



DEVELOPMENTAL DISABILITIES ADMINISTRATION
Olympia, Washington

TITLE: POSITIVE BEHAVIOR SUPPORT POLICY 5.19
FOR CHILDREN AND YOUTH

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TITLE:

POSITIVE BEHAVIOR SUPPORT
FOR CHILDREN AND YOUTH

POLICY 5.19

ATTACHMENT A

*Recommended Guidelines for Developing Functional Assessments & Positive Behavior
Support Plans.....19*



DEVELOPMENTAL DISABILITIES ADMINISTRATION
Olympia, Washington

TITLE: POSITIVE BEHAVIOR SUPPORT POLICY 5.19
FOR CHILDREN AND YOUTH

Authority: [Chapter 71A RCW - Developmental Disabilities](#)
[Chapter 388-101 WAC - Certified Community Residential Services and Supports](#)
[Chapter 388-148 WAC - Licensing Requirements](#)
[Chapter 388-825 WAC - DDA Services Rules](#)
[Chapter 388-826 WAC - Voluntary Placement Services](#)
[Chapter 388-845 WAC - Home and Community Based Services Waivers](#)

Reference: DDA Policy 5.20, *Restrictive Procedures and Physical Interventions for Children and Youth*

BACKGROUND

Since 1996, the Developmental Disabilities Administration (DDA) has formally endorsed positive behavior support as the systematic approach for intervention and prevention of challenging behaviors. The literature indicates that positive behavior support with parental and/or caregiver involvement and technical support is an effective intervention for children and youth with developmental disabilities, including autism and other disorders, and can significantly prevent and reduce severe challenging behaviors.

Using positive behavior support principles and techniques with children and youth can:

- Reduce and prevent challenging behaviors;
- Encourage family/caregiver involvement;
- Improve communication abilities;
- Enhance educational experiences;
- Expand opportunities for social interaction; and
- Avoid the need for restrictive procedures.

PURPOSE

This policy describes the Administration's expectations regarding the use of positive behavior support (PBS) for children and youth with challenging behaviors. Procedural requirements are

included regarding functional assessments, positive behavior support plans, restrictive procedures, physical interventions, and psychoactive medications.

Refer to DDA Policy 5.20, *Restrictive Procedures and Physical Interventions with Children and Youth*, for information and requirements concerning the use of restrictive procedures and physical interventions.

SCOPE

This policy applies to all children and youth who receive DDA funded services in:

- A. Licensed Children’s Residential Services, including:
 - 1. Child Foster Homes;
 - 2. Group Care Facilities, including Staffed Residential Homes;
 - 3. Contracted Behavior Support, Counseling and Consultation Services Providers used in the settings described above; and
 - 4. Agency consultants providing behavior support and consultation services.
- B. The Family Home, including:
 - 1. Children’s Intensive In-Home Behavioral Support Program (CIIBS) Behavior Specialists and Behavior Technicians;
 - 2. Contracted Behavior Support, Counseling and Consultation Services Providers (including psychologists and counselors); and
 - 3. Contracted agency providers of behavior support and consultation.
- C. Early Intervention Services provided through contract with the counties.

DEFINITIONS

CRM/SW/SSS/SSS means the Case Resource Manager, Social Worker, or Social Service Specialist.

Challenging behavior means actions by the child/youth that constitute a threat to the child/youth’s health and safety, the health and safety of others in the environment, a persistent pattern of behaviors that inhibit the child/youth’s functioning in public places and integration with the community, or uncontrolled symptoms of a physical or mental condition. These behaviors may have been present for long periods of time or have manifested as an acute onset.

Child/Youth means age birth up to 21 years. For Children’s Residential Services, “youth” refers to individuals age 18 up to 21 years.

Developmentally-based approaches means structured interventions that focus on each child/youth’s individual differences and build healthy foundations of emotional, social, and intellectual development by helping all providers, caregivers and therapists to tailor the approach to the child/youth’s unique developmental profile.

Emergency means an extreme hazard or an unanticipated, unpredicted action by a child/youth that presents an immediate risk to the health and safety to self, others, or property (e.g., when a child/youth is standing or sitting in the street or at immediate risk of danger from a fire).

Exclusionary Time Out means the removal of a child/youth from a situation where positive reinforcement is available to an area where it is not, contingent on the occurrence of a specific behavior. This means a room used solely for the purpose of time out and where exiting the area is prevented. *This procedure is prohibited.*

Psychoactive means possessing the ability to alter mood, anxiety level, behavior, cognitive processes, or mental tension, usually applied to pharmacological agents.

