior Support Plan:

ISP Span dates:

Birth Date:

Aversive Interventions included in the plan: *Time out up to 5 minutes, escort up to 2 minutes, etc...*

Behavior Support Plans with Positive and Aversive interventions must include the following elements:

- Summary of Behavioral Concerns. Address all areas where the behavior occurs, including during transportation.
- Background information: (Case history including medical information which clarifies physical or medical issues associated with the behavioral difficulties, list of diagnosis, and list of medications with associated diagnosis and possible side effects)
- Target behavior: (to be decreased):
- Target behavior: (to be increased or alternative behavior to be taught):
- Baseline Data (and program data if applicable) of the target behaviors to be decreased and target behaviors to be increased: (Baseline Data is the record of target behaviors in the absence of a plan)
- Program Data of the target behaviors to be decreased and target behaviors to be increased (Program Data is the record of target behaviors during the time of a behavior plan)
- Behavioral Assessment (functional and structural analysis-who what, where, when, why and how) Address all environments where the target behavior(s) occur(s), including times when the individual is transported in a vehicle.
- Least restrictive measures tried, include dates, and results:
- Behavioral Objective for the target behaviors to be increased and the target behaviors to decrease
- Positive Plan and established schedule of reinforcers: Aversive Plan:
- Possible complications:
- Data collection process:
- Persons responsible for implementation:
- Documentation of how and when staff will be trained on the behavior plan:
- Evidence of team involvement developing the plan (see sample signature page)
- Team members consent to use of the plan (see sample signature page)
- Dissenting opinions documentation (see sample, signature page)
- Completion of Informed Consent (see form)
- Evidence that consumer reviewed their plan (see sample, signature page)
- Evidence that a copy of the Administrative Resolution of Complaints Procedures has been reviewed and given to all members of the team (county board staff, provider, individual, parents of minor children, guardian...) (See sample signature page)

SAMPLE OUTLINE Behavior Support Plan

Type of Plan:

	Positive		Home
	Aversive		Work/day program
			Transportation

Behavioral Consultant:

Plan Status:

	New
	Renewal
	Revision
	Emergency

Start Date of Behavior Support Plan:

ISP Span dates:

Birth Date:

Aversive Interventions included in the plan: *Time out up to 5 minutes, escort up to 2 minutes, etc...*

Summary of Behavioral Concerns:

Describe a brief summary of the concerns. Background info will be included later. Address all areas where the behavior occurs, including during transportation.

Background Information:

Include pertinent background re: residential and/or school/work placement.

Medical Information:

Diagnoses:

- *Include current diagnoses*
- *Medications below should correspond to diagnoses.*
- *Psychotropic medications given without a corresponding DSM diagnosis are considered chemical restraints and would be an aversive procedure.*

Medications

Medication	Dosage	Frequency	Reason Ordered	Side Effects
				Can get side effects from website such as webmd.com

**** This is not an exclusive list of side effects. For full drug information, please consult a physician or pharmacist. _____ is responsible for keeping a current list of medications. Medication changes will be reviewed at team meetings.**

Include other pertinent medical issues that may relate to behavioral concerns. Surgeries, etc. may also be beneficial in some cases.

Target Behaviors:

1. *List the each specific behavior to be decreased separately (to be decreased)*
2. *List behavior to be increased, which should typically be a replacement behavior to the ones decreased. (to be increased)*

Behavioral Assessment:

Explain who the person is. Answer questions about when and where the behavior occurs, patterns seen with people or places, any instigating factors. Be sure to describe the behavior well so that it can be noted by anyone. Most importantly, identify the reason why the person exhibits the behavior. This may be a guess on your part. Each target behavior needs to be explained separately.

Baseline Data: *Considered part of the assessment information. This info can be obtained from incident reports, baseline tracking or other forms of data. You must have baseline for each specific behavior to be decreased.*

Dates behavior was tracked	Target Behavior	Home	Work	Transportation	Total Average per month

Program Data: *This is used to update data annually to show progression/regression under the plan.*

Program Dates:	Target		Target											
	Ttl	Avg	H		W		H		W		H		W	
<i>6/1/04 – 12/31/04</i>														
<i>3/05 – 11/05</i>														
<i>3/06 – 11/06</i>														

Least Restrictive Measures Tried with Dates and Results:

List hx of other plans aversive and/or positive, dates and results. The behavior committee will be looking to see if the least restrictive measures were used first and to see if the behavior is serious enough to warrant an aversive.

