

Complex Behaviors

CLIENT'S NAME

CLIENT ACES ID NUMBER

REGION

MENTAL HEALTH DIAGNOSIS

☐ Yes ☐ No

Principle diagnosis:

Current presentation in
Section 1.

Information can be obtained
from conversation with
Psychiatrist, Nurse, Medical
Physician, Social Worker,
Mental Health Professional,
Counselor, or Certified Peer
Specialist.

CLINICAL IMPRESSIONS

RISK ASSESSMENT Completed by Hospital staff or Behavioral Health Provider

☐ Yes ☐ No ☐ NA

Date:

INDIVIDUAL CRISIS PLAN (See WAC: 388-107-0160 for Behavioral Support plan.)

Document within CARE the expected date Crisis Plan is to be received by provider. Some key components of a crisis plan include but are not limited to primary behavioral triggers, effective de-escalation techniques, crisis intervention contacts, and recommended supports.

☐ Yes ☐ No ☐ NA

MEDICATION AND MEDICAL CONDITIONS MONITORING

Is the individual taking medication as directed and agreeable to medical treatment(s):

☐ Yes ☐ No ☐ NA

Last medication review:

COORDINATED BEHAVIOR SUPPORT AND TEAM MEETINGS ESTABLISHED

Complete a comment within CARE in Treatment List: Type Programs: Behavior Management Plan detailing the plan. Refer to WAC: 388-107-0100 through 388-107-0160: 388-106-0336

☐ Yes ☐ No ☐ NA

STAFFING PLAN COMPLETED

The plan must be provided and kept in the provider file and Electronic Case Records (ECR) and documented with the CARE assessment.

☐ Yes ☐ No ☐ NA

Section 1. Check one or all that apply (documentation must be present in file)

See the instructions page first for some descriptions.

Does the client have any behaviors listed below (currently or historically)?

Check all relevant boxes below.

HISTORY OF OCCURRENCE
INDICATE FREQUENCY AS APPLICABLE
DAILY, WEEKLY, OR MONTHLY

Frequency Examples: 30/60/90 DAYS, 1-2 YEARS, 3-5+ YEARS

☐ **Assaultive**

Describe / clarify:

Frequency:

☐ **Destructive**

Describe / clarify:

Frequency:

☐ **History of felony and/or misdemeanor type behavior.**

Describe / clarify:

Frequency:

☐ **History of arson**

Describe / clarify:

Frequency:

☐ **Inappropriate sexualized behavior**

Describe / clarify:

Frequency:

☐ **Self-injurious**

Describe / clarify:

Frequency:

☐ **Substance Use related behavior**

Describe / clarify:

Frequency:

LEGAL STATUS

- ☐ Current charge pending; if checked, specify: _____
- ☐ Not Guilty by Reason of Insanity (NGRI)
- ☐ Current Less Restrictive Alternative (LRA) (attach copy of court order)
- ☐ Conditional release (attach conditions of release)
- ☐ Current incarceration status; projected release date: _____
- ☐ Convictions
- ☐ Active warrants: ☐ Yes ☐ No ☐ N/A
- ☐ Active No Contact Orders: ☐ Yes ☐ No ☐ N/A
- ☐ DOC supervision: ☐ Yes ☐ No ☐ N/A
- If yes, DOC Contact: _____
- ☐ Registered Offender Notifications (specify): ☐ Yes ☐ No ☐ N/A
- If yes, specify: _____

CASE MIX COMPLETED

Document findings within CARE on Comments screen. See instructions.

- ☐ Yes ☐ No ☐ NA

Emergency situations of Individual – see instructions: ☐ Yes ☐ No ☐ NA

Section 2.**INFORMATION VERIFICATION BY:**

- ☐ Police report ☐ Court records ☐ Psychiatrist, Nurse ☐ Medical Physician ☐ Social Worker
- ☐ Mental Health Professional ☐ Counselor ☐ Certified Peer Specialist ☐ Self-report
- ☐ Parent / guardian ☐ Psycho-sexual assessment ☐ Other (Specify): _____

CURRENT RESIDENCE

- ☐ AFH ☐ AL ☐ ARC ☐ CFH ☐ CH ☐ CPRS ☐ DOC ☐ EARC ☐ ESF
- ☐ ESH ☐ GH/GTH ☐ ICF/ID ☐ JR ☐ SL ☐ WSH ☐ Own home
- ☐ Parent / relative home ☐ Other (specify): _____

Current Address and Telephone:

SPECIFY OTHER CURRENT SERVICES (E.G., THERAPIES, COUNSELING, MPC, CFC, CFC+COPES, RSW, ETC.)

