GUIDELINES FOR SUPPORTING ADULTS WITH CHALLENGING BEHAVIORS IN COMMUNITY SETTINGS

A Resource Manual for Georgia's Community Programs
Serving Persons with Serious and Persistent Mental Health Issues
And Serving Persons with Mental Retardation or Developmental Disabilities

TABLE OF CONTENTS

APPENDICES

I. PREFACE

This resource manual is intended to provide parameters for addressing behavioral concerns of persons with serious and persistent mental health issues and for addressing behavioral concerns of persons with mental retardation and other developmental disabilities who are served in community programs supported by funding, in whole or in part, that is authorized by the Division of Mental Health, Developmental Disabilities and Addictive Diseases (DMHDDAD). Additionally the manual is a resource for the development of individual local program policies for behavioral support planning and programming.

The manual sets forth both guidelines and requirements to be followed when behavioral supports are utilized in the care of persons served. Policies developed within community programs regarding behavioral supports are expected to comply with the guidelines and requirements set forth in this manual, including current regulatory standards, individual rights, core values and philosophy of treatment of the Division of MHDDAD, and to be consistent with empirical knowledge related to behavior analysis.

This manual was developed in compliance with the Division's *Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases Providers Under Contract with the Division of Mental Health, Developmental Disabilities and Addictive Diseases* as well as federal and state law, rules and regulations.

Readers will note that disability groups use different language to describe similar things. For example, within MR/DD the Individualized Service Plan is referred to as the ISP. Within MH it is referred to as the Individual Recovery Plan, or IRP. And you will find similarities when discussing positive behavior supports and WRAP Plans. If the differences and similarities do not become clear as you read, feel free to contact staff in the respective disability sections of the Division of MHDDAD.

Appreciation and recognition are expressed to those individuals who served on the task force to develop the manual and to the staff who offered their suggestions on its content. This manual is provided to be a useful resource to facilitate the best services possible within the Division of MHDDAD.

II. PURPOSE

The manual has several purposes:

- To provide person-centered guidance for supporting adults with challenging behaviors, regardless of their disability
- To promote consistent and effective services and supports in different settings and circumstances (e.g., families, supported living, etc.).
- To protect the rights of individuals served (client rights), especially the right to participate in and determine the development of their services and supports.
- To provide strategies that promote the highest quality of life possible as determined by the individual.
- To provide tools to enhance skills of persons supporting individuals (staff, family, etc.).
- To provide strategies that maintain resilience in caregivers.

III. VALUES OF THE DIVISION OF MHDDAD

The Division of Mental Health, Developmental Disabilities and Addictive Diseases hold these values with regard to persons served through the Division.

A. Consumer choice

Consumers and families have choices about MHDDAD services through:

- Participation in designing the MHDDAD service system;
- Full participation in development of their service plan;
- Selection of service providers, location of services and other factors related to implementation of the service plan; and
- Opportunity for and development of the capacity to make choices in every day life.

B. Inclusion

Consumers are supported to participate in the everyday life of their community, with their family, friends and natural/community support system. Children and adolescents are supported to remain in their own homes with their families.

C. Appropriate environment

Consumers are served in the least restrictive, least intrusive environment possible that meets the needs of the individual served.

D. Quality of services

Consumers have the highest quality services provided by a competent staff, utilizing flexibility and incentives that reinforce quality and efficiency.

E. Individualized services

Individuals are provided services at the appropriate level of intensity based on their individual strengths, needs and choices with sensitivity to cultural differences, age appropriateness and gender specific needs.

IV. PERSON-CENTERED PLANNING

Person-centered planning is a way to get to know a person and their "story" so that you know what they want in life, where they want to live and what makes them happy. It is a planning process used within all disabilities that addresses all areas of a person's life, including health, community involvement, relationships with friends and family, and work. It is a collaborative process to help individuals get the supports and services they need to live a quality life, based on their own preferences and values. The individual served and those who know the person best are the most important participants in the planning process.

The person-centered planning process starts with listening to the person and honoring his/her vision. A person-centered approach asks us to remember people as whole human beings with hearts, souls, and desires like everyone. To realize their wishes and potential, support and encouragement is required. **Person-centered planning focuses on identifying and maximizing the strengths and preferences rather than creating lists of what the individual can't do.**

A person-centered approach for developing a behavior support plan is similar in that it requires listening to the person to gain an understanding of who the person is, the person's wishes and hopes for his or her life, honoring his/her vision, understanding his or her strengths and challenges, and giving consideration to the context of his or her social and environmental setting, including any relevant medical or psychiatric conditions. It requires listening to the individual through their words and actions so that the significance of the behavior(s) can be understood.

When using a person-centered approach, it is most important to identify the gaps between the person's life and how he or she wants his or her life to be. The person-centered planning process may include strategies for minimizing situations that cause stress for the person and maximizing the person's control over his or her life.

Listening is a **critical component** of person-centered planning. What follows in Example 4.1 are some **really good tips** to use when communicating with people.

EXAMPLE 4.1

PERSONAL CONDUCT THAT SAYS YOU ARE LISTENING
And that will
MINIMIZE NEGATIVE RESPONSES FROM OTHERS

Following these suggestions in your daily interactions with others will assist you in minimizing and de-escalating negative responses from others. **If at *any* time another person's behavior starts to escalate beyond your own comfort zone, disengage from the situation.**

DO THIS	DO NOT DO THIS
Focus your full attention on the other person to let them know you are listening and interested in what they are saying.	
Encourage the other person to talk. Listen patiently and with empathy.	
Maintain a pleasant, open and accepting attitude.	Know the person before you use humor… it can be misinterpreted as making fun of someone.
Stay calm. Move and speak slowly, quietly and project confidence. Watch your own body language, voice pattern, facial expressions and rate of speech.	Do not use a style of communication that suggests apathy, "the brush-off", coldness, sarcasm, condescension, minimizing concerns, or giving the run-around.
Maintain a relaxed posture, positioning yourself at a right angle.	Don't stand directly fact-to-face, hands on hips, crossing arms, finger pointing, or hard stare eye contact. These are very challenging behavioral messages.
Make sure there are 3 to 6 feet between you and person with whom you are speaking.	Don't invade another person's personal space. Don't lean into or over the person.
	Don't touch the person if the person is not harming himself or herself or someone else. Touching escalates behaviors at the moment.
Make sure you are at a level of eye contact with the person. Adjust your position so that you are communicating with the person literally at the level of their physical height so that their eyes can look at your eyes without difficulty.	Don't tower over a short person or a person in a bed, chair or wheelchair.
Be direct and to the point.	Don't speak with a lot of technical terms, use large vocabulary words, or use complicated information **especially** when emotions are high.
Listen objectively.	Don't take sides with what the person is saying. Don't agree with distortions.
Acknowledge the other person's feeling even if you disagree. Let them know that it is clear that what they are saying is important to them.	Don't challenge, threaten or dare the other person. Never belittle or make fun.
When acknowledging a person's feelings, use words like "frustrated," "upset" or other words that describe a softer version of the emotion displayed.	Don't use words that are emotionally charged, like "angry" or "pissed off." If the emotion that you named is NOT on target, allow the individual the control of naming the emotion!
	Don't try to make it all seem less serious than it is. Do NOT minimize the person's feelings!
Even if you disagree, you can still listen to someone. You might say something like "I hear what you are saying, but I don't share that same view…"or "I hear what you are saying… but have you considered XXX?"	Don't argue back to or over the person. Don't try to change their mind about something.

Accept criticism in a positive way. If a complaint is valid, use statement like "you are probably right". If the criticism is invalid, ask clarifying questions.	Don't criticize or act impatiently toward an agitated individual.
Break big problems into smaller, more manageable problems.	
Ask for small, specific responses from them such as moving to a quieter area or lowering their voice. Focus on small requests.	
Be reassuring and point out the choices available to the person. Allow them to have control of the choice made to the extent possible given the circumstance.	
Be truthful.	Don't make false statements or promises you know you cannot keep. If you are unsure, say that you are unsure.
Establish ground rules or set boundaries if unreasonable behavior continues. Calmly describe the consequences of any inappropriate behavior.	Don't attempt to bargain or bribe a threatening person.
Ask for their opinions or recommendations. Paraphrase back to the individual what they said.	Don't immediately reject demands made without listening and communicating to the individual that you are hearing the words **and/or** the message that is not directly in the words.
Use delaying tactics that will give the person time to calm down. For example, offer a drink of water in a paper cup.	
Position yourself to have access to an exit if need be. Be aware of surroundings and people walking in and out, but try to maintain a soft eye contact.	

Refer to Appendix A for a real example of the impact of NOT listening.

V. UNDERSTANDING BEHAVIOR

A. What is behavior?

Behavior is what all people do. It includes our observable actions such as smiling, talking, eating and dressing. Everybody "behaves" almost all the time.

Different situations or environments have different rules or expectations about how to behave. For example, we are expected to behave differently in a library than we do at a ball game. Also, beliefs about what is expected may differ with each person. When someone does not understand these expectations or fails to conform to them, his/her behavior may limit the opportunity for success, participation, status, and friendship.

B. What influences behavior?

Behavior is related to many things. Usually it has a purpose and has a function. Examples of purpose and function are getting something, avoiding something undesirable or enjoying something.

Some behaviors, like unexplained movements or sounds, are neurologically based and cannot be changed with behavioral interventions. These behaviors often "just seem to happen." While the individual has no control over these behaviors, sometimes the individual or staff is able to figure out that certain stimuli in the environment are helping to trigger their occurrence.

Behavior is a result of or response to something the person is experiencing or has experienced. The stimulus for a particular behavior can come from any of these sources:

- **Physiological** (from within the physical part of us);
- **Social** (from any situation involving all people we have ever encountered);
- **Psychological** (from emotions, feelings or thought processes); or
- **Environmental** (from any part of our surroundings).

Some examples of internal and external sources just listed are:

1. Physiological - such as feeling full or satisfied, feeling pain, having skips in your heart [that can mean you have less oxygen to the brain], low blood sugar so you feel really hungry and can't think, needing to go to the bathroom, etc.;
2. Social - such as seeing a face that reminds you of someone you don't like, going to a party, seeing the same faces day after day, sitting in church, going to a movie, being at a dance, etc.

3. Psychological - such as an angry response to a particular word, hearing someone laugh when we don't understand why, being called a name, being given a compliment, feeling frustrated because things are not as you want them to be, thinking about something nice that happened, etc.; and
4. Environmental - such as a dark corner, a rainstorm, a beautiful garden, a hot sultry day, a car horn blowing, coffee brewing, etc.

While what is going on inside our bodies is hard to see, behavior can be observed and described. **But remember to consider what might be going on inside!** Most people would find it difficult to concentrate if they had to go to the bathroom, had a toothache, were incredibly thirsty, were hearing voices telling us what to do or had a fight with a family member before coming to work.

Too often we jump to behavior programs as soon as an "undesirable behavior" is present. We need to first ask the question **"What is the person's behavior communicating to us?"** Example 5.1 has **many examples** of physiological, environmental, psychological or social issues that may be affecting a person's behavior. Be sure to take a look!

EXAMPLE 5.1

BEHAVIORAL "CAUSES" OR INFLUENCES

PHYSIOLOGICAL	ENVIRONMENTAL	PSYCHOLOGICAL	SOCIAL
Allergies	Air quality	Anxiety	Being stared at
Arthritis	Close proximity to others	Assertiveness	Change in staff
Attention deficit	Humidity	Attitudes	Criticism
Constipation	Lighting	Beliefs	Danger
Delusions	Limited physical space	Boredom	Demands
Dementia	Noise	Dominance	Disapproval
Ear aches	Smells	Fear	Disruption
Energy – too much	Temperature	How thoughts are processed	Frequent change
Energy – too little	Uncomfortable furniture	Loneliness	Lack of social attention
Fractures		Phobias	Not having choices
Headaches		Personality traits	Presence of specific person(s)
Hallucinations		Sex drive	
Hunger		Shyness	Relocation
Hyperactivity		Submissiveness	Sexual provocation
Itching		Suspiciousness	Teasing by others
Medication reactions		Vengeance	Tone of voice
Medication side effects		Worry	Too little to do
Pain			Too much to do
Premenstrual syndrome			
Seizures			
Sex drive			
Thirst			
Tobacco craving			
And many more possibilities!	***And many more possibilities!***	***And many more possibilities!***	***And many more possibilities!***

C. What are challenging behaviors?

Challenging behaviors are behaviors that are defined as problematic or maladaptive by others noticing the behavior or by the person displaying the behavior.

Challenging behaviors are those actions that come into conflict with what is accepted by the individual's community. Challenging behaviors are behaviors that often isolate the person from their community or are behaviors that can be barriers to the person living or remaining in a specific community. Challenging behaviors vary in seriousness and intensity.

What is determined to be a challenging behavior can vary depending on what is accepted by the individual, a community or by society.

D. How do we figure out what the challenging behavior is communicating or what is "causing" the challenging behavior?

First, medical and psychiatric conditions have been found to play a **direct**

role in "causing" challenging behaviors. This is especially true for persons who communicate in ways we are not used to hearing. Is the person constipated? [This is a very common side effect of certain medications or not having enough fluids, fruits or vegetables]. Is the person taking their medication for the voices they hear? [Often people will say that the side effects of the medication are worse than hearing the voices tell them what to do]. Does the person have an infection? [How would you know when this is true?].

A second and similarly important consideration is that **challenging behaviors result from being lonely, being on the outside looking in.** Again, this is especially true for persons who communicate in ways we are **not** used to hearing. Is the quality of the person's life acceptable **(in their opinion)?** Do relationships exist in the person's life that support choice and maximize social and personal skills? Are the relationships between staff and the individual appropriate from a professional perspective? Does the person have opportunity for involvement in the community that would support personal social relationships?

There is a HUGE difference between developing an appropriate relationship with an individual and simply being with that person because it is your job. If the interventions used do not lead to a meaningful life and relationships for an individual, what have we accomplished?[2]

E. Focus first on possible medical or psychiatric issues.

We do not usually look at medical or psychiatric issues or personal satisfaction as reasons for challenging behaviors. Instead we get frustrated and say, "they are just being a pain" or "she's just 'that way.'" And sometimes caregivers get frustrated to the point of acting or reacting in ways that make things worse. The challenging behaviors of the individual coupled with our reaction can become a downward spiral!