Psychoactive medication means medication prescribed to treat a mental illness, to improve functioning, or to reduce challenging behaviors. Psychoactive medications include antipsychotics/neuroleptics, atypical antipsychotics, antidepressants, anticonvulsants, stimulants, sedatives/hypnotics, and anti-mania and anti-anxiety drugs. Anticonvulsants and other classes of drugs are included in this category when they are prescribed for behavioral purposes.

Restrictive procedure means a procedure that restricts a child/youth’s freedom of movement, restricts access to the child/youth’s property, requires a child/youth to do something which he/she does not want to do, or removes something the child/youth owns or has earned.

POLICY

- A. Positive Behavior Support (PBS) must be emphasized in all services funded by DDA for individuals of all ages with intellectual and developmental disabilities. This policy focuses on changing the physical and interpersonal environment of children and youth to increase their skill sets so that they are able to meet their needs without having to resort to challenging behavior.
- B. Along with positive behavior support, developmentally-based approaches should be used to support children and youth with challenging behaviors. This means interventions, methods, and techniques that focus on each child/youth’s unique developmental profile, but are respectful of the child/youth’s chronological age.

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- C. Non-restrictive teaching, training, and support methods must be used whenever possible. Section III of this policy contains a description of approved procedures and interventions that may be used with children and youth, which are not considered restrictive.
- D. If any restrictive procedures are considered for protection, providers must follow the requirements described in DDA Policy 5.20, *Restrictive Procedures and Physical Interventions with Children and Youth*. Use of restrictive procedures and interventions during an emergency must be documented in an incident report (IR) per DDA Policy 6.12, *Mandatory Reporting Requirements for Residential Services Providers*, or DDA Policy 12.01, *Incident Reporting*, as appropriate.
- E. Contracted providers working with CIIBS clients in the family home are not authorized to use or recommend restraints or restrictive physical interventions as described in this policy and DDA Policy 5.20, *Restrictive Procedures and Physical Interventions with Children and Youth*.
- F. Children and youth with developmental disabilities and mental illness and/or persistent challenging behavior, and their parents/legal representatives, should have appropriate access to information and treatment with psychoactive medications, and reasonable protection from serious side effects or the inappropriate use of these medications. See Section II of this policy, *Psychoactive Medications*, for more information on the use of psychoactive medications with children and youth.

I. POSITIVE BEHAVIOR SUPPORT

- A. Positive behavior support helps develop effective ways of meeting a child/youth's needs while reducing and preventing challenging behaviors. Supports must be individualized for each child/youth. Some common types of support include:
1. Assisting a child/youth to live in a home in which the child is safe and has access to their community, activities, friends, and relatives; and
 2. Providing a child/youth with opportunities and assistance to:
 - a. Learn how to make choices and exercise personal power as developmentally appropriate;
 - b. Choose daily activities, pursue personal goals, and access good health care;
 - c. Form and maintain friendships and relationships; and

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- d. Participate in a broad range of activities in the home and in the community that the child/youth enjoys which promote positive recognition by self and others.

B. Components of Positive Behavior Support

1. Supportive Environments and Learning Opportunities

A supportive environment helps a child/youth to meet his/her needs through positive expression, instead of resorting to challenging behaviors to get the environment to respond. In a supportive environment, caregivers proactively plan to meet a child/youth's needs. Many things contribute to a good environment, including:

- a. Promoting warm and caring relationships between immediate and extended family members, school personnel, and paid support staff to the greatest extent possible;
- b. Increasing a child/youth's opportunity to make daily choices and decisions;
- c. Reducing factors and forms of treatment that may make a child/youth feel threatened, anxious, afraid, angry, or devalued;
- d. Arranging any adaptive needs necessary for a child/youth to participate more fully in their immediate environment. Licensed homes must also comply with [WAC 388-148-0260 through 0270](#).
- e. Providing consistent positive responses to the child/youth's appropriate behavior;
- f. Providing a consistent, predictable environment;
- g. Calmly interrupting and redirecting challenging behavior; and
- h. Assisting the child to understand, to the best of the child's ability, how and why behavior change is helpful, in a developmentally appropriate manner.

2. Skill Development and Status

Skill development and improvement help increase a child/youth's status and confidence. Skill acquisition is dependent upon age, capabilities, interests, and personal motivation. Important types of support include, but are not limited to:

- a. Teaching a child or youth new skills to more effectively and appropriately obtain wants or needs;
- b. Improving a child/youth's functional communication skills;
- c. Increasing the child/youth's participation in typical community activities;
- d. Fostering skills and behaviors that promote mental and physical wellness;
- e. Helping a child/youth to find ways to make meaningful contributions to others; and
- f. Encouraging a child/youth to take more responsibility as appropriate. This may mean experiencing negative (natural as well as logical) consequences for challenging behavior as well as positive consequences that help the child/youth learn socially appropriate behavior. **Note:** Any such "negative" consequences must be in compliance with DDA policy.