Behavioral Objectives:

1. *Should be one objective for each target behavior to be reduced and for the target behavior to be increased.*
2. *Objectives should be based on the program/baseline data and should have a reasonable measure of success.*

Proactive Strategies: ****Make sure to specify where the proactive strategy is to be used (home, work, transportation, community, etc).**

These strategies should correspond to your theory about why the person is exhibiting the target behaviors. These strategies should attempt to support the person by address coping strategies and by encouraging possible replacement behaviors.

Reinforcement strategies would be included here. Each positive and aversive plan should include reinforcement strategies, even if verbal praise.

Reactive/Intervention Strategies:

Target Behavior #1: ****Make sure to specify where the intervention strategy is to be used (home, work, transportation, community, etc).**

1. *There should be intervention strategies for each target behavior to be decreased.*
2. *Aversive strategies will be included here. The following is a short list of aversive strategies that require aversive plans and plan review by the BSC.*
 - *Any type of restraint: chemical, manual (hands on), mechanical (devices which limit movement. Must document time applied and released).*
 - *Withholding of routinely given items: (trips to the store, etc)*
 - *Time out (use of time out must have documentation of time in and out and must have limits on the total time allowed.*
 - *Response cost: The loss of a previously earned token or item contingent on a target behavior.*
 - *Overcorrection: restoring an environment after destroying it, then... being required to restore other environments in addition.*
 - *Restitution: Requiring payment for items damaged. This should be used only when the person has a knowledge and appreciation for the value of money.*
 - *Right's restriction such as restricted phone use, locked cabinets, etc.*

Target Behavior #2: ****Make sure to specify where the intervention strategy is to be used (home, work, transportation, community, etc).**

- 1.

Possible Complications:

- *List possible complications from running the plan such as injury during restraint etc. This does not include complications seen as a result of the display of the behavior such as injury to another person.*

Data Collection Process/Monitoring:

See attached documentation sheets. The team will meet monthly to review progress. _____ will assist with analyzing data collected and monitoring the plan.

Persons Responsible for Implementation:

All staff who work with ----- are responsible for implementing this plan.

Documentation of how and when Staff will be Trained:

All staff who work with ----- will be trained following BSC and HRC approval and prior to the implementation date of the plan. ----- will be responsible for coordinating the training for work staff and obtaining written documentation of the training. ----- will be responsible for coordinating training for home staff and obtaining documentation of the training.

Informed Consent: Attached.

Informed Consent

BEHAVIOR SUPPORT PLAN

Individual's Name _____ Start Date _____

Informed Consent

(Informed consent is defined as the ability to identify target behaviors, risks and benefits, acceptable alternatives, consequences and the right to refuse the plan)

This form must be completed by one of the following:
(Circle the applicable number)

- 1. Parent or guardian of a minor (under 18 year of age).
- 2. The individual, if he/she is his or her own guardian and the team determines he/she can give informed consent.
- 3. Guardian of the individual regardless of the individual ability to give informed consent.

Informed Consent giver, please initial statements:

_____ Record the informed consent giver's response.
Initials

- 1. The target behavior(s) is:

- 2. The risks and benefits of the plan (s) is:

- 3. Acceptable alternative(s) to this action, treatment or service is:

- 4. Consequences of implementing the plan:

_____ I agree to the Plan
Initials

OR

_____ I do not agree with the Plan for this reason(s):
Initials

Signature

Relationship to Individual

Date

5123:2-9-05 HCBS waivers - waiver service documentation requirements for services provided to individuals.

(A) Purpose

This rule sets forth the requirements of the information that must be maintained by the provider of services in order to fully disclose the nature and extent of the services delivered as authorized in accordance with section [5111.871](#) of the Revised Code.