However, looking at medical or psychiatric issues is imperative! One expert in the MR/DD field who works with persons with challenging behaviors said, "**Until proven wrong, my first assumption is that part of the body hurts. Until we help the person feel better, the behavior *will not stop*.** If the person is in pain they have two

choices: 1) the pain controls me; or 2) I control the pain. The behavior is a form of intentional communication."[1]

As further illustration, in the state of Massachusetts a hospital psychiatric unit was set up to work with MR/DD individuals who had very difficult challenging behaviors. They were taken to the psychiatric unit when the "cause" of the challenging behavior could not be figured out in the community. In that psychiatric unit, it was documented that better than 75% of issues determined to be "causing" challenging behaviors were **medical** in origin, such as chronic infection, enlarged prostate, etc.

For persons with MH issues, challenging behaviors often result from internal physiological or psychological stimuli that cannot be tolerated, or from misperception of social or environmental situations.

We owe it to the person served and to ourselves to try to figure out what the challenging behavior is communicating! Here are some questions to keep in mind while analyzing what is "causing" complex, challenging behaviors:

1. **Is the challenging behavior a symptom of a medical disorder?** For example, a person with a neurological disorder may strike out when becoming excited due to involuntary movements or poor muscular control.
2. **Is the quality of the person's life acceptable** (*in their opinion*) **in terms of personal relationships, personal choices or living situation, etc?**
3. **Is the challenging behavior a side effect of a medication they are getting?**
4. **Is the challenging behavior part of a cluster or chain of related behaviors?** For example, if a person does not want to go to a workshop, the person may use several behaviors to keep from going, such as refusing to get up, pretending to be sick, running away or attacking others. If so, one intervention may solve many challenges. If not, priorities will have to be set because trying to change many different behaviors at the same time is likely to cause confusion and reduce the chance for success.
5. **Is the challenging behavior the result of a lack of a skill or skills?** Often challenging behaviors occur because of a missing skill. If a person is asked to do something that he or she does not understand or is unable to do, the person may

[1] Pitonyak, David, Ph.D., "Supporting Persons with Difficult Behaviors", a workshop held September 27, 2004

become frustrated and strike out or hurt him or her self to make the demand go away.

In summary, be certain to ask these questions:

1. What does the behavior get for the person? ***What is experienced as positive is entirely in the eyes of the beholder!*** For example, some people enjoy attention of any kind! Some people prefer to be quiet and alone. Behavior that results in a change that the person perceives as positive in some way is likely to be repeated. Therefore it is *important* to give people choice as a form of personal control.

2. What does the behavior help the person escape? For example, hitting others who are making too much noise may result in getting sent away from the noise, which is what the person wants!

3. What does the behavior help the person avoid? For example, playing sick may result in getting to stay home from school, which may be a very stressful place. Example 5.2 is a very extensive list of common "problem" behaviors and what their causes might be. Take a look.

EXAMPLE 5.2

COMMON "PROBLEM" BEHAVIORS AND SPECULATIONS ABOUT THEIR CAUSES

BEHAVIOR	SUSPECTED CAUSE
Biting side of hand/whole mouth	• Sinus problems • Ears/Eustachian tubes • Eruption of wisdom teeth • Dental problems • Paresthesias/painful sensations (e.g., pins & Needles) in the hand
Biting thumbs/objects with front teeth	• Sinus problems • Ears/Eustachian tubes
Biting with back teeth	• Dental • Otitis (ear)
Fist jammed in mouth/down throat	• Gastroesophageal reflux • Eruption of teeth • Asthma • Rumination • Nausea
General Scratching	• Eczema • Drug effects • Liver/renal disorders • Scabies
Head Banging	• Pain • Depression • Migraine • Dental • Seizure • Otitis (ear ache) • Mastoiditis (inflammation of bone behind the ear) • Sinus problems • Tinea capitis (fungal infection in the head)
"High pain tolerance"	• A lot of experience with pain. • Fear of expressing opinion. • Delirium • Neuropathy (disease of the nerves/many causes)
Intense rocking/preoccupied look	• Visceral pain • Headaches • Depression
Odd un-pleasant masturbation	• Prostatitis • Urinary tract infection • Candida vagina • Pinworms • Repetition phenomena, PTSD
Pica	• General: OCD, hypothalamic problems, history of under-stimulating environments • Cigarette butts: nicotine addiction, generalized anxiety disorder • Glass: suicidality • Paint chips: lead intoxication • Sticks, rocks, other jagged objects: endogenous opiate addiction • Dirt: iron or other deficiency state

	• Feces: PTSD, psychosis
Scratching/hugging chest	• Asthma • Pneumonia • Gastroesophageal reflux • Costochondritis/"slipped rib syndrome" • Angina
Scratching stomach	• Gastritis • Ulcer • Pancreatitis (also pulling at back) • Porphyria (bile pigment that causes, among other things, skin disorders) • Gall bladder disease
Self-restraint/binding	• Pain • Tic or other movement disorder • Seizures • Severe sensory integration deficits • PTSD • Paresthesias
Stretched forward	• Gastroesophageal reflux • Hip/back pain • Back pain
Sudden sitting down	• Altlantoaxial dislocation (dislocation • Between the vertebrae in the neck) • Cardiac problems • Seizures • Syncope/orthostasis (fainting or light-headedness caused by medications or other physical conditions) • Vertigo • Otitis (thrown off balance by problems in the ear)
Uneven seat	• Hip pain • Genital discomfort • Rectal discomfort
Walking on toes	• Arthritis in ankles, feet, hips or • Knees • Tight heel cords
Waving fingers in front of the eyes	• Migraine • Cataract • Seizure • Rubbing caused by blepharitis (inflammation of the eyelid) or corneal abrasion
Waving head side to side	• Declining peripheral vision or • Reliance on peripheral vision
Whipping head forward	• Atlantoaxial dislocation (dislocation between the vertebrae in the neck) • Pain in hands/arthritis
Won't sit	• Akasthisia (inner feeling of restlessness) • Back pain • Rectal problem • Anxiety disorder

[2]Ruth Ryan, M.D. James Salbenblatt, M.D., Melodie Blackridge, M.D.

[2] Ruth Ryan, MD, The Community Circle; 1556 Williams Street, Denver, Colorado 80218; Handbook of Mental Health Care for Persons with Developmental Disabilities. (1999)

Pain is often a very real cause of challenging behaviors. Look at Appendix B.1 for excellent ideas to consider about pain being the source of the challenging behavior. And in Appendix B.2 you will find an extensive list of medical issues that should be considered. Be sure to look at both of these for additional ideas.

VI. SUPPORTING PEOPLE IN POSITIVE WAYS

No matter who the person is that we work with (friend, co-worker, person that we support), we can ALL support people in positive ways. You probably already use these approaches and don't know that they are also called "positive behavior supports".

A. What can I do on a day-to-day basis that might be helpful to the person?

Consistency is important in working with others. Keep your word! Follow through on what you promise. This is very important in cultivating the trust of persons we serve. Being genuine goes hand-in-glove with consistency.

Treat people in ways that you would want to be treated. Remember that you hope to get MORE support, not less, when you need help. When was the last time you said, "I was non-compliant today, so I don't believe I'll smoke that cigarette." Instead, if you're having a really hard time and someone knows you are a smoker, they will likely offer you a cigarette!

Have you noticed that we often ask those who have the least adaptive skills, or persons struggling to deal with their internal world and the world around them, to make the most accommodation within their lives? Would you want to live your life in the same way you are asking of them?

All of us working with other persons can be sensitive to the comfort needs of an individual. For example:

1. If the person is hungry, provide a snack, if permitted.
2. If the person is thirsty, provide water or other suitable drink, if permitted.
3. If the person is hot or cold, alter the environment or assist them into more comfortable clothing.
4. If the person is sad, talk with them about what is making them sad.
5. If the person is bored, talk with them about what they want to do; help them with getting the resources necessary to feel occupied and productive.
6. If a person is uncooperative, provide incentives or offer choices.
7. If a person is being annoying to you, try ignoring the behavior or see if you can figure out what is behind the behavior that is annoying to you.
8. If the person needs to get away from stimulation, support them in finding a quiet place.

9. If the person cannot concentrate during an activity or event, see what you can do to structure the activity or event to be more manageable for them.
10. If the person is not feeling well and does not want to attend what is "required", permit a "sick day" or figure out how to help them feel better.

B. Using positive behavior supports.

All of us can use positive approaches when working with persons we serve and support. These approaches are called **"positive behavior supports."** The purpose of positive behavior supports is **to support individual growth, enhance the person's quality of life, and make the use of more intrusive measures unnecessary.** Positive behavior supports *work best when we understand what works from the point of view of the individual.*

Positive behavior supports include ways to minimize situations or issues that are stressful for the individual and ways to help the individual have maximum control over their life. Positive behavior supports don't emphasize rewards and punishments. Positive behavior support strategies include:

- Understanding how and what the individual is communicating;
- Understanding the impact of other's presence, voice, tone, words, actions, and gestures, and modifying these as necessary;
- Supporting the individual in communicating choices and wishes;
- Supporting staff to change their behavior when it has a detrimental impact;
- Temporarily avoiding situations that are too difficult or too uncomfortable for the individual;
- Allowing the individual to exercise as much control and decision-making as possible over day-to-day routines;
- Assisting the individual to increase control over life activities and environment;
- Teaching the person coping, communication and emotional self-regulation skills;
- Anticipating situations that will be challenging and assisting the individual to cope or to respond in a calm way;
- Filling up the person's life with opportunities such as valued work, enjoyable physical exercise and preferred recreational activities; and
- Modifying the environment to remove stressors (such as irritating noise, light or cold air).

C. Combining person-centered planning with positive behavior supports

All of us have dreams or goals we want to achieve. And every environment has certain rules and regulations that we must follow in order to achieve those goals or dreams. When working with someone who has identified a goal or dream, you must find out what the person already understands AND what skills the person already has before you teach new rules or skills that will help them achieve the goal or dream.

The steps to take to help the person reach a goal or dream may not be immediately clear. Sometimes you have to figure out how you can help someone reach a goal of "I want to get a part-time job in housekeeping" or "I want to live with my sister." What follows is one example of how staff helped an individual increase control over his environment so that he could reach a desired goal.

Emmanuel wanted to continue to live with his sister, Beatrice. Beatrice said he could not live with her because Emmanuel leaves smoldering cigarettes in the ashtrays. So the "rule" was that Emmanuel must put out his cigarettes completely in order to continue living there.

Emmanuel DID know how to get his cigarettes into an ashtray, but he DID NOT extinguish the cigarette. Staff had to teach Emmanuel how to completely extinguish his cigarettes. Staff also had to figure out what he needed that would help him get the cigarette all the way out.

By figuring out what the person already knows how to do, what they don't know how to do, and what they might need to achieve a goal, we can come to understand how we need to support the person in reaching that goal. Below is an example of how this information might be captured.

EXAMPLE 6.1

BEHAVIOR	WHAT THE PERSON KNOWS	REQUIRED SKILL OR BEHAVIOR	SKILL TO BE TAUGHT	RESOURCE REQUIRED
Leaves cigarette butts smoldering in ashtray	Puts cigarettes in an ash tray	Put the cigarette completely out	Extinguish cigarettes completely	Ashtray with sand

If you look at Appendix C you will find examples of questions that could be used to help you determine an individual's level of satisfaction with their life and circumstances that surround it.

D. In closing…

As we close this chapter on positive behavior supports, remember that it is important that people have choice in decisions that must be made, that people have

supports necessary to help them reach their goal or dream, and that there are things to look forward to. It is important that we understand the strengths, skills and preferences of the individual as well as their needs or limitations. And it is important that we help people develop enduring, positive relationships.

The use of positive behavior supports toward helping people live purposeful and satisfying lives should be a natural part of how we support and care for individuals.

VII. WHAT DO I DO FIRST? Identify and Remove the Cause of Challenging Behaviors

We've got to understand what the person is communicating through the challenging behavior or what is "causing" the challenging behavior. Have you answered these questions found in Section V.D.?

1. Is the challenging behavior a symptom of a medical disorder?
2. Is the quality of the person's life acceptable (in their opinion) in terms of personal relationships, personal choices or living situation, etc?
3. Is the challenging behavior a side effect of a medication they are getting?
4. Is the challenging behavior part of a cluster or chain of related behaviors?
5. Is the challenging behavior the result of a lack of a skill or skills?
6. What does the behavior get for the person?
7. What does the behavior help the person escape?
8. What does the behavior help the person avoid?

Remember to consider the details that are part of these questions. Consider the examples of physiological, social, psychological or environmental issues that may be "causing" a person's behavior that are listed in Section V.B., Example 5.1. Look at the list of common "problem" behaviors and speculations about their causes in Section V.D, Example 5.2. And refer Appendix B for examples of how pain might be communicated and for an extensive list of medical issues and how they may be communicated through behavior.

A. Show me some real examples of what you are talking about.

What follows are three examples of how situations could have been avoided if providers had looked at some common sense causes before assuming that the challenging behavior was due to some "out-of-control" mental illness or developmental disability.

EXAMPLE 7.1

Mr. Jones has severe cognitive challenges and he cannot speak. He has no history of being violent or destructive. One evening, he displayed rage and began throwing the furniture in his home. He was taken to the local emergency room to be seen by a psychiatric crisis intervention specialist. He was admitted to a psychiatric hospital with a diagnosis of psychosis.

However, the physician at the hospital determined that Mr. Jones was suffering from a severe bowel impaction. Mr. Jones was promptly treated and his outburst did not reappear. His diet and fluid intake were adjusted and his home provider was trained to look for signs of constipation and irregularity. By dealing with these causes, Mr. Jones did not require further psychiatric admission nor did he need a behavior support plan.

EXAMPLE 7.2

Ms. Smith is a person who had never been known to act up. She began to show considerable withdrawal at her work-training program and would not participate in the program. In fact, over a period of days, her withdrawal turned to anger and she would refuse to attend the program. She began complaining of illness and making excuses to avoid going to work. She was taken to the outpatient mental health clinic for psychiatric evaluation. She was prescribed medication for both depression and psychosis.

Days later, a counselor who had worked closely with Ms. Smith in another agency came to work at Ms. Smith's work-training program. This counselor knew Ms. Smith very well and recalled that Ms. Smith had been a victim of rape years earlier. The rapist was a tall man with tattooed forearms. The work-training staff recognized that about the time Ms. Smith's challenging behavior began to surface, she had been assigned to a new work group. In this group was a man whose forearms were tattooed. Although this man was not the rapist, his appearance had triggered a post-traumatic stress reaction in Ms. Smith. Armed with this knowledge, the work-program staff reassigned Ms. Smith to work with others and away from the man with the tattoos. Ms. Smith's withdrawal, anger, and refusal to cooperate with the work-program vanished immediately. Ms. Smith did not require further medication or a behavior support plan, although she did resume therapy at the local mental health center to help her develop coping strategies for when she encountered men with tattoos.