3. Healthcare

Healthcare support must be offered to the child/youth to ensure prompt assessment and treatment of any ongoing or suspected problem(s). Untreated or under-treated health issues are often related to challenging behavior. Healthcare support should be offered until the problem is resolved. Establishing an ongoing relationship with a primary healthcare provider and dentist is part of healthcare support. Whenever possible, the child/youth should have access to a pediatrician experienced with children and youth with developmental disabilities.

4. Treatment of Mental Illness

Children and youth who are experiencing mental health problems should be evaluated by a mental health professional, preferably one with pediatric expertise in developmental disabilities. The professional's recommendations should be considered in developing a PBSP for the child/youth. If this includes prescription of psychoactive medication, its use should be integrated into the larger plan to build a supportive environment for the child/youth (see Section II of this policy).

C. Functional Behavioral Assessment (FA)

1. PBS uses functional behavioral assessment to help build respectful and effective support plans for children and youth with challenging behaviors. Some professionals may use the terms "functional analysis" and "functional assessment." For the purposes of this policy, these terms are the same as "functional behavioral assessment."

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2. A functional behavioral assessment is a process that evaluates:
 - a. The overall quality of the child/youth's life;
 - b. Factors or events that increase the likelihood of challenging behavior occurring, including review of health factors that may contribute to challenging behaviors (e.g., urinary tract infections, constipation, gastro esophageal reflux disease (GERD), seizure disorders, headaches, and behavioral characteristics or traits associated with genetic syndromes).
 - c. Factors or events that increase the likelihood of appropriate behavior;
 - d. When and where challenging behaviors occur most frequently;
 - e. The presence of a diagnosed mental illness or neurological conditions that may contribute to challenging behaviors; and
 - f. The functions or purpose of the challenging behaviors (what the child/youth obtains or avoids by engaging in the behavior).
 3. Efforts should be made to get input for the FA and involvement in the proposed interventions from all relevant stakeholders, including schools, mental health providers, extended family and community connections when appropriate, and other social services connected with the family. This “wraparound” planning is the standard of care in serving children with multiple systems involvement.
 4. For more detailed information on conducting Functional Assessments and developing Positive Behavior Support Plans, refer to Attachment A, *Recommended Guidelines for Developing Functional Assessments and Positive Behavior Support Plans*.

D. Positive Behavior Support Plans (PBSP)

1. The completed functional behavioral assessment (FA) provides the basis for developing a PBSP that will help to eliminate or reduce the frequency and severity of the child/youth's challenging behavior.
2. Teaching, training, and support strategies included in the PBSP must be appropriate to the child/youth's developmental level and readiness. PBSPs require the following common elements:
 - a. Recommendations for improving the general quality of a child/youth's life;

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- b. Providing developmentally and therapeutically appropriate activities to complete a child/youth's day;
 - c. Strategies to avoid, minimize, or modify events that are likely to provoke the use of or increase the rate of the challenging behavior;
 - d. Methods to teach alternative appropriate behaviors that will achieve the same results for the child/youth as the challenging behavior;
 - e. Methods to reduce the effectiveness of the challenging behavior in obtaining the desired outcomes; and
 - f. Professional recommendations for treating mental illness and/or neurological conditions, as appropriate.

E. Positive Behavior Support in the Family Context

- 1. PBS in the family home must involve the family members in the design as well as the implementation of strategies. Better outcomes are achieved when families and professionals partner during the FA and when families direct the selection of strategies that will work for them.
- 2. Behavior support providers should take the following contextual characteristics into account when developing strategies for children and youth in their family home:
 - a. Family constellation;
 - b. Daily routines and frequent activities;
 - c. Availability of natural supports;
 - d. Cultural background;
 - e. Values held by the family; and
 - f. Health of family members.

PROCEDURES

- A. PBSPs are required for children and youth receiving residential services or contracted behavior support services when:

1. Challenging behaviors interfere with a child/youth's ability to have positive life experiences, form and maintain relationships, learn new skills, or limits their ability to attend school and other community activities; and/or
2. A child/youth is taking psychoactive medications to reduce challenging behavior or treat symptoms of a mental illness. For children and youth receiving DDA funded services in a home or facility that is licensed, providers must adhere to [WAC 388-148-0352](#) in addition to this policy; and/or
3. The use of certain restrictive procedures is planned or used in a licensed residential setting. See DDA Policy 5.20, *Restrictive Procedures and Physical Interventions with Children and Youth*.