This form was completed based on available information.

CASE MANAGER'S SIGNATURE

DATE

I have reviewed all information for **Name**, and upon acceptance of said individual will incorporate the information received to develop **Name's** negotiated care plan or person-centered service plan pursuant to WAC: For detailed information regarding Adult Family Home Negotiated Care Plan refer to ([WAC 388-76-10355](#) through [388-76-10385](#); [Assisted Living Negotiated Service Agreement \(WAC 388-78A-2130](#) through [388-78A-2160](#)); and Person-centered service plan for Enhanced Service Facility ([WAC 388-107-0110](#) through [388-107-0130](#))

PROVIDER'S SIGNATURE

DATE

DISTRIBUTION: Client Electronic Case Record Provider

Instructions for Complex Behaviors

This form must be part of the client's referral packet provided to residential providers.

Copies will be kept in the:

- Client record; and
- Client file maintained by the residential program and Provider.

Case manager / social worker responsibilities:

- Provide the forms / copies to the residential provider; and keep the client information on the form current. Form to be reviewed at the annual CARE assessment and anytime an Interim or Significant Change is done. The form should be updated accordingly based on necessary changes. Input an SER addressing the status of the form and indicate if additional / updated signatures were obtained.

Residential provider responsibilities:

- Maintain the client files;
- Ensure the safety of all clients; and
- Inform DSHS of any change of condition regarding the individual's complex behaviors.

Instructions:

Principal Diagnosis: Clinical diagnosis, a focus for treatment. Information to be obtained from a medical doctor who treats mental illnesses, Psychiatrist, Psychologist or licensed counselor. **Current Presentation:** How are the individual's thoughts and perceptions currently? Summarize behaviors. Indicate current, status of relationships with others to include interactions that are healthy and unhealthy.

Mental Health Diagnosis: A mental condition detailed in the Diagnostic and Statistical Manual of Mental Disorders. Indicate only "Yes", "No", or "NA".

Medical Condition: Includes any illness, injury, or disease.

Individual Crisis Plan: A plan that identifies and addresses ways to prevent escalation and intensifying behaviors that are challenging in addition to outlining supports needed when an individual is in crisis. Indicate only "Yes", "No" or "NA". This document is to be completed by the Provider. The Case Manager is to document receipt of the plan and ensure the Provider understands the crisis plan and how to institute the plan.

Medication Monitoring: Describe the extent to which an individual is compliant with medications. Some examples include refusal, and necessary medical interventions. Medical intervention refers to actions a healthcare professional took to achieve compliance. Indicate only "Yes", "No", or "NA".

Coordinated Behavior Support and Team Meetings: Meetings to discuss individual support needs to deliver quality care. Indicate only "Yes", "No", or "NA". Copy of scheduled meetings to be placed in individual's Electronic Case Record.

Risk Assessment: The Risk Assessment is completed by the Hospital staff or Behavioral Health Provider and is used to assess the individual's risk and how the risk is mitigated in an institutional setting. Note, Providers must be able to duplicate the mitigation strategy safely in the community. Documentation of who completed the assessment, and pertinent information should be documented within the CARE assessment. Appropriate documentation should be in the pertinent sections of the CARE assessment for example the behavior sections. Place a copy in the individual's Electronic Case Record. Identify the date the risk assessment was received.