EXAMPLE 7.3

Ms. Stacy is a woman in her thirties who has autism. She does not communicate with words, but has strong opinions about what she likes and dislikes. Ms. Stacy lives in her own home, with 24-hour support. For many years, Ms. Stacy attended the local day habilitation center. The center had strict rules about "appropriate conduct," but Ms. Stacy never followed them. While she liked individual staff at the center, she refused to participate in many of the organized group activities. During these group activities, she would regularly scream, throw things and occasionally strip down to her underwear. On community outings she would often wreak havoc while on the center's van by yelling, stripping or lying on the van floor, or by refusing to get up.

The center's staff was incredibly stressed and frustrated by Ms. Stacy's behavior. Ms. Stacy was only calm when she was allowed to look at her magazines without others

around her, often with the support of one staff. However, the center could not guarantee individual staffing all of the time, because it took attention away from other clients. Ms. Stacy, her family, and her providers had numerous meetings about Ms. Stacy's infractions of the center's rules and tried a number of behavior modification techniques to address the unacceptable behavior. Nothing worked.

The center discharged Ms. Stacy for repeatedly failing to follow the center's rules. Ms. Stacy's personal support provider began supporting Ms. Stacy during her day. Ms. Stacy was no longer required to participate in group activities, could plan her own activities and was accompanied by a companion she adored. Her stripping stopped almost immediately and her other challenging behaviors greatly decreased. Ms. Stacy now smiles more and is much calmer. While she still yells and throws things occasionally, this behavior is typically a result of menstrual cramps or anger about a specific event. Her "behaviors" are more isolated, making them easier to address. Because of individualized supports in an environment that is comfortable for her, Ms. Stacy is able to experience her community on her terms and is enjoying her life more.

B. The Wellness Recovery Action Plan[3] (WRAP Plan) is an effective way to identify and remove the cause of challenging behaviors

In Georgia, many consumers and staff have been introduced to the process of developing a Wellness Recovery Action Plan. The Wellness Recovery Action Program is a structured system for monitoring uncomfortable and distressing symptoms and, through planned responses, reducing, modifying or eliminating those symptoms. It also includes plans for responses from others when an individual's symptoms have made it impossible for the individual to continue to make decisions, take care of him or her self and keep him or her safe. When the WRAP Plan is used, the person is able to MINIMIZE or AVOID challenging behaviors that can result when symptoms are not properly addressed.

While this approach is being taught and used in mental health care, persons in MR/DD care who have the cognitive and verbal or expressive skills to describe how they feel and what helps them feel better or worse could also use it.

Anecdotal reporting from persons who are using this system indicates that by helping them feel prepared, they feel more in control of their lives resulting in a better quality of life, even when symptoms of the illness are troublesome.

[3] *Wellness Recovery Action Plan: A System for Monitoring, Reducing and Eliminating Uncomfortable or Dangerous Physical Symptoms and Emotional Feelings,* Mary Ellen Copeland, MS, MA, Peach Press, Revised 2002

What follows is the basic outline of a WRAP Plan. Refer to the publication noted in the footnote for full detail. Crisis plans will be discussed in greater detail in Section XI of this manual.

EXAMPLE 7.4

BASIC OUTLINE OF A WRAP PLAN

Section 1 Daily Maintenance Plan
Part 1: Description of how you feel when you feel well
Part 2: List everything you need to do every day to maintain wellness

Section 2 Triggers
Part 1: Events or situations that might cause symptoms to begin
Part 2: A plan of what to do if the triggers occur

Section 3 Early Warning Signs
Part 1: Identification of subtle signs that indicate a worsening situation
Part 2: A plan of what to do if these early warning signs occur

Section 4 Symptoms That Indicate Worsening
Part 1: What to do if these symptoms occur

Section 5 The Crisis Plan
Part 1: What I'm like when I'm feeling well
Part 2: Symptoms that say I'm not doing well
Part 3: Who are my supporters?
Part 4: Medication that works; medication that does not work
Part 5: Treatments that work; treatments that do not work
Part 6: Where can I go in the community?
Home/Community Care/Respite Center
Part 7: Treatment facilities that are options for me
Part 8: What help do I need from my supporters?
Part 9: How do my supporters know I am better?

Section 6 Post Crisis Planning
Descriptive behaviors, feelings and activities that will indicate healing is under way.

VIII. APPROACH I: GATHER INFORMATION ABOUT THE CHALLENGING BEHAVIOR

A. We have not been able to figure out the behavior! Now what do we do?

Not all cases are like the above examples. And not all persons have the cognitive and verbal or expressive skills to develop a WRAP Plan.

When a WRAP Plan is NOT appropriate and when the less obvious causes of a challenging behavior cannot be determined, it is time to figure out the source of challenging behavior by doing a **functional assessment.**

B. What is a functional assessment?

A functional assessment is a systematic way to look at information. Functional assessment is based on the understanding that ALL behavior is influenced by the person's internal AND external environment.

Functional assessment involves looking at what is happening *before and after* a behavior occurs in order to understand how the behavior is influenced by those events. Such events can take place within the person's *external environment or internal environment.* In this sense, a challenging behavior might be influenced by external events like a noisy, over-crowded social situation, but might also be influenced by internal events such as a headache or a feeling of frustration.

Events that take place before a behavior occurs are called **antecedents**. Events that take place after a behavior occurs are called **consequences.** By collecting information about events that occur BEFORE a behavior takes place *(antecedents),* we will begin to see that when the particular event occurs, the behavior of concern will likely occur. Conversely, when these events do not occur, or when the events are modified or interrupted in some way, the behavior of concern is less likely to occur.

By collecting information about events that occur AFTER a behavior takes place *(consequences),* we will begin to see that if a behavior results in a DESIRABLE consequence for the person, he or she is *more likely* to repeat that behavior in similar situations. Conversely, if the behavior results in an undesirable consequence for the person, he or she *is less likely* to repeat that behavior in the future in similar situations.

C. Looking for the A-B-C's

The analysis of antecedents and consequences is often referred to as the **A-B-C Model** of functional assessment:

- **A** stands for the influential events that take place *before* a behavior occurs *(antecedents)*
- **B** stands for the *behavior* (appropriate or challenging)*;* and
- **C** stands for the influential events that take place *after* a behavior occurs *(consequences).*

Conducting a systematic, organized assessment helps to identify those events that are likely to have the greatest influence on the behavior of concern.

D. How much information needs to be collected and for how long?

It is important to look for the A-B-C's over time and to gather information *each time* the behavior is repeated. Some functional assessments can be completed after only a few recorded observations of the behavior. Others may require numerous observations or may even continue after some treatment interventions have been implemented.

Sometimes a functional assessment can be conducted informally by looking at what happened before a challenging behavior occurred. For challenging behaviors that occur with some degree of regularity, it is helpful to write down your observations, to help take a "fresh look" at the situation.

E. How do I collect information about the A-B-C's?

Examples of ways to document this information are available in books and on the Internet, but basically the process looks something like the following.

EXAMPLE 8.1

COLLECTING THE A-B-C'S

A = Events that occur *before* the behavior, or *antecedents*	**B = The behavior**	**C = Events that occur *after* the behavior, or *consequences***
• Physiological • Social • Psychological • Environmental	The behavior should be described in *measurable* and *observable* terms that *everyone understands*	• Did the behavior result in a reward for the person? • Did the behavior result in escape from a particular situation? • Did the behavior allow the person to avoid something?

To further illustrate the use of this form, read the case below, and then refer to the grid that follows.

James, a nonverbal individual with severe mental retardation, had a habit of plopping down in front of the refrigerator when he wanted something to eat. He was in the way when staff tried to cook, and because he would not move, they could not open the refrigerator. He also occasionally hurt himself when he plopped himself down on the floor.

EXAMPLE 8.2

COLLECTING THE A-B-C'S – AN EXAMPLE

A = Events that occur *before* the behavior, or *antecedents*	**B = The behavior**	**C = Events that occur *after* the behavior, or *consequences***
• James smacks his lips • James sits on the floor only when people are cooking	James "plops" himself down in front of the refrigerator, often with enough force that he bruises himself. He then refuses to move, sitting in a place that blocks the refrigerator door.	• Staff give James bits of food while they cook • James makes happy-sounding noises after getting something to eat

As a result of collecting the data, staff decided that giving James food in front of the refrigerator was encouraging him to repeat the behavior. They also decided that James should be offered food ONLY at the table. Staff decided to teach James to use sign language for "eat" and for "drink". When he used the sign, staff rapidly responded to the sign with a snack or drink, which was given to him at the dining table.

It took a while to replace the behavior of sitting in front of the refrigerator because James would exhibit both behaviors - plopping down in front of the refrigerator and signing - at the same time. Since the food was offered at the table and not while he was in the floor in front of the refrigerator, he gradually began going to the table and signing for what he wanted.

The analysis of the event showed staff that James' internal response (hunger) was being rewarded by an external action or response by the staff (the socialization with staff as they cook AND getting to eat bits of food).

And there can be negative responses to social situations. For example, Johnny loves to watch TV alone. But when others who live in the home come into the room during his TV time, Johnny begins to bang his head. If the others are asked to leave the room, Johnny quits banging his head.

Sometimes you can figure out the "why" of a behavior based on watching the events that occur right before and right after the behavior. But if it is not obvious or you cannot figure it out after trying to collect data on your own, then it is time to call in a professional!

IX. APPROACH II: CALL IN A PROFESSIONAL TO DEVELOP A POSITIVE BEHAVIOR SUPPORT PLAN (PBSP)

When a WRAP Plan is NOT appropriate AND when collecting the A-B-C's described in Approach I DOES NOT result in identifying the "cause" of the challenging behavior, the provider should call in a professional who is qualified to develop a positive behavior support plan.

A. What is a Positive Behavior Support Plan ((PBSP)?

A positive behavior support plan (PBSP) is a formal plan to help everyone do the same thing on a consistent basis. The plan is based on an assessment of the challenging behavior that includes understanding the strengths, preferences and interests of the individual, the goal that is to be achieved, and the A-B-C's related to the behavior that is of concern,

The plan consists of using *the fewest* interventions or support strategies possible coupled with reinforcement for appropriate alternative behaviors that will modify, decrease, re-direct or eliminate the challenging behavior. Success is measured by reductions in challenging behaviors, performance of alternative skills, and improvements in quality of life.

The plan uses ONLY ***positive interventions*** to replace the challenging behavior with other behavior judged to be more acceptable. **The PBSP does not use *any* restrictive or unpleasant techniques to modify challenging behaviors**.

The PBSP couples the science of behavior analysis with person-centered values that respect the individual. These values include but are not limited to:

1. Understanding the person's "story," including their strengths, skills and limitations;
2. Having respect for the person's desire to follow his or her dreams to live life as normally as possible while being supported to overcome the challenging behavior;
3. Respect of his or her dignity, the right to make choices, and the right to live as independently as possible.

The person with the challenging behavior must be made aware of the plan as evidenced by their signature or the signature of their representative or legal guardian.

Positive behavior support plans involve all of the components of Approach I "and then some." It is the "and then some" that makes it a new approach.

B. Thirteen outcomes you should expect to find in a completed PBSP

The development of a PBSP includes a written plan for ALL involved persons to follow. The following thirteen outcomes are critical in achieving a consistently positive approach in all aspects of the person's life. This is the "and then some" mentioned above.

1. **Ensure that a person-centered approach is used in developing the plan.** This may seem obvious, but plans can quickly become "controlling," in the name of safety when addressing severely challenging behaviors.
2. **Establish clear operational definitions of behaviors to be decreased as well as those to be increased.** This means using descriptive terms that *everyone* understands so that there is consistency in identifying the challenging behavior:
    a. There must be **agreement** between the professional and staff as to the behavior that is occurring.
        i. Behaviors must be described in **observable** terms
        ii. Behaviors must be described in **measurable** terms
3. **Ensure that the plan is practical… that it can be done.** A plan that is not practical, that is cumbersome, that does not consider practical, day-to-day issues WILL FAIL.
4. **Identify the antecedents and consequences that influence the occurrence of the behaviors of concern.** It is critical to a PBSP to know what events, both before and after a behavior, increase the likelihood of that behavior's occurrence.
5. **Ensure that functional skills are taught as part of the active treatment routine.** Learning efforts should focus on meaningful and purposeful skills that:
    a. Support the individual's choices and goals;
    b. Are essential to personal independence;
    c. Are needed often;
    d. Afford opportunity to participate in meaningful, purposeful and age-appropriate activities;
    e. Enable the individual to do and attain the things they desire as well as to avoid those things they dislike.

6. **Ensure the person's environment is a positive, healthy, educational, supportive, nurturing, safe and therapeutic environment that:**
    a. Encourages and honors choices by the individual;
    b. Promotes normalcy;
    c. Is suited to the individual's needs; and
    d. Includes the individual's preferred items and events.
7. **Identify and reduce or eliminate conflicts regarding individual choice making.** Ensure that choice is built into the plan and that everyone involved knows how to help the individual express choices (especially if the person is unable to talk).
    a. Not having choice means not having control;
    b. Not having control means anger;
    c. Anger will be expressed by challenging behaviors
8. **Ensure that positive and meaningful social interactions are available both with peers and staff.** Identify and reduce or eliminate social interactions that contribute to the occurrence of challenging behavior. Ensure that everyone involved knows how to interact with the individual in a group setting, how to interact in a positive way, and how to interact in a manner that is suited to the individual's capacity as well as chronological age.
9. **Ensure that everyone involved knows how to use prompts, error correction, and task analysis** to increase the likelihood of desirable appropriate behavior. These methods help increase consistency from setting to setting and from person to person.
10. **The plan should identify teaching methods such as "shaping" and "chaining."** These methods make teaching and learning easier by conducting learning activities in smaller segments at a pace suited to the individual's abilities.
    a. If you ever taught someone to throw a ball, you used "shaping"
    b. If you ever taught someone to memorize his or her phone number, you used "chaining."
11. **Ensure that the fundamental components of the PBSP are clearly described and understood by everyone involved.** Regardless of the format used for a PBSP, the fundamental components should address the following:

a. What are the behaviors to increase?
b. What are the behaviors to decrease?
c. What things should be *provided* in the individual's environment on a day-to-day basis *to decrease the likelihood of challenging behaviors?*
d. What things should be *avoided* in the individual's environment on a day-to-day basis *to decrease the likelihood of challenging behaviors?*
e. What event(s) are likely to occur right before a behavior of concern?
f. What should you do if that event(s) happens, or what can you do to keep it from happening?
g. What should you do if the behavior to increase occurs?
h. What should you do if the behavior to decrease occurs? This **should not** involve punitive reprisals, unpleasant consequences or any other restrictive interventions.