Note: Splints applied for purposes of physical therapy or other mechanical devices used to maintain proper body posture, wheelchair safety (e.g., seat belts or chest straps), and medically necessary devices used to protect a child/youth from accidental injury (e.g., helmets for children and youth with seizures, gait belts, vehicle safety harness, etc.) or the use of car door locks for safety purposes are not considered restrictive procedures and do not require a PBSP unless there is a behavioral component.

B. Timelines

1. For children and youth receiving **residential services**, a written FA and PBSP must be conducted and submitted to the DDA Social Worker or Social Service Specialist (SW/SSS) for approval within sixty (60) days of the identification of the challenging behavior(s).
2. For children and youth receiving behavior support services in the family home, a written FA and PBSP must be conducted and submitted to the DDA Case Resource Manager (CRM) for approval according to the provider's contract requirements (see section D below).
 - a. For CIIBS providers, the FA and PBSP must be submitted to the CIIBS CRM within ninety (90) days of referral; and
 - b. For providers holding a behavior support contract (1733XP) or other specialized contract including behavior support services, the FA and PBSP must be submitted to the CRM/SW/SSS within sixty (60) days of referral.
3. PBSPs should be implemented immediately upon approval (see section D below). If there is a delay, the provider must notify the CRM/SW/SSS.

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4. The provider must submit written progress reports at least quarterly. Residential service providers must follow [WAC 388-148-0560](#). CIIBS providers must use [DSHS 15-384, Provider Progress Report](#). This form is optional for non-CIIBS service providers.

C. FA and PBSP Requirements

1. The written FA must include all of the following as distinct sections in the assessment (see also Attachment A, *Recommended Guidelines for Developing Functional Assessments and Positive Behavior Support Plans*):
 - a. A description of the child/youth and pertinent history;
 - b. A detailed description of the child/youth's challenging behavior(s);
 - c. The data analysis and assessment procedures used to conduct the functional assessment; and
 - d. The summary statement(s) describing the predictors and function(s) of the behavior(s).
2. The written PBSP must include all of the following as distinct sections in the plan (see also Attachment A):
 - a. A clear description of the targeted challenging behavior(s);
 - b. Prevention strategies; and
 - c. Teaching/training supports; and
 - d. Strategies for responding to challenging behaviors; and
 - e. Data collection plan and monitoring schedule to determine the effectiveness of the PBSP.

Note: Any requests or recommendations for purchases by the family must be described in a separate memorandum and discussed with the client's CRM. Contracted providers of behavior support services must not include these recommendations in the FA or PBSP. This includes recommendations regarding hours of service. The CRM will follow the regional process in determining what action will be taken including total number of hours authorized.

3. For Licensed Residential Settings and CIIBS services:

- a. Use [DSHS 15-383, DDA Functional Behavioral Assessment](#), to conduct and record the FA. All sections must be completed. This form is required for any consultants employed by licensed staffed residential agencies to provide this support. However, the form is optional for other providers such as individual contracted behavior support and consultation providers.
 - b. Use [DSHS 15-382, DDA Positive Behavior Support Plan](#), to record the PBSP. All sections must be completed. This form is required for any consultants employed by licensed staffed residential agencies to provide this support. However, the form is optional for other providers such as individual contracted behavior support and consultation providers. Refer to the note under '2' above.
 - c. The provider (or author of the plan) must send copies of the completed FA and PBSP to the client's CRM/SW/SSS for approval and signature.
4. Contracted behavior support providers must send copies of the completed FA and PBSP to the child/youth's CRM.

D. Approval Process

Prior to implementation, the proposed PBSP must be approved as follows:

1. The CRM/SW/SSS must review and sign PBSPs within ten (10) days of receipt from the provider when no concerns or questions exist. If the CRM/SW/SSS has concerns or questions about the plan, the CRM/SW/SSS can discuss these with the provider who wrote the plan and/or seek additional consultation from the Case Management Supervisor or the DDA Field Services Psychologist; and
2. Parents/guardians must be in agreement with the PBSP. If parents/guardians have questions or concerns about the plan, they can discuss it with the provider or CRM/SW/SSS. Document the parent/guardian's agreement in the service episode record (SER). For youth ages 18-21 years, also notify the Necessary Supplemental Accommodation (NSA) for the youth and document the notification in the SER.

E. Data Collection and Monitoring of PBSPs

1. The program or contracted provider responsible for developing the PBSP must review the plan and data collected at least every thirty (30) days.