(B) Definition of service documentation

“Service documentation” means the maintenance of all records and information on one or more documents, including documents that can be printed from electronic software programs, in such a manner as to fully disclose the nature and extent of the services delivered and must include each of the following items to validate medicaid reimbursement:

- (1) Date of service;
- (2) Place of service;
- (3) Name of the recipient;
- (4) Medicaid identification number of the recipient;
- (5) Name of the provider;
- (6) Provider identifier/contract number;
- (7) Signature of the person delivering the service or initials of the person delivering the service if a signature and corresponding initials are on file with the provider;
- (8) Type of service (for homemaker/personal care, type must include if routine, on-site/on-call, or level one emergency);
- (9) Number of units of the delivered service or continuous amount of uninterrupted time during which the service was provided;
- (10) Group size in which the services were delivered as defined in paragraph (D)(12) of rule 5123:2-9-06 of the Administrative Code;
- (11) Arrival and departure times of the provider of service’s site visit to the recipient’s location or of the recipient’s visit to the provider of service’s location;
- (12) Description and details of the services delivered that directly relate to the services specified on the recipient’s approved individual service plan as those services to be provided;
- (13) A notation made at least monthly indicating the response to services delivered; and
- (14) Forms that identify, for the individual, the ISP service(s) to be delivered. The forms shall include all of the above and may be checked off and initialed by staff for each continuous period of service delivery time for each date of service. Any variation between the ISP requirements and actual staff to individual ratios, times of service delivery, group size, or type of service delivered shall be documented. Documentation shall reflect the actual staff to individual ratios and the time period of the variation.

(C) Invoices the provider of services submits to the department for reimbursement of services delivered shall not be considered service documentation. Any information contained on the submitted invoice may

not and shall not be substituted for any required service documentation information that the provider of services is required to maintain to validate medicaid reimbursement.

(D) Services shall not be considered as delivered unless the provider maintains service documentation.

(E) Reimbursements made to the provider of services for services delivered that are not supported by service documentation or are supported by service documentation that does not include all the required items listed in paragraph (B) of this rule may be recoverable under paragraph (P) of rule 5123:1-2-08, paragraph (N) of rule 5123:1-2-11, paragraph (O) of rule 5123:2-8-16, and paragraph (I) of rule 5123:2-9-06 of the Administrative Code.

(F) Each provider of services shall maintain all service documentation in an accessible location. The service documentation shall be available, upon request, for review. Agencies with the authority to view such records upon request are the centers for medicare and medicaid services, the Ohio department of job and family services, the Ohio department of mental retardation and developmental disabilities, the county board of mental retardation and developmental disabilities and regional councils of government that submits to the department payment authorization for the service and those designated or assigned authority by the Ohio department of job and family services or the Ohio department of mental retardation and developmental disabilities.

(G) The provider(s) of services shall maintain all service documentation for a period of six years from the date of receipt of payment for those services or until an initiated audit is resolved, whichever is longer.

(H) Should the provider of services discontinue operations, the provider of services shall, within seven days of discontinuance, notify the county board as to the location of where the service documentation will be stored, and provide the county board with the name and telephone number of the individual responsible for maintaining the records.

Effective: 09/30/2005

R.C. 119.032 review dates: 09/30/2010

Promulgated Under: 119.03

Statutory Authority: 5123.04, 5111.871

Rule Amplifies: 5123.04, 5111.871

BSC Review of Behavior Support Plan Monthly Data

Name		Behavior plan start date	
New plan and consent due		Type of plan	
Behavior Con.		ISP date	

BSC Comments

BSC meeting date		
Next month's due date		

BSC meeting date		
Next month's due date		

BSC meeting date		
Next month's due date		

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Next month's due date		

BSC meeting date		
Next month's due date		

Questions? Please contact:

Committee Chair – Melinda Draper (740) 201-5808 or Melinda.Draper@dcbdd.org
 Committee Co-Chair – Kelly Benke (740) 201-5877 ext. 510 or Kelly.Benke@dcbdd.org

BSC File		
Main File		

**Delaware County Board of Developmental Disabilities
Approval Process Checklist for Behavior Support Plans**

Plan For:					
Plan Designee:			Phone number:		
ISP span:			Birth Date:		
Start date of Plan:					
Type of Plan	<input type="checkbox"/>	Positive	<input type="checkbox"/>	Home	
	<input type="checkbox"/>	Aversive	<input type="checkbox"/>	Work	
	<input type="checkbox"/>		<input type="checkbox"/>	Combined	
	<input type="checkbox"/>	New to BSC	<input type="checkbox"/>	Renewal	<input type="checkbox"/>

To be completed by BSC

Received by BSC on this date: _____ Date reviewed by BSC: _____

Not Approved Pending Approval (circle one)

Were recommendations made? Yes No (circle one – if yes, please refer to review for specifics)

