POLICY TITLE and number	**701 Behavioral Intervention and Change**
HEADER INFO - Adopted - Revised	**Adopted 10/1985** **Revised 10/1994, 8/2002, 2/2012, 8/2014, 12/2020, 2/2021**
RULE REFERENCE	**5123:2-2-06**
GLOBAL POLICY STATEMENT (what and why)	Choices In Community Living, Inc. requires all employees to respond to the need for ongoing behavior support within all client environments (i.e. work, home, community). It is the policy of CICL to review these Behavioral Intervention and Change policies with all staff and to make them available to individuals receiving services, legal guardians and county/state personnel. The agency uses positive teaching and support strategies and the least intrusive forms of interventions. The agency uses strategies that promote dignity, growth, development and self-reliance of the individual being served, emphasize choices in daily decision making and emphasizing self-management and self-determination. Behavior support strategies are integrated into the client's service plan and provide a systematic approach to helping the individual learn positive behaviors while reducing inappropriate behaviors. The agency engages in teaching and support strategies to change behavior with supervision that ensures the due process, safety, welfare and rights of its clients. All staff will be trained (and documented) on the details of a written Behavior Support Plan and ISP behavior strategies before they work alone with individuals.
GUIDELINES/PROCESS STATEMENTS (how)	Aversive Intervention A behavior support plan which employs an unpleasant and/or intrusive stimulus. This stimulus has the purpose and effect of decreasing the target behavior. Baseline A measure of strength or level (rate, duration, latency) of behavior before an intervention is introduced. Baseline measures are continued until enough information is gathered to develop an appropriate intervention and can be used as comparisons to assess the effects of different interventions on the same target behavior. Crisis A situation when a client ceases to use only verbal and gesture threats and challenges, is no longer responding to staff direction and support, observable behavior escalates for a prolonged period of time, or is so intense as to cause harm to self, others or property. Functional Analysis A systematic assessment of factors in the environment which may serve as reinforcing consequences for an existing behavior.

Informed Consent
An agreement to allow proposed action, treatment or service to happen after a full disclosure of the relevant facts. The facts necessary to make the decision include information about the risks and benefits of the action, treatment or service; acceptable alternatives to such action, treatment or service; the consequences of not receiving such action, treatment or service; and the right to refuse such action, treatment or service.

Positive Behavior Plan
A systematic plan contracted for the purpose of replacement behaviors solely by using positive reinforcement. The replacement behavior may or may not be a substitute behavior for target maladaptive behavior. Consistent positive behavior plans will be implemented prior to the use of aversive techniques. The Interdisciplinary Team uses periodic reviews and updates to track positive behavior plans. All aversive
plans must have a positive component.

Restrictive Measures
Means a method of last resort that may be used by persons or entities providing specialized services only when necessary to keep people safe and with prior approval by the human rights committee. "Restrictive measures" include:

- Manual restraint. "Manual restraint" means use of a hands-on method, but never in a prone restraint, to control an identified action by restricting the movement or function of an individual's head, neck, torso, one or more limbs, or entire body, using sufficient force to cause the possibility of injury and includes holding or disabling an individual's wheelchair or other mobility device. An individual in a manual restraint shall be under constant visual supervision by staff. Manual restraint shall cease immediately once risk of harm has passed. "Manual restraint" does not include a method that is routinely used during a medical procedure for patients without developmental disabilities.
- Mechanical restraint. "Mechanical restraint" means use of a device, but never in a prone restraint, to control an identified action by restricting an individual's movement or function. Mechanical restraint shall cease immediately once risk of harm has passed. "Mechanical restraint" does not include:
    - A seatbelt of a type found in an ordinary passenger vehicle or an age-appropriate child safety seat.
    - A medically necessary device (such as a wheelchair seatbelt or a gait belt) used for supporting or positioning an individual's body;
    - A device that is routinely used during a medical procedure for patients without developmental disabilities.
- Time-out. "Time-out" means confining an individual in a room or area and preventing the individual from leaving the room or area by applying physical force or by closing a door or constructing another barrier, including placement in such a room or area when a staff person remains in the room or area.
    - Time-out shall not exceed thirty minutes for any one incident nor one hour in any twenty-four hour period.
    - A time-out room or area shall not be key-locked, but the door may be held shut by a staff person or by a mechanism that requires constant physical pressure from a staff person to keep the mechanism engaged.