Note: In certain limited circumstances, this requirement may be waived at the discretion of DDA (for example, where a PBSP is developed for implementation

by the family in the family home and there is no ongoing consultation/review with the PBSP author/provider). The CRM/SW/SSS should consult with the Case Management Supervisor to determine if such a waiver is appropriate.

2. If the data indicates progress in decreasing the challenging behavior(s) is not occurring after three (3) months, but no later than six (6) months, the FA and the PBSP must be reviewed and revised as needed.

F. Annual Review of Functional Assessment and Positive Behavior Support Plan

Due to the multiple changes that occur as a child grows, the FA and PBSP must be reviewed and updated annually at a minimum. The FA and PBSP must also be revised whenever a significant change occurs. Updates of the FA must include a description of the data and progress achieved since the previous FA/PBSP was implemented.

II. PSYCHOACTIVE MEDICATIONS

- A. Psychoactive medications should not be the first or only treatment of choice for children and youth with challenging behaviors. Positive behavior support approaches may be equally or more effective and treatment team decisions should always be made on an individual basis. The literature suggests that best practice approaches include the use of positive behavioral support interventions when psychoactive medications are prescribed.
- B. Psychoactive medications may be prescribed to enable a child/youth to function better, to reduce challenging behavior, or to treat a mental illness. These medications have proven to be an effective treatment for several mental health and behavioral disorders in children and youth, including conditions such as Attention Deficit Hyperactivity Disorder (ADHD) and severe agitation or anxiety.
- C. As with other prescription medications, psychoactive medications have the potential for unwanted side effects. Regular monitoring for side effects and evaluation of medication effectiveness is especially important for children and youth with developmental disabilities who may have a reduced capacity to communicate symptoms or potential side effects.
- D. Psychoactive medications must only be administered as prescribed.
- E. A Functional Assessment (FA) and a Positive Behavior Support Plan (PBSP) must be developed and implemented for children and youth who take psychoactive medications to reduce challenging behavior or treat a mental illness that is interfering with their ability to develop, learn skills, form relationships, and have positive life experiences or limits their ability to attend school and other community activities.

PROCEDURESA. Assessment

1. If the child/youth appears to be displaying symptoms of mental illness and/or persistent challenging behavior, any physical, medical, or dental conditions that may be causing or contributing to the behavior must first be considered. A medical and/or dental examination may need to be conducted to accomplish this. If no physical or other medical condition is identified, then a psychiatric assessment should be conducted. It is recommended that a psychiatrist, a psychiatric ARNP, or a physician or physician's assistant with psychiatric experience in treating children and youth with developmental disabilities conduct this assessment.
2. Prior to the assessment, the parent or provider may find it useful to prepare a psychiatric referral summary ([DSHS 13-851, Psychiatric Referral Summary](#)) and send or take this to the treatment professional conducting the assessment. This form may help parents and other caregivers organize their child/youth's issues and behaviors so that the psychiatrist or other treating professional is fully informed at the time of the appointment. The summary should describe the frequency and severity of the child/youth's symptoms or behaviors and what has been tried previously.
3. Licensed residential settings must adhere to the requirements of [WAC 388-148-0352 \(11\)](#) relative to psychotropic medications in addition to this policy.
4. Contracted residential providers must have an information sheet for each psychoactive medication being used by children and youth served by the provider. This includes medications prescribed as PRN (*pro re nata*: as needed). These sheets must be available to all direct support staff and should describe potential side effects and potential adverse drug interactions that may occur from use of the medication. Use the information sheet provided by the dispensing pharmacy whenever possible.

B. Monitoring Psychoactive Medications in Licensed Residential Settings

1. Children and youth who take prescription medication of any type, especially psychoactive medications, require careful monitoring. The provider must monitor the child/youth to help determine if the medication is effective. If the medication does not appear to have the desired effects, the provider must communicate this to the child/youth's parent or guardian and the prescribing professional.

2. The agency must observe the child/youth for any changes in behavior or health that indicate possible side effects of the medication and inform the prescribing professional of any concerns.
3. Continued need for the medication and possible tapering/reduction should be assessed and documented at least annually by the prescribing professional.

III. **TEACHING, TRAINING, AND SUPPORT METHODS**

The non-restrictive procedures and physical interventions listed below are commonly-used teaching and training techniques. Using these procedures and interventions does not require a PBSP, although written plans and instructions may be helpful for parents and other caregivers.