12. **Ensure that staff knows when to ask for help! You have a right and responsibility to ask!** The professional should identify, with the help of staff, the types of problems that may occur when implementing a PBSP, and should be certain that everyone knows who to ask for help if implementation problems occur.
13. **Ensure that there is some form of reliable data collection taking place.** This should be simple, efficient and manageable for staff. The professional should establish the means for evaluating effectiveness of the PBSP using an efficient, reliable data collection method. This is essential to making sound decisions regarding continuation, revisions, or discontinuation of a PBSP.

C. What kind of professional can write a positive behavior support plan (PBSP)?

A PBSP should ONLY be written, implemented and supervised by a qualified professional. The PBSP is considered to be part of the treatment plan for the person served and **must be incorporated into the Individualized Service Plan (ISP) or Individual Recovery Plan (IRP) by reference**.

The same professional requirements apply to the development of a PBSP that apply to the development of a treatment plan. Generally people in mental health services will develop their own WRAP Plan with the support of a professional. However, if a PBSP is developed:

1. For an individual in mental health services, it must be developed by someone who is a Qualified Mental Health Professional (QMHP)
2. For an individual in MR/DD services, it must be developed by someone who is a Qualified Developmental Disability Professional (QDDP)

For more information about professional qualifications for QMHP or QDDP, refer to the ***Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases Providers Under Contract with the Division of Mental Health, Developmental Disabilities and Addictive Diseases,*** Section III B, "Core Requirements for All Providers," section C, "Professional Designations."

In both cases, someone who has experience with positive behavior supports MUST develop the PBSP. When you are researching to find a professional, here are some suggestions to consider:

1. Network in the field to get names of several professionals
2. Get references!
3. Talk to other providers who have had a plan written by that professional
    a. Was the plan clear?
        i. Refer to the list of thirteen outcomes (above)
    b. Did the plan include practical considerations?
        i. Could it be implemented in the "real world"?
    c. Did the professional train the staff
        i. About the plan?
        ii. About how it should be implemented?
    d. Was the professional available to the staff?
    e. How much support did the professional provide?
    f. Was the professional willing to figure out an alternative plan when the original plan needed to be modified?
    g. Did the professional see the plan through until there was a satisfactory outcome?

D. How do I know that the plan is written using positive behavior approaches?

Remember that the plan uses ONLY ***positive interventions*** to replace the challenging behavior with other behavior judged to be more acceptable. **The PBSP does not use *any* restrictive or unpleasant techniques to modify challenging behaviors**.

In Appendix D, a variety of positive behavioral approaches are identified. If you have a concern, check Appendix D.

E. Checks and balances to be sure staff know what to do

Below are four things that SHOULD BE CHECKED to be certain you understand the plan. If you can answer these questions, the plan is likely a complete and comprehensive plan.

1. **Do you understand the behaviors of concern that are targeted by the plan?**
    a. What are the behaviors to increase?
    b. What are the behaviors to decrease?
2. **Do you know what environmental supports MUST be in place on a day-to-day basis to reduce the likelihood that problems will occur?**
    a. What things need to be in place on a daily basis to support the individual?
        i. For example, Gina was known to HAVE to have her purse with her at all times! If she forgot her purse, she became inconsolable and absolutely nothing else could be done until she had her purse. This is an example of an environmental support for Gina.
    b. What things should be avoided to support the individual?
        i. For example, it was well known that loud sudden noises triggered a post-traumatic stress reaction for Joe that would become psychotic in nature. Therefore it was important to try to avoid settings where this might occur.
3. **Do you know the antecedents to look for?**
    a. The plan needs to identify those things that occur prior to the challenging behavior. This is AS IMPORTANT as knowing what the target behavior is.
    b. When those events happen, what needs to happen to modify, re-direct, interrupt, remove or prevent the challenging behavior?

NOTE that ALL PBSPs need to identify the antecedents. **If you can't respond before the behavior occurs, that leaves ONLY an option of responding after, *which is NOT proactive but is reactive.***

4. **Do you know what you should do following a challenging behavior?**
    a. What do we do when appropriate behaviors occur?
    b. How do we respond in a non-restrictive way when challenging behaviors occur?
        i. This means doing as little as possible or only what is necessary to stop the challenging behavior or to assure that no one gets hurt.

IF YOU CANNOT ANSWER THESE QUESTIONS, YOU DO NOT KNOW WHAT TO DO! It is a good idea for staff to write their own answers to these questions after the plan is developed. That way the professional can see what staff understands in their own words, and the professional can be certain that everyone has a correct understanding of the plan and how to implement the plan.

F. Review and oversight of the PBSP

As stated, all consumers have a treatment plan that must be developed and approved by either an interdisciplinary treatment team or a multidisciplinary treatment team. **The PBSP must be incorporated by reference into ISP or the IRP.** The rules set within each agency for the monthly, quarterly, and annual review of ISP's should be made applicable also to the PBSP.

Review and approval by all of the above stakeholders should occur when a PBSP is first developed. When the plan is first implemented, it may need tweaking as often as weekly, monthly or quarterly. Additionally, the plan should be reviewed and re-authorized more frequently if the PBSP undergoes a significant revision. The data should be reviewed at least annually thereafter. NOTE that annually is the LEAST frequent interval that the plan should be reviewed.

Remember to obtain appropriate consents and authorizations from:

1. The consumer or his or her representative
2. The interdisciplinary team
3. And to incorporate it into the ISP

Despite your best efforts, there will be occasions when serious and challenging behaviors represent a danger to the individual or to others. If the individual has this sort of history OR if this becomes the case, there should be a safety plan or crisis plan to fall

back on. These plans, along with parameters for implementation and management, will be discussed next.

X. WHAT CAN WE DO IF THE BEHAVIOR SUPPORT PLAN IS NOT WORKING?

A. Seek additional review and consultation

The first and most obvious answer is to re-evaluate the PBSP *as well as* re-evaluate the implementation of the plan. Actions to take and issues to consider in the re-evaluation of any plan include but may not be limited to the following:

1. Call the professional who wrote the PBSP and ask for an evaluation of:
    a. The plan
    b. The implementation of the plan
2. Talk with the individual to the extent possible regarding:
    a. The plan
    b. The implementation of the plan
3. Talk with the staff regarding
    a. The plan
    b. The implementation of the plan
        i. Assure that the plan has been implemented in a personal, caring and consistent manner
4. Affirm with staff what they are doing right
5. Tweak the plan as necessary
6. Invite the interdisciplinary or multidisciplinary team to review and discuss the concerns
7. Invite subject experts to sit in, including regional or state MHDDAD staff
8. Seek additional consultation as required

REMEMBER: something that works initially will not be effective indefinitely. The plan WILL have to be tweaked and revised on more than one occasion!

B. What if the challenging behavior is affecting the individual's personal health and safety, or the health and safety of others?

If the challenging behavior is affecting or is likely to affect the individual's personal health and safety or the health and safety of others, then a crisis plan or safety plan should be done.

1. A crisis plan should be developed as a part of the WRAP Plan by the individual with the support of a professional.
2. If the person is in MR/DD care and a WRAP Plan is not appropriate for them, a safety plan should be done by a professional.

The same recommendations and requirements about professionals discussed in Section IX. C. applies here.

Both the safety plan and the crisis plan (as part of the WRAP Plan) should be incorporated by reference into the ISP or IRP.

XI. APPROACH III A: DEVELOP A CRISIS PLAN

A. What is a crisis plan?

Crisis plans are used largely in the MH side of care. However, any individual who has the cognitive and verbal or expressive skills to describe how they feel and what helps them feel better or worse can develop a crisis plan. This can be accomplished independently or with the help and support of a professional.

Crisis plans are part of the Wellness Recovery Action Plan[3] (WRAP Plan) that is developed by the individual. A professional may give guidance to assure the plan is well thought through, but the crisis plan should represent the individual's work and their wishes.

Noticing and responding to symptoms BEFORE they are manifest as challenging behaviors reduces the chances that the individual will be in crisis. By writing a clear crisis plan when the individual is well, he or she can instruct others about care when he or she is not well. Thus the individual maintains responsibility for his or her own care.

The crisis plan portion of the WRAP Plan is different from the rest of the WRAP Plan in that *other persons will use the crisis plan on behalf* of the individual. Once the individual has completed their personal crisis plan, copies of the plan should be given to the people named in the plan as supporters.

B. What are the essential components of a crisis plan?

The essential components of a crisis plan are the following. Since the individual is writing their own plan, the components are described in first person language.

1. Describe what I'm like when I'm feeling well
2. List the symptoms the would indicate to others that they need to take over responsibility for my care and make decisions on my behalf
3. Identify my supporters or those people who I want to take over for me when the symptoms come up
    a. There should be at least five people on the list of supporters
4. List all of the information about my medications
    a. The name of my physician or physicians and phone numbers

[3] *Wellness Recovery Action Plan: A System for Monitoring, Reducing and Eliminating Uncomfortable or Dangerous Physical Symptoms and Emotional Feelings,* Mary Ellen Copeland, MS, MA, Peach Press, Revised 2002

b. My pharmacy and the number
c. My allergies
d. The medications I am currently on
    i. Why I take these medications
e. The medications I prefer to take if medication becomes necessary
    i. Additional medication I prefer to take if required
    ii. Why I choose these medications
f. The medications that should be avoided
    i. Why those medications should be avoided

5. List the treatments I would want in a crisis situation
    a. Tell why the treatment is selected
    b. Also list treatments that have negative connotations
        i. Why those treatments feel bad or don't work
6. Identify options for community care
    a. Would you be able to stay at home?
        i. If so, what supports would you need to make that happen
    b. Is community care outside of the home an option as an alternative to hospitalization?
        i. If so, identify what that is, where it is and how to access it
    c. Is respite an option?
7. Specify where you would go if you need a safe facility outside the scope of community care
    a. Where do you want to go?
    b. Where do you want to avoid?
8. What do I need my supporters to do for me?
    a. What could they do that would reduce symptoms?
    b. What could they do that would help me relax?
    c. What could they say to me that helps?
    d. What could they do for me that MUST be done?
        i. Get the mail
        ii. Feed the pets
        iii. Pick up the kids

iv. Pay my bills

e. What do my supporters need to avoid because those things make me worse?

9. How do my supporters know when to back off or that I am feeling better?

The crisis plan should be updated whenever there is new information that needs to be shared or when a different decision is made that needs to be communicated. Remember that the supporters need to have copies when this information is updated.

Be sure that the individual signs the crisis plan in the presence of two witnesses. While crisis plans are not considered a legal document in Georgia in the way Living Wills or Durable Powers of Attorney are, if the plan is witnessed, the seriousness of the plan and its intent for use is emphasized.

APPROACH III B: DEVELOP A SAFETY PLAN

A. When should a safety plan be written?

In instances where challenging behaviors affect the health and safety of the individual or others, a safety plan should be developed.

Safety plans should begin with the use of interventions written in the PBSP, but should further specify additional steps to take in response to challenging behavior that is dangerous to the health and safety of the individual or others.

B. Where does the PBSP leave off and the safety plan begin?

A safety plan should be written when there are indications of challenging behavior(s) that may jeopardize the psychological or physical health and safety of individual or others. The safety plan should be constructed so that the individual AND staff are aware of how such challenging behaviors(s) are to be addressed.

IN ALL CASES, interventions found in ANY safety plan should begin with the least restrictive intervention that would reduce or eliminate risk. Examples of issues to consider when making a safety plan follow.

1. Identify and document the challenging behavior(s) that represent risk to the psychological or physical health and safety of others.
2. Do contingency planning so that the individual and staff know “what to do if” or “what will happen if.”

a. For each challenging behavior, document the interventions to be used, such as:
    i. Specify verbal intervention strategies
    ii. Opportunity for quiet music, exercise, or some other form of activity that would re-direct his or her attention and energy
    iii. Offer the individual an opportunity to get away from stimulation

3. Determine what technological devices might offer extra supports for staff assistance, such as, but not limited to:
    a. Warning devices
    b. Staff cell phones
4. Determine whether more intensive supports in the form of staff presence is needed
    a. Specify under what conditions the more intensive supports could be accessed
    b. Specify how staff should access these supports
5. Specify the challenging behaviors that would trigger the use of a safety intervention of last resort:
    a. The challenging behavior MUST be one that threatens the health or safety of the individual or others.
    b. **Only manual hold** (also known as personal restraint) may be used. ***Refer to Section XIII for a full discussion of this safety intervention of last resort.***
6. Specify the challenging behaviors or circumstances that would require the support of law enforcement
7. Specify the challenging behaviors or circumstances that would require professional emergency intervention, such as stabilization at an emergency receiving and evaluating facility

The safety plan must be developed under the direction and supervision of a QDDP **and must be incorporated by reference into the ISP,** or for persons in MH care, the plan must be developed under the direction and supervision of a QMHP **and must be incorporated by reference into the IRP**. The rules set within each agency for the

monthly, quarterly, and annual review of ISP's should also be made applicable to the safety plan.

Review and approval by all of the above stakeholders should occur when a safety plan is first developed. It should be reviewed and reauthorized more frequently if the PBSP undergoes a significant revision or if it is determined that it is not meeting the needs of the individual. Remember to obtain appropriate consents and authorizations from:

1. The individual or his or her representative
2. The interdisciplinary team

And to incorporate it into the ISP or IRP

C. Are there any particular processes that must occur when a safety plan is used?

When an emergency intervention of last resort is used, there are certain specific processes for documentation and debriefing that must be followed. Don't forget that situations such as elopement or the use of an emergency intervention requires that an incident report be completed. Be sure to refer to your agency policies and procedures on these issues as well as policies and procedures of the Division of MHDDAD, which are referenced in the ***Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases Providers Under Contract with the Division of Mental Health, Developmental Disabilities and Addictive Diseases.*** Processes for documentation and debriefing after the use of an emergency safety intervention are discussed in Appendix E.2, **"***Processes for documentation and debriefing after the use of an emergency safety intervention."*

D. Can medication be used in a safety plan?

Did you notice that medication is NOT referenced as part of the equation of the safety plan? A group of physicians, psychiatrists and pediatricians who work with psychiatric and behavioral issues in public ***and*** private settings stated that medications should be used for **targeted symptoms.** Using this line of thinking, **medication should be used within the safety plan** ONLY **if there are targeted symptoms that are addressed by the medication,** such as:

1. Hallucinations
2. Impulsive thoughts, etc.

You will find a full discussion regarding the use of medication for challenging behaviors in Section XII.