- A time-out room or area shall be adequately lighted and ventilated and provide a safe environment for the individual.
- An individual in a time-out room or area shall be protected from hazardous conditions including but not limited to, sharp corners and objects, uncovered light fixtures, or unprotected electrical outlets.
- An individual in a time-out room or area shall be under constant visual supervision by staff.
- Time-out shall cease immediately once risk of harm has passed or if the individual engages in self-abuse, becomes incontinent, or shows other signs of illness.
- "Time-out" does not include periods when an individual, for a limited and specified time, is separated from others in an unlocked room or area for the purpose of self-regulating and controlling his or her own behavior and is not physically restrained or prevented from leaving the room or area by physical barriers.

- "Chemical restraint" means a medication prescribed for the purpose of modifying, diminishing, controlling, or altering a specific behavior. "Chemical restraint" does not include medications prescribed for the treatment of a diagnosed disorder identified in the "Diagnostic and Statistical Manual of Mental Disorders" (fifth edition) or medications prescribed for treatment of a seizure disorder. "Chemical restraint" does not include a medication that is routinely prescribed in conjunction with a medical procedure for patients without developmental disabilities.
- Restriction of an individual's rights as enumerated in section 5123.62 of the Revised Code.

"Risk of harm" means there exists a direct and serious risk of physical harm to the individual or another person. For risk of harm, the individual must be capable of causing physical harm to self or others and the individual must be causing physical harm or very likely to begin causing physical harm.

Behavior Support

Behavior support is the use of reinforcement, deliberate environmental manipulation and/or aversive consequences to produce an observable measurable decrease in maladaptive behavior and increase in appropriate replacement behavior.

Behavior support plans (positive and aversive) are always written and are designed to teach appropriate new skills as well as to reduce and/or eliminate inappropriate behaviors.

CICL uses the county specific board of DDS Human Rights Committee to review and approve all Behavior Support plans.

Behavior support is characterized by:

- Interactions and speech that reflect respect, dignity and a positive regard for the client
- The setting of acceptable behavior limits for the client
- The use of people first language instead of referring to the client by trait, behavior or disability

- Staff speech that is even toned, made in positive and personal terms, and without threatening overtones or coercion
- Conversations with the client rather than about the client while in the client's presence
- The absence of demeaning, belittling or degrading speech or punishment
- Respect for the client's privacy by not discussing the client with someone who does not need the information

The agency uses the following types of behavior support:

A. Instructional Strategies

Strategies used routinely by all staff to affirm, reinforce, shape, motivate, reward and encourage the individual in maintaining positive skills and behaviors.

B. Positive Intervention Strategies

Required when normal, routine positive reinforcement paired with instructional strategies are unsuccessful and the behavior can be defined as an interfering behavior, or if the frequency and severity of the behavior warrants more formal programming.

C. Aversive Intervention Strategies

Strategies which employ an unpleasant or intrusive procedure to reduce or control maladaptive behavior. They are used in situations in which the behaviors exhibited are dangerous to the client or others, and only after less aversive teaching and support strategies have been ineffective.

All behavior support plans include, but are not limited to:

- Case history including medical information
- Results of a behavior assessment
- Baseline data
- Descriptions of the specific behavior
- The intervention strategy
- The desired outcome
- Persons responsible for implementation
- Training of persons responsible for implementation
- Review guidelines
- Signature
- Date
- Space for dissenting opinions

Ensure reasons for dissenting opinions are stated. The Interdisciplinary Team attempts to resolve any dissenting opinions.

The intervention plan remains in place until the Interdisciplinary Team determines it needs revision or can be discontinued.