1. Teaching, Training, and Support Methods
 - a. **Prompting** (verbal and physical cues or gestures and physical assistance).
 - b. **Simple correction** (explaining or showing how to do something correctly, coaching and/or guiding the child/youth with or without physical assistance). Correction should always be demonstrated in a respectful manner.
 - c. **Not attending to specific behaviors that are inappropriate** (e.g., ignoring certain behaviors).
 - d. **Offering or suggesting alternatives**, and discussing consequences of different behaviors.
 - e. **Setting up incentive programs** using tokens or points with special motivators (e.g., toys, activities, extra money, CDs, videos, etc.). These incentives must not be purchased with the child/youth's money.
 - f. **Teaching and encouraging a child/youth to choose and purchase healthy, nutritional food.**
 - g. **Cancelling an activity because the child/youth is agitated at the time of the event.** Contracted residential providers must document all cancelled activities and the reason for the cancellation.

Note: If repeated cancellation of scheduled activities begins to limit the client's access to his/her community, efforts should be made to develop a PBSP or modify the current plan to account for the conditions leading to the scheduled event cancellations. See Procedures A1.

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- h. **Controlling access to prescription medicines, over the counter medications, and hazardous chemicals that can be harmful** (e.g., laxatives, cleaning products, insecticides). Licensed residential settings must adhere to [WAC 388-148-0195 \(storing dangerous chemicals or other substances\)](#), [WAC 388-148-0205 \(storage of medications\)](#), and [WAC 388-148-0352 \(medication management\)](#) in addition to this policy.
 - i. **Physically blocking a child/youth for protection without holding them.**
 - j. **Requiring a child/youth to leave an area for protection without physical force.** Also, when age appropriate, prompting a child/youth to take a time out in order to allow the child/youth to calm down (e.g., stepping outside a restaurant with a child/youth when the behavior is escalating to allow time for him/her to calm down before returning to the table). **Note:** This is not the same as a formal “time out room” or “exclusionary time out” (see Definitions section).
 - k. **Use of medical code alert devices for child/youth health and safety** (e.g., food allergies, seizures, falls, etc.). Medical alert devices such as necklaces and bracelets may be worn on the child.
 - l. **Use of audio monitors** for child/youth health and safety in licensed settings:
 - a. Audio monitors are permitted when medically necessary (e.g., for a child/youth who has frequent falls resulting in injury or uncontrolled seizures) under the following conditions:
 - 1) Audio monitors must not be used for staff convenience or to invade a child/youth’s privacy;
 - 2) The child/youth must be aware of the monitor and the parent/guardian must give consent for its use. Such consent must be documented in the client record; and
 - 3) There is a written plan that includes the reason for use of the monitor and specific details as to when the monitor will be turned on and off. This plan must be documented in the client record.
 - b. Contracted residential providers must inform the child/youth’s SW whenever use of an audio monitor is contemplated and provide the

SW with a copy of the written plan for inclusion in the client record prior to implementation of the plan.

- c. The SW will notify the regional Field Services Administrator of the use of an audio monitor with the child/youth and document the notification in the client record.

2. Use of Mechanical/Physical Restraints during Medical and Dental Treatment

The use of mechanical or physical restraints during medical and dental treatment is acceptable if under the direction of a physician or dentist and consistent with standard medical and dental practices. Efforts should be made to familiarize the child/youth with the medical or dental procedure so that the least restrictive procedure is used.

3. No Contact and Protective Physical Interventions

The protective interventions listed below are permitted without a PBSP. These are not considered restrictive procedures.

1. **Avoiding:** eluding/escaping physical contact through the use of slides, stance, and arm/hand maneuvers without holding on to the child/youth's body;
2. **Deflecting:** using physical contact such as step and guide maneuvers;
3. **Blocking:** obstructing or hindering using physical contact;
4. **Releasing:** escaping a physical hold. This may involve briefly holding on to the child/youth to release oneself and/or another person;
5. **Physical escort that is not resisted by the child/youth:** briefly holding a child/youth, without unnecessary force, in order to calm the child, or holding a child/youth's hand to safely escort him/her from one area to another; and
6. **Supporting ambulation:** physically holding a child/youth to steady or support the child while walking to keep the child/youth from falling or slipping. This may involve the use of gait belts, specially designed belts, vests or clothing.

Note: The person doing the supporting follows the lead of the child/youth being supported. The child/youth must be released when physical support is no longer needed to be safe.