E. Should a safety plan be written when the health and safety of the individual or the health and safety of others is NOT affected?

A safety plan could be written when the health and safety of the individual or others is NOT affected. Examples of when this might occur are the following:

1. Verbal threats that do not result in physical harm to the person or to others
2. Destruction of property that does not affect the health and safety of the individual or of others
3. Challenging behaviors such as stealing, arson, vandalism, pulling fire alarms, etc.

You will need to give THOUGHTFUL consideration when you write plans for issues that, when put into action, are actually crimes. Incorporating legal responses to these behaviors needs to be carefully considered.

When writing a safety plan that addresses challenging behaviors that DO NOT affect the health and safety of the individual or of others, the interventions written **MAY NOT include using a safety intervention of last resort.** A discussion of safety interventions of last resort will follow in Section XIII.

XII. USING MEDICATIONS FOR CHALLENGING BEHAVIORS

Unfortunately it has been noted from time to time that medication is periodically used to "control" challenging and not so challenging behaviors. The worst case discovered in a provider setting was one in which ALL individuals in the care of the provider (20 plus people) were prescribed some form of major tranquilizer such as Haldol, Mellaril or Thorazine; benzodiazepine such as Ativan, Xanex or Valium; AND medication ordinarily given for extra pyramidal symptoms that was given in such amounts that it was causing sedation, such as Benadryl or Cogentin.

This is an extreme example, but variations of this example are periodically found in the community.

A. Is it ok to give medication for challenging behaviors?

We have talked about the fact that behavior is something you can see. It is something you can count. Behavior is NOT a mood, an attitude, or the fact that someone has an unbounded amount of energy.

So is it ok to give medication for challenging behaviors? No, it is NOT ok to give medication for challenging behaviors. A group of physicians, psychiatrists and pediatricians who work with psychiatric and behavioral issues in public ***and*** private settings said, **"NO…behaviors are best treated with specific behavioral solutions".** They went on to say that medications should be used to treat ILLNESSES and their symptoms.

What follows are the points these physicians made about behavior and how to intervene with challenging behaviors. If you have read the other chapters that precede this one, these comments sound VERY familiar.

1. The overall goal when caring for individuals is that we support them with a safe and satisfying quality of life.
2. Many times we try to modify a behavior that is not really that big of a deal. Maybe it is OK for them to do something that we see as inappropriate. The behavior may be obnoxious but it is not hurting anyone.
    a. An example is that of an individual who sits down in the floor and will not move. How important is it that they move at that time?

3. BEWARE OF POWER STRUGGLES! Many times the only winning move is not to play!
4. There is not a behavior that does not have an antecedent. We may not understand what that is, but there is definitely an antecedent behind that behavior.
5. Staff needs to be trained in how to look at a challenging behavior and figure out what might be happening that affects that behavior or the meaning of the behavior. *All staff working with individuals needs to be more aware of antecedents.*
6. Not every behavioral intervention will successfully address the challenging behavior. Sometimes you must go through series of changes in the plan in order to figure out how best to address the behavior.
7. It is very important to prioritize which challenging behavior to address and to work on one behavior at a time.
8. Think of behavior plans in terms of baby steps, not huge giant steps.
9. People have to see plans as fluid in nature. If the positive reinforcer is not working, it is not a positive reinforcer.
10. Staff's interventions are only as good as the plan that is developed.
    a. A behavior plan is only as good as the trained person developing it
    b. A behavior plan is only as good as the consistency with which it is carried out
11. If the recommendations made are not followed, there is no chance that the intervention will work. Recommendations MUST be followed!
12. Decisions about the effectiveness of behavioral interventions need to be DATA DRIVEN.
13. It is very important to know what has been tried in the past.
14. Behavior plans need to be individualized to include choice and preferences of the individual. Homogenized plans (what is good for one is good for another) don't work!
15. It comes back to identifying the cause of challenging behaviors.
16. Interventions recommended may be more difficult or time consuming to do, but the result is more positively life-changing in the long run.

Additionally, the physicians recommended that staff be trained in non-physical means of intervening with individuals, and that the training should emphasize maintaining the dignity of and respect for the person.

B. Are medications EVER appropriate to give to someone with challenging behaviors?

The answer is **"yes," but *ONLY*** if the medication is used to treat symptoms of an illness. The group of physicians discussing these issues made the following points.

1. Medications should be used to treat ILLNESSES and their symptoms. Medications should NOT be used for challenging behaviors that are not a product of illnesses and their symptoms.
2. You may see self-hurtful or injurious behaviors with psychiatric disorders; HOWEVER the medication used in these situations is treating psychiatric symptoms.
3. Symptoms should be treated even though it may not be totally clear what the diagnosis is.
4. When you cannot clearly explain that you are giving medication for particular symptoms, the line has been crossed.
5. The line has been crossed when medication effects interfere in daily life.
6. The purpose of medication is to improve the quality of life for the individual. If you are doing anything else with medication, it is not appropriate.
7. Medication should be used for specific symptoms only research supports the use of that medication for those symptoms.
8. It is important to know what medications have been tried in the past.
9. It is important for staff to understand that most psychiatric medications take a while to work. Some take up to a month or so to get a therapeutic level in the body.
10. It is VERY important to add only one medication at a time.
11. Decisions about medications and their effectiveness on targeted symptoms need to be DATA DRIVEN.
12. It is important that staff understand that any of us might have idiosyncratic reactions to medication (reactions that are opposite or different from the intended

effect). This is ESPECIALLY true for individuals who have MR/DD disabilities AND with children.

C. Are PRN medications ever OK to use for individuals living in the community?

On this topic, the group of physicians was very clear: **PRN medication should be to treat specific symptoms of illness, *NOT* challenging behaviors.** Additionally, PRN medications are very appropriately used for psychiatric symptoms as a part of a WRAP or relapse plan.

PRN medications should be used ONLY in this way:

1. For specific targeted symptoms
2. The frequency of use should be tracked
    a. How often is the PRN medication used?
    b. What are the circumstances when the PRN medication is used?
3. What symptom was the PRN medication used for?
    a. How effective was the medication for that symptom?

Orders for PRN medications should be written in this way:

1. Use X medication
2. Given or taken in X way
3. For X symptom
4. Not to exceed X amount in X times

D. When we take an individual to the doctor, what does the doctor need to know?

It is VERY important to both TAKE and BRING BACK the right information when seeing a physician. The physicians gave VERY SPECIFIC suggestions about what a doctor needs to know in order to make their best determination about how best help the individual.

REMEMBER, physicians see literally hundreds of people a month in their practice, regardless of whether it is a public or private practice. The more detail you can have available for the doctor at the time of the visit, the better able the doctor will be to properly treat the individual. **Here is what the physician group said.**

1. Physicians need a good description of the symptoms or challenging behavior. They need to understand as clearly as possible exactly:
    a. What is going on
    b. When it is occurring, and

c. What is going on within the environment when these symptoms, issues or challenging behaviors occur?

2. They need to understand exactly what supports are in place so that the individual can live in the community

Additionally, they suggested having a more objective person make observations about the symptoms, challenging behavior or other issues going on…someone who is not as closely involved on a day-to-day basis.

E. How should we prepare for a visit to the doctor?

These are specific points that were made about ***HOW TO PREPARE FOR A VISIT TO THE DOCTOR***.

1. Come to the physician with a brief but succinct and accurate description of the individual's medical history to include
    a. A history of illnesses, surgeries, etc.
    b. A list of chronic and ongoing medical issues for the individual
        i. Include how each chronic and ongoing medical issue affects the life of the individual
    c. A list of allergies and sensitivities
2. Bring a GOOD description of the symptoms or challenging behavior that is the concern, including
    a. Exactly what is going on
    b. Exactly when it is occurring
    c. Exactly what is going on within the environment when these symptoms, issues or behaviors occur
    d. Bring any data or tracking sheets that relate to the reason for the visit
3. Bring a complete list of the current medications that the individual is on, including
    a. The name, dose, route and frequency of each medication
    b. The purpose of each medication
    c. Who ordered each medication
    d. The original date the medication was ordered

4. Be able to clearly describe the community supports that are in place, which would include the individual's
    a. Living situation
    b. Work situation or other daytime activities
    c. Who is available to support the individual (who is important to the person)
5. It is VERY important to have someone accompanying the individual who knows the person's story.
    a. It is equally important that the person accompanying the individual be someone who can connect with and relate to the person.
    b. Encourage family to come if possible or appropriate
6. Staff accompanying the individual need to make it clear that the purpose of the visit is to seek help for the individual, and to be specific about
    a. The description of the behavior, issue or symptom
    b. Exactly what we have attempted to do
    c. And that we are willing to come back for additional visits if necessary to resolve the illness, issues or symptoms

F. What information needs to GO BACK to best support the individual?

It is important that good and accurate information ***GO BACK WITH*** the individual and staff so that care given to the individual is EXACTLY what the physician orders. The physician's suggested this list of questions that the PROVIDER staff should ask.

1. Exactly what is being treated?
2. Ask for explicit instructions about the interventions or care that is ordered by the physician
    a. Staff might consider using a tape recorder to help remember ***what*** gets said
3. If medications are ordered, be sure the individual AND staff understands
    a. What are risks, benefits and alternatives to medication?
        i. Say "the team wants to know"
4. Ask for explicit instructions about use of medications (this information could also come from a pharmacist)
    a. How does the medication interact with food?

b. Are there any issues about taking this medication with other medications?
c. Are there any issues about the time of day the medication is ordered for?
d. What should be done if a dose is missed?
e. Are there any symptoms that would indicate that the medication is causing a problem?
f. Are there any lab requirements with the use of this medication?

NOTE: Use same pharmacy to fill ALL prescriptions so that the pharmacist is WELL AWARE of ALL medications used by the individual and so adverse interactions between medications can be prevented

5. How long will medication take to effect a change in the symptom or illness?
6. If the medication is stopped, how long will it take to wear out of the person's system
7. Be certain that staff understand the instructions given. If the use of a tape recorder was not an option
    a. Ask for copy of physician's note for the person's record
    b. If you have an agency form, the physician might be willing to make these notes on your form
8. Ask the physician if it is possible to e-mail questions to him or her (or some other form of written communication) if questions arise.
    b. In regard to communication, the physician group also said that it is INCUMBENT upon the service provider, advocates, etc. to be a link for person served. It is CRITICAL that each person in our system of care have someone who can support him or her in his or her story being heard.

G. In Summary

The physician group summarized the work of the day with these thoughts. When individuals have challenging behaviors:

1. First, look for medical issues that might be going on.
    a. Refer to Appendix B.2, B.3 and B.4 for many ideas of things to look for
2. Second, determine if the environment or persons in that environment is having an impact on the individual's behavior.
    a. Refer to Appendix B.1 for ideas.
3. Last, **medication used for the purpose of behavior modification or chemical restraint is NEVER an option.**

XIII. EMERGENCY SAFETY INTERVENTIONS OF LAST RESORT

There is only **ONE** emergency safety intervention of last resort that may be used within community settings, and that is personal (manual) restraint.

The **definition** of personal (manual) restraint is**: The application of physical force, *without the use of any device*, for the purpose of restricting the free movement of a person's body.**

Personal restraint *does not include* briefly holding a person without undue force in order to calm or comfort the person or holding the person's hand to safely escort the person from one place to another.

Personal or manual restraint IS permitted within all community settings associated with the Division of MHDDAD ***EXCEPT*** in homes operated under a Personal Care Home license. Personal Care Home rules DO NOT permit the use of any safety intervention of last resort.

The use of personal or manual restraint as an emergency safety intervention of last resort MUST be incorporated into a crisis plan or a safety plan.

Training of staff in the use of personal or manual restraint must be done using procedures and techniques taught by nationally benchmarked emergency safety intervention training programs.

There are other emergency safety interventions of last resort that you may have heard about, HOWEVER **NONE are permitted under any circumstance in community outpatient, day habilitation or residential settings.** Of course there is one exception. Crisis Stabilization Programs, which are residential Emergency Receiving and Evaluation Facilities whose mission it is to provide psychiatric stabilization or detoxification, **may** use the other emergency safety interventions of last resort which are listed in Appendix F.

Finally, the use of medication to modify behavior or for the purpose of chemical restraint **is NEVER permitted**. Refer also to Appendix F for additional information.

XIV. AFFORDING RESPECT TO THE INDIVIDUAL, OBSERVING CLIENTS RIGHTS, FEDERAL AND STATE LAWS AND DEPARTMENTAL RULES

A. Afford respect to persons served

As you think about how you will work with person(s) with challenging behaviors, special care must be given to the protection of the dignity of the individual and to each person's unique needs. Remember to afford the person with the same respect you would want for yourself. **Always remember that the most effective teaching tool you have is how you behave.**

B. Know the story of the person you serve

Spending time with people and getting to know their stories will tell you most of what you want or need to know. Also remember that you may be the only voice for the person that you serve. Being known is strategic to the individual over their lifetime. *Vulnerability and isolation can lead to serious trouble.*

C. Informed consent

Every person has a right to consent to or deny services, unless a court has taken that right from the person or a licensed psychologist, physician, licensed clinical social worker or clinical nurse specialist believes that he or she is an imminent danger to self or others and signs an emergency document indicating the same.

In order for an individual to give his or her consent, he or she must be informed both of the potential risk and benefit associated with the proposed treatment. It can be a difficult process to explain potential risk and benefit to someone who has difficulty understanding words or to someone who has trouble verbally communicating. However the risk and benefit MUST be explained to each person using means that they can best understand.

While full family participation should always be encouraged, *do not automatically conclude that the person wishes family or friends to participate or that a parent is authorized to give consent.* In Georgia, persons who are adults must consent BEFORE any other person who is NOT a professional can be given any information about the individual, their treatment or care. Unless the person has a guardian, or has in some other way been adjudicated incompetent, an adult person is the only one who can legally give consent for his or her treatment. However, it would be advisable to have a client

representative participate in this process when the individual has difficulty understanding or communicating.

D. Laws and regulations

Special care must be taken to ensure that all services, treatment and care take place in full compliance with applicable laws and regulations. The Official Code of Georgia Annotated (O.C.G.A.) makes it very clear in Chapters 33, 34 and 37 that persons will be served in the least restrictive environment [least restrictive way] that meets the needs of the person served. This is further emphasized in the Rules and Regulations for Clients' Rights Chapter 290-4-9.

The Division's "Core Requirements for All Providers" found in the *Provider Manual for Community Mental Health, Developmental Disabilities and Addictive Diseases Providers Under Contract with the Division of Mental Health, Developmental Disabilities and Addictive Diseases* provide additional detail about how these ideas must be implemented. For additional information, refer to the source documents mentioned.