Recommendations are due to this person: _____ by this date: _____

Recommended changes verified by this person: _____ on this date: _____

Submitted to HRC by this person: _____ on this date: _____

To be completed by HRC

Received by HR on this date: _____ Date reviewed by HRC: _____

Not Approved Pending Approval (circle one) Final approval of plan by HRC on this date: _____

Were recommendations made? Yes No (circle one – if yes, please refer to review for specifics)

Recommendations are due to this person: _____ by this date: _____

Recommended changes verified by this person: _____ on this date: _____

To be completed by BSC

Date of home training: _____ Date of work training: _____

Final approval of plan by BSC: _____ Date of Informed Consent: _____

Final approval of plan by HRC: _____ Date of Team Consent: _____

Start date of plan at home: _____ Start date of plan at work: _____

DODD reporting form submitted by this person: _____ on this date: _____

To be completed for all **new** plans and major revisions going to Behavior Support Committee for review.
This form must accompany the behavior support plan through the entire process

**Delaware County Board of Developmental Disabilities
Approval Process Checklist for Behavior Support Plans**

Plan For:		
Review Questions	Yes	No
1. Is the described behavior destructive to self or others and/or detrimental to the development of self or others? Comments:		
2. Does the plan include complete background information? Comments:		
3. Does the plan include all target behavior(s) to be decreased? Comments:		
4. Does the plan include all target behavior(s) to be increased? Comments:		
5. Does the plan include complete baseline data (and program data if applicable)? Comments:		
6. Does the plan include a complete behavioral assessment? Comments:		
7. Does the plan include all environments where the target behavior occurs including times when the individual is transported in a vehicle? Comment:		
8. Does the plan indicate that least restrictive measures have been tried, with dates and results? Comments:		
9. Does the plan state the objectives? Comments:		
10. Is there a positive portion in the plan, which includes an established schedule of reinforcers and alternative behaviors to be taught? Comments:		
11. Does the plan include aversive interventions? Comments:		
12. Are all possible complications included in the plan? Comments:		
13. Are all data sheets included? Comments:		

**Delaware County Board of Developmental Disabilities
Approval Process Checklist for Behavior Support Plans**

Plan For:		
Review Questions	Yes	No
14. Does the plan include all persons responsible for implementation? Comments:		
15. Does the plan document how and when staff will be trained on the behavior plan? Comments:		
16. Does the plan include documentation of training for home? Comments:		
17. Does the plan include documentation of training for work? Comments:		
18. Does the plan include evidence of team involvement developing the plan? Comments:		
19. Does the plan include team consent? Comments:		
20. Does the plan include whether or not there are dissenting opinions? Comments:		
21. Has informed Consent been obtained and included with the plan? Comments:		
22. If the individual is not the informed consent giver of the plan, is there documentation of how/when the plan was shared with the subject of the plan, and is there a record of the individual's response? Comments:		
23. Is there evidence of Administrative Resolution of Complaints has been reviewed and a copy given to all team members? Comments:		
24. Was the plan given pending approval by the Behavior Support Committee? Comments/ Date:		Not approved

Does the plan contain these interventions? If yes, what is the maximum duration per episode? **If any are Yes, notification needs to be sent to the state.**

Time Out	Yes No	Max. duration per episode		Target Behaviors & Baseline w/dates	
Mechanical Restraint	Yes No	Max. duration per episode		Target Behaviors & Baseline w/dates	
Manual Restraint	Yes No	Max. duration per episode		Target Behaviors & Baseline w/dates	
Chemical Restraint	Yes No	Max. duration per episode		Target Behaviors & Baseline w/dates	

Due to Human Rights Committee:

General Comments	

HUMAN RIGHTS COMMITTEE MEETING MINUTES

Date of Meeting: _____ Location: _____

MEMBERS PRESENT/TITLE (Signatures):

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____
- 9. _____

MEMBERS ABSENT:

- 1. _____
- 2. _____
- 3. _____

PRESENTER'S SIGNATURE/TITLE (if any):

- 1. _____
- 2. _____
- 3. _____

AGENDA/OUTLINE:

C:

_____	_____	_____
_____	_____	_____
_____	_____	_____

DELAWARE COUNTY BOARD OF DEVELOPMENTAL DISABILITIES
HUMAN RIGHTS COMMITTEE
Behavior Plan Review Sheet

Code for Individual _____ Date of Review _____

Behavior Consultant _____ Final Approval Date _____

Behavior Program: Aversive _____ Type: Home _____ Work or Day Program _____
Combined _____