IV. PROTECTIVE PROCEDURES THAT REQUIRE A POSITIVE BEHAVIOR SUPPORT PLAN

- A. The protective procedures listed below are permitted only with an approved PBSP as described in this policy:
1. **Using door and/or window alarms to monitor children and youth who present a risk to themselves or others** (e.g., lack traffic skills, elope, physically or sexually assaultive). Consult with the CRM/SW/SSS if you are unsure about other security devices and their programmatic requirements.
 - a. The provider must inform the child/youth's CRM/SW/SSS whenever use of a door or window alarm for client safety and security is contemplated; and
 - b. The CRM/SW/SSS must document the use and reason for the alarms in the Individual Support Plan (ISP).
 2. **Taking away or securing items that could be used as weapons** when the child/youth has a history of making threats or inflicting harm with those or similar items (e.g., knives, matches, lighters, etc.).
 3. **Removing the child/youth's property when it is being used to inflict injury on the child/youth, others, or cause property damage.** This includes restricting access to the child/youth's personal belongings due to a history of destructive behavior (e.g., storing clothing outside of the child/youth's room). The PBSP must include a timeline and directions for when the property, including clothing, will be returned to the child/youth.
- B. The use of the protective procedures described in 2 and 3 above is allowed without a PBSP in an emergency situation to protect the health and safety of the child/youth or others. An incident report must be completed for each use. If the same procedure is used on an emergency basis more than three (3) times in a six (6) month period, a FA must be conducted and a PBSP developed and implemented.

EXCEPTIONS

No exceptions to this policy may be granted without the prior written approval of the Deputy Assistant Secretary.

TITLE:

POSITIVE BEHAVIOR SUPPORT
FOR CHILDREN AND YOUTH

POLICY 5.19

SUPERSESION

DDD Policy 5.19

Issued January 3, 2012

Approved: /s/ Janet Adams for Donald Clintsman
Deputy Assistant Secretary
Developmental Disabilities Administration

Date: November 15, 2014

Attachment A - Recommended Guidelines for Developing Functional Assessments & Positive Behavior Support Plans

RECOMMENDED GUIDELINES FOR DEVELOPING FUNCTIONAL ASSESSMENTS & POSITIVE BEHAVIOR SUPPORT PLANS

These guidelines are intended to assist people who conduct functional assessments (FA) and develop positive behavior support plans (PBSP) for individuals with challenging behaviors. The guidelines describe the type of information that should be included in a written FA and PBSP.

Some professionals use the terms “functional analysis” and “functional behavioral assessment.” For the purpose of these guidelines, these mean the same as “functional assessment.”

FUNCTIONAL ASSESSMENT (FA)

The format for the written FA is flexible regarding where the information listed below is entered, especially if a different organization leads to a more concise and understandable rationale. However, all FAs must contain these four major sections:

- *Description and Pertinent History;*
- *Definition of Challenging Behavior(s);*
- *Data Analysis/Assessment Procedures; and*
- *Summary Statements.*

Description and Pertinent History

- ✓ Briefly describe the person to help the reader understand the “whole person” and not just the person’s challenging behavior.
- ✓ List abilities (strengths) and disability conditions.
 - Briefly describe the person’s cognitive, adaptive and emotional functioning when the person is doing well.
- ✓ List interests, activities, and hobbies. Refer the reader to a person-centered plan for more detail, if one exists.
 - Pertinent life experiences that may impact current behaviors.
 - Estimate how well the person’s current life meets his/her wishes and needs.
- ✓ List current medical and psychiatric conditions. List current diagnoses (Axis I –V) and medications. When the collected information has conflicting diagnoses, make sure that you are using those of the current treating professional. The diagnoses contained in the FA should be consistent with the client’s other plans (e.g., Cross System Crisis Plan, Individual Support Plan).
- ✓ If requesting to use restrictive procedures, describe why less restrictive methods are not sufficient.

Definition of Challenging Behavior(s)

- ✓ Describe each behavior of concern separately unless you are defining a consistent grouping, such as tantrums or delusions.

ATTACHMENT A

- ✓ List frequency and severity of the behavior based on the best available data (severity = risks to person and others).

Data Analysis/Assessment Procedures

- ✓ List how the data was collected for the assessment (e.g., structured and informal interviews, observations, record reviews, scatter plots, etc.).
- ✓ Describe the data and how it fits with the **A-B-C** model:

Antecedents (Setting Events & Predictors) → Behavior → Consequence (Function)

- List the setting events and predictors identified through the analysis of collected information and the behavior(s) and consequences (functions) to which those setting events and predictors relate.
 - List specific medical, psychiatric and quality of life problems that appear to be setting events or predictors.
- ✓ If the same behavior serves more than one function, identify which factors predict which function is being served.
 - ✓ Assess and list the setting events or predictors for the positive, prosocial behavior that the person exhibits as one basis for designing preventive interventions (by increasing those positive events).

Summary Statements

- ✓ Summarize the FA with the best hypothesis or guess of why the person engages in the behavior. Describe the typical relationship between the setting events/predictors and the behavior. One way to construct a summary statement is:

When Predictor X occurs, Behavior Y is likely to occur so the person can obtain/avoid Consequence Z (the function). This behavior will be more likely to occur when setting events A, B, or C is present.