XV. STRATEGIES THAT MAINTAIN RESILIENCE IN CAREGIVERS

Someone who takes care of him or her self takes better care of another person's needs. If we don't take the time to take care of ourselves, we behave in ways much like the challenging behaviors of the person that we serve. In other words, our thoughts and feelings about what is not tended to in our lives will often easily manifest in ways we do not want or plan.

Having the tools to do the work required is imperative! In the business of working with people, some of the tools required are likely to be: 1) knowing our personal story including our strengths and limitations; 2) knowing the story of the person; 3) knowing something about characteristics of the issues the person struggles with; 4) knowing what is expected in the work setting; and 5) knowing how to access support and clarification when needed.

There are two metaphors that can apply to those of us who take care of others:

1. The first is to remember that before taking off in a plane, you are taught to put the oxygen mask on yourself before helping anyone else. If you pass out from lack of oxygen while trying to help someone else, you have done neither of you any good.
2. The second is for you to imagine that your job is to jump into the water to rescue someone who is drowning. You may know that if you swim directly toward a drowning person, that person will grab on to you and try to keep from going under the water by holding on to your neck or literally trying to climb on top of you.

In both of these examples, you **must first** know what to do. And **you must** have the skills through training to do the job! It simply won't work any other way.

XVI. WE HOPE THE MANUAL IS HELPFUL

As you strive to provide the best quality of care to individuals that you serve, we hope you find this manual helpful.

Feel free to contact staff in the disability sections of the Division of MHDDAD should you have additional questions that are not addressed in this manual.

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APPENDICES

APPENDIX A

LEARNING TO LISTEN

Carlene was an eighteen-year-old young lady with a developmental disability who was scheduled to graduate from high school this year. However, she was presenting major behavioral problems both at home and at school. Because of her frequent episodes of threatening others, name-calling, running away and general uncooperativeness, she was at risk of losing her residential placement with a caring home provider as well as being expelled from school and losing her chance to graduate. Carlene would occasionally tell others that what she really wanted was her own apartment. Staff never took this seriously and she was told she would have to learn to behave while living with a home provider before even being considered for apartment living.

Program staff was careful to rule out possible medical causes for Carlene's behavior. Her mother was a diabetic and recent blood-sugar tests suggested that Carlene might also have diabetes. If this was the case, it was hoped that Carlene's behavior would improve once her blood-sugar level was controlled. However, the doctor found that she did not have diabetes or any other physical condition that might be contributing to her behavior problems.

The next strategy was to develop a positive and very individualized behavior support plan to eliminate Carlene's inappropriate behaviors. A plan was designed which used a token system to reinforce the absence of the targeted behaviors. Carlene was excited about the chance to earn some things that she had been wanting, but an apartment of her own was not among the choices. Despite some initial improvement, Carlene quickly reverted to displaying the same challenging behaviors as before. It wasn't long before she had burned out two home providers and was suspended from school.

As a last resort, and only because there were no other home providers or group homes available, Carlene was placed in a semi-independent living apartment complex, with plans to provide close supervision on a temporary basis until a more structured and better supervised living arrangement could be made available. It was decided that the behavior support plan would not be immediately resumed until Carlene's adjustment to her new environment could be evaluated.

Carlene, of course, was thrilled with her new apartment and the challenging behaviors immediately ceased. She was able to return to school and graduated with her class. Supervision in the apartment was decreased without incident and there has been no reoccurrence of the behaviors that had threatened her reputation and quality of life. Having learned a valuable lesson, staff are <u>listening</u> closely to what Carlene says she would like to do now that she is out of school.

One of the biggest mistakes we as providers make is to insist that one must demonstrate appropriate behavior in one environment to earn the opportunity to be in a more desirable situation. Challenging behaviors often communicate unhappiness with something about one's physical or social environment. A change to something that better matches what the person really wants will increase his/her satisfaction and eliminate the need to show discontent through maladaptive behavior. It is rare that accommodating people in this way actually has the effect of increasing the frequency or intensity of undesirable behavior.

APPENDIX B: PHYSIOLOGICAL (MEDICAL) ISSUES TO CONSIDER

Appendix B.1

PAIN*

Everyone experiences pain in a unique way. However, a person with a developmental disability who has impaired communication skills (or is possibly nonverbal) may at times communicate his/her pain through dangerous or socially inappropriate behaviors.

QUESTION	RESPONSE
What causes Physical Pain?	• Chronic medical conditions • Recent, non visible injuries • Untreated dental problems • Emotional and interpersonal problems
Who May Be More Prone to Behavioral Expressions of Physical Pain?	• Those who have an expressive language disorder • Individuals with impaired cognitive abilities • Infants and children • People with idiosyncratic behaviors (i.e., a person with • Autism)
Clues That Physical Pain is Causing Behavioral and Emotional Problems	• Aggression and self-injurious behaviors (such as head • banging or self-biting) • Agitation and restlessness, especially at night • Temper tantrums (caused by frustration due to an inability to verbally communicate) • Various attention seeking behaviors • Feeding and eating problems (i.e., general food refusal or refusal of firm textured foods) • Holding a body part (such as gripping one's cheeks) or hitting a body part (such as the stomach)
What Approaches Can Be Used to Increase the Person's Comfort When Experiencing Pain?	• Seek a through health evaluation • Prepare the person adequately before the healthcare visit so that the exam can be completed. • Remember, regardless of a person's level of disability she is a partner in his/her own healing – allow him/her that. • Ask primary health care provider about the appropriateness of prescription or over the counter pain reducing medications for temporary relief. • Show patience and empathy (reassurance that the person can understand). • Speak slowly and softly. • Softly touch where and when appropriate. (For example, massage feet, legs, back, or shoulders). • "De-stress" the environment by turning on soft music, eliminating loud noise, and decreasing stimuli. • Be sensitive to non-verbal communication, such as body posture, facial expression, words, or sounds. • Respond in a caring, non-judgmental way.

*Ellen Arcadi, R.N., M.P.H., Westside Regional Center, California

Appendix B.2

MEDICAL CONSIDERATIONS IN THE APPROACH TO PROBLEMATIC BEHAVIOR
Listed by Body System

A. GENERAL CONSIDERATIONS

1. Pain

Pain can precipitate virtually any behavior, the two most obvious of which are **self-injurious** and **aggressive behaviors**. When an individual develops a behavior in which he/she is hitting a particular body part, it is wise to examine that body part. Previous trauma may be a precipitator of behaviors related to pain. An individual could become aggressive when they are experiencing pain as a result of their lack of understanding of what pain is and how to seek relief.

a. Behaviors such as **agitation, pacing** and **running** away can also be precipitated by pain. Individuals with pain from any source may also display a variety of sleep disturbances.

b. Also to be considered when evaluation such behaviors is the phenomenon of counter stimulation. The dentist uses this when injecting lidocaine into the mouth. The dentist will shake your lip to provide counter stimulation. This provides additional stimulation for the nerves and the brain to process, thus lessening the experience of pain at the injection site. The individual with MR/DD may be providing him or herself with some counter stimulation, potentially far from the site of the pain, in an effort to gain relief from the pain or discomfort.

2. Medication Effects, Medication Side Effects and Medication Toxicity

Medication effects, side effects, and toxic effects can precipitate many behaviors with the most common being **aggression** and **agitation** or **motor restlessness** (sometimes called hyperactivity). **Self-injurious behaviors** and **altered sleep patterns** can also be related to medication effects. The direct care staff must be informed when making any medication change for the individual, indicating to the staff that observation is required and any changes in the behavior of the individual need to be reported.

a. Many of these behaviors will be due to a **direct effect** of the medications. The most obvious example of this would be over-sedation from the use of a medication to sedate an individual.

b. **Side effects** of medications precipitating behavior problems are a common phenomenon. Akasthisia is a commonly recognized example and is generally expressed as agitation and/or motor restlessness. Sedation from medication not used for sedation is another example.

c. **Toxic effects** also may precipitate behaviors. Most frequently, these effects result in an altered sensorium and loss of coordination. The individual may appear "drunk" or "ill".

d. Finally, remember that one medication may affect another medication and may cause **any** of the above effects.

B. NEUROLOGIC EFFECTS

1. Headaches

The expression of headache pain may be through any behaviors, but should be considered when head-banging or hitting behaviors occur.

a. **Seizures**. The relationship between seizures and behavior is an exceeding important one. Individuals with MR/DD do not, by definition, have a normal central nervous system. Individuals with diagnosed temporal lobe seizures may have ictal, postictal and interictal aggressive behaviors.

i. **Ictal (seizure) aggression** may be manifest as unpredictable outbursts of rage or aggression. Unilateral motor manifestations of the seizure may precede the aggression, as may autonomic signs.

ii. **Postictal aggression** may occur while the individual is disoriented and may be directed at the caregivers that are attempting to provide aid to the individual.

iii. During acts of **interictal aggression**, the individual is alert and attentive. All of the other signs of seizure activity are absent.

Between seizures the individual may become angry at seemingly trivial events and may experience an urge to hit someone. In addition, these temporal lobe seizures may precipitate a psychotic state in that the individual, leading to other behavior issues.

Ictal aggression also occurs with non-convulsive frontal lobe seizures. Common manifestations of these seizures include repetitive, bilateral arm motions that result in striking items in the environment, including persons. A blank stare or "wild" facial expression, grimacing, teeth clenching, intense vocalizations, and

occasionally biting or spitting may accompany these. Autonomic signs are also seen. These seizures often occur nocturnally, awakening the individual. These episodes can follow anger or frustration or occur with provocation. They may last for a few minutes up to a half-hour. Frequently, the individual seems to be physically stronger than usual during these involuntary outbursts.

Behavior changes also occur with other seizure types. Some individuals experience an aura that is represented by behavioral changes while others may have post-ictal behavior changes related to the area of the brain that is affected by the seizure activity. In all of these individuals, seizure control is the primary treatment modality for these behaviors.

1. Meningitis/Encephalitis

Central Nervous System (CNS) may produce behavioral changes through the intermediaries of pain or fever (delirium) or by directly altering the individual's sensorium. Infections may be accompanied by specific symptomatology.

2. Dementia

The early onset of Alzheimer's and non-Alzheimer's types of dementia particularly in the individual with Down's syndrome (Trisomy 21) must be considered in the differential diagnosis of behavioral change. The potential medical causes of dementia must be addressed, as many of these may be correctable.

C. EYES

Cataracts and Glaucoma may produce behavior changes by altering the individual's ability to see. These behaviors are primary aggression and self-injury, although agitation is also fairly common. In addition, acute angle closure glaucoma can be quite painful, manifesting with behaviors related to the intermediary of pain.

D. EARS, NOSE, AND THROAT

Otitis media, wax impaction, sinus infection and dental caries or abscess may alter behaviors through the intermediary of pain.

E. PULMONARY or CARDIOVASCULAR

The authors have not seen any pulmonary issues present with behavioral manifestations with any degree of frequency**.**

F. GASTROINTESTINAL

1. **Constipation/Fecal Impaction**

   These two common problems in the MR/DD population can precipitate a wide variety of behaviors ranging from rectal digging to aggression. In addition, the usual behavioral changes to be expected from persons with normal cognition, such as decreased appetite, may not occur in this population.

2. **Diarrhea**

   The individual may bring this problem to the attention of the staff by soiling, rectal digging **or** fecal smearing **or** flinging**.**

3. **Inflammatory Bowel Disease (Crohn's Ulcerative Colitis)**

   These medical issues will have other symptoms, but if behavioral manifestations are present, will most likely be related to pain or diarrhea.

4. **Gastroesophageal Reflux/Hiatal Hernia**

   The behavioral manifestations of these problems will most likely be related to pain. In addition, rumination may also be a related behavioral manifestation that can lead to significant illness and malnutrition, and in its extreme, death.

5. **Ulcer Disease (H. pylori)**

   The primary behavioral manifestations will be those related to the intermediary of pain.

6. **Intestinal Parasites/Pinworms**

   Pinworm infestations are the most common and are frequently manifested by rectal scratching or digging related to itching. Other infestations are much less common but are also found in individuals who display PICA behaviors, and would manifest behaviorally through the intermediary of pain.

G. GENITOURINARY

1. **Dysmenorrhea and Urinary Tract Infection**

   Behaviorally manifested through the intermediary of pain.

2. **Premenstrual Syndrome and Premenstrual Dysphoric Disorder**

   The behavioral manifestations are myriad and include irritability, agitation, and aggression. Occasionally self-injury will also be present. The key to diagnosis is the timing of these behaviors, occurring in the one to two weeks prior to menses, on a regular basis.

3. **Vaginitis and Vaginal Candidiasis**

The primary behavioral manifestation of these issues will be related to unrelenting itching of the genital area. In the less mobile and less verbal individuals, these manifestations may be simple irritability or agitation. More mobile individuals may engage in scratching of the genitals, and verbal individuals may complain of itching.

H. INTEGUMENTARY

Most issues here relate to itching of the skin. Behavioral manifestations include self-injurious behaviors such as rubbing, scratching, gouging and picking at the skin. Specific issues to look for are rashes such as contact dermatitis, eczema and psoriasis.

I. MUSCULOSKELETAL

The behavioral manifestations of fractures, bunions, degenerative joint disease and other podiatric issues are related to the intermediary of pain. A particular issue to note is that nail care is a difficult issue in this population. Problems related to ingrown toenails and toenails that are too long may also include refusal to walk or bear weight.

J. ENDOCRINE

The incidence of hypothyroidism is higher in this population than it is in the general public. In addition, some medications will predispose individuals to hypothyroidism. Individuals with hyper and hypo-thyroidism may present with withdrawal and depression, lethargy, aggression, self-injury, agitation, sleep disturbance and changes in eating habits, just to list a few.

K. MENOPAUSE

Menopause can place great emotional strain on the individual. The physiologic changes that occur in the peri-menopausal female can lead to significant behavioral changes. Virtually any behavior that is seen in a peri-menopausal female can be attributed to this dramatic change in endocrine status, ranging from agitation and motor restlessness to aggression and self-injury to withdrawal and depression. Menopause may occur at a younger age in the MR/DD population, and therefore the diagnosis may be missed.

L. HEMATOLOGIC

Many individuals with mental retardation display pica behaviors. Sometimes these behaviors result in anemia, but at other times they result from anemia. All individuals who display pica behaviors should be screened for anemia when the behavior appears and at periodic intervals as long as the behavior exist.