Prior to Implementation

Obtain informed consent from the client or legal guardian if client is over 18 years of age and from the legal guardian if client is under 18 years of age prior to implementing positive behavior support plans. Obtain approval from the Program Director. Present behavior support plans in a manner that can be understood by the client and legal guardian. When informed consent cannot be documented in writing at the time it is obtained, document the

	consent in writing within three days of implementation. Update informed consent annually. The Interdisciplinary Team approves any revisions to a behavior support plan. Obtain a new informed consent. Prior to implementation of plans with aversive components, obtain informed consent. Complete a Medical/Medication review to ensure there are no medical contraindications to the plan. **Review** A Behavior Review Committee shall initially review and approve/reject all plans that incorporate aversive strategies, including restraint and time out. This committee shall also review ongoing plans that incorporate aversive strategies including restraint and time out. The agency will use the County Board of DD HRC committee. The Human Rights Committee reviews and approves or rejects all plans that incorporate aversive strategies, including restraint and time out, and those which involve potential risks to the client's rights and protections. This committee ensures the rights of the client are protected. It will also approve all crisis intervention personal safety techniques used by direct service providers. After required approvals, review behavior support plans initially within two weeks of implementation to determine if any modifications are needed. After that, review behavior support plans at all formal reviews of the Individual Service Plan, not exceeding 180 days for positive plans. Review aversive support plans every 30 days. Provide status reports from these reviews to the client or legal guardian, legal guardian if the client is under 18, provider and others from the Interdisciplinary Team. **Prohibited Actions** Prohibited actions are those interventions which are damaging to a client's health, safety, mental and emotional well-being, personal dignity or self-esteem. Report prohibited actions as major unusual incidents. "Prohibited measure" means a method that shall not be used by persons or entities providing specialized services. "Prohibited measures" include: (a) Prone restraint. "Prone restraint" means a method of intervention where an individual's face and/or frontal part of his or her body is placed in a downward position touching any surface for any amount of time. (b) Use of a manual restraint or mechanical restraint that has the potential to inhibit or restrict an individual's ability to breathe or that is medically contraindicated. (c) Use of a manual restraint or mechanical restraint that causes pain or harm to an individual. (d) Disabling an individual's communication device. (e) Denial of breakfast, lunch, dinner, snacks, or beverages. (f) Placing an individual in a room with no light. (g) Subjecting an individual to damaging or painful sound. (h) Application of electric shock to an individual's body. (i) Subjecting an individual to any humiliating or derogatory treatment

	(j) Squirting an individual with any substance as an inducement or consequence for behavior. (k) Using any restrictive measure for punishment, retaliation, instruction or teaching, convenience of providers, or as a substitute for specialized services. **Crisis Interventions** A crisis is an unexpected emergency which necessitates an immediate response to protect a client from injuring themselves or others. A sudden change in behavior such as pacing, crying, shouting, refusal or obsessing can signal that a crisis may occur. These sudden changes in behavior are a form of communication. The response to these changes in behavior can determine whether a situation will calm down or escalate. Respond in a manner that is least intrusive and move to more intrusive, as necessary. Do not use time out as a crisis intervention technique. Crisis intervention listed below from least intrusive to most intrusive: 1. Verbal intervention. Ask the client what is wrong. Ask if you can help. 2. Alter the environment. Change seating or remove objects or other clients. 3. Redirection/distraction. Refocus attention on something else without minimizing the problem. Ask a question about an unrelated topic. 4. Offer alternative choices. 5. Set clear limits -Say “When you speak softly, we can talk” or “You need to stay in this area”. 6. Utilize personal safety techniques Staff receive training in the implementation of approved crisis intervention techniques. The Executive Director is responsible to ensure training occurs. Document each crisis situation. If the crisis intervention involved any type of restraint, report it according to guidelines set forth in the individuals ISP/BSP. If the individual does not have reporting guidelines within their ISP/BSP, report according to the MUI/UI rule for Unapproved Behavior Restraints. Monitor these crisis situations to determine patterns. If crisis interventions are used on a frequent basis, it is no longer considered crisis behavior. Review the now predictable behavior through the behavior plan development process. If the behavior occurs more than once per week, three times a month, or nine times a year, review the behavior through the program planning process. The County Board of DD Human Rights Committee approves all crisis intervention personal safety techniques. The Executive Director is responsible to submit crisis intervention personal safety techniques for approval.
FORMS	

Titles of forms	
TRAINING Titles of training	