- ✓ When there are multiple behaviors that do not appear to serve the same function for the person, include a summary statement for each behavior.
- ✓ When there are multiple functions identified for a single behavior, you may want to write separate summary statements for the different setting events and/or predictors. One example is:

When asked to do chores like take his dirty clothes to the laundry room or take his dishes to the kitchen after meals, hitting himself serves the purpose of escaping those requests as staff don't want to see more self-injury. At other times, when his favorite staff is busy helping others, he may hit himself to try to regain their attention.

POSITIVE BEHAVIOR SUPPORT PLAN (PBSP)

It is recommended that the FA and PBSP be two distinct documents. If you are writing the FA and PBSP as separate documents, start the PBSP with a recap of the Behavioral Definitions and the Summary statements from the FA so that the reader will understand the rationale for the procedures in the PBSP. If you are including both the FA and PBSP in one document, start below. Keep instructions clear, concise, and let the reader know exactly what actions he/she should take.

Prevention Strategies

The goal in writing prevention strategies is to address major deficiencies in quality of life factors (i.e., deficiencies in power and choice, community integration, status, relationships, competence, health, and safety) and each setting event/predictor identified by the FA. Prevention strategies try to avoid the setting events/predictors that occur prior to the challenging behavior, or to minimize their occurrence and impact when they can't be avoided. Strategies might also be developed to modify the antecedents so they do not predict the challenging behavior. These strategies should be specific, measurable actions that staff or caregivers can do (i.e., not just general ideas).

- ✓ **Environmental** - Changes in the person's environment to avoid, modify, or minimize antecedents/predictors identified in the FA.
- ✓ **Psychosocial /Interpersonal** - More general changes that improve the quality of the person's life and promote obtaining more natural reinforcers via relationships, integration, power and choice, competence, and status or dignity.
 - List needed changes in the person's life, even if they cannot be achieved right away. Tie these identified needs into the broader Person Centered Plan or the Individual Instruction and Support Plan (IISP).
- ✓ **Intrapersonal** - Medical, psychological, and/or psychiatric interventions that address setting events/predictors identified in the FA.

Teaching/Training Supports

- ✓ Define and list teaching and reinforcement procedures (if not covered under *Prevention Strategies*) to improve general skills that will allow the person to access important reinforcers or lifestyle outcomes and reduce the person's need to use challenging behaviors.
- ✓ Define and list procedures to teach and reinforce specific behaviors that can serve as a replacement behavior (i.e., an appropriate behavior that achieves the same function for the person as the challenging behavior) or
- ✓ If the person has these skills already, list procedures to reinforce the appropriate replacement behavior(s) so that they will be used while minimizing or stopping reinforcement for the challenging behavior(s).

Strategies for Responding to Challenging Behaviors

- ✓ List specific actions that staff or caregivers should take when reacting to challenging behaviors (there may be different responses, depending on the behavior):
 - To ensure protection.
 - To redirect, distract, etc.
 - To help the person problem solve.
 - To minimize reinforcement of the challenging behavior.
- ✓ If implementing a restrictive procedure, clearly describe the specific procedure(s) and provide directions for implementing the procedure(s).

Consistency with the Cross Systems Crisis Plan (CSCP)

- ✓ If there is a Cross Systems Crisis Plan (CSCP) in place, make sure these steps are consistent with the CSCP.
- ✓ If there is not a CSCP or other crisis plan document, list in the PBSP the specific actions that staff or caregivers are to take prior to/during a crisis to ensure protection and request assistance from internal and external resources (e.g., staff supervisor, police, DDA).

Data Collection and Monitoring

- ✓ Operationally define the goals of the PBSP in terms of specific, observable behaviors.
- ✓ Indicate what data is needed to evaluate success (e.g., frequency, intensity and duration of target behaviors).
- ✓ Provide instructions to staff or caregivers on how to collect this data (e.g., forms, procedures), i.e., frequency, intensity and duration.
- ✓ List who will monitor outcomes, need for revisions, and evaluate success and process for monitoring.
- ✓ Recommend displaying data in a graph over time for easy analysis.

For more information regarding functional assessment and positive behavior support plan requirements, refer to the following DDA policies, as appropriate:

- **Policy 5.14, *Positive Behavior Support***
- **Policy 5.15, *Use of Restrictive Procedures***
- **Policy 5.19, *Positive Behavior Support for Children and Youth***
- **Policy 5.20, *Use of Restrictive Procedures with Children and Youth***