In summary**, multiple medical issues may present with identical behavioral manifestations. The key** to diagnosis is maintaining a high index of suspicion and performing a history, physical examination and special studies as indicated. ***Medical illness should never be overlooked nor should its behavioral manifestations be treated with psychoactive agents or behavioral management without first addressing the appropriate diagnosis and treatment of the medical illness.***

APPENDIX C

QUALITY OF LIFE SATISFACTION INTERVIEW FOR PERSONS WITH CHALLENGING BEHAVIORS

The following interview questions are intended to provide a framework for exploring the relationship between a person's quality of life and challenging behaviors displayed by the person. Behavior often functions to communicate a person's satisfaction or dissatisfaction with his or her personal life situation. Circumstances at home, at work, at school or in other environments may cause unhappiness, frustration, anger or other negative feelings that come out in the form of "maladaptive" behaviors that may be displayed in other settings as well as the one that is the source of the discontent. Things that typically trigger these behaviors are less likely to do so if the person is generally satisfied with his or her quality of life.

It should be kept in mind that it is the ***individual*** who defines what a desirable quality of life is for him or her and not others who assume what this should be. The first goal is to find out how closely "what is" matches with "what the person wants" for his or her life. The greater the discrepancy, the greater will be the likelihood for discontent, dissatisfaction and problematic behaviors. The second goal, and the greatest challenge for us, is to figure out how to help enable the person's real life to match ***as closely as possible*** to that which he or she truly desires.

The questions below serve only as a guide for the interview and should be rephrased as needed to increase the individual's understanding of what is being asked and to elicit a response that accurately reflects the person's true feelings. Before asking the questions, it should be explained that you want to find out how satisfied or happy the person is in order to help you understand why he or she is doing certain things that are considered to be inappropriate or detrimental. Explain this in a way the person will understand, and be specific about the behaviors of concern. Ask any follow-up questions needed to gain additional information. For persons with limited communication skills, it may be helpful to interview whoever knows the person best, asking that individual to respond the way the person with challenging behaviors would respond if he/she could talk.

TOPIC	EXAMPLES OF QUESTIONS
Living Situation	1. How do you feel about where you live? 2. What do you like about where you live? 3. What do you not like about where you live? 4. What would you like to change about where you live? 5. Would you rather live somewhere else? (If so) Where? Why? 6. If you could live anywhere you wanted to, where would that be? 7. Does someone live with you? (If so) How do you like living with him/her/them? 8. What do you like about whom you live with? 9. What do you not like about whom you live with? 10. What would you like to change about who you live with? 11. Would you rather live with someone else? (If so) Who? 12. How do you like the staff (or if home provider, give name) that helps you at home? 13. How do they treat you? 14. Is there any staff at your home that you don't like? (If so) Why? 15. What would you like to change about the staff (or home provider's name) that helps you? 16. Is there anything wrong about the house/apartment that you live in? (If so) What? 17. What do you like best about your house/apartment? 18. Are there any rules at your home that you think are unfair? (If so) What are they? 19. Is there somewhere you can go if you want to be alone? (If so) Where?
Day Activities	1. Where do you usually go during the day? 2. How do you like it there? 3. What do you like about it the most? 4. What do you not like about it the most? 5. What would you like to change about it? How? Why? 6. Are there any rules there that you think are unfair? (If so) What are they and how are they unfair? 7. What do you do there? 8. How do you like doing that? 9. Would you rather be doing something else? (If so) What? 10. How do you like the staff that supervises you there? 11. Is there anyone there, staff or others that you don't get along with? (If so) Tell me about it. 12. If you could do anything you wanted during the day, what would that be? 13. If you could have any job you wanted, what would it be?
Relationships	1. Who are your best friends? 2. Do you get to spend enough time with them? 3. Do you have a boyfriend/girlfriend? (*If so*) Do you get to spend enough time with him/her? 4. Is there something you'd like to do with your friends but can't? (*If so*) What? Why? 5. Who are you closest to in your family? Do you get to spend enough

	time with him/her? 6. Is there anyone that you don't get along with or who makes you feel bad? *(If so)* Tell me about it.
Self-Assessment	1. Are you usually happy or sad? 2. What makes you happy? 3. What makes you sad? 4. What really makes you mad? 5. Is there something you would like to change about your life? (If so) What? 6. Is there something you really want to do but haven't been able to? (If so) What? 7. What's something you do that makes you feel good and proud of yourself? 8. What's something you do sometimes that makes you feel bad? 9. Is there anything you do sometimes that bothers staff or others around you? a. (If so) What? b. (If no) People say you sometimes … (Describe challenging behavior reported). 10. What do you think makes you do this? 11. Why does this bother others? 12. When do you do this most often? 13. Where does it happen most often? 14. Who is usually around you when this happens? 15. What do you think would have to happen for you to stop (the challenging behavior) 16. What would things be like for you if you were to stop (the challenging behavior) 17. What's something we could do to help you learn to control your own behavior?

APPENDIX D: GLOSSARY OF NON-RESTRICTIVE TECHNIQUES

Appendix D.1

Brief Overview of Non-Restrictive Methods
For Use in Positive Behavior Support Plans

Technique	PBSP
1. Positive reinforcement	♦
2. Negative reinforcement	♦
3. Extinction (excludes aggression and SIB)	♦
4. Differential reinforcement of *incompatible* behavior (DRI)	♦
5. Differential reinforcement of *other* behavior (DRO)	♦
6. Differential reinforcement of *alternative* behavior (DRA)	♦
7. Behavioral Contracting with Positive Consequences (Earning Extra Privileges)	♦
8. Reinforced practice	♦
9. Contingent observation	♦
10. Response blocking or interruption	♦
11. Restoration of environment	♦
12. Non-contingent dietary management	♦
13. Withdrawal to a quiet area	♦
14. Brief Manual Hold (Less than 10 Seconds)	♦

Appendix D.2

Definition and Characteristics of
Non-Restrictive Methods that may be used in PBSPs

1. Positive Reinforcement

Positive reinforcement refers to the presentation of a stimulus or event (usually thought of as pleasant) following the desired response, resulting in an increase in the frequency, duration, or intensity of that response. Several methods that maximize the effects of reinforcement are listed below:

a. The functional nature of the reinforcer must be empirically established by demonstrating an increase in the desired behavior. Praise and approval may be powerful reinforcers for one individual but may have no effect on another individual who may respond only to tangible objects or edible reinforcers.

b. The reinforcer must be delivered as quickly as possible following the targeted response. Being paid once a month for arriving at work on time in a sheltered workshop is probably not adequate to maintain the targeted behavior of prompt arrival.

c. Use of the name of the individual while the reinforcer is being delivered and telling the individual which behavior is being reinforced will serve to strengthen the relationship between response and reinforcer.

Examples of Positive Reinforcement
An individual remains on task for only brief periods of time. The staff member begins giving a penny candy (a preferred treat) to the individual when he remains on task for short periods of time. As the individual remains on task more consistently, the candy is given contingent upon the individual remaining on task for gradually longer periods of time.
An individual is learning to ask for permission rather than demand that the music channel be changed. When the individual is successful in asking politely, a staff member says, "That's very nice of you, I am proud of how nice you said that!" The individual then becomes more skillful at politely asking for permission to adjust the radio channel.

2. Negative Reinforcement

Negative reinforcement is one of the most misunderstood behavioral principles. Negative reinforcement refers to an increase in the frequency of a response that has led to the ***removal of a stimulus or event*** (usually thought of as noxious or unpleasant).

A common error is to confuse negative reinforcement with punishment. The difference between the two operations is that punishment serves to decrease the rate of a specific behavior, typically by introducing an unpleasant consequence, whereas **negative reinforcement produces an increase in the rate of a specific behavior, typically by the removal of an unpleasant consequence.**

It is important to recognize that negative reinforcement is no different than positive reinforcement in its effects upon the behavior it strengthens, and thus the same considerations outlined under positive reinforcement apply here as well. The following points are also noteworthy:

a. The reinforcing nature of the removal of the stimulus must be empirically established by the demonstration of an increase in the target behavior.
b. The event/stimulus must be removed as quickly as possible following the targeted response.
c. The use of the name of the individual while the event/stimulus is being withdrawn and verbalizing to the individual which behavior is being reinforced will aid in establishing the association between the behavior and the removal of the stimulus.
d. The treatment team must remember that the inadvertent application of this technique may serve to reinforce negative or problematic behaviors. For

instance, if withdrawal is an approved procedure for an extremely aggressive individual and he frequently becomes aggressive during work time, aggression is likely being negatively reinforced by removing him from the work situation.

Example of Negative Reinforcement
An individual finds a particular task unpleasant and is permitted to terminate the task contingent upon asking for a break. In this example, appropriate communication (rather than aggression or self injurious behavior, which may have worked in the past) is reinforced by the termination of the unpleasant task.

3. Extinction of Maladaptive Behavior that is not Dangerous

The procedure of extinction involves a discontinuation of the contingent relationship between a response and its maintaining consequences resulting in a decrease in the rate, intensity or duration of the response.

An extinction procedure requires that the reinforcers which normally maintain a response first be identified and subsequently no longer be presented when the response occurs. In many cases the reinforcer may be social or some form of attention. For some individuals, attention in the form of social disapproval or even physical restraint may be maintaining an undesirable behavior. Further, it is not uncommon for expulsion from the classroom to be the reinforcer (negative reinforcement) of inappropriate "talking in class." Talking in class can be put on extinction, by ignoring it and not allowing the student to be expelled from the class. Extinction is most effective when used in conjunction with reinforcement for desirable behaviors. The conditions under which extinction may not be an appropriate procedure may include:

a. The reinforcer(s) maintaining the response cannot be identified.
b. It is not possible to discontinue the contingency between a response and its consequence. For example, stealing food (response) automatically produces extra food reinforcement.
c. The inappropriate response is likely to produce serious tissue damage to the individual and/or other persons in the environment or is likely to result in the serious destruction of property.

Extinction procedures often produce a temporary initial increase in the rate and intensity of the response, or increase other inappropriate responses such as aggression. Extinction procedures should therefore be used:

1. Only when the expected initial increase in the rate, variability, and force of the response cannot reasonably be expected to be physically dangerous to any person or likely to result in property destruction.
2. Only in conjunction with the reinforcement of other, appropriate responses.

3. When the behavior to be extinguished is not physically harmful to anyone, or likely to result in the destruction of property.
4. When reinforcers have been independently identified and provisions have been made for the absolute suspension of the contingency between the reinforcers and the inappropriate response.

The individual's treatment team is responsible for determining if the behavior placed on an extinction program is non-aggressive and not self-abusive and, therefore, requires a PBSP. Although extinction may not be suitable for use as the sole intervention, it should be part of any overall program to treat inappropriate behavior; i.e. any program should include minimizing reinforcement for the problem behavior.

4. Differential Reinforcement of *Incompatible* Behavior (DRI)

DRI involves reinforcing a behavior that is incompatible with the identified target behavior. The maladaptive target behaviors are ignored or not reinforced, whereas the incompatible behavior is reinforced. The individual is not able to exhibit both behaviors simultaneously.

Ignoring target behavior and reinforcement for desired behaviors are the components of differential reinforcement. Ignoring behavior is more effective when reinforcement for incompatible behavior is delivered. Delivery of reinforcement for desired behavior must occur at a rate that is higher than the frequency of the targeted maladaptive behavior. Some examples of maladaptive behavior and the corresponding incompatible behavior are shown below.

Undesirable Behaviors	Incompatible Behaviors
• Out of seat • Lying on the floor • Throwing objects • Pushing in line	• In seat • Sitting in a chair • Writing or reading • Standing in line with arms at side

5. Differential Reinforcement of Other Behavior (DRO)

Differential reinforcement of other behavior is the delivery of reinforcement to the individual **when he is not exhibiting the target maladaptive behavior(s)**. That is, the individual is reinforced when he/she is engaged in any behavior other than the target maladaptive behavior.

When possible, it is preferable to use DRI (instead of DRO) in order to teach a specific functional but incompatible behavior. In DRO, as contrasted with DRI, the individual may be reinforced for any of several adaptive behaviors. As with DRI, in determining the frequency of reinforcement for desired behaviors, baseline data on the frequency of maladaptive target behaviors must be available. Delivery of reinforcement for other behavior must occur at a rate that is higher than the frequency of the target maladaptive behavior.

Example of Differential Reinforcement of Other Behavior (DRO)
An individual usually screams for his personal items to be brought to him. If the individual does not scream for 15 minutes, a staff member brings to him something that he likes. This schedule may continue at 15-minute intervals or it may be extended by adding five minutes to each time interval, up to some designated maximum DRO time period (e.g., 30 to 60 minutes).

6. Differential Reinforcement of Alternative Behavior (DRA)

DRA involves the reinforcement of a specific alternative behavior instead of the target maladaptive behavior. The target maladaptive behavior is ignored or is not reinforced, whereas the alternative behavior is reinforced. DRA differs from DRI in that the alternative behavior does not have to be incompatible with the target behavior. As with DRI and DRO, the frequency of reinforcement for alternative behaviors is dependent upon the baseline frequency of maladaptive target behavior(s). Delivery of reinforcement for alternative behavior must occur at a rate that is higher than that of the maladaptive behavior(s).

The example described earlier under "negative reinforcement" includes the method of DRA. In that example, the individual learned to politely request a break to leave a non-preferred area. In this case, requesting a break is not incompatible with maladaptive forms of escape, such as aggression or SIB, but it can be learned as a more socially acceptable and effective means of escape. In other words, it can be learned as an alternative to aggression and SIB.

7. Behavioral Contracting with Positive Consequences (Earning Extra Privileges)

This type of behavioral contract is a written specification of the goals, the replacement behaviors and target challenging behaviors, and the reinforcement contingencies for a behavior-change program. There are no provisions in this type of contract for restrictive consequences for target challenging behavior. The focus is entirely on the added privileges that the individual may earn for his positive or replacement behavior. The contract is mutually negotiated between the individual and the clinician.

The contract clearly specifies the problem behavior, the appropriate alternative behaviors, and the positive consequences of the behavior, the criteria for success and the signatures of both parties involved. An example of a behavioral contract follows:

Example of Behavioral Contracting with Positive Consequences (Earning Extra Privileges)

INDIVIDUAL'S NAME

PROBLEM: (Name of individual) refuses to clean up his room.

TARGET BEHAVIORS: As his part of this contract, (name of individual) agrees to:

1. Clean his room by 9:30 AM each day.
2. Contact a staff member for room inspection when room is clean.
3. Promptly make any needed corrections following room inspection.

REINFORCEMENT SCHEDULE:

Successful completion of the above target behaviors on a daily basis will result in:

- An extra trip on Tuesday to the swimming pool**.**
- An extra weekly trip into town to eat at a restaurant.