QUESTION/ISSUE #	EVALUATION	SOURCE/PLAN PAGE
1. Have any rights been violated?	1. ___ Yes ___ No	1. _____
2. Does the severity of the behavior justify the recommended aversive procedure?	2. ___ Yes ___ No	2. _____
3. Is it clear that efforts have been made using less aversive interventions?	3. ___ Yes ___ No	3. _____
4. Is this the least restrictive alternative?	4. ___ Yes ___ No	4. _____
5. Are positive behaviors and skills being taught?	5. ___ Yes ___ No	5. _____
6. Do some procedures need to be monitored?	6. ___ Yes ___ No	6. _____
7. Are reinforcers being used in this procedure?	7. ___ Yes ___ No	7. _____
8. Could there be possible side effects?	8. ___ Yes ___ No	8. _____
9. Has informed consent been obtained?	9. ___ Yes ___ No	9. _____

Overall Discussion/Comments

Human Rights Committee Signatures	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Original: Behavior Support Committee
Cc: Behavior Consultant

CLIENT RIGHTS SECTION 5123.62 BILL OF RIGHTS (HRC)

The rights of person with developmental disabilities include, but are not limited to:

- A. The right to be treated at all times with courtesy and respect and with full recognition of their dignity and individuality;
- B. The right to an appropriate, safe, and sanitary living environment that complies with local, state, and federal standards and recognizes the persons' need for privacy and independence;
- C. The right to food adequate to meet accepted standards of nutrition;
- D. The right to practice the religion of their choice or to abstain from the practice of religion;
- E. The right of timely access to appropriate medical or dental treatment;
- F. The right of access to necessary ancillary services including, but not limited to, occupational therapy, physical therapy, speech therapy, and behavior modification and other psychological services;
- G. The right to receive appropriate care and treatment in the least intrusive manner;
- H. The right to privacy, including both periods of privacy and places of privacy;
- I. The right to communicate freely with persons of their choice in any reasonable manner they choose;
- J. The right to ownership and use of personal possessions so as to maintain individuality and personal dignity;
- K. The right to social interaction with members of either sex;
- L. The right of access to opportunities that enable individuals to develop their full human potential;
- M. The right to pursue vocational opportunities that will promote and enhance economical independence;
- N. The right to be treated equally as citizens under the law;
- O. The right to be free from emotional, psychological, and physical abuse;
- P. The right to participate in appropriate programs of education, training, social development, and habilitation and in programs of reasonable recreation;
- Q. The right to participate in decisions that affect their lives;
- R. The right to select a parent or advocate to act on their behalf;
- S. The right to manage their personal financial affairs, based on individual ability to do so;
- T. The right to confidential treatment of all information on their personal medical records;
- U. The right to voice grievances and recommend changes in policies and services without restraint, interference, coercion, discrimination, or reprisal;
- V. The right to be free from unnecessary chemical or physical restraints;
- W. The right to participate in the political process;
- X. The right to refuse to participate in medical, psychological, or other researches or experiments.

If you have questions or concerns about your rights, you may call Ohio Legal Rights Service's statewide toll free intake services at 1-800-282-9181 or DODD 1-800-231-5872

CONFIDENTIALITY STATEMENT

Senate Bill 322 enacted May, 1986 guarantees the rights of persons with developmental disabilities. Among these is the right to confidential treatment of all information shared within all County Board programs. This also cannot be reviewed, removed or disseminated without prior approval from the individual or the individual's guardian. In addition, knowledge concerning any person should not be discussed outside of the actual meeting as this is in violation of the contents of Senate Bill 322.

Violations of the right to confidentiality may result in legal action being taken on behalf of the individual.

_____ Date _____
Committee member's signature

**DCBDD
2011 Behavior Support Policy
Training**

I have received the policy and completed the self directed training via achieving the outcomes listed below:

Training Syllabus

- I Origin and Development of Behavior Support Regulations

- II Interventions
 - Prohibited
 - Crisis
 - Positive
 - Aversive

- III Process for Plan Development

- IV Committee Functions
 - Behavior Support
 - Human Rights

- V Reporting Responsibilities

- VI Conflict Resolution and Due Process

Objectives

- 1. Participants will identify methods of intervention
- 2. Participants will identify the process for plan development
- 3. Participants will be familiar with all the contents of the DCBDD Behavior Support Policy

Name_____Date_____