Case Mix: Consideration of adequate resources. A Case Mix *describes differences in residents within a population in terms of their physical and mental conditions and the resources that are used in their care.* This section takes into consideration the safety and vulnerability of people in the entire facility. The case mix considers staffing and additional wrap around support for residents. Indicate only "Yes", "No", or "NA". **Documentation Example:** Case Mix: There are five residents in the home with complex behaviors. All are redirectable, and take medications as directed. Caregivers will need to note any incidences between residences to include frequency in addition to noting the caregiver to resident ratio at the time of incident.

Staffing Plan: A plan developed to ensure the appropriate staffing resources with the necessary skills are available. This plan should indicate a type of supervision (e.g. line of sight, arm's length). Indicate only "Yes", "No", or "NA". Documented within General comments section and indicate Staffing Plan. May need to refer Provider to specific sections within the "Behavior," "Medical," "Suicide," or "Depression" comments sections. A copy of the plan to be placed in the individual's Electronic Case Record.

Emergency Situations: An incident in which immediate attention or aid was needed for the Individual due to the individual's behavior that resulted in local authorities, or a Designated Crisis Responder being called and the individual detained in the community as a result. Describe / Clarify: This section includes specific details of the situation, the triggers, everyone involved (limiting some details due to HIPAA) and the outcome associated with the situation or incident. For example: "*Client experienced significant agitation leading to police involvement; effective management included verbal de-escalation and temporary medication adjustments.*"

Active Warrants: Only identify “Yes,” “No,” or “NA”. Please work with institutional staff, the client, the Department of Corrections if applicable, and the identified Provider to address active warrants. It is in the best interest of the client to ensure there’s a plan to have the issue resolved prior to transitioning when this is not possible it should be understood and documented how the active warrant will be resolved in the community.

Some Examples for Behavior Description:

- **Assaultive:** Significant aggression (bullies, threatens, or intimidates others) or physical harm or cruelty to people or animals. Has used a weapon that caused physical harm to people (e.g., a bat, brick, broken bottle, knife, gun)
- **Destructive:** Deliberately destroyed other people’s property.
- **History of felony and/or misdemeanor type behavior:** Has broken into someone’s home, car, or building, shoplifting,
- **History of arson:** Has deliberately engaged in fire setting with the intention of causing serious damage.
- **Inappropriate sexual behavior:** Examples of inappropriate sexual behavior are those that have adverse consequences. examples: inappropriate sexual comments, non-consensual touching, or sexual aggression.
- **Self-injurious:** suicidal behavior (behaviors by the time of initiation expected that the set of actions would lead to his or her own death;) significant self-injury; inflicting damage to the surface of their body, e.g. cutting, burning, stabbing.
- **Substance Use associated behavior:** Conduct that could be viewed as problematic behavior: inappropriate sexual or aggressive behavior, mood lability, impaired judgement, hallucinations, illusions, agitation, and difficulty sleeping.

Frequency:

Identify the frequency in which the behavior occurs (e.g., weekly, within the last 30/60/90 days, 1-2 years, or 3-5+years)

RESIDENCE TYPES:

AFH	Adult Family Home
ALF	Assisted Living Facility; this includes Assisted Living Facilities with specialized contracts.
ARC	Adult Residential Care facility licensed as an Assisted Living facility
CFH	Children’s Foster Home
CH	Companion Home (contracted with DDA)
CPRS	Community Protection Residential Services (Supported Living)
DOC	Department of Corrections
EARC	Enhanced ARC facility
ESF	Enhanced Services Facility
ESH	Eastern State Hospital
GH	Group Home (contracted with DDA) with an Assisted Living license
GTH	Group Training Home
ICF/ID	Intermediate Care Facility for Individuals with Intellectual Disabilities
JRA	Juvenile rehabilitation facility
SL	Supported Living Services
SH-RTF	State Hospital Residential Treatment Facility
WSH	Western State Hospital

SPECIFY OTHER CURRENT SERVICES (E.G. THERAPIES, COUNSELING, MPC, CFC, CFC+COPES, RSW, ETC:)

The case manager should include the Managed Care Organization information, Community Behavioral Health Support (CBHS) tier information as applicable.

SIGNATURES:

Case Manager’s signature: Signature of the staff completing the form.

Provider’s Signature: Signature of Provider willing to accept Individual for admission.