Failure to complete the above target behaviors on a daily basis will result in:

- Not getting the extra trip on Tuesday to the swimming pool.
- Not getting an extra weekly trip into town to eat at a restaurant.

AGREEMENT STATEMENTS AND SIGNATURES:

I agree to follow the provisions of this contract by exhibiting the described target behavior. _____

(Name of individual)

I agree to provide the consequences that are specified in this contract.

_____

(Staff name)

8. Reinforced Practice

Reinforced Practice is a procedure whereby an individual is afforded many opportunities to practice and receive reinforcement for a behavior in his/her repertoire in order to ensure the retention of that behavior. Many appropriate adaptive behaviors that occur under normal circumstances take place infrequently. The individual is, therefore, limited in the number of opportunities that he/she has to practice the behavior once acquired. The purpose of this procedure is to design a structured program in which the practice of such adaptive behaviors occurs frequently and the appropriate behavior is reinforced.

Example of Reinforced Practice
An individual has mastered the skill of brushing his teeth. A maintenance program consisting of being afforded frequent opportunities to receive reinforcement for practicing this skill will increase the probability that he will retain it in his repertoire.

9. Contingent Observation

Contingent observation is a procedure whereby, contingent upon a specified inappropriate behavior, an individual is removed from an activity for a brief period of time and is required to observe the appropriate behavior of the other individuals in the group. The individual remains in the room where training is conducted with a group. After a specified period of observation, not to exceed 30 minutes, and after remaining quiet for a specified period of time (e.g., 5-15 minutes) or after having indicated that he will behave appropriately, the individual rejoins the group.

Contingent observation is recommended for situations in which an extensive program of planned activities exists. Furthermore, the level or quantity of disruptive behavior must be more than momentary. Brief or one-time occurrences of a behavior do not warrant the use of contingent observation since the contingent observation may provide reinforcement for the undesired behavior.

Example of Contingent Observation
An individual who, while participating in a group activity, is exhibiting a behavior that disrupts that activity. The individual is promptly removed from the activity and required to sit on a chair to observe the appropriate behavior of the remainder of the group. In this manner, the individual is provided with modeling of the appropriate behavior that is expected of him.

Caution must be used when utilizing contingent observation. For example, an individual who is non-compliant with the requirement of sitting and watching the others might gain inappropriate attention by attempting to escape the contingent observation. In addition, certain

individuals might increase their inappropriate behavior in the group if contingent observation provides them with the opportunity to engage in higher rates of self-stimulation. Some individuals might also increase their inappropriate behavior in the group if the escape from the group or activity provided by contingent observation is reinforcing.

10. Response Blocking or Interruption

Response blocking is the physical interruption of a specific behavior by interposing a barrier (a hand, forearm, etc.) to temporarily prevent motion. Response blocking is intended to prevent the normal consequence of a behavior when said consequence may be immediately reinforcing.

Response blocking does not involve extended grasping and holding of an individual. By itself, response blocking does not promote adaptive behavior; hence the procedure is almost always used in conjunction with DRO, DRI, DRA, or some other reinforcement procedure.

Example of Response Blocking or Interruption
As an example of response blocking, a staff member would stand behind a seated individual who regularly engages in head banging. When the individual attempts to hit himself, the staff member quickly interposes his own hand between the individual's hand and head, momentarily blocking the individual's range of motion and preventing a blow to the head. A second staff member concurrently works with the individual using reinforcement procedures to promote the individual's involvement in some functional task incompatible with head banging.

11. Restoration of Environment

Restoration of the environment is a method used to have the disruptive individual return the environment to the condition in which it was prior to the disruption displayed by that individual. Restoration of the environment is not *restitution* in that the individual does not have to modify the environment into a vastly improved state. The staff working with the individual should use the least amount of prompting and guidance necessary to ensure that the individual returns items to their original location and condition. Verbal prompts and facial expressions of staff should be "matter of fact" with no emotions displayed. Excessive talk and expression during this procedure can be reinforcing to the individual who has disrupted the environment, leading to an increase in the disruptive behavior. The individual is simply directed to rearrange those parts of the environment that he has disrupted.

In order to utilize restoration of the environment, the individual must have the skills and physical ability necessary to restore the environment to its original condition. If the individual is unable to perform full restoration, then partial restoration may be appropriate. Successful restoration is *not* to be followed by praise for the individual. If praised, the individual could learn

to disrupt the environment so that he can have the opportunity to restore it and gain praise and social attention.

Example of Restoration of Environment
When an individual who frequently knocks over furniture and throws household objects when angry disrupts the environment, the staff should direct this individual, using the least amount of prompts possible, to pick up things and put them back into place.

12. Non-Contingent Dietary Management

Non-contingent dietary management is simply the provision of a diet plan aimed at addressing the antecedents to specific target challenging behaviors. Usually the challenging behavior is associated with eating or digestion, such as pica, rumination, or food stealing. When utilizing non-contingent dietary management the medical staff must authorize the specific dietary management regimen that has been individualized and the dietitian must be involved in the development and monitoring of the diet management plan.

Example of Non-Contingent Dietary Management
Examples of non-contingent dietary management include: • The use of peanut butter to decrease ruminating behavior. • The use of extra portions to decrease the self-induced vomiting. • The use of extra meal portions or additional snacks to decrease food stealing.

13. Withdrawal to a quiet area

Withdrawal to a quiet area, also referred to as "withdrawal," is a form of "Time Out" from reinforcement. Withdrawal is the prompt and temporary removal of an individual from his present environment or activity to another specified area following the occurrence of a specified inappropriate behavior that is disruptive to the situation. The individual must be under observation by a staff member and there should be no social interaction with the individual by staff.

The purpose of withdrawal is to remove the individual from the reinforcement with the intent to guide re-entry to the pre-withdrawal situation as soon as the individual has regained control of his/her behavior.

It is very helpful to understand what is keeping the target behavior in place. . For example, if the target behavior is maintained by a *positive* reinforcer (e.g., social attention, access to reinforcing items or activities), using withdrawal to a quiet area for behavior maintained by *positive* reinforcers would focus on *removing, withholding or otherwise preventing access* to

social attention or reinforcing items/activities for a specified period of time immediately after the target behavior occurred. Conversely, if a *negative reinforcer* is maintaining the target behavior (e.g., escape from an instructional or work task, avoidance of certain social situations, etc), withdrawal to a quiet area for behavior maintained by *negative* reinforcers would focus on *preventing escape or avoidance* of the instructional/work task or social situation for a specified period of time immediately after the target behavior occurred.

Withdrawal to a quiet area can occur without removing the person from the actual location where they are at that moment. This is called "non-exclusionary time-out". Non-exclusionary time out involves temporarily removing *the reinforcer* from the individual. The individual remains in the ongoing activity or setting, but the reinforcer is removed or the individual is not afforded access to the reinforcer for a specified period of time.

And withdrawal to a quiet area can occur through actually removing the person from the situation. This is called "exclusionary time-out". Exclusionary time-out involves temporarily removing the individual from the setting in which reinforcers are available. In some cases, the individual may be removed to an adjacent area where she/he cannot observe, have access to, or otherwise take part in ongoing reinforcing activities. In other cases, the individual is removed entirely from the area.

The area to which the individual is removed should be free of other persons and generally free of distractions, HOWEVER withdrawal *does not* make use of special seclusion type rooms. It is important to make the distinction that **egress from the area MAY NOT be prohibited**. When egress is prohibited, this becomes seclusion, which is NOT permitted. The individual may never remain in withdrawal or "time-out" for more than 30 minutes. Any staff member trained in the use of withdrawal may be authorized to make implementation decisions. **Once the individual has remained calm for a specified time period (usually 3 to 15 minutes), he or she shall be allowed to return to the original environment.**

When utilizing withdrawal, certain factors, listed below, must be considered:

Important Considerations about Withdrawal
Withdrawal should not be used when the functional assessment suggests that the target maladaptive behavior is maintained by the negative reinforcement derived by escaping demanding or unpleasant situations.
Interaction between the individual and staff members must be minimized to ensure that withdrawal does not become positively reinforcing.
Special rooms designed for use with restrictive time-out are not to be used with withdrawal.
Individuals may become physically resistant or aggressive during withdrawal. In such a circumstance, it may be necessary to use withdrawal in conjunction with other procedures, such as a manual (personal) restraint, in order to reduce the possibility of physical harm to the individual or staff member.

The following is an example of withdrawal to a quiet area.

Example of Withdrawal to a Quiet Area
An individual begins to yell loudly to gain attention during class. The teacher immediately instructs him to stop, but he refuses. He is then promptly removed from the classroom, taken to another room and required to remain there for a brief period of time (e.g., five minutes) until quiet. Once the time is up, he is allowed back in the class.

14. Brief Manual Hold (Less than 10 Seconds)

The brief manual hold procedure consists of manually holding or physically guiding an individual to interrupt or prevent inappropriate behavior. Each hold must last less than 10 seconds.

When using brief manual hold, the staff must bear in mind that *NO* ***mechanical devices can be employed*** to implement the brief manual hold. In addition, brief manual hold involves guidance up to a maximum of 9 seconds. Behavior requiring contact 10 seconds or more is considered a *manual restraint* described later. When utilizing brief manual hold, certain factors, listed below, must be considered.

Factors that Must Be Considered When Using Brief Manual Hold
When the functional assessment of the target behavior suggests that physical contact is maintaining the behavior as a form of social reinforcement, then brief manual hold should not be used.
The brief manual hold(s) to be used in the PBSP must be sufficiently described so that staff will know how to implement them correctly. Using the term "manual hold" by itself is too general and could result in inconsistent program application.

Brief manual holds may not be used as punishment or as a substitute for activities or active treatment.
Only the minimum amount of persons and pressure necessary to control the individual's behavior are to be used during the implementation of a brief manual hold.
Only staff members who have received in-service training and demonstrated competence in specific brief manual holds may be assigned the responsibility of implementing the specific brief manual hold.
Brief manual hold procedures are designed and utilized in such a manner as to minimize and prevent physical discomfort and injury to the individual.

The special requirements for the use of brief manual holds are as follows:

Special Requirements for Brief Manual Hold
Every use of a brief manual hold must be made a part of the individual's record. The following items must be documented in the record: • The antecedent to the target behavior that led to the brief manual hold. • The behavior that led to the brief manual hold. • Date and time of application and release from the brief manual hold.
Review of programs using brief manual holds is the responsibility of the PBSP author and must be documented in the record at least every month.

APPENDIX E: THE EMERGENCY SAFETY INTERVENTION OF LAST RESORT THAT *MAY* BE USED IN A SAFETY PLAN OR AS PART OF A CRISIS PLAN WITHIN COMMUNITY SETTINGS

Personal (Manual) Restraint	Permitted in Safety Plans or Crisis Plans

1. Personal (Manual) Restraint

Personal (manual) restraint is defined as the application of physical force, without the use of any device, for the purpose of restricting the free movement of a person's body. Personal restraint *does not include* briefly holding a person without undue force in order to calm or comfort the person or holding the person's hand to safely escort the person from one place to another.

Personal or manual restraint is a safety intervention of last resort that IS permitted within community outpatient or day habilitation settings or within Community Living Arrangement rules. Personal Care Home rules DO NOT permit the use of any safety intervention of last resort.

The use of personal or manual restraint as an emergency safety intervention of last resort MUST be incorporated into a crisis plan or safety plan.

2. Processes for documentation and debriefing after the use of an emergency safety intervention

Conducting an emergency safety intervention of last resort is an emotional, scary and potentially traumatic time for the individual and for staff. Debriefing of the individual AND of staff involved should occur as soon as possible within the first 24 hours. Staff that was not involved in the conducting the emergency safety intervention should ideally conduct the debriefing.

The following are potential issues to explore with the person:

- What the person remembers happening prior to their becoming angry, destructive or self injurious
- Whether the person remembers sensory changes prior to the emergency safety intervention being used
- What thoughts the person has about why the emergency safety intervention was used
- How the person felt while the emergency safety intervention was in use
- How the person felt after being released from the emergency safety intervention

- Was there something the person did that was helpful in gaining personal control?
- Was there something the staff did that was helpful in the person gaining personal control?
- What changes could be made to assist the person in future instances when the person might lose control?

The person's responses shall be documented with pertinent intervention information incorporated within the person plan of care.

The staff members involved in the emergency safety intervention episode shall be interviewed immediately after the episode to determine the following information. The identified leader of the episode shall conduct the critique of the seclusion or restraint episode.

- What physical cues were present that indicated escalation of the person's behaviors?
- What interventions were conducted, by what staff member and in what order as the events unfolded leading up to use of the emergency safety intervention?
- What was the person response to each intervention conducted?
- Could alternate interventions result in a different outcome other than having to use an emergency safety intervention?
- What did the staff involved do well?
- What could staff do differently in the future that might avoid reaching the point of using a safety intervention?
- What recommendations shall be documented within the person's plan of care for use in future situations?

APPENDIX F: EMERGENCY SAFETY INTERVENTIONS OF LAST RESORT THAT MAY BE USED WITHIN THE COMMUNITY ONLY WITHIN RESIDENTIAL CRISIS STABILIZATION PROGRAMS

Appendix F.1: Specific Techniques

1. Seclusion	CSP Only
2. Physical (mechanical) restraint	CSP Only

1. Seclusion of an Individual

Seclusion means the involuntary confinement of a person in a room or an area from which the person is physically prevented from leaving. Seclusion is an emergency safety intervention of last resort that may be used under strict medical protocol in residential or hospital-based emergency receiving and evaluating facilities.

When the egress of an individual is restricted, it is considered seclusion. **Seclusion is NOT permitted for use as part of a crisis plan or a safety plan.**

2. Physical (Mechanical) Restraint

Physical (mechanical) restraint means a device attached or adjacent to the person's body that he or she cannot easily remove that restricts freedom of movement or normal access to his or her body. Physical restraint may also be referred to as mechanical restraint.

Physical restraint is an emergency safety intervention of last resort that may be used under strict medical protocol in residential or hospital-based emergency receiving and evaluating facilities. Physical (mechanical) restraint is NOT permitted for use as part of a crisis plan or a safety plan.

Appendix F.2

Chemical Restraint May NEVER Be Used

Chemical restraint	**NOT PERMITTED**

1. Chemical Restraints

Chemical restraints are over the counter or prescribed medications or drugs that are administered to manage a person's behavior in a way that reduces the safety risk to the individual or to others that have the effect of reducing the person's freedom of movement, and that is not a standard treatment for the person's medical or psychiatric condition. Chemical restraints are **NEVER** permitted under any circumstance.

For a full discussion about medications, refer to Section XII of the manual.